THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

Fall 2001, Vol. 44, #3 • Bringing New York State Psychiatrists Together

President's Message: Responding to Disaster and Aftermath

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

Jim Nininger, M.D.

As I write this message, thousands of psychiatrists in New York City, New York State and across the country are responding to the attack on the World Trade Center and the Pentagon. There are thousands of casualties, tens of thousands of family members who must deal with the loss of loved ones and millions of virtual eyewitnesses in every corner of this nation who saw over and over, and in excruciating detail, the face of evil on September 11th.

NYSPA has responded to a request from Commissioner Stone of the NYS Office of Mental Health and prepared a list of psychiatrists who are ready to volunteer their services to those in need. Psychiatrists who want to add their names to this list should contact the NYSPA Central Office and check the NYSPA website (nyspsych.org) for more information. Many district branches have organized efforts to provide support, counseling and referral. Members should contact their district branches directly. Hospitals, clinics and social service agencies also are offering counseling and referral. Help is out there.

Psychiatrists are especially prepared by their training and expertise to address the short and long term impact of this event. Whether it is called shell shock, battle fatigue, Vietnam War syndrome or post traumatic stress disorder, psychiatrists know about the impact of this type of disaster. The true scope of the psychiatric problems from this tragedy will be seen not just over the ensuing months, but over years, and not only among those who were at "ground zero" or who lost, or feared they had lost, a family member or friend, but also among those who only viewed the horrific scenes on their television.

We are also awaiting a public statement from the behavioral managed care industry affirming their intention to insure that patients in

[See **President's Message** on page 2]

Coping With Bioterrorism Anxiety

The following is a press release from the APA central office. It is intended for the lay press and is reproduced here for your use with your patients and to help answer questions from the public. Feel free to distribute as needed. –Ed.

Fear and anxiety are normal human reactions to a perceived threat or danger. But such uncertainty is manageable if people keep the threat in perspective, the American Psychiatric Association said today.

"The reports and images of the September 11 atrocity and recent bioterrorism are frightening to all of us," says Richard K. Harding, M.D., APA President. "But knowledge and information based on fact can help us manage our understandable anxiety."

The Association offers the following advice on how to live with the fear and anxiety caused by the threat of bioterrorism.

Educate yourself about the potential danger. Facts are frequently less frightening than rumors and myth. The federal Centers for Disease Control is an excellent source at www.cdc.gov <http://www.cdc.gov/> .

If television or other news reports significantly increase feelings of anxiety and helplessness, don't watch or read them; you don't need to know every last detail. Television news of violence can be frightening to children, especially when it is viewed repetitively.

Find ways to distract yourself from thinking about the potential for harm. Get involved in an activity that you can control: work in the garden, clean the basement, do volunteer work, take up an old hobby, take a "time out" and go to the movies or a play.

[See **Bioterrorism** on page 2]

As we were going to press, the tragic events of September 11, 2001 were unfolding. This issue of the Bulletin is over one month late and contains a mixture of pre-September 11 and post-September 11 items. You are encouraged to e-mail me with any news from your individual District Branches ASAP at <citrome@nki. rfmh.org> for inclusion in the next issue of the Bulletin to be published in December 2001.

Physician Discipline in New York State

by Martha Crowner, M.D.

Dr. Crowner is on staff at Manhattan Psychiatric Center. What follows is a description of the sometimes mysterious disciplinary processes in place in New York State. Additional information can be found at <http://www.health.state.ny.us/nysdoh/opmc/main.htm>. -Ed.

Earlier this year the New York State Commissioner of Health suspended the license of a prominent surgeon at New York Methodist Hospital in Brooklyn. His license was suspended though hearings to investigate numerous charges of negligence and incompetence are still ongoing because, according to Dr. Novello's order, he constitutes an imminent danger to the health of the people of our state.

How does this happen? What process does New York State employ to police physicians? How are complaints investigated? What is reportable misbehavior? What is not?

Many Complaints

The process starts with a complaint. In 2000 the New York State Department of Health's Office of Professional Medical Conduct (OPMC) received 6106 complaints, while in the same year the Board for Professional Medical Conduct (the Board) carried out 357 disciplinary actions. At each successive step of the process between receiving a complaint and issuing a disciplinary action many matters are resolved.

Who Complains?

The great majority of complaints, 60%, came from the public, but substantial proportions came from insurance companies (13%), other states (11%), and governmental agencies (10%). A much smaller proportion came from hospitals or health care facilities (3%), or other physicians and medical societies (2%). Hospitals, nursing homes and HMO's are required by law to report when they have a probable suspicion of misconduct. Other states are required to report physicians against whom they took disciplinary action. If the doctors are also licensed in New York, our state may take action against their licenses. Physicians are required to report misconduct in their colleagues. In case they cannot be certain that another physician's behavior is misconduct they may consult with OPMC while not revealing the physician's name or they may choose to report to a hospital peer review committee or to a county medical society.

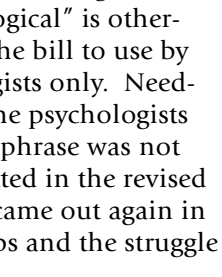
[See **DISCIPLINE** on page 7]

INSIDE THIS ISSUE:

LEGISLATIVE UPDATE

Legislative Year in Review

by Richard Gallo, NYSPA Legislative Consultant



The scope of practice debate was in the forefront by mid-April as the sponsors of the various bills at issue pushed for closure by June. Electroconvulsive Therapy (ECT) came under attack in May as the result of two controversial cases at the Pilgrim Psychiatric Center on Long Island. The Mental Health Insurance parity bill in the Assembly was strengthened, during the legislative session, to a full mandate for a broad array of benefit plans. And the New York State Psychiatric Association's efforts with the Legislature and the Governor with respect to State Budget bills is ongoing with expectations of positive results if and when a comprehensive budget is adopted.

