retirement as mayor of the village of Great Neck, NY, on Friday, March 24th.

Mayor Rosegarten's work in Great Neck has been recognized on both the national and State level. His work to revitalize the downtown Great Neck shopping area is a model for local municipalities nationwide. Under the mayor's dynamic supervision, the village of Great Neck has not only experienced financial success, but is also highly regarded for its aesthetic beauty. Mayor Rosegarten's service to the community will undoubtedly be used as a measuring stick for future Great Neck public officials.

Prior to his distinguished service as mayor of Great Neck for the past 8 years, Mr. Rosegarten held the position of deputy mayor of Great Neck for 8 years and was also a village trustee for 2 years. Mayor Rosegarten has further distinguished himself in the Great Neck community as president of the Great Neck Village Officials Association, commissioner of the Great Neck Central Police Auxiliary and member of the executive board of Great Neck's United Community Fund.

In addition to his work in the village of Great Neck, Mayor Rosegarten has been a successful executive in the advertising industry for over a quarter of a century.

Robert Rosegarten is an avid sculptor and painter, whose art works have gained wide attention by appearing in many local galleries on Long Island. Mayor Rosegarten is a dedicated husband, a loving father of three sons and a proud grandfather to six grandchildren.

Mr. Speaker, I ask my colleagues in the House of Representatives to join me today in honoring Robert Rosegarten as he completes another milestone in his career and in wishing him many more years of active service to his family and his community.

THE 44TH ANNIVERSARY OF TUNISIA'S INDEPENDENCE

HON. FLOYD SPENCE

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, March 21, 2000

Mr. SPENCE. Mr. Speaker, I rise today to congratulate the citizens of the Republic of Tunisia on the occasion of their 44th anniversary of independence. Despite its diminutive size, Tunisia has exerted a sizeable presence in North Africa, the Middle East, Europe, and North America for many centuries.

Indeed, the United States and Tunisia have enjoyed a remarkable relationship for over 200 years. In fact, we continue to honor a 1797 treaty with the Republic of Tunisia that calls for perpetual and constant peace.

Our relationship with Tunisia has survived civil, regional, and global conflict—growing stronger with every challenge. During World War II, Tunisia supported United States and allied forces as they landed in North Africa. In the ensuing cold war, Tunisia established itself as a steadfast ally in the strategically critical Mediterranean Sea. In the post-cold war years, the Republic of Tunisia has remained our friend and taken steps to develop closer military and economic ties with European allies and NATO.

Today, the Republic of Tunisia continues to make progress toward democracy. Tunisian citizens enjoy universal suffrage, and the nation is considered by many to be a leader among Muslim nations in safeguarding the rights of women and children. Indeed, Tunisia has come so far, so fast, that it is sometimes easy to forget that Tunisia was a French protectorate as recently as 1954, and only gained full independence on March 20, 1956.

The United States was the first great power to recognize Tunisia's independence in 1956, and in keeping with this tradition I would like to be the first to congratulate the Republic of Tunisia on its 44th anniversary of independence this March 20th. I urge my colleagues to join me in honoring Tunisia on this momentous occasion.

WENDELL H. FORD AVIATION INVESTMENT AND REFORM ACT FOR THE 21ST CENTURY

SPEECH OF

HON. ELIJAH E. CUMMINGS

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, March 15, 2000

Mr. CUMMINGS. Mr. Speaker, I rise in strong support of the rule and the underlying bill.

Chairman SHUSTER, Ranking Member OBERSTAR and Representatives DUNCAN and LIPINSKI have worked hard to ensure that funds collected in the aviation trust fund are protected and used to support our Nation's aviation system only.

This bill sends a strong message to the American people that we care about improving their lives.

Provisions in this bill:

- authorize desperately needed funds to improve airport infrastructure, to reduce congestion, delays and improve safety;
- enforce passenger's rights;
- establish whistle blower protections for airline employees; and
- improve airline competition.

Again, this bill sends a strong message to airline passengers, airline companies, and our States and that we as a Congress are committed to ensuring safe and efficient air travel.

LIFE AND DEATH: IT'S YOUR CHOICE IN SURGERY OR ''HIGH VOLUME EQUALS BETTER RESULTS''

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, March 21, 2000

Mr. STARK. Mr. Speaker, the March 1 issue of the Journal of the American Medical Association contains further documentation of life-saving importance: if you are going to have surgery, have it in a hospital that does a lot of it: your chances of survival and good health are much better.

Put another way: avoid hospitals that can't do the procedure in their sleep.

As public policy makers, we should encourage, in every way possible, our constituents and Medicare beneficiaries to seek out the high volume hospitals and avoid the low volume hospitals. The President's Medicare reform proposals move us in that direction.

