WEB VERSION

THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

Summer 1999, Vol. 42, #2 • Bringing New York State Psychiatrists Together

President's Message: Managed Care Fee Reductions – What NYSPA Has Done

by Jim Nininger, M.D., President, New York State Psychiatric Association

Jim Nininger, M.D.

When our members ask what they get for their NYSPA dues, we can point to our prompt and effective response to the 1999 fee reductions imposed by the big three behavioral managed care companies operating in New York State: Magellan, ValueOptions and United Behavioral Health. When these fee reductions were announced, NYSPA immediately developed and implemented a plan of action to protect the interests of our members and their patients:

- Inform our members about their rights under the managed care contracts and state law.
- Communicate our concerns to the three managed care companies and insist on full compliance with the provider contract and state laws.
- Contact appropriate state and federal government agencies and ask them to investigate the simultaneous fee reductions and the possibility of an illegal restraint of trade.

NYSPA's plan of action has already yielded significant and dramatic positive results.

On February 10, 1999, United Behavioral Health notified all providers that its fee decreases were rescinded retroactive to January 1, 1999, and that UBH will return to its 1998 fee schedule. This represents a significant victory for our members and their patients and reflects the concerted efforts by NYSPA to com-municate our members concerns.

NYSPA was also successful in securing compliance by both companies with the requirements of their contracts and state law. As a direct result of advocacy by Seth Stein, NYSPA Executive Director and General Counsel, both Magellan and ValueOptions have reversed their prior positions and have agreed in writing that psychiatrists who filed a timely objection to the fee decreases will be paid at the prior fee schedule and will be reimbursed for all services rendered in 1999 that were paid at the new lower fee schedule. Psychiatrists who timely objected and who received reduced reimbursement for 1999 services should contact NYSPA Central Office regarding securing a corrective payment.

In addition, both Magellan and ValueOptions, at NYSPA's insistence, have notified patients whose providers either dropped out of the network, or were terminated from the network by the managed care company, of the patient's right under state law to a 90 day extension of the termination date, if the provider agrees to continue to provide services during that period.

We are also continuing to meet with representatives from Magellan and ValueOptions to encourage them to recognize in their fee schedules the enhanced value of integrated treatment, i.e., where the psychiatrist provides both psychotherapy and medication. Recent articles in *Psychiatric Services* indicate that integrated treatment by a psychiatrist is more clinically effective, shorter in duration and less expensive than bifurcated treatment where the psychiatrist provides only medication and a non–physician mental health professional provides psychotherapy.

Finally, NYSPA has filed complaints with state and federal officials seeking an investigation to determine whether the simultaneous fee reductions resulted from improper collusive activities in restraint of trade. I can report that NYSPA has already received a response from the Anti–Trust Division of the United States Department of Justice indicating that our complaint is under review. ■

The Current Political Crisis in Patient Privacy

by Leon Hoffman, M.D.

[A version was presented at The Psychiatric Society of Westchester County and Bronx District Branch on March 17, 1999 —Ed.]

Leon Hoffman, M.D.

The danger to privacy and confidentiality is THE most central issue facing our profession today. We need to communicate to Congress that:

- Privacy is vital to quality care;
- The supreme court recognized this and is consistent with our experience; and
- There can be no preemption of state laws, many with effective privacy standards.

If Congress does not pass a Privacy Bill by August 21, 1999, as mandated by The Health Insurance Portability and Accountability Act of 1996, Health and Human Services rules become law by default. The administration undoubtedly agrees with the observation that there has been a "disastrous erosion of the precious but fragile conventions of personal privacy in the United States over the past 10 or 20 years." Yet, they proposed that, law enforcement agencies seeking health care fraud could access patients' records at will without patient consent or without a court order. They have proposed a "unique health identifier," assuming that privacy rights should be subordinated to the hope that, once all medical data is electronically stored and at everyone's finger tips, medical care will become more efficient, errors will no longer occur, and care will improve. The implementation of such an Orwellian scenario will inevitably result in the public's withholding of crucial medical information.

A source for this unfortunate trend lies in the thinking of Lawrence Gostin, a bioethicist, chair of the Task Force on Health Information Privacy of CDC and the Carter Center: privacy must be sacrificed for societal good; accessibility to records replacing privacy and confidentiality as the guiding principle for the management of medical records in order to prevent fraud, save money, do clinical research

[See **Patient Privacy** on page 5]

APA 1999 Federal Legislative Institute

by Barry B. Perlman, M.D.

Barry B. Perlman, M.D.

The American Psychiatric Association's biennial Federal Legislative Institute was held in Washington, D.C. from April 11-14, 1999. Those participating in the Institute were the Area representatives to the Joint Commission on Government Relations, the DB Legislative Representatives, interested members, DB Executive Directors, and others. During the Institute those in attendance were exposed to seminars in health care policy and the related politics. They were treated to presentations, taught how to be effective "citizen lobbyists", and dispatched to Capitol Hill to meet with their elected members of Congress to educate and agitate for the concerns of our patients and our profession.

The program, crafted by Jay Cutler, the APA's Director of Government Relations, and his outstanding staff, stirred the juices of those attending through a White House briefing held in the Old Executive Office Building and presentations by prominent leaders concerned with the care of those with mental illness. Among those who spoke before the attendees were Rep. Jim McDermott (D-WA), the only psychiatrist currently serving in the House of representatives, David Satcher, M.D., Ph.D., United States Surgeon General and Assistant Secretary for Public Health and Science, U.S. Department of Health and Human Services, and Senator Paul Wellstone (D-MN), whose "parity" legislation co-sponsored with Senator Pete Domenici (R-NM), was poised to be introduced in the Senate. At the same time the companion legislation was being introduced on the House side by Rep. Marge Roukema (R-NJ).

In addition to the "celebrity" political appearances, there were many seminars dealing with the substantive issues central to the agenda of organized psychiatry in its quest to improve access and quality of care, and confidentiality of medical records, for those with mental illness. Those presenting on the panels were key staff serving the elected officials on the committees through which the relevant legislation must move. In order that participants be effective in discussing the "3 Ps" of Parity, Protection, and Privacy with their Representatives and Senators and their staffs, a valuable session that taught "lobbying" skills was held immediately before the trips to "The Hill". In preparation for the visits, those who would attend the Institute had written to their elected representatives well in advance of the meeting so that conferences could be scheduled.

