

When hospitals close, it puts more pressure on those that survive. At Inova Fairfax, occupancy averaged a jam-packed 92 percent over the past year. Thom Mayer, chief of our emergency department, put it this way: "The inpatient population is so high so regularly that a mere 20 or 30 extra patients throws us back into full crisis mode." And that can happen during one shift in a busy emergency room.

Beyond the number of beds, just how many are available at any given time often comes down to two letters: RN. A hospitalized patient needs a doctor for just a few minutes each day, but nursing care must be available around the clock. But, like hospital beds, fully qualified nurses have been disappearing fast, too. A widely cited study from Vanderbilt University, published last year in the *Journal of the American Medical Association*, pointed to some ominous trends. A key finding: The average age of nurses is rising. The number of nurses under the age of 30 fell from 419,000 in 1983 to 246,000 in 1998; by the end of this decade, the study said, 40 percent of working nurses will be older than 50. Retirement will create an estimated shortfall of half a million nurses in the year 2020. The clear reason: A decline in the number of high school girls who go to college intent on becoming nurses. "Women, who traditionally comprise the majority of nursing personnel, are finding other career options that are less physically demanding, more emotionally rewarding and come with a higher rate of pay," Brandon Melton, representing the American Hospital Association, told a Senate subcommittee earlier this year. And men aren't making up for the shortfall.

My wife, a savvy, experienced nurse, last did floor work more than 10 years ago, and though conditions were tough enough then, she recoils at what she would face if she went back now: More and sicker patients on an exponentially higher number of meds; less time getting to know the person who is the patient, and therefore less opportunity to catch early signs of deterioration; widespread use of "health techs"—people who take vital signs and dispense pills but have no training for more meaningful interaction. No wonder students at nursing schools dread the first few years following graduation, because before they can get to the challenging, rewarding places to work, such as ERs or ICUs, they have to get experience on inpatient wards.

It's crowding in those ICUs that puts the worst pressure on the ER. In the highly sophisticated environment of the ICU, a patient's heart rate or blood pressure can be fine-tuned with a shift of an IV drip. A phalanx of monitors register any number of physiological trends to answer the question, "Is this person getting better or worse?" When a patient requires this moment-by-moment scrutiny and all ICU beds are filled, the only place with roughly equal capacity—the only place we can perform the same level of care—is the ER. This ties up our nurses and blocks the bed from the next guy waiting to get in.

And chances are, that next guy is in pretty bad shape. Most people who come to the ER these days have higher "acuity" than a decade ago—that is, they're sicker. There's been no easy way to quantify this change, but, like tornado victims, ER docs know what we've been big with. We spend more time trying to get a borderline patient "tuned up" enough to go home rather than be admitted to a busy, barely staffed hospital floor. We arrange home delivery of nebulizer machines for asthma patients. We check out the patient discharged yesterday after surgery who is back today, feeling weak, wondering if he's really well enough to be home. I kind of miss the good old days when a 10-hour shift

meant a string of straightforward technical procedures—like reducing a dislocated shoulder or sewing a complex laceration. These days, it seems more time is spent tracking down a patient's three or four specialists—the oncologist, the psychiatrist, the infectious disease guy—or negotiating with the intake person to authorize a bed or transfer the patient to a hospital that accepts his insurance.

Whine, whine, whine. I started writing this as a letter of apology to all the miserable, aggravated patients who wonder why they have had to wait so many hours to see me, and here I am complaining about my own problems. I'll try to get back on track, because the worst is still ahead. And the worst by far is ambulance diversion.

It happened a lot over this past winter. In Boston—hardly a hospital-deprived town—the *Globe* reported that 27 area ERs went "on diversion" for a total of 631 hours in November, 677 hours in December and more than 1,000 hours in January. And it was worse in Northern Virginia: In January, the area's 13 ERs placed themselves on diversion for more than 4,000 hours. Evenly divided, and it most assuredly was not, that would be every ER refusing ambulances for 10 hours every day. Almost half the time, back in that icy January, if you needed an ambulance to get to an ER you were SOL: severely out of luck.

