AMERICAN THORACIC SOCIETY

ATS NEWS

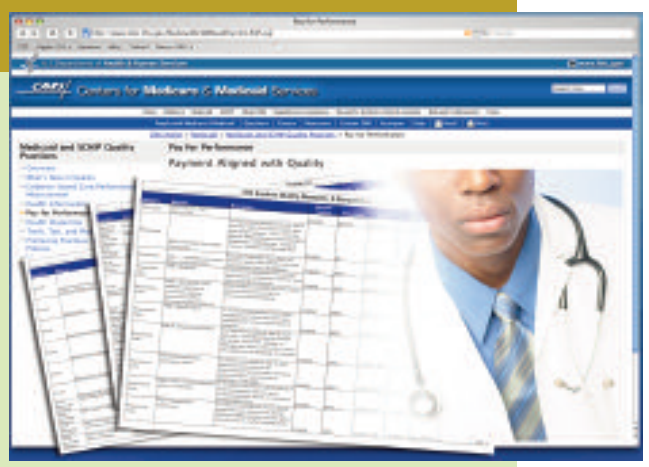
ONLINE EACH MONTH http://www.thoracic.org/go/news

IN THIS ISSUE

ON THE *web*

Visit the ATS Web site at **www.thoracic.org/go/mechanical-ventilation** to access the Assembly on Critical Care's new web-based lecture series on mechanical ventilation. In the first edition, "Pathophysiology of Respiratory Failure and Use of Mechanical Ventilation," ATS members Puneet Katyal and Ognjen Gajic review the classification, epidemiology and pathogenesis of respiratory failure. They also provide guidelines for diagnosis and management of respiratory failure with invasive or non-invasive mechanical ventilation.

AN IMPERFECT REALITY: CMS OFFERS FIRST BONUS FOR P4P



Performance metrics and financial incentives for higher quality care are moving beyond hospitals and other healthcare institutions and into physicians' practices.

In December, Congress passed legislation requiring the Centers for Medicare and Medicaid Services (CMS) to enroll volunteer physicians who could earn up to a 1.5 percent bonus on all their Medicare reimbursements in the second half of 2007 by meeting certain performance standards.

The legislation was bolstered by an Institute of Medicine report, "Rewarding Provider Performance: Aligning Incentives in Medicare," commissioned by Congress, calling for pay for performance, or P4P, for individual providers to improve the nation's healthcare.

In response to the legislation, the CMS has identified 74 performance measures (www.cms.hhs.gov/pqri) that doctors may report beginning July 1 to become eligible for the bonus. This effort extends the CMS P4P effort, which tracked 16 measures in 2006. CMS is calling this year's expanded program the Physicians Quality Reporting Initiative (PQRI).

Most of the measures were developed by the American Medical Association Physician Consortium for Performance (PCPI) and other medical societies and quality organizations, endorsed by the National Quality Forum (NQF) and then adopted by the Ambulatory Quality Alliance (AQA).

Ten of the 74 measures relate directly to adult or pediatric pulmonologists, working in outpatient and inpatients settings. Among those measures are standards for the diagnosis and treatment of asthma and COPD, and the assessment and care of patients with community acquired pneumonia (*see table on page 6*).

PQRI, Voluntary for Now

Based on interviews with ATS members knowledgeable about P4P issues, it appears that few within the Society are volunteering to participate in this year's program, though it is widely recognized that P4P, in one form or another, is growing and likely to affect everyone's practice.

"Measuring the quality of the care we provide is something we should all be doing," said Louis Libby, M.D., Immediate Past-Chair of the ATS Council of Chapter Representatives. "Payers, the public, and others are sick and tired of paying enormous amounts of money without proof that we are even trying to do the 'right' thing."

But as Co-President and Chief Medical Officer of the Oregon Clinic, Dr. Libby notes an absence of outcome measures among the 74 standards, and also the lack of a significant financial incentive to participate in the voluntary program. His back-of-the-envelope calculations indicate that the cost of additional reporting would quickly consume any bonus money the Oregon Clinic might earn—this despite the fact that the clinic has developed a robust electronic medical record that would facilitate the collection of data to be reported to CMS.

Electronic Health Records

For physicians who rely on paper patient records—the vast majority of practices across the country—it is nearly impossible to participate in PQRI, according to ATS member William Bria, M.D., Chief Medical Information Officer for the nation's 22 Shriners Hospitals. Automation,

(continued on page 6)

The ATS is solely responsible for all content. Questions and comments may be addressed to Suzy Martin at **smartin@thoracic.org**.

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MESSAGE FROM THE PRESIDENT

John E. Heffner, M.D.

Many of us have watched with mixed interest and concern the rapid development of pay-for-performance programs used by private health plans, designed to improve the quality and efficiency of healthcare by linking reimbursement to outcomes of care (*see article on page 1*). Now legislated by Congress for Medicare, this strategy represents the most recent effort to stem escalating healthcare costs and promote more evidence-based care.

Many questions exist regarding pay-for-performance. Will payment incentives cover the costs of data collection and reporting? How can physicians and hospitals without electronic medical records compete with large organizations that have already invested in sophisticated data systems? Will payers reward measures that are important for quality outcomes, or just those that are most readily measurable? Will this effort divert resources toward administrative costs and away from direct patient care resources? How can pay for performance promote better integration and coordination of care to manage patients with multiple chronic co-morbidities? Will physicians have to report multiple disease-specific outcomes for a single patient who has several chronic conditions? Or will integrated healthcare systems receive financial incentives for coordinating services to patients with multiple co-morbidities and pass the rewards to their physician medical staff?

And, most importantly, will pay for performance become the ultimate solution to controlling costs and improving quality, or will it serve only as an interim program on the path to more comprehensive payment reform?

Regardless of eventual answers to these questions, pay for performance has now become a reality and will soon affect healthcare reimbursement for all providers. So the most relevant question now facing the ATS is: "How can we engage in the dialogue around pay for performance and influence these programs in a manner that improves patient care, while avoiding excessive administrative costs and unnecessary burdens to physicians and other providers?"

> *"How can we engage in the dialogue around pay for performance and influence these programs in a manner that improves patient care, while avoiding excessive administrative costs and unnecessary burdens to physicians and other providers?"*

With this question in mind, the ATS began its efforts to address pay for performance during the strategic planning process three years ago. Anticipating this trend, the ATS Vision highlights the Society's commitment to "setting the standards for quality and excellence" and assisting "the development of quality metrics for clinical practice as new relationships with payers adjust reimbursements on the basis of measured quality of care."

This prescient Vision moved the ATS into a new realm of inquiry that required some organizational adjustments. First, we needed to further expand the focus of our membership to include payment policy and quality improvement sciences. Last spring, as incoming ATS President, I rewrote our committees' charges to direct some of their attention to payment reform. The Clinical Practice, Clinicians Advisory, and Health Policy Committees received recommendations to examine emerging payment systems and develop strategies for the ATS to engage in the debate. The Clinical Practice Committee also adopted a focus on patient safety, which intersects with quality of care as a future driver of reimbursement. The committee now collaborates with the American College of Chest Physicians' Quality Improvement Committee to leverage our shared resources to address these needs.

The Education Committee assumed responsibility for examining opportunities for the ATS to develop Practice Improvement Modules (PIMs), which offer physicians a potential approach for profiling to payers their quality of care through board certification. And all of these efforts are now coordinated through the ATS Committee on Communications and Marketing that reports to the Board integrated efforts of our various committees around pay for performance, quality improvement and patient safety. The ATS has also joined the National Quality Forum, which vets new healthcare quality measures for use in pay for performance.

