

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 na-

tion 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 al⁴ 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 colleagues⁹ 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