Scope Of Practice

The thirty years of rancor over who should be licensed as a mental health professional and what they should or should not be authorized to do may be coming to an end. Three and one half years of a concerted effort to craft legislation acceptable to all of the parties involved appears to be in the offing. NYSPA, together with the Medical Society of the State of New York (MSSNY), have negotiated bill language with respect to the licensing of "mental health practitioners" that will enable the medical community to remove its opposition to the bill. Similarly, an agreement was reached in June with the State Psychological Association with the help of Senate Majority; but the agreement, as discussed below, has become undone.

Psychology

The new problem with the psychology scope of practice bill surfaced when the psychology proposal and the mental health practitioners' bill were reattached to one another in late June. In the resulting amendment, three words were left out of the psychology portion of the bill. The three words, "use of titles," were part of a broader exemption to amplify that nothing in the psychology scope of practice law would affect or prevent the practice, conduct, activities, services, or "use of titles" by a licensed physician. The net effect of dropping the three little words would be to prohibit physicians from performing "psychological" services, including psychological and neuro-psychological testing because the term "psychological" is otherwise restricted in the bill to use by licensed psychologists only. Needless to say, when the psychologists acknowledged the phrase was not inadvertently omitted in the revised bill, the weapons came out again in the opposing camps and the struggle continues.

[See **LEGISLATIVE** on page 8]

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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 editor for current rates and media requirements. NYSPA members receive a discount of 50% off the basic classified ad rate.

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From the Editor's Desk…
Deep Six The Bulletin? More Nays than Yeas!


Leslie Citrome, MD, MPH

I received a total of fourteen responses from the NYSPA membership regarding the questions raised last issue about the future of the printed Bulletin. Responses were received by e-mail and telephone calls (about 50/50). Twelve responses were positive — usually along the lines that the printed Bulletin is easier to bring with you, comes passively in the mailbox, and serves as a reminder that NYSPA is there for you. There were several responses that included statements such as "I don't really use the internet," "I don't have a computer," and "If I had to actively go to the website, I never really would." I also received several responses from non–NYSPA members. These were newsletter editors from other District Branches who indicated that they were grappling with very similar issues.

I received one ambivalent response, and one negative response. To illustrate the latter, I have reproduced it below (preserving the anonymity of the sender):

From: [Name withheld by the Bulletin]
Sent: Thursday, July 19, 2001 3:16 PM
To: citrome@nki.rfmh.org
Subject: NYSA Bulletin

Deep six the Bulletin. Too much of my dues gets wasted on this junk.

From this small sample of 14, we see that 86% were in favor of continuing The Bulletin, 7% were ambivalent, and 7% were negative. If these responders were representative of the general membership, we could make the assumption that of 4454 NYSPA members, 3830 want the Bulletin to continue, 312 are ambivalent, and 312 would like to see it cease operations. Another interpretation could be that from the 4454 members, 12 want The Bulletin to continue, one is ambivalent, one wants it to cease operations, and 4440 don't really care. Which interpretation is more accurate? I would like to see more responses — please call me at 845-398-5595 or e-mail me at citrome@nki.rfmh.org TODAY!

This issue devotes space to committee reports and the intention is that one issue per year would serve as a min-annual report of the activities of the NYSPA committees. Some committees are more active than others. Which ones are YOU most interested in? A list follows:

- Committee on Addiction Psychiatry
- Committee on Awards
- Budget Committee
- Bulletin Editorial Board
- Committee on Children and Adolescents
- District Branch Presidents Committee
- Committee on Early Career Psychiatrists
- Committee on Economic Affairs
- Committee on Ethics Education
- Executive Committee
- Committee on Legislation
- NYSPA-OMH Liaison Group
- New York State Psychiatric Political Action Committee, Inc
- Committee on Nominations
- Committee on Procedures
- Practice Research Network
- Committee on Psychiatry and the Law
- Committee on Public Affairs
- Committee on Public Psychiatry
- Committee on Members in Training
- Task Force on Practice Guidelines
- Task Force on Strategic Planning

Each committee consists of a chairperson and several members. A membership directory is available from the NYSPA office.

Finally, please note an announcement on page three. As planned we are searching for a successor for when my five–year term ends with the Winter 2001-02 issue. If interested feel free to contact me in addition to contacting the NYSPA office. ■

President's Message
Continued from page 1

need of care will receive necessary treatment. Now is the time for this industry that controls access to treatment for millions of Americans to join with the rest of the health care system and respond to the special and unique circumstances arising from this attack on our country. Patients suffering from psychiatric problems arising from this tragedy need access to care — not managed care.

As the dust literally begins to settle from this catastrophe, the provision of mental health services becomes paramount. Finally, to those who lost a family member, relative, or friend, we offer our deepest condolences. To the police, fire officers, emergency workers, and physicians who risked (and in some cases, lost) their lives to help others, we give our heartfelt thanks and to those who are suffering and in need of emotional support, we offer our help and assistance. ■

Bioterrorism
Continued from page 1

Take advantage of the weekends to refuel. A day or so away from normal routine — whether spent at home or on a weekend getaway — breaks the cycle of preoccupation with disaster.

Talk about your anxiety with family or friends; avoid being alone.

When you find yourself worrying about the unknown, mentally change the subject.

Avoid or at least minimize alcohol and caffeine intake; caffeine can add to "the jitters," and both disrupt sleep.

Get regular exercise.

If you smoke, don't increase your tobacco consumption. While it may seem to ease anxiety in the short run, increased smoking poses significant long–term health hazards.

If you are uncontrollably fearful and preoccupied with the threat of harm to the extent you cannot continue your daily activities, you should consider talking to your physician or a mental health professional. Symptoms indicate a need for a medical evaluation include but are not limited to:

- Changes in eating and sleeping habits;
- Physical problems: stomach upsets, back and neck aches, headaches;
- Inability to focus or concentrate on the task at hand;
- Lack of interest in previously enjoyable activities; and
- Extreme fear of leaving your home.