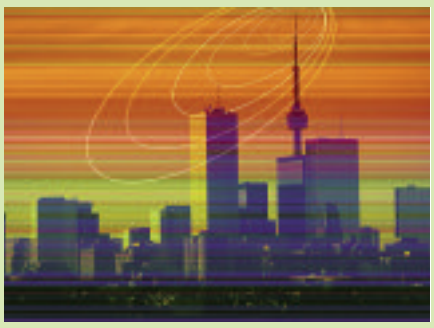
The Society's Documents Development and Implementation Committee has made major strides in accelerating the translation of new discoveries into improved patient care through implementation of our clinical guidelines. The ATS Section on Pulmonary Rehabilitation is examining approaches to embracing chronic disease management as a core focus. And finally, our ATS Chapters and Council of Chapter Representatives have provided strong leadership in evaluating trends that impact clinical practice.

The results of these efforts are already apparent. The PIM subcommittee of the Education Committee has developed a comprehensive proposal for developing ATS PIMs. And, most importantly, we developed an inter-committee collaborative process that "hardwired" payment reform and pay for performance into many of our strategic and tactical plans, which were approved by the Board last December. These strategies call for the ATS to partner with other organizations around the pursuit of improved quality in healthcare and more advanced measures to ensure quality healthcare delivery.

Whether pay for performance is the future of reimbursement or just a signpost along the road to payment reform, it will be with us for a number of years to come. I believe the ATS is now better positioned to influence its future direction.

NEWS BRIEFS

CALL FOR PROPOSALS: ATS 2008 · TORONTO



The ATS is now accepting proposals for the scientific and medical program for the 2008 ATS International Conference, which will be held May 16 to 21 in Toronto. Proposals for sessions covering all areas of pulmonary, critical care and sleep medicine are encouraged.

Submission formats include scientific symposia, track sessions, seminars, workshops, evening postgraduate seminars and postgraduate courses. All proposals must be submitted electronically through the ATS Web site by June 14, 2007. To submit a proposal, visit **http://conference.thoracic.org**.

ATS MEMBER NEWS

Philip O. Ozuah, M.D., Ph.D., has been named Chairman of the Department of Pediatrics at the Albert Einstein College of Medicine of Yeshiva University and Montefiore Medical Center. He has also been appointed Physician-in-Chief of the Children's Hospital at Montefiore. A member of the Einstein faculty since 1992, Dr. Ozuah has served as Interim Chair of Pediatrics since 2005. As Professor of Pediatrics and of Family and Social Medicine at the medical school, his research focuses primarily on the effects of environmental exposures on children.

In March, **David S. Wilkes, M.D.**, was one of five physicians appointed to the National Advisory Allergy and Infectious Diseases Council, the principal advisory body for the National Institute of Allergy and Infectious Diseases (NIAID). He will serve a four-year term on the council, providing recommendations on the conduct and support of research, including training young scientists and disseminating health information derived from NIAID research.

Dr. Wilkes currently serves on the Board of Directors and chairs the Society's Assembly on Allergy, Immunology and Inflammation.

ATS MEMBERS LEAD LARGEST TRIAL ON HOME OXYGEN THERAPY FOR COPD

Last November, the National Heart, Lung and Blood Institute (NHLBI) and the Centers for Medicare and Medicaid Services (CMS) launched the largest randomized clinical trial of the effectiveness and safety of long-term, home oxygen therapy for COPD. The study's 14 regional clinical centers, all of which are directed by ATS members, are expected to begin patient recruitment later this year.

As part of the six-year, $28 million Long-term Oxygen Treatment Trial, ATS members at clinical centers across the country will study approximately 3,500 patients with moderate COPD to determine whether supplemental oxygen helps them lead longer, more active lives. The results will help Medicare decide whether to extend coverage for home oxygen treatment to patients with moderate disease.

"The prospect that home oxygen therapy could lessen the disability of COPD and perhaps even prolong life when given earlier during the course of disease is enticing, but we need more information to determine the risks and benefits," said NHLBI Director Elizabeth G. Nabel, M.D. "This study will provide important information to help patients and their health providers decide whether home oxygen treatment is a good choice for them."

The decision to undertake the study evolved from a scientific working group convened in May 2004 by the NHLBI in cooperation with the CMS and the Department of Health and Human Services Agency for Healthcare Research and Quality. The group called for more research on the safety and efficacy of long-term oxygen therapy in COPD patients.

Several of the 14 regional centers—including Ohio State University, Denver Health and Hospital Authority, and Temple University—are collaborating with other cooperating institutions. Among the 17 investigators at these associated sites listed below, 16 are ATS members.

The ATS members who will lead the study at regional centers and their counterparts at associated sites are:

- John Reilly, M.D., Brigham & Women's Hospital
- James Stoller, M.D., M.S., Cleveland Clinic Foundation
- Rick Albert, M.D., Denver Health Medical Center
  - Mary Gilmartin, R.N., Denver VA Medical Center/National Jewish Medical and Research Center*
  - Chris Vacaro, R.N., University Hospital (Denver)*
- Neil MacIntyre, M.D., Duke University
- Thomas Stibolt, M.D., Kaiser Permanente Northwest
- Richard Casaburi, M.D., Los Angeles Biomedical Research Institute
- Philip Diaz, M.D., Ohio State University
  - Ralph Panos, M.D., University of Cincinnati*
  - Dennis Doherty, M.D., University of Kentucky*
- Gerard Criner, M.D., Temple University
  - Peter Marshall, MD, Lehigh Valley Medical Center (non-member)*
  - Steven Scharf, M.D., University of Maryland*
  - Howard Lee, M.D., St. Mary's Medical Center, Lower Bucks Hospital*
  - Benjamin Solomon, M.D., St. Mary's Medical Center, Lower Bucks Hospital*
  - Melvin Pratter, M.D., Cooper Medical Center*
  - Steven Akers, M.D., Cooper Medical Center*
  - Gerald O'Brien, M.D., Christiana Hospital*
  - Michael Sherman, M.D., Hahnemann University*
  - Samuel Kuna, M.D., Philadelphia VA Medical Center*
  - Frank Leone, M.D., Thomas Jefferson University Hospital*
  - John Hansen-Flaschen, M.D., University of Pennsylvania*
  - Bennett Ojserkis, M.D., Atlantic Shore Pulmonary Associates, Shore Memorial Hospital*
  - Lee Greenspon, M.D., Lankenau Medical Center*
- J. Allen Cooper, Jr., M.D., University of Alabama at Birmingham
- Fernando J. Martinez, M.D., M.S., University of Michigan
- Frank Sciurba, M.D., University of Pittsburgh
- Richard Kanner, M.D., University of Utah
- David Au, M.D., M.S., University of Washington
- Roger Yusen, M.D., M.P.H., Washington University

For more information treatment trial as it progresses, visit the NHLBI Web site at **www.nhlbi.nih.gov** or **www.lottsite.org**.

** Associate site*

AJRCCM FOCUSES ON STRESS AND BURNOUT IN ICU PHYSICIANS AND NURSES

This month, the *American Journal of Respiratory and Critical Care Medicine* (*AJRCCM*) features three articles and one editorial on the prevalence of burnout and psychological symptoms among critical care nurses and physicians in the intensive care unit (Vol. 175, No. 7).