It really is a matter of life and death.

The JAMA article follows:

HIGH-RISK SURGERY—FOLLOW THE CROWD

(John D. Birkmeyer, MD)

Each year a large number of patients die following elective surgery. In the Medicare population alone, 17,000 patients died in 1995 after undergoing 10 types of elective procedures, such as coronary artery by-pass surgery, carotid endarterectomy, and lung resection.[1] Quality improvement initiatives at the local and regional levels may be important for reducing mortality at individual hospitals,[2, 3] but, for many procedures, choosing at which hospitals surgery is performed may be equally important for improving surgical quality.

The idea of concentrating high-risk surgical procedures in high-volume hospitals is not new. Since seminal work by Luft et al[4] 2 decades ago, large, population-based studies have consistently demonstrated better outcomes at high-volume centers for cardiovascular surgery, major cancer resections, solid organ transplantation, and other high-risk procedures.[5, 8] Lower surgical mortality at high-volume hospitals does not simply reflect the presence of more skillful surgeons and fewer technical errors with the procedure itself. More likely, it reflects more proficiency with all aspects of care underlying successful surgery, including patient selection, anesthesia, and postoperative care.

In this issue of the Journal, Dudley and colleagues[9] are among the first to estimate how many lives could be saved by regionalization (''selective referral'') at the population level. Based on careful review of the extensive volume-outcome literature, they used explicit criteria to identify the single highest-quality study for each surgical procedure or clinical condition that could be considered for regionalization. (The volume-outcome literature is too heterogeneous for formal meta-analysis.) Statistically significant relationships between hospital volume and mortality were identified for 10 procedures and 1 medical condition (care for patients which human immunodeficiency virus infection/acquired immunodeficiency syndrome). For example, compared with those at high-volume hospitals, patients undergoing abdominal aortic aneurysm repair at low-volume hospitals (30 or fewer procedures per year) were 64% more likely to die following surgery; children undergoing heart surgery at low-volume hospitals (fewer than 100 procedures per year) were 42% more likely to die. The authors used 1997 California hospital discharge data to estimate the potential benefit of moving patients from low-volume hospitals to higher-volume centers. For 10 surgical procedures alone, it is estimated that regionalization would prevent as many as 500 deaths each year in California. If extrapolated to the nation as a whole, this estimate translates to more than 4000 deaths averted each year.

Two cautions are necessary in interpreting the findings of this study. First, the authors' estimates of the benefits likely to be achieved by regionalization are no more reliable than the volume-outcome studies on which they are based. Much of this literature is outdated or skewed by results from a small number of national referral centers. Additional generalizable, population-based studies are needed. Second, analysis of California data may overestimate the decrease in mortality rates likely to be achieved by regionalization elsewhere. Because California has few restrictions on where surgical care may be delivered, more patients may be

References at end of article.

undergoing high-risk surgery in low-volume hospitals there. In 1 study, 65% of coronary artery bypass graft operations performed in California in 1989 occurred at low-volume hospitals (<200 procedures/year).[10] In New York State, which has stricter Certificate of Need regulations based in part on volume criteria, only 20% of these procedures were performed at low-volume hospitals that year.[10] More information is needed about how other high-risk procedures are being delivered in other parts of the country.

Concentrating surgery in selected referral centers would facilitate the monitoring of outcomes at individual hospitals. Many high-risk procedures are performed too infrequently to achieve statistical precision with mortality rates, particularly at low-volume hospitals. For example, what inferences could be made about outcomes at a hospital performing 3 esophagectomies a year? By concentrating selected procedures in a relatively small number of high-volume hospitals, it would be more feasible to measure outcomes aside from mortality, such as nonfatal complications, patient functional status, and costs. The ability to monitor surgical outcomes systematically would make hospitals more accountable and create ideal platforms for quality improvement initiatives.

How can the proportion of elective but high-risk procedures being performed in high-volume hospitals be increased? The least intrusive approach may be to focus on educating patients about the importance of hospital volume for specific procedures and to recommend that patients acquire this information from the hospital that they are considering for surgery. Although many hospitals do not have data on their own procedure-related morbidity and mortality rates, all hospitals should be able to provide information on the number of procedures (of a given type) they perform each year.