Area II of the APA, which is com-

[See **Legislative Institute** on page 7]

INSIDE THIS ISSUE:

THE BULLETIN
NEW YORK STATE PSYCHIATRIC ASSOCIATION

Editorial Board
Leslie Citrome, M.D., M.P.H.
Editor-in-Chief
Nathan Kline Institute
140 Old Orangeburg Road
Orangeburg, NY 10962
Tel: (914) 398-5595
Fax: (914) 398-5483
e-mail: citrome@nki.rfmh.org
http://www.nyspsych.org/bulletin

Syed Abdullah, M.D.
Michael Blumenfield, M.D.
James Chou, M.D.
David Harwitz, M.D.
Craig Katz, M.D.
Brian Ladds, M.D.
Howard Owens, M.D.
Ann Sullivan, M.D.
Seeth Vivek, M.D.

Robert J. Campbell III, M.D.
Editor–in–Chief Emeritus

New York State Psychiatric Association
100 Quentin Roosevelt Blvd.
Garden City, NY 11530
(516) 542-0077; Fax: (516) 542-0094
e–mail: nyspamd@idt.net
http://www.nyspsych.org

Executive Committee 1998-99
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Information for Contributors
The Bulletin welcomes articles and letters that NYSPA members will find timely, relevant, and compelling. Articles should be between 750 and 1500 words (three to five double–spaced manuscript pages) and letters no more than 750 words. All submissions must be made electronically, preferably by email to the editor. All authors are encouraged to also provide a photograph of themselves which will be printed alongside their article.

Information for Advertisers
The Bulletin welcomes advertisements from both NYSPA members and commercial enterprises. Total circulation averages 5,500 copies per issue. The Bulletin is received by all 5,000 members of the American Psychiatric Association who belong to a district branch in New York State. The Bulletin is also sent to the leadership of other district branches across the United States and to New York State legislators, medical libraries, and science writers. The Bulletin is published quarterly. Both classified advertisements and display advertisements are available. Please contact the managing editor for current rates and media requirements. NYSPA members receive a discount of 50% off the basic classified ad rate.

Graphic Design & Production
Donna Sanclemente, Point of View
donna@ptofview.com

From the Editor… NY DBs Take Prizes


Leslie Citrome, M.D., M.P.H.

New York State was well represented in the annual APA Newsletter of the Year Awards for 1999. Congratulations to Robert Sobel, MD and Syed Abdullah, MD, of the West Hudson Psychiatric Society. Their newsletter, Synapse, won the Newsletter of the Year Award for the category of Small District Branch. Congratulations to David Hellerstein, MD, editor of the New York County District Branch newsletter, who earned an Honorable Mention Award.

The Bulletin was also the proud recipient of an Honorable Mention Award. The contest process afforded us the opportunity to receive a comprehensive review of our layout and content, and how well we have adhered to our promises to our readership. We got some good advice which will be reflected in this issue and in the ones to follow. You can look forward to more graphics, pictures, and white space. This will counterbalance the text that was at times too dense.

You will see more news from the District Branches – we need your help to get this information. Syed Abdullah, MD has been assigned the task of coordinating this regular column.

You will from time to time also see articles that have already appeared in the other NY District Branch newsletters — this material will spotlight some of the talent that we have across the State.

This issue features two letters to the editor — keep them coming! We also hear about patient privacy, adolescent psychiatry training opportunities, and about serving the homeless. You'll also find a table of phone numbers to call with complaints regarding health insurers.

This issue goes to press at the same time the APA Annual Meeting gets underway. Watch for the next issue for pictures from this event. Any and all feedback is, of course, welcome. The deadline for the next issue is August 1, 1999. Have a nice summer! ■

LETTERS TO THE EDITOR

Letters to the Editor are welcomed but are limited to 750 words.The full text of all letters will be available on The Bulletin web site at <http://www.nyspsych.org/bulletin>.

An Open Letter to Dr. Stephens

See also The Bulletin, Spring 1999 issue, Vol. 42, #1, page 2—Ed.

Congratulations for taking up the fight against MCOs.

In that regard, up to now, the Courts have not been helpful. It seems you are after establishing collusion which will demonstrate antitrust action on the part of the MCO. While they may be required to reverse any such action which stemmed from it, and maybe even fined for what they did, it will only make them be more careful about collusion in the future, just as we are required to be careful not to act in consort. It will, however, not level the playing field.

It will not stop what was stated in the same issue of *The Bulletin* as your letter what Dr. Nininger said: "Of course, we can't simply mandate to 'roll back' the fee decreases. Managed care companies are under increasing pressure to maintain their profitability. Reducing the cost of care by reducing physician fees is the simplest way to protect their 'bottom line' and guarantee the ability to pay executive salaries and shareholder dividends. Each individual managed care company acting alone retains the right to set its own fee schedule and to reduce fees at its discretion." This is a remarkably accurate statement of the MCO position. And so we are back to square one.

The Courts must come to recognize that a "monopsony" exists whereby a few MCOs, even without acting in consort, have the power unilaterally to control the fees to physicians. While your court case may move us in that direction, it will not yet establish that principle, it will not level the playing field.

What must be established is that all physicians contracting — in essence, working for an MCO — just like any other employee group, must have the power to act in concert to organize, as one, the terms of any contract for the group.

No MCO will go along with this. It is a political axiom that no group that has power gives it up voluntarily. If the Courts do not force it — and they have not been inclined to do so to date, - then we must do it, as has all "labor" done it in the past.

Even if you win this Court case, it is going to take leaders like yourself to take us over the goal line.

Gordon R. Meyerhoff, MD, FAPA, FAGA
Roslyn Heights, New York

Outpatient Civil Commitmemt

The following letter was shortened to comply with The Bulletin's 750 word limit for Letters to the Editor. —Ed.

I am writing in response to Dr. Howard Owens' article about outpatient civil commitment in the Spring issue of *The Bulletin*. I strongly agree with Dr. Owens' suggestion that, in light of the results of the Policy Research Associates (PRA) evaluation of the Bellevue Involuntary Outpatient Commitment Pilot Program, great caution should be exercised in expanding outpatient commitment in New York State.

Dr. Owens suggests that the findings of the PRA study were inconclusive. I believe they were indeed conclusive; they empirically demonstrated what dedicated mental health service providers have understood for years.

Both the control and experimental groups received enhanced discharge planning and follow–up through a Coordinating Team that made sure patients would receive on–going access to all the services they needed. Both groups did very well, spending significantly less time in the hospital than previously. The group ordered by a judge to comply or else did no better than the group that received enhanced services without threats.

Here's what the PRA study discovered: Discharge planning is good. Access to services matters. If they can get their medications and get services, most people with mental illness will take medications and accept services. If caring, consistent people, such as Bellevue's Coordinating Team, are available to encourage compliance with treatment, patients will usually comply.