This text is available for easy downloading at <www.nyspsych.org>. ■

Bioterrorism - Information For Physicians

Additional medical resources available free on the web. JAMA is offering the following five articles viewable free of charge

- Tularemia as a Biological Weapon June 6, 2001
- Botulinum Toxin as a Biological Weapon February 28, 2001
- Plague as a Biological Weapon May 3, 2000
- Anthrax as a Biological Weapon May 12, 1999
- Smallpox as a Biological Weapon June 9, 1999

To access, go to <http://www.ama-assn.org/ama/pub/category/6232.html>.

COMMENTARY

NYS Psychiatrists: How Many, How Old?

From MSSNY's News of New York report of an analysis by the SUNY (Albany) School of Public Health's Center for Health Workforce Studies:

In 1999 there were 55,541 physicians actively providing care in NYS, 305 physicians per 100,000 population (2nd highest state), 328 persons per physician (76,160 licensed but the balance included those practicing out of state, residents, fellows, retired, inactive, etc). But the physicians were not well distributed and access to care was very limited in places.

5,829 physicians actively providing care were psychiatrists, 32 per 100,000 population, an increase of 166 (3%) since 1995. 84% were trained in NYS.

Age: 2% under 35 (8% PCPs, 9%OB/GYN), 19% 35-44 (28% PCPs, 27% OB/GYN), 29% 45-54 (30% PCPs, 28% OB/GYN), 23% 55-64 (17% PCPs, 21% OB/GYN), 27% 65+ (17% PCPs, 15% OB/GYN)

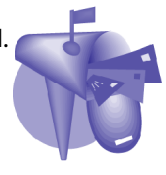
Race/ethnicity: 74% White (66% PCPs, 69% OB/GYN), 4% Black (6% PCPs, 10% OB/GYN), 5% Hispanic (5% PCPs, 4% OB/GYN), 15% Asian (20% PCPs, 16% OB/GYN), no Native Americans.

Herb Peyser, M.D.

Letters to the Editor are welcomed but must be sent electronically. Send your submissions to:

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

email:
citrome@nki.rfmh.org



Central APA Reorganization and Money Issues

by Herb Peyser, M.D.

APA's reorganization is moving APA's shape towards a more vertical, organized, centralized, corporate and efficient one, more a pyramid than the horizontally layered stack of pancakes it seemed before (DBs, Areas, Assembly, Board, management). It had ought to be done but, as with everything, there are positives and negatives.

Herb Peyser, M.D.

New Executive Committee

The Board now has a seven person Executive Committee, officers only, that meets biweekly by phone and can take action if necessary. It plans to act only in "housekeeping" and emergency situations and will report regularly to the full Board by e-mail and at the regular quarterly Board meetings. The fourteen other voting Board members have requested some parameters and plan to be carefully attentive.

Power to Amend By–Laws

Similarly, the reorganization had granted the Board more power re amending APA's By–Laws in "housekeeping" and emergency situations. Concerns expressed in the DBs and Assembly have resulted in including the Assembly more. (There can always be a referendum of the members.)

Money, Money, Money

Then there's central APA's significant involvement in activities with major legal, business and financial implications. APA, as other professional organizations, is suffering gradual membership attrition and entering an era of projected potential budget deficits. In addition to decreasing expenditures and conserving reserves APA continues seeking non-dues income producing initiatives to support its advocacy and education work, but members properly get concerned when it appears APA might be getting in bed with pharmaceutical and managed care industries. Major expenditures, such as Information Service purchases, Medem.com, etc., have to be watched closely.

Lack of Money Smarts

The Board, with fiduciary responsibility, has a watchdog mandate but is unlike most boards of for–profit and other non–profit organizations, which include many business and financial people. APA, however, is a membership organization, elects only members to its Board, people without major business and financial expertise. APA's Trustees must nevertheless vote on issues involving significant expenditures and initiatives with legal, business and financial risk, and have done so on various occasions without full neutral expert input.

Before business and financial documents are signed or enacted APA's Counsel should review and explain them to governance before and at the meetings where they are voted on. This is usually but should always be done, and I'll develop an action item on that.

Getting Help From Money Experts

In addition I developed, and NYSPA and the Assembly approved, a plan to develop an advisory council of neutral business and financial experts from the outside, with some members appointed by and for governance (Board and Assembly), and others similarly by and for management. Their input regarding our enterprises, available as soon as possible, will help the Board maintain its fiduciary responsibility.

The importance of representational governance's full understanding and oversight of APA's entrepreneurial activities cannot be overemphasized. Pyramids may be more efficient than pancakes but they have their problems.

Remember the Sunbeam Fiasco

For one disturbing example, APA's AMA delegation reviewed what happened in pyramid–structured AMA several years ago in that unfortunate Sunbeam matter where AMA had to withdraw at great expense from that questionably proper enterprise. AMA then let its Executive Vice President and top staff go. Echoes of Sunbeam continue to reverberate along with concerns over an unhappy real estate matter, and AMA has now let its new Executive Vice President go too; he then sued AMA. Informed governance participation such as we work for in APA and in that action item might have helped AMA prevent such things.

Data, Data, Data

After working on this for a couple of years I think we are on the road to getting our Information Service to work. It has not been easy. I have gotten central APA together with the DB execs, governance and our components experts, and now they agree first to fix what is broken: the dues billing, reports to the DBs, transfers, applications, reinstatements, the database, etc., and then work with the DBs on simplifying the complex, expensive membership categories and procedures. Only when this is done and credibility restored will they work incrementally toward an overall integrated system, proceeding only after each clearly established success. The final system will be expensive, over $3 million. No commitment yet. As several of us insisted, the Information Service must prove itself first. The Board voted about $130,000 this year (and perhaps $70,000 more next) to get the broken parts fixed.

Responsiveness of Central Staff and Other Matters

Other matters: The Board supported the Assembly in requesting the Medical Director to report on the matter of adequate responsiveness of the central staff to membership requests. Movement will be made in the direction of parity of representation in governance for women and other minorities.

The Board retreat, held with increased austerity in accordance with the reallocation, focused on access to care, with, among other matters, developing how to work with family practitioners in the area of mental health care.