Two of the studies explore the incidence of burnout syndrome (BOS)—a psychological condition characterized by an inability to cope with emotional stress at work—in critical care physicians and nurses at a large number of ICUs in France. The third article focuses exclusively on the increased prevalence of post-traumatic stress disorder symptoms among critical care nurses within the United States.

"ICUs are stressful environments, where care is provided to patients with high levels of morbidity and mortality," said Edward Abraham, M.D., editor of the *AJRCCM*. "While these articles provide worrisome data about the rates of stress syndromes among critical care providers and raise important concerns about the effects of such problems on critical care delivery, the authors also provide insight into modifiable factors that may help remedy the problem."

The French studies present some alarming statistics. About half of the 954 physicians and a third of the 2,392 nurses surveyed reported high levels of BOS. Depression was also frequent, affecting about a quarter of physicians and 12 percent of critical care nurses. The authors also found increased rates of burnout to be associated with worse interdisciplinary relationships in the ICU, quality of the work environment, high levels of involvement in end of life care, and increased work hours.

Similar results were found among ICUs throughout Georgia, where 29 percent of 351 surveyed nurses reported symptoms of post-traumatic stress disorder (PTSD) and depression, and about 20 percent had significant symptoms of anxiety. After exposure to a traumatic event, individuals with PTSD "experience persistent recollections and avoid reminders of the events and have symptoms of increased arousal."

"These studies provide compelling evidence of significant problems that occur during the delivery of critical care to patients and their families," said ATS Secretary-Treasurer J. Randall Curtis, M.D., M.P.H., who co-authored the editorial on the research with ATS member Kathleen Puntillo, R.N., D.N.Sc.

Although Drs. Curtis and Puntillo discuss the limitations of each study—including the potential for bias, regional specificity, and limited evidence for a causal link between risk factors and the psychological symptoms—they conclude that the three studies provide convincing evidence of an important problem and agree that the research "provides useful hints at the directions we should take."

Promising approaches to address clinicians' psychological symptoms include improving nurse-physician communication, enhancing interdisciplinary collaboration, establishing and sustaining a healthy work environment, and improving palliative care for ICU patients and their families.

"Although these studies do not provide clear evidence regarding the prevalence of clinically significant psychiatric disease among critical care clinicians, we believe that this research, in combination with prior studies, provides compelling evidence that we have a significant problem in critical care that requires both further study and immediate action," Dr. Curtis said. "We also believe such actions will improve the care received by critically ill patients and their families and do much to address the workforce shortages for critical care nurses and physicians."

To read the three studies and editorial in full, please visit **http://ajrccm.atsjournals.org/content/vol175/issue7/index.shtml**.

LOOK FOR THESE ARTICLES IN THE *AJRCCM* THIS MONTH:

"High Level of Burnout in Intensivists: Prevalence and Associated Factors"

"Burnout Syndrome in Critical Care Nursing Staff"

"Increased Prevalence of Post-Traumatic Stress Disorder Symptoms in Critical Care Nurses"

"Is There an Epidemic of Burnout and Post-Traumatic Stress in Critical Care Clinicians?"*

** Editorial*

WHO'S WHO at ATS

LEE K. BROWN: AN OBLIGATION TO SERVE

A physician with an admitted "entrepreneurial streak," Lee K. Brown, M.D., has spent his career building sleep medicine programs, practicing and teaching sleep medicine and actively participating in professional societies.

"When I finished my medical training, sleep medicine essentially did not exist as a specialty, which meant there was a lot of opportunity for growth," said Dr. Brown, who completed his undergraduate work in electrical engineering at MIT before earning his medical degree from Mount Sinai School of Medicine in 1976. Since then, he has concentrated on expanding sleep disorders clinical services and education.

In addition to serving as Executive Director of the University of New Mexico Health Science Center's Program in Sleep Medicine, Dr. Brown directs the university's internal medicine subspecialty and on-site primary care clinics, develops new clinical service lines for the department, and teaches pulmonary and sleep medicine.

"Specializing in pulmonary medicine was the best thing I ever did," said Dr. Brown, who is also a tenured Professor of Medicine and Pediatrics and Vice-Chair, Clinical Program Development in the Department of Medicine. "I owe a huge debt of gratitude to the physicians who helped guide me throughout my career."

He remains in close contact with Albert Miller, M.D., who introduced him to pulmonary medicine during his first year of medical school at Mount Siani. "He makes sure I don't stray from the academic fold," Dr. Brown explained.

Interestingly, among the mentors Dr. Brown credits with shaping his career, all have been members of the ATS and three–Marvin Sackner, Adam Wanner and John Heffner–have served as president of the ATS.

"All of these individuals are role models for ongoing scholarship, and they taught me the importance of service–an obligation to serve both medicine and the public by actively participating in local and national medical societies, and patient advocacy groups," he said.

Dr. Brown has taken this obligation seriously: He has been active in 12 professional medical organizations and has served on the board of directors of four, including the ATS. He is currently president-elect of his county medical society, a member of the board of the American Academy of Sleep Medicine, an associate editor of *Clinical Sleep Medicine*, and an editorial board member of *CHEST*.

Since joining the ATS in 1980, he has chaired the Society's Council of Chapter Representatives, served on the Board of Directors for three years, and been a member of the Communications, Clinical Practice, and Planning Committees. He currently chairs the Health Policy Committee and serves on the Audit and Finance Committee, the Assembly on Clinical Problems Planning and Nominating Committees, and the ATS Congressional Action Team. "The ATS is the most scientifically rigorous and research-oriented organization in pulmonary medicine," said Dr. Brown.

While he currently dedicates most of his day to clinical and administrative work, he hopes to make more time for other pursuits, including expanding his editorial role in professional journals and increasing his public policy efforts. Another goal is to devote more time to research. "One of the most exciting parts of being a physician is being able to use my background in electrical engineering, and that is particularly true of research," he explained.

"The ATS is the most scientifically rigorous and research-oriented organization in pulmonary medicine."

To date, Dr. Brown has published more than 75 articles and book chapters on respiratory physiology, pleural disease and sleep-related breathing disorders. He has also been involved in a number of clinical studies of novel treatments for sleep apnea, including trials of several auto-titrating bi-level flow generators, one of which is now available to patients. "It is an amazing experience to be involved in testing a device and to later be able to use it to help patients," explained Dr. Brown.

One of the dominant themes of his career has been clinical program development. During his 12-year tenure as a full-time faculty member at Mount Sinai School of Medicine in New York, he established the university's first sleep-disordered breathing laboratory.

"Since sleep medicine was relatively new at that point, building the lab took a lot of creative effort," he said. "We literally had to scrounge for equipment, starting off with a cast-off EEG machine and a lot of home-made circuitry in the corner of the pulmonary function laboratory."

In 1993, he was recruited by John Heffner, M.D., to establish a Sleep Disorders Center at St. Joseph's Hospital and Medical Center in Phoenix. Over the next four years, he worked with his colleagues to build a flourishing sleep program there, and then left to direct the New Mexico Center for Sleep Medicine and chair the Department of Sleep Medicine at the Lovelace Clinic in Albuquerque.

He returned to his "first love"–academic medicine–in 2003, when he moved to UNM. "I like the thoughtfulness of academics and the huge variety of things to do," he said. "To be able to combine so many different things–an active practice, working with fellows, researching new treatments and creating new programs–makes for an incredibly fulfilling career."

Dr. Brown has two grown sons (Matthew, a computer scientist, and Douglas, an electrical engineer), and lives in Albuquerque with his wife, Carol. His hobbies include Ham radio (he has a 45-foot antenna tower in his back yard), running, fishing, hiking and travel.