Discussions of forced treatment always revolve around the word compliance. Far too infrequently, however, is there any discussion of how our current mental health system undermines compliance. What we see constantly at my agency are people who are non–compliant for a host of reasons beyond their control. Our clients are discharged from hospitals before they are psychiatrically stable and have regained enough insight to make a reasoned decision about taking medicine. Poor and uninsured people are frequently denied access to the newer psychotropic medications that encourage compliance by causing fewer crippling side effects. Patients who leave the hospital with every intention of being medication compliant find that their Medicaid case has been closed. Or that pharmacies won't take their temporary Medicaid card. Programs have waiting lists. Patients sit in intake shelters for months waiting to be assessed. Maybe the person just got out of jail and doesn't know where to go. Maybe they just need help finding their way to and from the clinic. Or perhaps, with no home and no income, trying to find food and not freeze to death takes up all their time and there's no time to worry about getting and taking medications.

There area multitude of obstacles that poor (and sometimes not poor) people face in accessing mental health services in New York City. But there's one basic truth — when people can't get medicine, they don't take it.

Since Dr. Owens wrote his article, State Attorney General, Eliot Spitzer, has drafted outpatient commitment legislation that he hopes will be introduced and passed by the State legislature. Spitzer's bill offers none of the things the PRA study found helped people; the bill offers no enhanced services, no money for caring teams to coordinate services and encourage patients to make their own choice to accept treatment — the components that helped the Bellevue patients stay out of the hospital.

Particularly reprehensible is the Attorney General's use of references to the death of Kendra Webdale to promote his legislation. It is easy to think of interventions that might have prevented Ms. Webdale's tragic death — more supportive housing, more

[See **Letters to Editor** on page 6]

AREA II TRUSTEE'S REPORT

Good and Not So Good News

by Herb Peyser, M.D.

Herb Peyser, M.D.

There's good news and not so good news. First, the not so good news. Only 36.6% of the members voted in the last election, one out of three, about the same in our Area, New York State. It was the lowest ever, an unhappy sign. Along with this there have been numerous complaints about member and DB distance from APA and an excessive centralization process imposing procedures and policies from top down. With the best of intentions these have nevertheless tended to take place without adequate consultation with the members and their DB/state organization leadership. There has even been talk by some of delinkage, a dangerous path to go down, one seriously hurting MSSNY and the AMA.

The Good News

Now the good news. An important contingent on the Board has heard the members and is doing something about the problem.

It all started some time ago as the last Medical Director presided over (and was in great part responsible for) the growth of APA. However, a style of Medical Directoring evolved that emphasized a great amount of staff independence from APA governance. The Board could propose but the staff disposed, and somewhat of a Chinese Wall was set up between them so that the membership–elected Board, despite its fiduciary responsibility, did not really oversee the projects. Such oversight was felt by some to be unnecessary, inefficient and interfering ("micromanaging"). In addition, within the staff itself, the individual departments and divisions grew and became increasingly autonomous, independent and separate from each other and more distant from the membership, the DBs, and the state organizations. There were disconnects.

In the process the APA grew lumpy and less efficient and there were disconnects and diminished communication within APA itself and between APA and the members and their DBs. Along with the decreased efficiency there were some less than fortunate consequences. This was the reason the Board chose Dr. Steve Mirin as Dr. Mel Sabshin's successor, recognizing his experience as a strong administrator with an efficient, businesslike approach in his previous work. After all, central APA is a $34 million outfit with a staff approaching 200 to do the work of government relations, public affairs, education, CME, conventions and other meetings, research, membership, DB/state organization backup, and many other functions.

Setting Goals

And that is what Steve has been doing, reorganizing, consolidating, rewriting staff contracts to set goals with raises dependent on meeting the goals, and getting things under control to tighten up and slim down the structure and make it more cost efficient. But in the process of this centralization, necessary as it is, we must take care that it does not encroach upon the membership aspects. APA is not just a business. It is a professional organization of colleagues.

For example, Steve is consolidating our book publishing outfit, APPI, with the rest of APA publications, our journals, etc. to diminish duplicative publishing and finance structures, to increase efficiency and to conserve money, but in so doing we must be careful to keep the edit side separate so that the business side cannot interfere with edit the way the AMA Executive Vice President interfered with and fired the JAMA Editor. APPI is the foremost publisher of psychiatric texts in the world but authors would leave if they thought that political or other non professional activities would play a role in the selection and promotion of titles. So APPI must still have its own Editorial Board while its publishing and financial structures are consolidated with APA's.

APA Database Referral Service

Similarly, an APA Database Referral Service, centrally initiated, may well be a good idea, but there are problems. The relationship with Lilly (which is contributing to the Service) must be carefully worked out, and the Service must be carefully interdigitated with the DBs/state organizations who must be consulted and may have their own referral services or their own ideas regarding the Lilly association or other such matters. Perhaps APA should primarily use the DB referral services where they exist and help DBs develop them where they don't, for the local DBs can handle referrals with direct voice contact and know the members, the nature and the geography of the local situation best. However, the legal and medical responsibilities for the referrals may present problems for the DBs, and they should also be able to opt out if they wish. To this end a few of us intervened when it first appeared, emphasizing that it must go to the Board first, representing member input. We worked out with Rod Munoz, APA President, a Board committee that met with the staff to begin to iron out the kinks and report to the Board before it is fully activated, and then continue as an oversight committee. It will be necessary to have a pilot trial period first.

We had tried previously to get routine Board involvement and oversight with all such projects this way but it was difficult. However it had been just such Board involvement that had brought the mid course consultation concerning our expensive but vitally necessary Electronic Communications Project by a major national firm, a consultation that stopped further work until APA got a business management and information system under a Chief Information Officer in place. This is something that will help avoid waste, unnecessary cost and inefficiency, and solve the Y2K problem while continuing to upgrade and consolidate our antiquated, non-communicating information systems, make them more interactive and standardize our software.

Dues Amnesty Program

Also the Board is having the Membership Committee's Dues Amnesty Program worked out with the DBs before being implemented, local option maintained, and the Board having continuing oversight. After all, the local DBs and their Execs know more about the members than the central office does, who they are, their track records, and how best to deal with them.

The Board reorganized the Components, terminating some, putting others under more appropriate Councils in the direction of efficiency and doing some downsizing, limiting the number of members on the Components but decreasing the number of Components a member could be on so as not to decrease member participation. But the Board did not really downsize itself. The Medicare Carriers Advisory Committee has been reactivated.