Revenues

APA net non–dues was defined and revenue sharing of that with the DBs will proceed along last year's lines, with $5,000 to each state and distributing the rest per capita. The APA dues rate moratorium will continue. Review with an eye to cost–efficient organization of central staff office space is in process.

PAC

The PAC was set up now that we are a 501[c][6] corporation, and a check–off box will appear on the dues notice. Funds were approved for Mississippi and Iowa for work in the area of parity legislation, and for Georgia and Louisiana in the area of scope of practice legislation.

Sexual Predators and Other Legal Issues

An amicus brief will argue for limitations on the circumstances in which special non-criminal commitment of "sexual predators," outside the normal standards of civil commitment, can be permitted. The death penalty for juveniles was opposed. APA will again strongly press the World Psychiatric Association to be more active in its investigation into the question of the misuse of psychiatry in China against the Falun Gong.

APA members will be informed regarding the new federal privacy guidelines, especially of psychotherapy notes. The Board pushed for limiting the prescribing of restraint and seclusion orders to licensed physicians. An initiative for public disclosure of managed behavioral health care carve–out cost containment strategies was supported.

The Borderline Personality Disorder guidelines were approved. ■

WANTED

Editor-in-Chief for The Bulletin of the New York State Psychiatric Association.

If interested please send cover letter with CV to Bulletin Search Committee, c/o Donna Gajda, NYSPA, 100 Quentin Roosevelt Blvd, Garden City, NY 11530 BEFORE FEBRUARY 1, 2002. The successful applicant will be appointed Associate Editor for the remainder of 2002 and then take the helm on January 1, 2003.

Addiction Psychiatry Committee

by Michael M. Scimeca, M.D.

The NYSPA Addiction Psychiatry Committee has met approximately every two months between September and June 2001.

The membership has increased, including participation from Westchester and Long Island as well as the New York City District Branches. The committee has paid careful attention to developments in OBOT, that is, Office–Based Opioid Therapy. Buprenorphine, in a combination form, is expected to be available for all licensed physicians to prescribe probably in 2002. The Committee has expressed concerns about the need for special training so that this medication and all other opioids agonists are properly prescribed and patients get appropriate psychosocial treatments. The Committee recently had a very informative update from the new Medical Director of the NYS Office of Alcohol and Substance Abuse Services and will cosponsor educational/training events in the future and serve as a conduit for other addiction treatment information. Members of the committee also share updates in clinical practice and other professional information.

Committee on Economic Affairs

by L. Mark Russakoff, M.D.

Over the past year, members of the Committee have been involved in three major projects.

The first project was the collaborative development of Utilization Review standards for Medicaid. This task was directed by members of NYS Office of Mental Health. NYSPA was represented by Jim Spencer, M.D. Notable in the final product were reasons to extend a patient's stay beyond the point of loss of acute risk for dangerous behavior. The inclusion of real clinical criteria into the UR standard set was not an easy task. Dr. Spencer alerted OMH and DOH of the importance of educating psychiatrists about the criteria, and volunteered to participate in such activities.

The second project was developed by Eliot Roy Singer, M.D. from Westchester. Dr. Singer's efforts have been directed against the abuses of Managed Care. He noted that there are few strict rules to which we can hold the managed care companies. The one area in New York which is clear relates to prompt payment of bills. The result of this effort has been the creation of the Prompt Payment Complaint Form. The purpose of this endeavor is to collate information about how the various managed care companies are treating psychiatrists. Submission of these forms to NYSPA will make it possible for NYSPA to approach either managed care companies individually or the Insurance Department with patterns of actions – or inactions. Without this effort, psychiatrists are left on their own and are likely to be treated by both the managed care administrators and the Insurance Department as isolated situations.

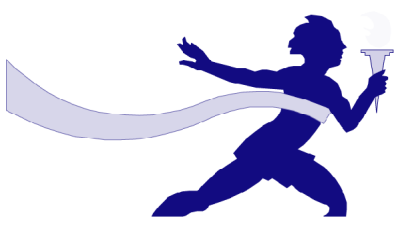
The third area relates to CEA member participation in the Empire Medical Services Carrier Advisory Committee. Edward Gordon, M.D. is the representative from NYSPA to the CAC. This year, EMS revised its Local Medical Review Policy regarding Part B Mental Health. The originally proposed policy was extraordinarily restrictive and totally unacceptable. For instance, it noted that psychotherapy was an "adjunctive" treatment that was "rarely" indicated. Dr. Gordon and Seth Stein worked extremely hard on explaining the inadequacies and inequities implicit in their proposal. The final policy — issued in May 2001 — while not all we requested, is much improved. At this current time, the CAC is considering its drug screening policy. Again, their original policy was extremely restricted (it did not permit any psychiatric diagnoses as a justification for drug screening) and Ed and Seth have been attempting to educate the EMS staff.

We have not reached closure on any of these issues. We expect all of them to be current in the coming year. How to confront issues such as phantom networks has vexed us. For that issue, we would be dependent upon patients informing us of the difficulties they have finding psychiatrists, while not tarnishing the reputation of psychiatry in the state.

Member-In-Training Committee

by Shauna P. Reinblatt, M.D.

Addressing declining resident membership in our Area of the APA has been a top priority for the Committee of Members-In-Training over the last year. Various outreach efforts are



ongoing with the aim of enhancing communication among the resident members of our association. One such measure involves the establishment of Interbranch Member-In-Training (MIT) meetings. With the fragmentation of our large geographic area into many smaller District Branches, activities to reduce the distance among residents would increase our cohesiveness and help to increase membership. 'Movie Nights' and similar events would encourage MIT discussion, interest, and participation in the APA. Another membership project involves the creation of a database of psychiatry residents within our Area so that they might be informed in future membership plans. This list would be helpful in identifying regions or programs with fewer members thereby enabling us to focus our recruitment efforts where they are most needed.