NEWS BRIEFS

NEW CCR OFFICERS ELECTED

The Society's Council of Chapter Representatives (CCR) has elected two new officers for the 2007-2008 term: Dennis E. Doherty, M.D., of the Kentucky Thoracic Society, as Chair-Elect, and Christine S. Fukui, M.D., of the Hawaii Thoracic Society, as Secretary. The new term will begin immediately after this year's International Conference in San Francisco.

Two other CCR officers will be installed in new positions at ATS 2007: Vera A. De Palo, M.D., of the Rhode Island Thoracic Society, will become CCR Chair, and Jonathon D. Truwit, M.D. of the Virginia Thoracic Society, will become Immediate Past-Chair.

AJRCCM in the News

As the leading journal in the field of respiratory medicine, the *American Journal of Respiratory and Critical Care Medicine* (*AJRCCM*) does more than educate ATS members and subscribers. In the last four months, more than 1,500 media outlets have covered research published in the journal and made it available for public dissemination in newspapers, magazines, medical journals and online venues. Some of the most frequently reported articles include:

"Regular Physical Activity Modifies Smoking-related Lung Function Decline and Reduces Risk of COPD" (March 1, 2007)

- *New York Times*
- *Atlanta Journal-Constitution*
- *Washington Post*
- *Baltimore Sun*
- *International Herald Tribune*
- *HealthDay News*

"Short-Course Montelukast for Intermittent Asthma in Children: A Randomized Controlled Trial" (February 15, 2007)

- *Rocky Mountain Telegram*
- *Asbury Park Press*
- *New York Daily News*
- *Milwaukee Journal Sentinel*
- *Tucson Citizen*
- *Reuters Health*

"Aspirin and Decreased Adult-Onset Asthma: Randomized Comparisons from the Physicians' Health Study" (January 15, 2007)

- *Fort Worth Star-Telegram*
- *Charlotte Observer*
- *Newsday*
- *South Florida Sun-Sentinel*
- *The Denver Post*
- *London Daily Mail*

ATS PARTNERS WITH IHI FOR LIFE-SAVING CAMPAIGN

The ATS has joined the Institute for Healthcare Improvement's 5 Million Lives Campaign, a national initiative to dramatically reduce incidents of medical harm in U.S. hospitals. The two-year quality improvement initiative ends December 9, 2008. Several ATS clinical practice guidelines promote best practices related to Campaign interventions and ATS has joined as Scientific Partner.

Formally unveiled last December, the campaign builds on the past success of the IHI's 100,000 Lives Campaign, in which 3,100 participating hospitals reduced inpatient deaths by an estimated 122,000 in 18 months through overall improvement in care, including improvement associated with six interventions recommended by the initiative.

The new campaign aims to enlist 4,000 hospitals, challenging all to adopt up to 12 of the following interventions–six of which were included in the 100,000 Lives Campaign, and six of which are new:

NEW INTERVENTIONS TARGETED AT HARM

- **Prevent Methicillin-Resistant Staphylococcus aureus (MRSA) infection**...by reliably implementing scientifically proven infection control practices throughout the hospital.
- **Reduce harm from high-alert medications**...starting with a focus on anticoagulants, sedatives, narcotics, and insulin.
- **Reduce surgical complications**...by reliably implementing the changes in care recommended by the Surgical Care Improvement Project (SCIP).
- **Prevent pressure ulcers**...by reliably using science-based guidelines for prevention of this serious and common complication.
- **Deliver reliable, evidence-based care for congestive heart failure**...to reduce readmissions.
- **Get boards on board**...by defining and spreading new and leveraged processes for hospital boards of directors, so they can become far more effective in accelerating the improvement of care.

THE SIX INTERVENTIONS FROM THE 100,000 LIVES CAMPAIGN

- **Deploy Rapid Response Teams**... at the first sign of patient decline – and before a catastrophic cardiac or respiratory event.
- **Deliver reliable, evidence-based care for acute myocardial infarction**...to prevent deaths from heart attack.
- **Prevent adverse drug events**...by reconciling patient medications at every transition point in care.
- **Prevent central line infections**...by implementing a series of interdependent, scientifically grounded steps.
- **Prevent surgical site infections**...by following a series of steps, including reliable, timely administration of correct perioperative antibiotics.
- **Prevent ventilator-associated pneumonia**...by implementing a series of interdependent, scientifically grounded steps.

For more information about the 5 Million Lives Campaign, visit **www.ihi.org/IHI/Programs/Campaign**.

SPECIAL EVENTS
FOR WOMEN AND MINORITIES AT ATS 2007

During the Society's International Conference next month, the ATS Membership Committee will once again host two specialty luncheons focused on the unique challenges faced by women and minorities in the science and practice of pulmonary, critical care and sleep medicine.

"These events provide an ideal forum for women and minorities to network, share their experiences and take advantage of the expertise and career experiences of more 'seasoned' members," said Past ATS President Sharon I.S. Rounds, M.D., Chair of the Membership Committee.

The ATS **Diversity Luncheon for Underrepresented Minorities** will take place on Sunday, May 20, from noon to 1:30 p.m. Former ATS President Talmadge E. King, M.D., Professor and Vice-Chairman of the Department of Medicine at UCSF and Chief of Medical Services at San Francisco General Hospital, will describe his own experiences as a minority in academic medicine. Over lunch, the 2007 Minority Trainee Travel Awardee (MTTA) recipients will be recognized and will receive a grant and one year's In-Training ATS Membership.

The ATS **Women's Luncheon** will be held on Monday, May 21, from noon to 1:30 p.m. Keynote speaker Mary F. Lipscomb, M.D., Executive Dean at the University of New Mexico School of Medicine, will share how her relationships with peers, seniors and the ATS community has affected her personal and professional growth over the course of her career. The 2007 recipient of the Elizabeth A. Rich, M.D., Award will also be honored and will briefly address attendees during the luncheon.

Registration is required for both events, which are supported by grants from Merck & Co., Inc. Although there is no charge for admission, tickets will be issued. However, because space is limited, tickets do not guarantee admission and attendees will be admitted on a first-come, first-served basis.

NEWS BRIEFS

ATTENTION ATS 2007 ATTENDEES IN CANADA, MEXICO AND BERMUDA

As of January 23, 2007, all citizens of Canada, Mexico, Bermuda and the United States must have a passport (or another accepted secure document) to enter or re-enter the United States when traveling by air or sea. For more information please contact the U.S. Department of State (**www.travel.state.gov**) or the U.S. Department of Homeland Security (**www.dhs.gov**).

ASSEMBLY MEETINGS AND DINNERS AT ATS 2007

Each of the Society's 12 assemblies will hold its annual membership meeting at the 2007 International Conference in San Francisco next month. All assembly members and other interested parties are encouraged to attend these meetings to receive updates on assembly activities and projects, vote for future assembly leaders and provide input on future directions.

Each assembly membership meeting, with the exception of the Assemblies on BSA and PEDS, will be held on Monday, May 21 from 4:30 to 6:30 p.m. at the Hilton San Francisco. The Assemblies on BSA and PEDS will meet on Sunday, May 20 from 6:30 to 8:30 p.m., at the Parc 55 Hotel.

In addition, the Assemblies on AII, NUR, RNS and RSF will hold dinners following their membership meetings on May 21 from 6:30 to 10 p.m. Since seating is limited, dinner reservations need to be made in advance and will be on a first-come, first-served basis.