The Board approved an Early Career Psychiatrist Trustee for one of the Trustee–at–Large spots and reviewed the proposal for a Minority/Underrepresented Trustee for another, but the latter still needs further work on it at the M/UR level to get full agreement among all the groups.

Membership Decline

Membership declines slowly, at the rate of about 1% a year (all professional organizations see declining membership, MSSNY having lost nearly 2000 members in the past two years or so), and we now have 37,000 members, 28,000 dues paying including 4000 MITs. We are planning member recruitment and member retention projects. At the moment the financial situation is good and APA is healthy, with good reserves, but we must plan for the future and the possibility of harder times, especially if the economy goes sour and advertising and other non dues revenue decrease.

Publications

APA and APPI are moving in the direction of on-line journal and text publishing as print sales there, as everywhere, slowly decline. The journals are being translated into other languages for Latin American, Spanish, Portuguese and Italian editions. There will be a text revision (no coding changes) of DSM-IV in 2000 or so, perhaps a coding update in conjunction with ICD-10CM between 2001-2005, and a DSM-V between 2007 and 2010.

Psychologist Prescribing

The first instance of psychologist prescribing permission on U.S. soil (other than in that pilot program in the military) has occurred in Guam where the legislature passed it over the Governor's veto and the opposition of the five psychiatrists there (four APA members). The Division of Government Relations is looking to see how it can help the psychiatrists there.

Opting Out: Medicare and Other HCFA Matters

HCFA reviewed our draft for the Medicare opting out contract and that is available. HCFA is looking into a prospective payment system (i.e., DRGs) for partial hospitalization and community health centers, and possibly even inpatient DRGs in time. It would all be devastating to the mental health system and APA is deeply involved to protect the members.

Again, I ask the DBs to invite me to their meetings so I can keep in touch with them and they in touch with me, and I can take their concerns back to the Board and the APA leadership. Consult my Website for discussion of the latest issues at <http://members.aol.com/hspeysermd>. ■

The Bulletin invites readers to send in their questions or comments regarding the APA and what the APA can do for you.

Forward your material to: citrome@nki.rfmh.org

The material will be sent to the Bulletin Editorial Board and/or the NYSPA Executive Committee for comments. You can look forward to seeing this in future issues of The Bulletin.

Why I Joined the Medical Society of the State Of New York

by C. Deborah Cross, M.D.

I have been an active member of the NYS Capital District Branch for many years, having served as President and currently serving as District Branch Representative. Last year, I was appointed Chief Medical Officer of the Capital District Psychiatric Center and was honored to be elected as Secretary of NYSPA. This year I decided to become a member of the Medical Society of the State of New York (MSSNY). As I became more fully aware over the past several years of the full range of challenges facing psychiatry and organized medicine in this state, I understood why it is vitally important that psychiatrists join MSSNY.

We need the support of all physicians in our fight for parity for the treatment of mental illness and to protect our profession from encroachment by non-medical practitioners. For example, right now NYSPA is working with MSSNY to respond to the challenge of legislation to confer upon non–medical mental health practitioners a scope of practice that includes treatment of mental disorders. MSSNY is also a critical member of the coalition fighting for parity in Albany. Psychiatrists cannot wage these battles alone.

We need the active support of organized medicine represented by MSSNY. The greater the number of psychiatrists who join and participate in MSSNY, the greater our influence and impact. I know our members feel burdened by APA, DB and NYSPA dues. However, we need to *invest* in our future in order to *insure* our future. An investment in a MSSNY membership is an investment in the future of our specialty and the profession of medicine. If you want information about joining MSSNY, please write to Eunice Skelly, Director of Membership, MSSNY, P.O. Box 5404, Lake Success, New York 11042.

News From the District Branches

by Syed Abdullah, M.D.

The Bulletin would like to spotlight some of the activities of the District Branches throughout New York State. To do this effectively we need a constant flow of information, including newsletters, details of professional, educational, legislative and community activities etc., from the DBs. All DBs have been contacted by letter, e-mail, and telephone. We appeal to all of you to participate in this project of sharing information with your colleagues. You can send your pieces to: Syed Abdullah, M.D. at 2 Hawk Street Pearl River, N.Y. 10965; Phone: (914) 735-5078; Fax: (914) 735-0318; E-Mail: <sydabd@aol.com>—Ed.

New York County District Branch

Rosalie Landy, the Executive Director of the NYCoDB was asked by the Speaker of the Assembly, Donna Norris, M.D., to speak to the Assembly members at the November '98 meeting at Washington, D.C. Ms. Landy, in her presentation reminded the audience: "...we, (the executive directors) are the ones who steer the ships and row the boats for the Association." She suggested that the inclusion of the Executive directors in the Assembly proceedings should become a regular feature of all the DBs nation-wide. Ms. Landy received a standing ovation at the end of her speech. She concluded with the following poem which she wrote for the occasion:

You've come a long way people to get where you are today
You're climbing up that mountain, no time for you to stray
You'll face many a battle, but must continue on your way
For only with persistence can you hope to see the day
When managed care and HMOs are clearly out the door
And the practice of psychiatry will reign again once more.
And so together as a group you must begin this task
To accomplish all you possibly can efficiently and fast.
So with this thought in mind as you go on your way
Remember that psychiatry is here and here to stay.

Her full speech was published in the New York County District Branch Newsletter in the Fall/Winter 1998 issue.

West Hudson Psychiatric Society

Synapse, the newsletter of the WHPS has again won the Newsletter of the Year award for small DBs. This is the second time, in nine years of publication, that this prestigious citation has been conferred on the Synapse. This lively little publication has also won other awards over the years including several honorable mentions, continued excellence awards, and the five years' continued excellence award. The Newsletter is noted for its original articles contributed mainly by members of the WHPS.

The WHPS has hosted a large number of scientific/educational meetings in recent months organized by David Brody, M.D., Chair Education Committee. These included the following topics: Psychiatric Treatment of Parkinson's Disease by Michael Serby, M.D., Mt. Sinai School of Medicine; Temperament, Personality and Classification of Mental Disorder by Robert Cloninger, M.D., Washington University School of Medicine; Management Issues for the Private Practitioner addressed by Seth Stein, Esq., Executive Director and James Nininger, M.D. President of NYSPA. Lois Kroplick , D.O., is active in Coalition building and community activities in conjunction with NAMI, FAMILYA and Allied Professions. She is currently busy organizing the next Picnic for Parity at Rockland Lake. Last year's Picnic was a great success attended by over 400 people, including patients and professionals.