This autumn the Committee will be launching a new annual Area 2 MIT Newsletter to inform MIT's about upcoming events and issues such as the Area Council Meetings. It is hoped that this will stimulate candidates to apply for nomination to MIT Deputy Representative to the Assembly, as well as disseminate information about the APA to residents.

The election process of the Area 2 MIT Deputy Representative has been a topic of discussion for some time now. While it was considered important to maintain an elected position, at the same time, we considered methods to alter the process somewhat, in order to give applicants from upstate a better chance, despite population differentials. We are limited by the fact that training is brief, and it can be difficult to get trainees involved within such a short time. The election process remains one of our top priorities, which we will continue to address in the upcoming year.

Over the past year, the MIT Committee wrote and presented several Action Papers on the APA Assembly Floor. One such Action Paper was passed to explore the establishment of a formal fellowship award in Child Psychiatry so as to attract more interest in this underserved specialty. Several other ideas for Action Papers are currently being explored as well.

Communication among MIT's has improved substantially this year with the establishment of monthly conference calls involving the MIT representatives of the Area District Branches. Although this has now become a regular activity for our MIT Committee, our goal is to improve the variable attendance in the coming year. To this end, it has been proposed that each District Branch appoint an alternate representative to attend conference calls if the appointed representative is unavailable. In the last year we have identified all but a few missing District Branch representatives whom we continue to seek.

At the last Spring Area Council Meeting, the MIT Committee decided that any interested MIT (in addition to the District Branch Representatives to NYSPA) would be welcome to attend future Area Council Meetings. This should help to attract and retain motivated members and thus expose them to opportunities available within our Committee.

We have made progress improving the lines of resident communication, but more work remains to be done. The recruitment and retention of resident members will be of utmost priority, so as to ensure the continued and future success of our committee and our organization.

Committee on Psychiatry and the Law

by Richard Rosner, M.D.

The NYSPA Committee on Psychiatry and the Law is composed of Board Certified forensic psychiatrists, who usually have held prior positions of organizational responsibility within the American Academy of Psychiatry and the Law (AAPL) and/or the American Academy of Forensic Sciences (AAFS). It has, for example, become customary to invite the outgoing president of the Tri–State Chapter of AAPL to join the NYSPA Committee on Psychiatry and the Law.

The Committee functions as a "think tank" considering both issues referred to it for evaluation by the elected officers of NYSPA and issues raised by its members. The task is to apply psychiatric expertise to legal issues that impact on the practice of psychiatry, regulation of psychiatry and socio–legal policy. Much of the work of the Committee now takes place by email, whereas in the past face-to-face meetings were needed to conduct business. On occasion, the Committee meets jointly with other NYSPA Committees to consider how best to implement action on specific issues.

Among the matters that have been considered this past year by the Committee on Psychiatry and the Law have been (1) the continuation and expansion of the Assisted Outpatient Treatment program, (2) the potential impact of legislation to mandate the civil incarceration of sexual offenders after completion of their prison terms, (3) whether or not the use of video equipment by voyeurs should be made a felony–level offense.

On the matter of Assisted Outpatient Treatment (i.e. civil involuntary outpatient commitment), the Committee was concerned that the research project that had analyzed the results of the trial program at Bellevue Hospital had reached an equivocal conclusion. Further, the

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PATIENTS WITH ALCOHOL PROBLEMS? Dr. Conor Farren and Mount Sinai School of Medicine are conducting a research treatment study of the combination of two medications plus psychotherapy for alcohol dependence. Call Amelia 718-584-9000 x6969 for information or referral. GCO # 99.598 Approved through 8/31/02.

PSYCHIATRIST(S) - FT/PT, Board Certified or within 3 years of completion of residency. VA Hudson Valley Health Care Services, Castle Point Campus. Work in Mental Health Clinic, Consultation-liaison with medical and long term care units, PTSD patients. May include PT at Community Based Clinics in Orange, Sullivan, Dutchess and Putnam Counties. Contact Ms. Monica DeRonda at 914-737-4400 X 2567.

Committee was concerned that the consequences of violating the terms of the Assisted Outpatient Treatment program were "toothless", i.e. failure to comply with civil involuntary outpatient treatment did not automatically lead to involuntary commitment. The proposed legislation included a broader potential population for civil involuntary commitment than had been included in the trial program at Bellevue Hospital (e.g. forensic patients and patients who did not freely agree to particpate in the program) so that it was uncertain that the Bellevue Hospital experience could be extrapolated soundly and effectively to the larger potential population. Some of these matters were considered in articles previously published in The Bulletin.

The psychiatric hospitalization of convicted sexual offenders after the completion of their prison terms raised concerns about the appropriateness of placing criminals with difficult-to-change personality disorders in hospitals designed to treat persons with Axis One DSM-IV diagnosis. There was the problem that, once admitted, such persons would be unlikely ever to be released into the community (because of the difficulty in guaranteeing their safety), so that they would gradually take up more and more of the limited bed space available for persons whose conditions could be treated effectively. The Committee felt that such persons should be held in correctional facilities rather than in psychiatric facilities.

The video–voyeurism case that caught the attention of the legislature involved a building superintendent who had secretly videotaped selected tenants in various states of undress.The issue was complicated because relatively little research has been done on this subpopulation of voyeurs, so that empirical data to guide legislation is extremely limited. However, as the current penalty is only 15 days in New York State, it was felt that a felony-level penalty for the offense would give law enforcement personnel more leverage in persuading video-voyeurs to participate in treatment programs, increasing the potential long-term protection of the public at large.

The Committee appreciates the opportunity afforded by this special issue of The Bulletin to bring its work to the attention of the NYSPA membership.

Strategic Planning Committee

by Ann Sullivan, M.D.

Planning for the future energizes an organization, gathers new ideas and recommends key actions. The NYSPA Area Council established a Strategic Planning Committee in 1998 to develop a comprehensive mission and specific goals for the next four years. The committee included area representation state wide, ECP's, members in training, minority representation and area and district branch leadership. Chaired by Deborah Cross, M.D. and Ann Sullivan, M.D., the committee first met in September 1998 and will finalize its report in October 2001.