For information on registration and location of these meetings and dinners, visit the ATS Web site at **www.thoracic.org/sections/about-ats/assemblies**, choose an assembly and click on "Assembly News."

"SLURPING AROUND" MOVES TO E-MAIL

"Slurping Around with PDW," ATS Immediate Past-President Peter D. Wagner's monthly wine column, is moving from the ATS News to interested readers' e-mail inboxes. If you would like to receive Dr. Wagner's discerning reviews of value-oriented wines, written in the inimitable style of a person who loves wine almost as much as he loves science, please send an e-mail to Suzy Martin at **smartin@thoracic.org**.

CMS OFFERS FIRST BONUS FOR P4P (continued from page 1)


(L to R) Drs. James O'Brien and John Popovich

Dr. Bria says, is "a survival issue, because P4P may turn out to mean 'no pay for no performance.'"

Dr. Bria sees a silver lining, though, in the current situation. Key technologies are coming together at a time when physician reimbursement and the explosion of medical information demands automation. The result, he said, may raise the standard of care far beyond what P4P by itself could do.

In the fully automated system he envisions, care would be better integrated and the best practices in medicine would, in many cases, be identified by rapid reviews of a national health database, rather than expensive, narrowly focused, multi-year clinical trials.

James O'Brien, M.D., an assistant professor of medicine at Ohio State and a member of the ATS Clinician's Advisory Committee, also looks forward to the day when interoperable computer systems make it possible for doctors and institutions to compare their outcomes with appropriate benchmarks culled from a national database.

To reach that goal, however, the babel of many different organizations and payers advocating different performance metrics will almost certainly have to become a chorus in support of the same metrics. And the conductor? Most likely CMS. Although the agency has lagged behind HMOs and private insurers in tying physician reimbursement to quality, its influence as the largest single healthcare payer is felt throughout the system.

"Traditionally, CMS has set the standard," explains Dr. O'Brien. "Third-party payers usually follow in six to eight months. I wouldn't be surprised if it happened in this case, because collecting data is very expensive, and it would be much more cost effective to provide the same data to everyone."

CMS Metrics and PIMs

Recognizing that data collection is an additional burden, even in practices and systems that rely upon electronic medical records, the American Board of Internal Medicine (ABIM) last March decided that physicians completing their Practice Improvement Modules, or PIMs, as part of their recertification, could use the clinical results provided to CMS.

"The vast majority of physicians practice in groups of less than four or five physicians," says John Popovich, M.D, an ATS member who served as chair of the ABIM. "Many of these practitioners feel besieged, even though they want to provide quality care."

Dr. John Popovich, chair of internal medicine at Henry Ford Hospital, believes that ABIM has responded appropriately by creating maintenance of certification programs that eliminate the need to cull new data, instead permitting doctors to use data they have collected for state health agencies and private insurers, as well as CMS.

By analyzing this data, physicians can learn not only how to improve the care they provide as individuals but also how the systems they practice within can be improved, according to Dr. Popovich. This, he believes, is also CMS's goal with PQRI.

Growing Pains

Despite believing that "what CMS has done is reasonable," Dr. Popovich, like the others interviewed for this article, believes the jury is still out on whether this particular effort will improve care. "The process measures being tracked, he says, "don't always have a strong correlation with hoped-for outcomes, or, if they do, the evidence for the correlation is not yet there."

Dr. Bria believes that by focusing on individual physicians, rather than the regional network of providers that are actually responsible, in the long-term, for most patients' care, CMS's approach is myopic and may not accurately reflect the quality of a particular physician.

Dr. O'Brien is concerned that the reward system CMS is preparing can be gamed. Physicians can "cherry pick" the healthiest patients, or those, by virtue of socioeconomic status, educational level, or even mobility are more likely to be compliant. "I fully expect," he says, "that different studies will show that the CMS effort can be beneficial or harmful or have no effect in improving health care, depending how physicians implement strategies to improve their scores."

All worry that the incentives for obtaining high quality marks will fall short of what it costs to report the data to CMS. Then there is the upcoming presidential election, which, no matter who wins, will mean new leaders at CMS.

Faced with these and many other arguments against P4P or for sitting on the sidelines, Dr. Popovich says that he feels obligated to remind his colleagues that the forces driving CMS aren't going away. "The expectations," he tells skeptics, "for a much higher level of care than we're now providing and for greater cost efficiency, is going to be there forever."

The following measures identified by the CMS Physician Quality Reporting Initiative (PQRI) are relevant to the practice of adult and pediatric pulmonary and critical care physicians. Physicians who want to participate in the bonus plan from July 1 to December 31, 2007, must report on at least three of these measures.

#	MEASURE	DESCRIPTION
51	COPD: Spirometry Evaluation	% of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented.
52	COPD: Bronchodilator Therapy	% of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC less than 70 percent and have symptoms who were prescribed an inhaled bronchodilator
53	Asthma: Pharmacologic Therapy	% of patients aged 5 to 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment
56	Vital Signs for Community-Acquired Bacterial Pneumonia	% of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed
57	Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia	% of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed
58	Assessment of Mental Status for Community-Acquired Bacterial Pneumonia	% of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental state assessed
59	Empiric Antibiotic for Community-Acquired Bacterial Pneumonia	% of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed
64	Asthma Assessment	% of patients aged 5 to 40 years with a diagnosis or asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms
65	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	% of children aged 3 months to 18 years with a diagnosis of upper respiratory infection (URI) who were not dispensed an antibiotic prescription on or 3 days after the episode date
66	Appropriate Testing for Children with Pharyngitis	% of children aged 2 to 18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode

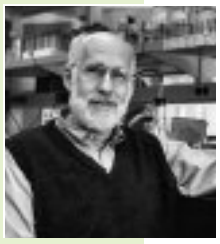
NEWS BRIEFS

200 PHYSICIANS ATTEND SOTA 2007

In March, 200 physicians attended the ATS State of the Art Course in Boston, which also featured 29 faculty members directed by Drs. Jesse Hall and Gregory Schmidt. Participants represented 12 countries and 36 U.S. states.

"I was overwhelmingly impressed with the course, the content of the syllabus and the informative nature of the presentations," said faculty member Kenneth E. Wood, D.O., Director of Critical Care Medicine and Respiratory Care at the University of Wisconsin School of Medicine and Public Health, who plans to send his fellows to the meeting next year.

RAVE REVIEWS FOR 2007 PRESIDENT'S LECTURER



Jerome Groopman, M.D., who will deliver the 2007 ATS President's Lecture at the International Conference this May, recently published his fourth book, "How Doctor's Think," a collection of essays on medical decision-making. The *New York Times* calls the book "medicine at its best, a mix of science and soul." Dr. Groopman is Professor of Medicine at Harvard Medical School and Chief of Experimental Medicine at Beth Israel Deaconess Medical Center, as well as a staff writer for the *New Yorker*.

FELLOWS PRESENT CASES AT FTS WINTERCOURSE

In February, fellows from four Florida medical schools participated in "Fellows' Presentations at Lunch," a special presentation at the 28th Pulmonary WinterCourse in Orlando. Sponsored by the ATS and the Florida Thoracic Society/American Lung Association of Florida, the WinterCourse is an annual CME event that provides attendees with an update on basic concepts and new developments in the diagnosis and management of adults and children with respiratory diseases.

During the fellows session, Vichaya Arunthari, M.D., of the Mayo Clinic Jacksonville, Sebastian Fernandez-Bussy, M.D., of the University of Florida, Louis Lit, M.D., of the University of Miami; and Stephen Clum, M.D., of the University of South Florida, presented unknown cases for diagnosis and discussion under the guidance of moderator Gene G. Ryerson, M.D. (center), and conference chairman Bruce Krieger, M.D. (far left).