Queens County Psychiatric Society

We have received the following information from Ms. Wessely, Executive Director of the Queens County Psychiatric Society: On Tuesday, June 15th, 1999, the Queens County Psychiatric Society and the Queens County Medical Society will host a CME Program on cognition. The speaker will be Philip Harvey, Ph.D. The Meeting will take place on board the THOMAS JEFFERSON STEAMER (a replica of the side wheel paddle steamers that cruised Long Island Sound's Gold Coast in the nineteenth century) leaving Glen Cove Harbor, Long Island at 6:45 p.m.. This three-hour dinner cruise is being sponsored by Janssen Pharmaceuticals. Michael Gordon, M.D., President of the Queens County Psychiatric Society, wishes to extend an invitation to NYSPA/DB officers to join his District Branch in this delightful evening. As seating is limited, please contact Debbie Wessely at 1-877-612-7110 (toll free in New York and New Jersey) for reservations and further information.

Western New York Psychiatric Society

As submitted by Donna M. Ball, Executive Secretary of the Western New York Psychiatric Society: March 25, 1999 was the night of a dinner meeting with William Glazer, M.D., Harvard Medical School. The topic was "Antipsychotic Medication and EPS: Bio-Psycho-Social Considerations." On April 22, 1999, Paul Jay Markovitz, M.D., Case Western Reserve University, was the featured speaker at another dinner meeting, focusing on "Pharmacotherapy of Borderline Personality Disorder." ■

Where to Register Complaints Regarding Health Insurers

The Greater New York Hospital Association (212-246-7100) has prepared a table of telephone numbers that can be used when pursuing complaints about health insurers.

	NYS Insurance Department	NYS Department of Health	NYS Attorney General	US Health Care Financing Administration
For complaints about…	**AHIs and HSCs unless otherwise noted**	**HMOs and PHSPs**	**Any insurer**	**HMOs with Medicare products**
Prompt payment of claims and other claims issues	800-358-9260 any insurer		800-771-7755 press 3	Mail or fax complaints to: HCFA/Health Plans Branch, 26 Federal Plaza, Room 3800, New York, NY 10278 Fax: 212-264-2665
Medical necessity decisions, utilitization review agents, appeal process (appeals are complaints by members and providers about medical necessity decisions)	800-342-3736 press 1/8/3 AHIs, HSCs, and their URAs	800-206-8125 HMOs, PHSPs, WC/NFs, and their URAs		
Provider contract terms		518-473-4842		
Member contract terms	800-342-3736 press 1/8/3 any insurer			
Grievance process (grievances are all complaints by members except those about medical necessity decisions), disclosure to members	800-342-3736 press 1/8/3	800-206-8125		
Quality of care				800-331-7767 (IPRO)
Insurance fraud	888-372-8369			

AHI = Accident and Health Insurer regulated under Insurance Law Articles 32 and 42

HMO = Health Maintenance Organization certified under Public Health law Article 44

HSC = Medical/dental indemnity or hospital/health services corporation licensed under Insurance Law Article 43

PHSP = Pre-Paid Health Services Plan certified under Public Health Law Article 44

URA = Utilization Review Agent required to register with the Department of Health under Public Health Law Article 49 Or a Utilization Review Agent required to report to the Insurance Department under Insurance Law Article 49

WC/NF = Workers Compensation or No-Fault insurer

Patient Privacy

Continued from page 1

and utilization review.

Privacy and Confidentiality

Privacy refers to the right of the patient or his or her agent; confidentiality to the ethical and legal requirement of the custodian of the information, whether it's the doctor or the owner of computerized data. Insurance, drug, and managed care companies wish to shift the debate from a focus on the privacy rights of the individual to a debate on what happens after records are electronically stored.

Once clinical information is stored in a computerized data bank neither patient nor clinician has control over its distribution. Some argue that privacy of records jeopardizes patient safety if, for example, an accident victim requires emergency care in a distant state. While this argument may be sound in the abstract, it becomes highly disconcerting when one learns of unauthorized uses of records. However, authorized uses of medical information are a much greater danger because consents are so broad that neither patient nor doctor have any idea where the information may wind up. Employers, especially those who self–insure, have legal access to an employee's medical records, to the detriment of current or prospective employees. Thirty five percent of Fortune 500 companies acknowledged using personal health information to make employment decisions. Prescription records and personal data are legally used to market drugs.

The Medical Record – a Valuable Commodity

Since the medical record is a valuable money–earning commodity, business enterprises, in essence, assume ownership over it as they would over any other asset. They, thus, deny control to the patient, to whom it justly belongs.

What is missing from the debate is the fact *that health information privacy is important for quality health care and privacy belongs to the patient*, as recognized under Constitutional, common, state statutory law, and standards of medical ethics. In all of medicine we need to vigorously argue that the privacy of the doctor patient relationship dates back to the time Hippocrates. However, this privacy of communications is especially central in a psychotherapeutic relationship.

Jaffee v. Redmond: Privacy = Quality Care

In 1996 The U.S. Supreme Court ruled in Jaffee v. Redmond that "effective psychotherapy… depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosures." The Court upheld that "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment." It rejected a "balancing component of the privilege" because "making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege." If the Court ruled the psychotherapist-patient privilege to be absolute in court cases, shouldn't the privilege be absolute in all situations, including psychological treatment under insurance coverage? If certain proposed bills in Congress were to be enacted into law, patients seeking psychotherapy could not be guaranteed a full protection of their "confidential conversations."

The Court's ruling was so important to both private interest and public interest that they created a new psychotherapist–patient privilege, without requiring a balancing test and creating a new exception to the principle that the court has the "right to every man's evidence." Although 50 states and the District of Columbia have laws protecting the privacy of communications in psychotherapy, until Jaffee there was no Federal rule to this effect.

Although the Court distinguished between the treatment of physical and mental ailments in their need for confidentiality, can one argue that the Court is not following its own examination of the centrality of privacy and confidentiality in the building of trust by all doctors? The Court believes that treatment for physical ailments can proceed successfully simply with objective measurements, not requiring full disclosure by the patient; yet to all of us, "reason and experience" demonstrates that without trust a patient will not confide in the physician.

Privacy Principles

A. Federal standards should expressly recognize that patients have a right to privacy for identifiable health information which should not be waived without meaningful notice and informed consent.

B. The principled approach to medical privacy requires an assurance that citizens not lose their rights whenever they seek health care. Eighty seven percent of Americans believe that laws should prohibit health care organizations from releasing medical information without their consent.