Highlights of the committee's actions and recommendations to date include:

- NYSPA adopted the Mission Statement: Aggressive Advocacy for our patients and our profession
- Member Input: A survey to assess what membership expected of NYSPA was randomly sent to 700 members and 161 responded. The overwhelmingly important activities to the members involved active legislative advocacy; Legislative efforts to regulate managed care; Parity; supporting litigation against insurance discrimination; protecting psychiatrists scope of practice. Members also placed major emphasis on the camaraderie and fellowship of the organization and patient advocacy issues.
- Goals Implementation: In September 1999 a planning day was held for all NYSPA committees to develop action plans based on the NYSPA mission of aggressive advocacy. Plans were submitted to the council for review and endorsement.
- Communication: A committee of District Branch Presidents was established to enhance communication between NYSPA and the District Branches. It was recommended that committee chairs periodically join Executive Committee meetings. Bulletin articles emphasized membership recruitment and input into the planning process.
- NYSPA Administration Structure and Budget Review: Comparing the overall Budget of NYSPA to other comparable state District Branches found it to be efficient and cost effective. NYSPA currently spends approximately 60% of its budget on advocacy activities, the most valued activity by its members.

The Strategic Planning Committee will endorse its final report in the fall of 2001. However, the need for ongoing suggestions, creative ideas and critical review by the membership continues. Remember to inform your Assembly Representatives of what NYSPA can do for your and your colleagues.

The Psychiatrist As Artist & A Concert for NARSAD

by Roxanne Lanquetot

Dr. Kogan was a member of my residency training class at NYU-Bellevue 1983-87 and is a very nice guy. We see each other at the APA Annual Meetings where for the past three years he has delighted audiences with his musical and psychiatric insights into the lives of famous composers from Beethoven to Gershwin -Ed.

Increasingly rare in this period of over–specialization, a few Renaissance men can still be found in medicine. With two careers, one as a concert pianist and another as a psychiatrist, Richard Kogan, M.D. is probably as close as anyone around. Dr. Kogan studied piano with Nadia Reisenberg at the Julliard School from age six to eighteen, supplementing his training with the legendary teacher, Nadia Boulanger, at the Ecole de Fontainbleau, in France. His mother, formerly a music teacher, recognized her son's innate talent and perfect pitch when he was only four-years-old and steered him towards the piano, his first profession. Another influence was that of his father, a gastroenterologist, who introduced him to medicine, his second profession, by allowing his young son to accompany him on medical rounds. He was playing concerts by age seven, but due to his wide variety of interests, he chose to attend Harvard College after graduation from high school rather than a conservatory where the focus would have been almost exclusively on music. His roommate at Harvard was Yo-Yo Ma, whom he met at Juilliard, and the two formed a trio with the violinist Lynn Chang, another Harvard student destined to become a musician.

Onto Harvard Medical School

By the time Dr. Kogan began Harvard Medical School, he was already an accomplished musician. The dean of the Harvard Medical School created a special five year schedule which allowed him to travel and concertize between his medical clerkships. He won first prize in the Chopin Competition of the Kosciuszko Foundation while still an undergraduate, and then the Concert Artists Guild Award and Portland Symphony National Piano Competition. He has performed as a recitalist and orchestra soloist throughout the United States, Europe, and Asia and as a chamber musician with Yo-Yo Ma and Lynn Chang.

Mind and Music

Dr. Kogan's two principal interests led to his exploration of the connection between music and the mind. "Music and medicine are both about healing," he said. He decided to specialize in Psychiatry, because he had always been fascinated by the brain. His interest in treating people with sexual dysfunctions developed during his residency in Psychiatry at NYU/Bellevue when he became aware of the widespread prevalence of sexual problems and sought to develop the skills necessary to improve these frequently treatable conditions. He is currently the Director of the Human Sexuality Program at the Weill–Cornell Medical Center and New York Presbyterian Hospital.

Sex and Music

Descriptions of the profound connections between sex and music can be found in the Kamasutra. The

Richard Kogan, M.D.

cycle of the four stages of lovemaking-desire, arousal, climax, and resolution-are represented in the structure of music, for example in Wagner's "Liebestod" or the last movement of Robert Schumann's "Fantasy", a secret love letter to Clara. "Good music, like good sex, relies on prolongation, on delaying the satisfaction of expectations. Great composers, like great lovers, know this instinctively," said Dr. Kogan. Beethoven was thwarted in acting on his sexual and emotional feelings, which he consequently poured out into music. Schumann, an obsessive personality, used sex as a way of organizing his life. Franz Liszt's hypersexual personality comes out in his flashy, virtuosic music.

Creativity and Madness

One of Dr. Kogan's main interests is the relationship between creativity and mental illness, and he gives lecture/performance demonstrations on the emotional lives of great composers and the ways their psychological problems influenced their art and creativity. Would artists such as Robert Schumann have been as creative if they were not mentally ill? How do composers sublimate their suffering and convert it into creativity?

Desire to Help

When I first spoke to Dr. Kogan about this article, his mellifluous voice made me remember him from his rotation on the children's ward at Bellevue where I worked, and I was delighted to renew our relationship. I recalled how intently he listens in order to understand and communicate with you. Caring deeply about improving patients' lives, he gives benefit concerts for health related organizations such as the Hadassah, the American Cancer Society, the National Multiple Sclerosis Society, and Music for Healing. On March 6, 2002 he is scheduled to give a concert for NARSAD (the National Association for Research in Schizophrenia and Depression) in Weill Recital Hall at Carnegie Hall.

NARSAD

NARSAD is the largest donor-supported, non–governmental philanthropy that raises funds for research in mental illness, concentrating on all brain disorders but especially the most disruptive to patients' lives—schizophrenia and manic–depression. Since its inception in 1987, this not-for-profit organization has raised more than $112 million in research grants for 1,300 scientists at 172 universities and medical research institutions worldwide. It is supported by contributions from individuals, families of the mentally ill, foundations, and corporations. Every dollar given to NARSAD goes to funding research grants, because the operating expenses are covered by separate grants from two family foundations. The Scientific Council, volunteers composed of 65 leading national research scientists, identifies the most promising research among the many applicants. Constance Lieber is the President of the Board of Directors and Jerry Callaghan the Chairman. Members of the board have relatives who are mentally ill, which gives them a vital personal interest in making the organization successful..