"We want to encourage these fellows to continue in pulmonary medicine, and this venue provides a great opportunity for them to network and sharpen their teaching skills," said FTS Chapter Administrator Candy Holloway.

the ADVOCATE

TB CONTROL LEGISLATION INTRODUCED IN THE HOUSE

Just in time for World TB Day, legislation aimed at eliminating TB in the U.S. and globally has been introduced in the House of Representatives. The Comprehensive TB Elimination Act (H.R. 1532), sponsored by Representatives Gene Green (D-TX), Heather Wilson (R-NM) and Tammy Baldwin (D-WI), was introduced on March 15th, and the Stop TB Now Act, sponsored by Representatives Eliot Engel (D-NY), Heather Wilson (R-NM) and Adam Smith (D-WA), was introduced on March 19th.

Domestic TB Bill

The Comprehensive TB Elimination Act will provide the U.S. Public Health Service with the resources needed to eliminate TB nationally and play a leading role in eradicating the disease globally. It will give the Centers for Disease Control and Prevention (CDC) authority to respond to international outbreaks of extensively drug-resistant TB (XDR-TB), increase funding for the Center's National Program for the Elimination of TB and expand research on diagnostic and treatment tools at the National Institutes of Health (NIH) and CDC. The bill would also:

- Expand CDC-sponsored research on the safety and efficacy of new drugs, diagnostics and vaccines, and studies of populations at risk for TB;
- Authorize and expand CDC demonstration activities on TB elimination, including targeted efforts to prevent, detect and treat the disease among African-Americans and foreign-born persons in the U.S.;
- Expand research, including study of the relationship between TB and HIV/AIDS, and research training programs at the NIH;
- Authorize funding for the "Blueprint Plan for TB Vaccine Development" at the National Institutes of Allergy and Infectious Diseases.

International Bill

The Stop TB Now Act implements the World Health Organization's recommendations for controlling TB globally and increases funding for global TB control at the U.S. Agency for International Development (USAID) and CDC. If passed, the bill will:

- Increase U.S. funding for international TB control and enhance U.S. technical assistance in responding to the global TB crisis;
- Support international TB control activities at the USAID and CDC, including expansion of directly observed treatment short-course (DOTS) coverage, strengthening of health systems, and promotion of the International Standards of TB Care.

A Senate companion bill to the Comprehensive TB Elimination Act is now being prepared and the ATS will alert members when it is introduced. The Senate version of the Stop TB Now Act, sponsored by Senator Barbara Boxer (D-CA), is expected to be introduced within the next few weeks.

The ATS played a key role in working with members of Congress to draft the legislation, and will continue its collaboration with partner organizations to seek enactment of these bills this Congress.

House Foreign Affairs Committee Holds TB Hearings

In March, the House Subcommittee on Africa and Global Health, chaired by Rep. Donald Payne (D-NJ), held a hearing on the Stop TB Now Act. The hearing included testimony from CDC Director Julie Gerberding, M.D., M.P.H., WHO STOP TB Program Director Mario Raviglione, M.D., USAID Global Health Assistant Administrator Kent Hill and U.S. Department of State Global AIDS Coordinator Mark Dybul. Rep. Eliot Engel (D-NY) also testified at the hearing.

PEDIATRIC LUNG HEALTH

Pediatric Medical Devices Legislation Reintroduced in the House

Christopher Dodd (D-CT)

Edward Markey (D-MA)

Legislation to speed the development of medical devices designed for children was introduced in the Senate last month by Sen. Christopher Dodd (D-CT) and in the House by Rep. Edward Markey (D-MA). The Pediatric Medical Device Safety and Improvement Act (S. 830 and H.R. 1494) offers incentives to manufacturers of medical devices for children, grants the Food and Drug Administration (FDA) authority to require post-market studies of devices to ensure their safety and efficacy, and enhances and coordinates research efforts at the NIH, Agency for Healthcare Research and Quality (AHRQ) and the FDA.

Currently, many essential medical devices, such as mechanical ventilators and CPAP and BIPAP machines, are not designed or sized for children because the market for pediatric devices is smaller than the adult market. The lack of devices designed specifically for children limits treatment options for children with respiratory diseases.

In October 2004, the FDA released a report that identified barriers to the development and approval of devices for children. In a 2005 report on post-market surveillance of pediatric medical devices, the Institute of Medicine (IOM) found serious flaws in safety monitoring, and recommended expanding the FDA's ability to require post-market studies of certain products and improve public access to information about these studies.

Edward Kennedy (D-MA)

The Senate Health, Education, Labor and Pensions Committee (HELP), chaired by Sen. Edward Kennedy (D-MA), held a hearing on March 22 on pediatric medical devices and the need for additional testing of medications for children.

The ATS Health Policy Committee worked closely with the American Academy of Pediatrics to develop the legislation introduced by Sen. Kennedy.

In March, the Clean Air Scientific Advisory Committee (CASAC) unanimously recommended a tightening of the current Environmental Protection Agency (EPA) standard for exposure to ozone to a standard between 0.060 parts per million (ppm) and 0.070 ppm. The current standards 0.080 ppm.

An expert panel convened by the EPA to provide scientific input for establishing national exposure limits for air pollutants, the CASAC explicitly rejected the idea of retaining the current standard of 0.080 ppm. Maintaining the current standard was one of the options presentedby EPA staff.

(continued on page 8)

The Advocate has been prepared by the ATS Washington Office to educate and update ATS members on pertinent legislative and regulatory issues. The ATS Washington Office is the hub of a nationwide Legislative Network that enables state and local ATS volunteers, members and staff to participate in grass roots advocacy or public policy initiatives in cooperation with ALA Washington Office. The ATS Washington Office maintains an advocacy Web site at www.thoracic.org/advocacy and can be contacted at (202) 785-3355.

TB CONTROL LEGISLATION

(continued from page 7)

RESEARCH

ATS Members Testify in Support of VA Research Funding

Last month, ATS members Galen Toews, M.D., and Suzanne Lareau, R.N., testified before the House Military Construction and Veterans Affairs Appropriations Subcommittee in support of funding for the VA research program. Testifying on behalf of the Friends of VA Health Care and Medical Research Coalition (better known as FOVA), Dr. Toews and Ms. Lareau requested the subcommittee provide $480 million for the VA research program in FY08–a $68 million increase.

Galen Toews, M.D.

Suzanne Lareau, R.N.

CLINICAL PRACTICE

Pulmonary Rehabilitation Legislation Picks Up More Cosponsors

Support for legislation to establish a Medicare pulmonary rehabilitation benefit (S. 329/H.R. 552) continues to grow in Congress. Introduced in January by Senators Mike Crapo (R-ID) and Blanche Lincoln (D-AR) and Representatives John Lewis (D-GA) and Chip Pickering (R-MS), the bill now has 39 co-sponsors in the House and 13 in the Senate, including.