C. Whenever identifiable health information is required, meaningful notice and informed consent has to be obtained in contrast to the use of blanket consents, essentially coerced. Ninety three percent of Americans believe that companies that sell information to others should be required by law to ask permission from individuals.

D. In rare situations where identifiable health information needs be obtained without the patient's consent or against the patient's will, procedural safeguards should require those seeking the information to bear the burden of showing that there is a need for the information and that it directly furthers an important public interest. There has to be evidence that patient consent cannot reasonably be obtained, that the need can be met only through the use of identifiable information, and the use of the information will be limited to the purpose for which it was obtained.

Legislative Agenda

Several bills are being considered in Congress. It is central that none pre-empt State laws such as the excellent privacy laws in DC and Illinois. In DC, a mental health professional's notes can only be disclosed if the professional is sued for malpractice by the patient. Disclosures to third parties are tightly regulated and re-disclosures to others prohibited.

By April 1999, Senators James Jeffords (R-VT) and Chris Dodd (D-CT) introduced the 1999 version of the Health Care Personal Information Nondisclosure Act. Senators Patrick Leahy (D-VT) and Edward Kennedy

[See **Patient Privacy** on page 8]

The Current Crisis in Adolescent Psychiatry

by Richard Rosner, M.D.

Richard Rosner, M.D. is President of the Society for Adolescent Psychiatry, Inc. and Chairman of the Council on Education and Scientific Affairs of the American Society for Adolescent Psychiatry. Dr. Rosner is Medical Director of the Forensic Psychiatry Clinic of Bellevue Hospital Center and former-Associate Commissioner for Forensic Mental Health Services of the New York City Depatment of Mental Health, Mental Retardation & Alcoholism Services. He is a Clinical Professor of Psychiatry at New York University School of Medicine. –Ed.

The most cursory perusal of current newspapers reveals the current crisis in adolescent psychiatry: teenagers whose mental health problems are flagrantly undetected and under-treated until they explode in violence against themselves and against innocent other people. There is a gross discrepancy between the needs of youth and the funds and personnel available to meet those needs. The number of persons entering general psychiatry, despite a recent slight increase in the number of USA medical school graduates applying for psychiatric residencies, continues to be relatively low in comparison to the past. Further, there remains a tendency in general psychiatry training programs to assume that persons interested in treating youngsters will be able to learn what they need to know by taking a subspecialty residency, notwithstanding the requirement of the Accreditation Council on Graduate Medical Education that child and adolescent psychiatry be part of the training of general psychiatrists. However, the number of psychiatrists who choose subspecialty residency training in child and adolescent psychiatry remains low. The result is that few general psychiatry trainees feel genuinely comfortable in the diagnosis and treatment of juveniles and an insufficient number of child and adolescent psychiatrists are available to address the needs of troubled teenagers.

If sufficient psychiatric personnel are to be made available in a timely manner to meet the needs of adolescents, such personnel must be drawn from the ranks of existing practitioners of general psychiatry. Such generalists must be provided with intensive training in the core didactic contents of adolescent psychiatry, in a convenient format and at a price that is affordable. The Council on Education and Scientific Affairs of the American Society for Adolescent Psychiatry, the Society for Adolescent Psychiatry, Inc., the Tri–State Chapter of the American Academy of Psychiatry and the Law, the Forensic Psychiatry Clinic of Bellevue Hospital and the Post-Graduate Medical School of New York University have pooled resources in a pilot project to begin to address the crisis in available personnel trained in adolescent psychiatry.

Adolescent Psychiatry: Forensic Considerations and Clinical Practice, a seventeen session course, granting 25+ hours of Category One credit in continuing medical education, has been offered at no cost to all interested persons during the Spring 1999 semester. The faculty is drawn from the cooperating organizations and consists of Board–certified forensic psychiatrists, Board-certified adolescent psychiatrists, and Board–certified child and adolescent psychiatrists. Approximately 30 persons will complete the 1999 training program and receive a certificate of course completion. Graduates of the course meet the minimum training requirements for eligibility to take the examination of the American Board of Adolescent Psychiatry, Inc.

The scope of the course is extremely ambitious, so that some participants exclaimed that they had not previously grasped how extensive adolescent psychiatry was, how much one had to know in order to assess and treat teenagers. The course curriculum covers assessment of adolescents, development, psychiatric disorders (and their treatments) in adolescents, adolescent sexuality and risk-taking behaviors, and adolescent forensic psychiatry.

A major goal of the course is to encourage the participants to seek additional reading, additional didactic training, and additional clinical experience. Interested persons are invited to attend the evening special educational sessions of the Society for Adolescent Psychiatry and the weekend courses of the Tri–State Chapter of the American Academy of Psychiatry and the Law. This year those programs included an address by Meg Kaplan, Ph.D., Clinical Associate Professor of Psychiatry at Columbia University College of Physicians and Surgeons, on Diagnosis and Treatment of Adolescent Sex Offenders and an address by Professor Joan Wexler, Dean of Brooklyn Law School, on The Legal Rights of Adolescents.

This year, participants read *Juvenile Psychiatry and the Law*, edited by Richard Rosner, published by Plenum Press, New York, in 1989. Next year, it is hoped that participants will have access to the *Textbook of Adolescent Psychiatry*, edited by Richard Rosner, to be published by American Psychiatric Press, Inc., Washington, D.C., in 2000.

Obviously, thirty graduates of a one semester didactic course will not meet the needs of the nation. Rather, this was a pilot project designed to demonstrate the feasibility of such educational ventures and to encourage the development of similar efforts across the USA. The purposes of the pilot project included determining whether (1) existing professional societies would cooperate in an inter-organizational public service program, (2) existing Board–certified specialists would be willing to serve as unsalaried teachers, (3) there were general psychiatrists with a sufficient interest in adolescent psychiatry to commit to 25+ hours of training, and (4) there were enough participants in the program to justify the effort in planning and implementing it. Based upon the initial success of the 1999 pilot project, and the strongly positive evaluations of the course by its participants, the course has constructively addressed a previously unmet need for substantive post–residency training in adolescent psychiatry. It will be continued in the future.

Persons interested in obtaining more information about post-residency training opportunities in adolescent psychiatry are invited to contact Ms. Frances Roton, Executive Director, American Society for Adolescent Psychiatry, P.O. Box 28218, Dallas, Texas 75228, telephone (972) 686-6166, FAX (972) 613-5532. ■

Free Training In Forensic Psychiatry

Each year, from September through May, the Tri–State Chapter of the American Academy of Psychiatry and the Law, offers a two–semester training program, covering all aspects of Forensic, Legal, and Sociolegal Psychiatry. The program meets Wednesday mornings, 9-10:30 A.M., at the Dept. of Probation, 115 Leonard Street, 2nd floor Conference Room, Manhattan. The first session of the 1999-2000 program begins on Wednesday, September 15, 1999.