Grant Programs

NARSAD has three grant programs. The Young Investigator Program awards grants of $30,000 per year for two years to young scientists who are beginning their careers. Constance Lieber believes that young investigators are the hope of the future. Independent Investigator Awards for more established researchers amount to $50,000 per year for two years. Distinguished Investigator Awards of $100,000 are for full professors involved in unique research. In addition three special awards are given for momentous contributions to the field — the Lieber Prize for Schizophrenia Research, the Nola Maddox Falcone Prize for Affective Disorders Research, and the Ruane Prize for Outstanding Research in Childhood and Adolescent Psychiatry. Amounting to $50,000 each, they are the largest awards especially aimed at brain disorder research.

The NARSAD–Nobel Connection

The three winners of the Nobel Prize in Medicine in the year 2000 are affiliated with NARSAD. Eric Kandel, M.D. and Paul Greengard, Ph.D are currently on NARSAD's Scientific Council. Dr. Greengard received NARSAD's Lieber prize for Schizophrenia Research in 1996 and a Distinguished Investigator Grant in 1992. Dr. Kandel was awarded Distinguished Investigator grants in 1995 and 2000. The third awardee, Arvid Emil Carlsson, M.D., received the Lieber prize in 1994.

NARSAD and Families

I am a member of NARSAD's Leadership Council, mainly family members who are faithful supporters of the organization. Council members organize benefits such as this concert. They hold seminars to inform the general public about mental illness in order to alleviate the stigma attached to being mentally ill. When I joined, I felt that I gained a new family, and in fact, NARSAD supporters are often called "the NARSAD FAMILY". Bound by the tragedies of our children's lost lives, we work together for a common cause.

The researchers I have met at NARSAD are kind, friendly and helpful.

Always ready to answer questions and explain their work without being condescending or overly simplistic, they make it comprehensible to those of us who are not scientists. Every fall Young Investigators present a series of seminars to explain their work, and the seminars are open to everyone. In July we had the honor of hearing a speech by Eric Kandel and seeing a videotape of the Nobel Prize Awards Ceremony in Stockholm.

Dr. Kogan's response when I asked him to give this concert for NARSAD reflects his concern and care about the mentally ill. His offer to volunteer his time and talent to raise money for NARSAD research comes from his belief that the organization is extremely important in furthering better treatments and cures for psychiatric disorders. Tools now available for clinicians and researchers promote discoveries that weren't possible before. Schizophrenia and Bi-polar illness affect millions of people who may be helped due to NARSAD's effort to conquer the mysteries of mental illness. The promise of NARSAD holds HOPE for these people and their families.

For information about the concert please call Kristi Dodson at NARSAD, 516-829-0091. ■

Discipline

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Initial Review

Complaints are first reviewed by staff of the OPMC to decide which may be complaints of physician misconduct as defined by state law and which are not. Most complaints are not. Patients and their families often report behavior which may not be the best practice, but which does not meet the legal definition of misconduct.

What is Misconduct?

There are 48 types of medical misconduct enumerated in New York State Education Law. These include negligence and incompetence. Negligence is defined as the failure to treat a patient, as would a reasonably prudent physician in the same situation. Patient injury is not required to demonstrate negligence, though it is in malpractice cases. Either one act of gross negligence or multiple acts of less serious negligence can constitute misconduct. Incompetence is lack of requisite skills or knowledge to practice medicine. As with negligence, a physician must be found practicing with incompetence on more than one occasion or to have committed one gross act to be prosecuted. Negligence and incompetence often occur together and are prosecuted together.

Sexual Abuse

Sexual abuse of patients is also misconduct, whether the abuse is by verbal means, as in suggestive remarks, or by inappropriate touching or by genital contact. By State policy, there is no such thing as consensual sexual relations between a doctor of any specialty and his or her patient. Sexual relationships between a psychiatrist and his or her patient is, per se, misconduct. The Miller case, heard in the 1990's, served as a precedent by which physicians in other specialties who have sexual relationships with their patients can be prosecuted for misconduct.

Impaired Physicians

The law also addresses physician impairment. It identifies four types: physical, mental, by alcohol, and by other drugs. To be considered misconduct a physical disability must impair the physician's ability to practice in his or her chosen area of practice. Therefore, while a blind doctor could not legally (or practically) perform surgery, he or she could maintain a psychotherapy practice. The other three types of impairment need not be in the practice of medicine to qualify as misconduct.

Rudeness

Patients or their family members often complain of rudeness or long waiting times. Rudeness or lack of a caring attitude (as perceived by the patient) may not of itself be misconduct, but willfully harassing, abusing or intimidating a patient is. Misconduct is also denying care because of a patient's race, ethnicity or religious background. Misconduct is abandoning or neglecting a person who is in need of immediate care after a doctor–patient relationship has been established.

High Fees

Patients often complain that physician's fees are too high. Charging what the patient believes is too much is not considered misconduct but charging for services that were never delivered is fraud, which is. Fraud is an act intending to deceive. Physicians can also be charged with excessive and unnecessary testing, another form of fraud, and with promoting the sale of goods and services in a way that exploits the patient. Fraud is the second most common reason for physician discipline in New York State and one of the most common reasons for revocation of licenses.

Promising a Cure

When appropriate treatment does not result in cure, or the outcome the patient wished, the physician may not necessarily be charged with misconduct, but when the physician guarantees a cure he or she could certainly be charged. Misconduct is also performing services the patient did not authorize and failure to maintain appropriate patient records.