Senate Cosponsors

Jim Bunning (R-KY)
Hillary Clinton (D-NY)
Susan Collins (R-ME)
Kent Conrad (D-ND)
Larry Craig (R-ID)
Byron Dorgan (D-ND)
Richard Durbin (D-IL)
Blanche Lincoln (D-AR)
Robert Menendez (D-NJ)
Patty Murray (D-WA)
Chuck Schumer (D-NY)
Olympia Snowe (R-ME)

House Cosponsors

Tom Allen (D-ME)
Jo Bonner (R-AL)
John Boozman (R-AR)
Rick Boucher (D-VA)
Lois Capps (D-CA)
David Davis (R-TN)
Lincoln Davis (D-TN)
Tom Davis (R-VA)
Diane DeGette (D-CO)
John Doolittle (R-CA)
Rahm Emanuel (D-IL)
Barney Frank (D-MA)
Jim Gerlach (R-PA)
Paul Gillmor (R-OH)
Phil Gingrey (R-GA)
Bart Gordon (D-TN)
Rush Holt (D-NJ)
Eddie Bernice Johnson (D-TX)
Sam Johnson (R-TX)
Steven Kagen (D-WI)
Carolyn Maloney (D-NY)
Jim Marshall (D-GA)
Thad McCotter (R-MI)
Todd Platts (R-PA)
Joe Pitts (R-PA)
Nick Rahall (D-WV)
Jim Ramstad (R-MN)
Mike Rogers (R-MI)
Dutch Ruppersberger (D-MD)
John Salazar (D-CO)
Jim Saxton (R-NJ)
John Shimkus (R-IL)
Mark Souder (R-IN)
Bart Stupak (D-MI)
Lee Terry (R-NE)
Zack Wamp (R-TN)
Bob Wexler (D-FL)
Albert Wynn (D-MD)

CONFERENCES, COURSES AND MEETINGS

Activities sponsored or endorsed by the ATS and its chapters are listed in **bold**.

DATE & PLACE	TITLE	CONTACT
May 18 to 23 San Francisco, CA	**"2007 ATS International Conference," sponsored by the American Thoracic Society**	**Phone: (212) 315-8658 ats2007@thoracic.org www.thoracic.org/go/international-conference**
May 3 to 4 Montreal, Canada	**"International Consensus Conference in Intensive Care Medicine: Management and Prevention of Acute Renal Failure in an ICU Patient"**	**Phone: (212) 315-8600 iccc2007@thoracic.org www.thoracic.org/go/iccc07**
May 4 to 5 Tampa, Florida	"Signature Program in Allergy, Immunology and Infectious Diseases Conference," sponsored by the University of South Florida College of Medicine	Phone: (813) 974-4296 www.cme.hsc.usf.edu/signature
May 5 to 6 Tampa, Florida	"Percutaneous Dilational Tracheostomy: A Practical Course for Providers," sponsored by the University of South Florida College of Medicine	Phone: (813) 974-4296 www.cme.hsc.usf.edu/airway
May 6 to 9 Cambridge, Mass.	"Pulmonary and Critical Care Medicine," sponsored by Massachusetts General Hospital Harvard Medical School	Phone: (617) 384-8600 hms-cme@hms.harvard.edu www.cme.hms.harvard.edu
June 6 to 9 Aspen, Colorado	"50th Annual Thomas L. Petty Aspen Lung Conference: Lung Injury and Repair"	Phone: (303) 315-7767 Jeanne.Cleary@uchsc.edu www.aspenlungconference.org
June 22 to 25 Istanbul, Turkey	**"World Asthma Meeting 2007," sponsored by the Turkish Thoracic Society**	**Phone: + 90 216 416 09 19 edagli@superonline.com www.wam2007.org**
June 22 to 24 Montreal, Canada	"Noninvasive Mechanical Ventilation," sponsored by the American College of Chest Physicians	Phone: (847) 498-1400 accp@chestnet.org
June 22 to 28 Philadelphia, PA	"AAI Introductory Course in Immunology," sponsored by the American Association of Immunologists	Phone: (301) 634-7178 infoaai@aai.org www.aai.org/Courses.htm
June 27 to 30 Riga, Latvia	"4th Congress of the IUATLD, Europe Region"	loddheck@zedat.fu-berlin.de www.tuberculosis.lv/congress2007
August 2 to 5 Kuala Lumpur, Malaysia	"1st Asia Pacific Region Conference," sponsored by the IUATLD	Phone: +60 3 2162 0566 Tibi2007@console.com.my www.tibi2007.com
August 4 to 10 Minneapolis, Minnesota	"AAI Advanced Course in Immunology," sponsored by the American Association of Immunologists	Phone: (301) 634-7178 infoaai@aai.org www.aai.org/Courses.htm
August 24 to 27 Phoenix, Arizona	"Sleep Medicine Board Review Course 2007," sponsored by the American College of Chest Physicians	Phone: (847) 498-1400 accp@chestnet.org
August 28 Phoenix, Arizona	"Lung Pathology 2007" and "Mechanical Ventilation 2007," sponsored by the American College of Chest Physicians	Phone: (847) 498-1400 accp@chestnet.org
October 4 to 6 Cape Town, South Africa	"Emergency Medicine in the Developing World," sponsored by the Emergency Medicine Society of South Africa	Phone: + 27 (0) 21 406 6407 E-mail: mcollin@curie.uct.ac.za www.emssa2007.co.za
October 14 to 16 Tel Aviv, Israel	"5th International Meeting on Intensive Cardiac Care," sponsored by the European Society of Cardiology and the Israel Heart Society	Phone: + 972 2 6520574 seminars@isas.co.il www.isas.co.il\cardiac-care2007
November 8 to 12 Capetown, South Africa	"38th Union World Conference on Lung Health," sponsored by the IUATLD	Phone: +33 1 44 32 03 60 CapeTown2007@iuatld.org www.worldlunghealth.org
November 25 to 28 Rio de Janeiro, Brazil	"2nd International Cancer Control Congress (ICCC07)"	Phone: (604) 681-2153 E-mail: iccc07@meet-ics.com www.cancercontrol2007.com
December 1 to 5 Washington, DC	"American Society for Cell Biology 47th Annual Meeting"	Phone: (301) 347-9300 ascbinfo@ascb.org www.ascb.org

From the Chair

As Chair of the ATS Nominating Committee, I would like to encourage you to vote in the 2007 ATS Secretary-Treasurer Election. This year, after careful review of several qualified individuals, the Committee has nominated two candidates for election. Since some members may not be familiar with the nominees' leadership qualification and past ATS service, each candidate has written a brief statement and responded to 9 key questions regarding his vision for the future of the Society.

Remember, your vote is important: the successful candidate will not only serve as ATS Secretary-Treasurer for the 2007—2008 term, but as ATS President in 2010. Members can vote electronically by visiting the ATS Web site at **www.thoracic.org** and clicking "Vote 2007."

Secretary-Treasurer Candidate:
Richard A. Helmers, M.D.

Richard A. Helmers, M.D., serves as Associate Professor of Medicine and Chair of Clinical Practice at the Mayo Clinic in Arizona. After earning his medical doctorate from the University of Iowa College of Medicine, he trained in internal medicine at Indiana University and the University of Iowa and in critical care at St. Luke's Hospital in Milwaukee, and pulmonary/critical care at the University of Iowa. He was on the faculty at the University of Iowa for four years before joining the staff at the Mayo Clinic. His research interests include critical care medicine, interstitial lung disease, pulmonary diagnostic procedures and coccidioidomycosis. He has published more than 40 articles, editorials and book chapters.

What qualifies you to be the ATS president?