There is no charge for the program, but all participants are expected to attend the entire series and acquire the required readings. CME credits are provided, hour for hour, and a Certificate is offered to all completing the entire course.

For further information and preregistration, contact the Course Coordinator, Dr. Alan Tuckman, Forensic Mental Health Service of Rockland County, (914) 638-5425 or (914) 354-6363.

Letter to Editor

Continued from page 2

assertive community treatment teams, more intensive case managers, more and faster mobile crisis teams, easier access to emergency hospitalization, and better hospital discharge planning and follow up are a few that come to mind. Outpatient commitment does not. In the form Eliot Spitzer proposes, with no extra services attached, outpatient commitment will not even be an effective monitoring mechanism, let alone a compassionate solution for people with mental illness who today fall through the cracks of our mental health system.

I understand how essential the outpatient commitment program seems to some family members and others who care about people with mental illness. But it's a mistake to expect this program to be a quick fix for the much larger problem of lack of access to services. I know that the proponents of forced treatment want to help people with mental illness, but this is not the best use of our efforts and resources.

Heather Barr, Staff Attorney
Urban Justice Center's
Mental Health Project
New York, NY

1999 Area II Council Spring Meeting

In attendance at the Millennium Broadway Hotel, New York City, were reps and deputy reps from New York State District Branches for the two–day affair held March 20-21, 1999.

Sunday, March 21, 1999: Special Presentation: A Discussion of the Report to the Commissioner of Health from the Advisory Work Group on Human Subject Research Involving Protected Classes. Discussants: Donald Klein, M.D. (right) and Allen Bennett, M.D. (center). Moderated by Herb Peyser, M.D. (left)

Candidates for Recorder of the APA Assembly Nada L. Stotland, M.D. (left) and Larry E. Tripp, M.D. introduced to the Area II Council by NYSPA President Jim Nininger, M.D.

Legislative Institute

Continued from page 1

posed of New York State and its District Branches, was especially well represented at the Institute. Led by its representative to the JCGR, Barry B. Perlman, M.D., NYSPA's Vice President and Legislative Chair, there were ten members from 6 DB's and 3 of the DB Executive Directors. Given the large turnout, the group was able to schedule meetings with the offices of both of the state's Senators and 18 of its Representatives from both sides of the aisle. These meetings, whether with the elected official or their staff, served to highlight organized psychiatry's concerns about the care of patients and the profession. It is hoped that lasting relations between psychiatrists and their elected officials can begin through such contacts.

Finally the Institute provides a vehicle for the APA to honor those in public life who work hard to protect persons with mental illness. This year the Jacob K. Javits Award, the highest award given by the APA to those in public service, was presented to Rep. Benjamin L. Cardin (D-MD), while Distinguished Legislator Awards were presented to Rep. Peter DeFazio (D-OR) and Rep. Jim Ramstad (R-MN). For the first time, awards for Distinguished Legislative Advocacy were presented to APA members who had made a difference. They were Jeffrey Akaka, M.D. of Hawaii, Helen Foster, M.D. from Virginia, Kathleen Thomsen-Hall, M.D. from Arkansas, and Captane Thomson, M.D. from California.

The following is a listing of NYSPA members and DB Executive Directors who attended the Federal Legislative Institute and lobbied on behalf of all New York Psychiatrists and their patients. New York County DB - Ann Sullivan, M.D. (NYSPA's Treasurer), Vivian Pender, M.D., Marvin Nierenberg, M.D., and Julie Schulman, M.D.(MIT trustee–elect to the APA Board); Greater Long Island DB - Frank Dowling, M.D.; Brooklyn DB - Ramaswamy Viswanathan, M.D.; Queens DB - Pauline Kuyler, M.D.; Bronx DB - Susan Stabinsky, M.D. (DB President); Westchester DB - Anthony Villamena, M.D. (DB President), Barry B. Perlman, M.D. (NYSPA's Vice President), Dione Ghisalbert, D.O., Harvey Stabinsky, M.D.; NYS Capital DB - C. Deborah Cross, M.D. (NYSPA's Secretary). The DB Executive Directors participating were Mary Cliffe from the Westchester and Bronx DBs, Rosalie Landy from the NY County DB, and Linda Majowka from the Brooklyn DB. ■

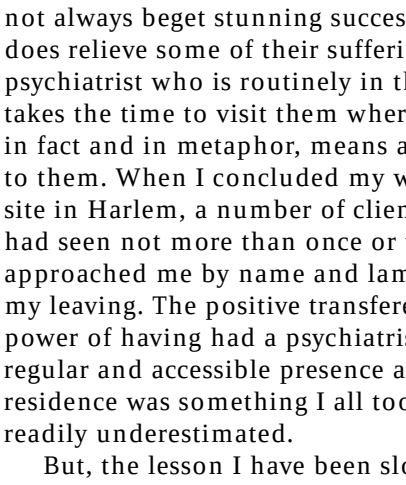
MIT CORNER

Serving the Homeless

By Craig Katz, M.D.

Psychiatry involves itself with an immense number of illnesses as well as treatments for those illnesses. It is truly a "big tent" under which a stunning variety of clinical and research endeavors occur, making it an endlessly fascinating field for those of us lucky enough to be counted as psychiatrists. I would here like to take the time to advocate for one aspect of psychiatry, the treatment of the homeless mentally ill, as a special opportunity for psychiatric residents to make use of their developing clinical expertise. Such work poignantly touches upon so many issues fundamental to psychiatry and to the human condition itself.

I have worked with the homeless mentally ill for the last year and one–half of my residency through a New York City based non–profit organization known as The Project for the Psychiatric Outreach to the Homeless (PPOH). PPOH serves as a critical link between homeless agencies in need of psychiatrists and psychiatrists who are able and willing to engage in this work. PPOH places volunteer, and less frequently salaried, psychiatrists at sites that otherwise would not have reliable access to psychiatric assistance for their clients. Through PPOH, I have worked at both a housing facility for previously homeless people in Harlem and at a homeless drop–in center on Manhattan's Upper East Side. How can I count the many positive clinical, educational, and personal aspects of these experiences?