More active strategies also could be implemented. Leaders of large, integrated health plans could designate referral centers for selected procedures and enforce their appropriate use. Professional societies also could take a role in regionalization. For example, the American College of Surgeons Committee on Trauma has established regional trauma networks, encouraging referral of the most severely injured trauma patients to designated trauma centers that meet established process and volume criteria.[11] Through reimbursement mechanisms, large payers (both government and private) have substantial leverage to limit surgery to high-volume hospitals. For example, the Health Care Financing Administration is currently exploring the development of exclusive contracts with ''centers of excellence'' for cardiac surgery and total joint replacement for Medicare patients.[12] In addition, through the Certificate of Need process, states can reduce the proportion of surgery being performed in low-volume hospitals by limiting the proliferation of new surgical centers.[13]

Many would argue that regionalizing high-risk surgery would have adverse effects, particularly in rural areas. For patients living far from referral centers, elective surgery could create unreasonable logistical problems for patients and their families. With excessive travel burdens, some patients may even decline surgery altogether.[14] Regionalizing surgery also could interfere with continuity of care because many aspects of postoperative care, including dealing with the late complications or other sequelae of surgery, would be left to local physicians who were not involved with the surgery. Regionalization could reduce access to health care for rural patients by threatening the financial viability of local hospitals or their ability to recruit and retain surgeons. Even if regionalization had no effect on the availability of local clinicians, it could reduce their proficiency in delivering emergency care that must be handled locally. For example, the local general surgeon no longer allowed to perform elective repair of abdominal aortic aneurysms could be less prepared for emergency surgery involving a ruptured aneurysm.

However, these problems may not be as important as they were once assumed to be. Most low-volume hospitals are not located in sparsely populated rural areas; they are more commonly located in hospital-dense metropolitan areas, often in close proximity to high-volume referral centers.[10] In the analysis by Dudley et al,[9] 75% of California patients undergoing surgery at low-volume centers in 1997 would have needed to travel fewer than 25 additional miles to the nearest high-volume hospital. In fact, 25% of patients traveled farther to undergo surgery at a low-volume hospital. These data suggest that a substantial degree of regionalization could occur without separating patients and surgeons or surgical centers by prohibitive distances.

With any regulatory attempt to regionalize high-risk surgery, policy makers need to be ready for a political firestorm. Many low-volume hospitals, already under significant financial pressures, would balk at relinquishing surgical revenue and would worry that regionalizing selected high-risk procedures would later lead to restrictions on other procedures. These hospitals also would worry about being branded as second class by patients. Many surgeons required to give up part of their practices—even a small part—would view regionalization as an affront to their professional judgment and competence.

Although some physicians and some institutions would resist regionalization, the potential benefits for patients are too large to ignore. Given the current ad hoc approach to delivering high-risk surgery, it seems that almost any effort aimed at concentrating these procedures in high-volume hospitals would be an improvement.

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IN HONOR OF MY FRIEND, THE LATE DICK SELBY

HON. SAM FARR

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, March 21, 2000

Mr. FARR of California. Mr. Speaker, today I honor a man who dedicated his life to democratic causes and was an avid participant in local Democratic Party politics. Richard Selby passed away unexpectedly on January 6, 2000 at the age of 73.

A native of Oakland, Dick was involved in national as well as international affairs. He was a former representative of the International Monetary fund and also served as a U.S. Foreign Service Officer. On the national front, Dick was a retired lieutenant colonel in the Air Force Reserve and was active in both the National Association of Retired Federal Employees (NARFE) and the Retired Officers Association. In his capacity as legislative liaison for the local NARFE Chapter, Dick kept the membership well-informed about current federal legislative issues. Locally, Dick was the chairman of the Santa Cruz Veterans Memorial Building's board of directors.

Dick was a tireless volunteer in community affairs and Democratic campaigns. He was an avid letter writer and was known for his candor and wit.

Richard Selby will be greatly missed by those who knew him personally and professionally. Dick is survived by his wife Mary Selby of Aptos; five daughters, Leigh and Anne Selby, both of Aptos; Lynn Selby of San Francisco; Cindy Shaner of Wooster, Ohio; Robyn Barker of Sugarland, Texas and his brother Alan Selby of Santa Rosa.

FEC REFORM

HON. STENY H. HOYER

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Tuesday, March 21, 2000

Mr. HOYER. Mr. Speaker, today, with my fellow House Administration Committee Democrats, CHAKA FATTAH, and JIM DAVIS, I am introducing a new bill to accomplish FEC reform.

Let me be clear—this bill is not and does not pretend to be campaign finance reform. Instead it is about making the Federal Election Commission more efficient, effective and responsive, and providing the agency with full funding so it can properly carry out its congressional mandate. It is about FEC reform.

The bill consists of provisions sought by the bipartisan FEC Commissioners, including six legislative changes the Republican and Democratic Commissioners agreed were of the highest priority in a letter they sent to the President and the Congress earlier this month. This