I am honored and humbled to be a candidate for ATS Secretary-Treasurer. I believe I am qualified to be President of the ATS because of what I have learned through the opportunities I have had within the ATS, the American Board of Internal Medicine, the University of Iowa and the Mayo Clinic. I have been a member of the ATS Council of Chapter Representatives (1994-2000), chaired the CCR (1999-2000) and served on the Board of Directors (1998-2001), Program Review Subcommittee (2000-2007), the Postgraduate Education Committee, International Lung Health Committee, Documents Editor Search Committee and the Workforce on Congressional Action Team. I have chaired the ATS Task Force for Clinicians and the Clinicians Advisory Committee since their inception in 2000 and received an ATS Presidential Commendation for these activities in 2002.

I have been an active member of the ATS Assembly on Clinical Problems for many years and served on its Long Range Planning Committee. I have also served as President of the Arizona Thoracic Society and as a member of the Board of Directors and Research Committee of the American Lung Association (ALA) of Arizona/New Mexico since 2000. I chaired the CCR during the year the ATS/ALA separated and feel strongly about supporting our chapters and the relationships with their respective lung associations.

I have been a member of the Pulmonary Board of the ABIM for the last five years. Being involved in the ABIM and writing test questions has been a very educational and rewarding experience. I have also been the Executive-Secretary of the International Bronchoesophagological Society since 2002.

At the Mayo Clinic in Arizona, I have served as Chair of the Pulmonary Division, Medical Director of Respiratory Therapy, and Vice-Chair of the Department of Medicine I currently serve as Associate Professor of Medicine and Chair of Clinical Practice, (equivalent to Chief of Medical Staff). In this role, I am responsible for the operation of the inpatient and outpatient practice of Mayo Clinic Arizona.

What are your top 3 goals for the ATS and how would you implement them?

I believe the mission of the ATS is to advance the science of pulmonary, critical care and sleep medicine and to serve the needs of its members. By that, I mean supporting research and providing clinicians with the education and tools to stay abreast of the latest scientific advances and to improve their clinical practice.

My primary goals as ATS President would be to:

- Increase the membership worldwide, but particularly in North America;
- Support the advancement of the science in pulmonary, critical care and sleep;
- Ensure that members of the critical care and sleep communities consider the ATS their primary "home;" and
- Increase the public's awareness of the scope of practicing pulmonary, critical care and sleep medicine, and that diseases like sepsis, emphysema and sleep apnea are just as important and in need of funding as cancer or heart disease.

My strategies for these goals would be:

- Implementing an active membership campaign to attract pulmonologists who are not currently members of the ATS;
- Working with local lung associations and their thoracic society chapters to enhance public awareness of pulmonary, critical care and sleep; and
- Continuing to support the efforts, scientifically and clinically, of intensivists and sleep physicians within the ATS.

What would you identify as strengths of the ATS?

The strengths of the ATS include:

- It is the pulmonary, critical care and sleep organization with the best science;
- The Society's annual International Conference and three scientific journals;
- Its broad-based, international membership;
- Its dedicated and hardworking staff; and
- The Society's reputation of scientific and clinical integrity.

What would you identify as weaknesses of the ATS? What are some of the threats you see to the ATS now and in the future?

The weaknesses and potential threats to the well-being of the ATS include:

- The Society's reliance on the International Conference as a major income source;
- The image among clinicians that the ATS is only a research organization;
- The potential for the separation of critical care and pulmonary medicine;
- Research funding challenges; and
- The public does not as readily recognize all that a pulmonologist does, in contrast to oncologists or cardiologists.

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Secretary-Treasurer Candidate:
Dean E. Schraufnagel, M.D.

Dean E. Schraufnagel is a Professor in the Departments of Medicine and Pathology at the University of Illinois at Chicago (UIC) and attending physician at the UIC and VA Medical Centers and the Chicago Tuberculosis Clinics. He is Program Director in the Section of Pulmonary, Critical Care and Sleep Medicine. After receiving his medical degree from the University of Wisconsin, he completed his residency at UIC and fellowship at McGill University in the Meakins Christie Laboratories and Pathology Institute. His research interests include pulmonary microcirculation, mycobacterial disease, scleroderma lung disease, sickle cell lung disease, pulmonary hypertension and bronchiectasis. Dr. Schraufnagel is part of the NIH Scleroderma Lung Study Network and an NIH Sickle Cell Pulmonary Hypertension group. He has published more than 100 articles and edited two books. He has received teaching awards and has been listed in Best Doctors in America for several years.

What qualifies you to be the ATS president?

I have been active in the ATS, having served on its Board of Directors for three years, Council of Chapter Representatives for 10 years, Postgraduate Education Committee for 3 years, and Communications & Marketing Committee for 11 years. I have been a member of the Committee to Develop the ATS Web site, Program Review Subcommittee, Committee to Select the Editor of *American Journal of Respiratory and Critical Care Medicine*, Committee to Develop the Bylaws for the New ATS, Revenue Development Committee, Nominating Committee, Information Systems Committee, Task Force on Clinicians, "Birthday Bash" Committee, Document Editor Search Committee, and Publications Policy Committee. I was appointed the first ATS Website Editor. I received the ATS Presidential Commendation and PAR-Excellence Award and edited the ATS centennial book, *"I remember…" Reflections on the American Thoracic Society's First Century."*

I was also on the Board of Directors of the American Lung Association, and currently serve on the Board of the Union (International Union Against Tuberculosis and Lung Disease). I served as President of the International Tuberculosis Foundation for six years. I have been on several NIH committees and study sections. I was chief officer of the DaVinci Society for the Study of the Airway Circulation. Cumulatively, I have helped raised more than $3 million for these not-for-profit organizations and my university. I have helped the ATS and other organizations adopt technology that has resulted in saving money and improving function.

What are your top 3 goals for the ATS and how would you implement them?

Serving the membership

The first and most important function of the ATS is to serve its members. Helping members succeed should be a driving force for everything it does. Examples of programs I would emphasize include:

- Strengthen advocacy for clinicians and researchers;
- Expand guideline development, including safety standards;
- Offer programs disseminating technologic information affecting practice;
- Expand opportunities for learning procedures;
- Support accreditation and practice improvement;
- Continue strong support of ATS Chapters;
- Continue strong support for researchers through publications, Web site and meetings; and
- Grow ATS Research Program.

Implementing the Strategic Plan

I favor surveying our members and supporters and having objective measurements to gauge our success. I would foster a can-do attitude, fiscal responsibility and the highest integrity. Building consensus is important. I believe a tagline is critical: It will help us identify ourselves to the public and other healthcare professionals.

Involving the public and patients enhances recognition of the ATS and can assist in fundraising, but the public must see the ATS as a standard-setting, teaching organization that fosters research and career development that will ultimately result in better respiratory health around the world. The ATS can offer expertise and education, as it does in the patient information series available on the Web site. Working with PAR, we could develop a journal for patients and hold disease-specific regional conferences for patients.

Win Marginal Groups to ATS

In many areas, there are competing organizations and specialties. Will tuberculosis, sleep and new procedures be part of pulmonary and critical care medicine? We must be proactive to make sure this happens. I favor specialized topics at our conferences and on the Web site. I would do more to involve the different respiratory nursing fields, chest radiologists, anesthesiologists, neonatologists, thoracic surgeons and lung pathologists. Because the ATS may be a secondary or tertiary society for many, I would favor offering discounts with other organizations, as we do with the European Respiratory Society.

What would you identify as the strengths of the ATS?

The ATS's greatest strength is its members. Our publications, dedicated staff, journals, Web site, conferences and tradition are also important assets. The ATS should use its strengths to direct new activities. While the International Conference is the best of its kind, we cannot take it for granted. Our goal is to make our meeting the one that *cannot be missed*. We can do this by offering opportunities for involvement, unique learning and networking.

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