The American College of Emergency Physicians is certainly concerned about the problem: Last October, an advisory panel proposed guidelines for ambulance diversion, blaming "a shortage of health care providers, lack of hospital-based resources and ongoing hospital and ED [emergency department] closures." But it's easy to get the feeling that others at the national level aren't taking it seriously. At a public health conference in November, at the beginning of the critical winter season, U.S. Surgeon General David Satcher was quoted as recommending that people be "educated" not to go the emergency room unless they really need to. Dennis O'Leary, head of the Joint Commission on Accreditation of Healthcare Organizations, a critical monitoring group, was quoted as saying: "Quite frankly, this problem waxes and wanes . . . but without anything tangibly happening it resolves itself . . . The system will somehow muddle through."

They're right: I muddle through each shift worrying about patients trapped in the waiting room or ambulances that can't discharge their passengers at our door. I mutter humble apologies to private docs outraged that the patients they sent in specifically for urgent treatment—pain control, antibiotics, whatever—cool their heels for hours on end. I go home exhausted and aggravated with myself after 10 hours of juggling alternatives so as not to put a patient into a scarce bed—telling people to try a "stronger" antibiotic, ratchet up the home respiratory treatments, take a few extra tabs of pain reliever each day, and always be sure to follow up with your own doctor tomorrow. I wonder which patients are going to be back in another ER the next day because I missed their real problems or insisted on an ineffective patch.

Doctors and nurses have a bottom line that ultimately distinguishes us from other professions: quality patient care. When we can't provide this, we have failed. Our hospital administrators and department chiefs assume that excellent patient care is a non-negotiable minimum standard. But every winter, and increasingly at other times, the crash of the system is the quite capitulation to these accumulated pressures. When forced to maneuver so many sick patients through an overwhelmed system, I just don't know if I'm doing a good job any more. As a result, I

often find myself phoning the patient the next day, checking in: "Everything okay today?"

Many of the region's hospitals have received, or are negotiating for, approval for more beds. Where more nurses will come from is another problem. Anthony Disser, the chief executive nurse at Fairfax, says the intrinsic value of nursing is already luring a certain number of burned-out software writers or disappointed entrepreneurs for a second career. Yeah, I guess we are muddling through, after all.

I look forward to that "Unraveling Safety Net" meeting in Atlanta in three weeks, where I expect to be transfixed, like the audiences at "Hannibal," by the horror stories and dire statistics of other ER docs and public health researchers. Maybe they've been coming up with some solutions. If they have, I hope they haven't been waiting till May to share them with the rest of us.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Tuesday, June 26, 2001, the Federal debt stood at \$5,656,750,181,308.17, five trillion, six hundred fifty-six billion, seven hundred fifty million, one hundred eighty-one thousand, three hundred eight dollars and seventeen cents.

One year ago, June 26, 2000, the Federal debt stood at \$5,647,619,000,000, five trillion, six hundred forty-seven billion, six hundred nineteen million.

Five years ago, June 26, 1996, the Federal debt stood at \$5,118,149,000,000, five trillion, one hundred eighteen billion, one hundred forty-nine million.

Ten years ago, June 26, 1991, the Federal debt stood at \$3,500,901,000,000, three trillion, five hundred billion, nine hundred one million.

Fifteen years ago, June 26, 1986, the Federal debt stood at \$2,040,983,000,000, two trillion, forty billion, nine hundred eighty-three million, which reflects a debt increase of more than \$3.5 trillion, \$3,615,767,181,308.17, three trillion, six hundred fifteen billion, seven hundred sixty-seven million, one hundred eighty-one thousand, three hundred eight dollars and seventeen cents during the past 15 years.

ADDITIONAL STATEMENTS

TIMOTHY J. RHEIN

● Mr. BREAUX. Mr. President, I rise today to pay tribute to Timothy J. Rhein, who recently retired after 34 years with American President Lines, Ltd. APL is today one of the world's largest shipping and intermodal lines, and a globally recognized brand, thanks in large part to Tim Rhein's leadership.

I came to know Tim through his appearances before the Subcommittee on Merchant Marine, and I can personally attest to his commitment to merchant shipping and his leadership in the U.S. shipping industry. His rise to president and chief executive officer of APL from 1995 to 1999, and then to chairman, was marked by key decisions in a difficult business.