More than anything else, I have been struck by the enormous impact that a dedicated psychiatrist can have on people. Treating homeless clients who seem to have nothing or little to nothing — family, shelter, income — can be daunting. On the other hand, your work in treating their underlying mental illness can lead to striking gains in function for these individuals.

I have treated seemingly recalcitrant clients who were plagued by severe but untreated mood or psychotic disorders that kept them endlessly homeless and hopeless only to see them go on to obtain housing, seek work, and reconnect with estranged family and friends once they were psychiatrically stabilized. By simply having access to sound, not necessarily complex, psychiatric care, these people have turned around their lives in ways that seem nearly miraculous to me. Consider a middle-aged male war veteran with a violent criminal history and years of homelessness who I evaluated for severe mood lability and hostility. Over several months of receiving a mood stabilizer and supportive psychotherapy, he went from being a loud, impulsive, table-pounding terror to a calm, almost puppy–like patient, who was able to then receive and accept permanent housing . He even grew to calling me when he could not make an appointment.

Of course, some homeless mentally ill seem to be trapped in an unending cycle of homelessness that even my best efforts have not changed. But, I have learned that while my work with such clients may not always beget stunning success stories, my presence and commitment does relieve some of their suffering. A physician and psychiatrist who is routinely in their lives and takes the time to visit them where they are, both in fact and in metaphor, means a great deal to them. When I concluded my work at the site in Harlem, a number of clients who I had seen not more than once or twice approached me by name and lamented my leaving. The positive transferential power of having had a psychiatrist as a regular and accessible presence at their residence was something I all too readily underestimated.

But, the lesson I have been slowest to acquire in my work at PPOH is my importance to the on–site caseworkers and support staff. I naturally assumed that my mission at the sites was to help the clients. Yet, homeless caseworkers deal with challenging and sometimes frightening clients on a daily basis without the supports for such work available to us who work at medical centers. To have a psychiatrist make educated sense of clients' confusing behaviors and attitudes and offer interventions was like a gift from the heavens full of unforeseen reassurances for the staff. Although my work has been supervised by attendings at my residency program, when I am on–site, my words and actions are treated like they were those of an APA President. As an ambassador for psychiatry in the real world beyond the hospital, I have steadily recognized just how much I have learned in my residency and just how appreciated it is when that expertise is brought to all members of the community, whether they are identified patients or not.

In short, working with the homeless mentally ill has meant as much to me as it has to those I have helped. In case you had forgotten, it, too, can remind you of why you entered into psychiatry.

(The Psychiatric Project for Outreach to the Homeless may be contacted at (212) 579-2650.) ■

Let the Work Begin

by Ann Maloney, M.D.

Ann Maloney, MD, is the new Trustee-at-Large elect. She is in full time private practice , a member of the voluntary faculty at NYU Medical Center and a candidate at the Columbia Psychoanalytic Center for Training and Research. The Bulletin looks forward to her regular contributions. –Ed.

Ann Maloney, M.D.

The most recent issue of *Psychiatric News* stated there are 37,000 members of the APA. This is down from 45,000 members in 1996 when I first became a member of the Assembly, almost a 20% reduction in three years. If we factor out medical students, life members and so forth, the reduction in dues paying members is even greater: 10% per year! Only 25% of the membership voted in the most recent elections. How did this disaffection happen? What does it mean? And most importantly, what can we do about it?

During the most recent election, I described the alienation of APA members from their governance — their sense that they are not stockholders in this organization. I ran on a platform of accountability, concrete returns on your investments, professional pride and knowledge. I suggested that you, the members, take ownership of this organization and I'm inviting you to do so now.

I believe the APA is important as our profession's collective voice and represents the best option for solving the problems faced by our patients and now ourselves. Each of the subspecialty organizations within psychiatry relies on the APA for local, state and national lobbying efforts essential to our patients' rights and to our ability to treat them. Without the APA, none of our interests can be represented or protected.

So why are our members dropping away? Simply put: they've become disillusioned and have lost their sense of professional identity. They don't see the APA as being essential or effective. How can we change that?

I believe that we, the District Branches, the Areas and the central APA need to become proactive and establish an agenda with clear cut objectives and mandates for "action" nation wide. But you the members who are the "owners" of this organization, need to decide what those goals are.

The New York State Psychiatric Association's Strategic Planning Committee is sending you a questionnaire in the next few weeks and the Central Office has offered funding for local initiatives. In addition, the New York County District Branch has established its 1999-2000 intention to actively promote a positive and professional image of psychiatry and psychiatrists. To this end, it is forming a new Public Affairs Committee, whose charge is to actively promote a positive and professional image of psychiatry and psychiatrists. Objectives include more newspaper and magazine articles on psychiatry, more public appearances, and more (positive) media attention. In addition, the executive council will direct each of the DB committees to focus their charge toward facilitating this goal. More information about the NYCoDB's efforts can be obtained by contacting the DB at (212) 421-4732, (212) 754-4671 fax, <NYDBAPA@mail.idt.net>.

In pursuing these and other initiatives, I need your input. Please fax or e-mail me at the same numbers. I look forward to hearing from you. ■

Save The Date

The Bronx Mental Health Coalition (under the leadership of the Bronx District Branch) is sponsoring an Art Show October 8, 1999 at the Bronx Museum of Art.

More details will be provided in the next issue of The Bulletin.

Patient Privacy

Continued from page 5

(D-MA) introduced the Medical Information Privacy and Security Act. Sen. Robert Bennett (R-UT) is expected to introduce yet another bill which "would create a national standard for the protection of identifiable medical information." In contrast Leahy's bill "would create a national 'floor,' allowing stronger state laws to be applied." The Jeffords bill "permits any stronger state laws existing at the time of enactment," and gives states 18 months to pass stronger protections in the areas of public health and mental health. Health industry groups have embraced Bennett's bill which would ease communication of data, while civil liberties advocates have attached themselves to Leahy's bill. However, his position in the minority makes it difficult for passage. Our hope is that the Jeffords bill and the Leahy bill come closer together.

Medical information, as Senator Dodd is quoted as saying, "is too available to too many people. We need to be able to say to people that your medical records are going to be behind a deadbolt and your privacy will be protected".

For more information call the American Psychoanalytic Association: Robert Pyles, MD, President (781) 235-6211 or Leon Hoffman, MD, Chair, Committee on Public Information (212) 249-1163; <73542.334@ compuserve.com>; the Coalition for Patient Rights: James Pyles at (202) 466-6550; the National Coalition for Patient Rights at 888-44-PRIVACY or at <www.national cpr.org>; or subscribe to Psych-Grass roots at <grassroots@ psychmd.net>. ■

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