Investigations

After initial triage, those cases, which seem to meet the standards for misconduct or raise serious suspicions, are investigated by an OPMC staff member and a physician coordinator. Nearly always the investigator interviews the physician and the party who complained and reviews relevant medical records. At this interview stage and at all stages of the process the physician has the right to have legal representation present. Investigators may or may not find enough evidence to support a charge of misconduct. If they do not, the case is closed. Both physician and the complainant are notified in writing and a record of the investigation is kept in OPMC files for possible future reference.

When Misconduct is Established

At the next level, where investigators believe there is evidence of misconduct, they refer an investigative report to a committee made of three members of the Board. Two committee members must be physicians and one a layperson. The Board has about 160 members, 2/3 of which are physicians, who are appointed by the Commissioner of Health after an internal vetting process and a review by the Governor's appointment office.

Final Steps

After the committee reviews the evidence it recommends one of several options to the Director of OPMC who, after consultation with the Executive Secretary, makes the final decision. The committee may recommend further investigations. It may recommend a physician impairment exam or an assessment of clinical skills. It may recommend warnings, an action, which is not punitive but educational. OPMC issued 121 such administrative warnings in 2000. The committee may decide there is insufficient evidence to support charges of misconduct. If it does, the case is closed, the physician and complainant are notified and a record is kept in OPMC offices. Or, the committee may decide there is sufficient evidence to warrant charges. If there is

[See **DISCIPLINE** on page 8]

MediComment: Coding Q & A

By Edward Gordon, M.D.

Ed Gordon, M.D.

Q. I was scheduled to see a demented patient yesterday for medication management, but she was unable to attend. Her daughter and a caregiver did come, and I spent 20 minutes with them reviewing recent symptoms, medication management, prognosis. I didn't bill anything yet, but can that be billed under 99213? The CPT descriptor that the service needs to be provided "face–to–face with the patient and/or family."

A. For E/M services, the patient is intended to be examined, and therefore present. In situations such as this, where family members need help in managing the patient, I usually advise the family that his is not a Medicare covered service, and that they will be privately billed. They generally agree. You are then free to charge any reasonable fee that can be agreed upon.

You are making the point that you are providing an E/M service, based on counseling or coordination of care, in which case the time spent controls the level of billed service. You would have to document the time spent, the nature of the coordination of care given. In the absence of a patient present, the note still would not withstand audit. 99213 is entitled: "Office or other outpatient visit for the evaluation and management..." Hard to evaluate an absent patient. Better, and safer, to bill the family for the services provided to them.

Code it 90887: Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient.

90887 is not a Medicare covered service. You are free to use it for your own purposes, and can bill family members directly. It is a good idea to advise them of the non-covered status in advance.

Send questions regarding coding, Medicare, managed care practices and denials, documentation, other problems with managed care, or other practice problems that you have experienced, together with documentation to : MediComment c/o The Bulletin (address on page 2) or by e-mail to NYSPA at centraloffice@nyspsych.org.

Legislative Update

Continued from page 1

Mental Health Practitioners

The organizations representing the mental health practitioners, (i.e. the marriage and family therapists, mental health counselors, creative arts therapists and psychoanalysts) have agreed to major changes in their bill. The changes accommodate most of the concerns voiced by organized medicine, including language prohibiting the four professions from treating seriously mentally ill persons without a case by case medical evaluation and consultation with a physician to determine whether medical care is indicated for such persons.

Regarding the licensing of psychoanalysts, we have been unsuccessful in our effort to defeat the proposal for a separate profession of psychoanalysis. However, we have been successful in strengthening a number of requirements with respect to qualifying psychoanalytic institute programs and graduate level study in a health or mental health field as a licensing prerequisite.

Mental Health Insurance Parity

Considered to be the most comprehensive mental health insurance parity mandate in the country, Assembly bill 4506 (by Assemblyman Martin Luster (D-Trumansville) et. al., passed the Assembly in late June by a 139-1 margin. Although the bill died in the Senate once again a bright spot in that house was the introduction by Senator John Marchi (R-Staten Island) of Senate bill 5381 — a companion bill to A.4506. Senator Marchi's action marks the first time the two houses have had identical bills on parity sponsored by members of their respective majorities.

A.4506/S.5381, if enacted, would require health benefit plans in New York State to cover mental illness to the same extent, terms and conditions as any other illness covered by the plan. Plans without benefits for mental illness would be required to initiate them on an equal basis with other covered illnesses and conditions. The bill excludes ERISA exempt and Workers' Compensation/No-Fault plans.

Watch for more on the New York State ECT saga in the next issue of The Bulletin. ■

Discipline

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an imminent danger the health commissioner may immediately suspend the physician's license.

The Hearing

When the committee recommends proceeding with charges, the Director, after consultation with the Executive Secretary, can order the legal department to draw up charges and to proceed to a hearing, which is much like a trial. The case is heard by another three–member committee of the Board, composed of two physicians and a layperson. One physician member is nearly always trained in the same specialty as the physician who is charged when patient care is an issue. Both the respondent (the physician charged) and New York State are represented by lawyers who call and examine witnesses and introduce evidence which the committee considers. An administrative law judge attends in order to advise the committee on legal questions. The respondent is expected to testify. Failure to do so and tc deny the charges is seen as an admission of guilt. Committee members then weigh the evidence and decide on whether or not to take punitive action. The hearing committee can chose one of many actions. It may require completion of a course of training or demand a monetary fine or community service. It can censure and reprimand or limit the respondent's license to a specific area of practice. It can also suspend, revoke or annul the license.

Appeals

At the 5th and last step, either the state or the physician can appeal to the Administrative Review Board of the Board of Professional Medical Conduct. This board is composed of three physicians and two laypersons.

The disciplinary system in New York is large and complex because it values due process for doctors. Due process is the right to be heard in a timely fashion. The system also values quality care and conscientious, careful professional behavior.

This article was prepared after discussions with executive staff at OPMC. For more information call 1-800-663-6114 or log on to the web site <www.health.state.ny.us> and click *Information for Providers* then *Professional Misconduct & Physician Discipline.* ■

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