THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

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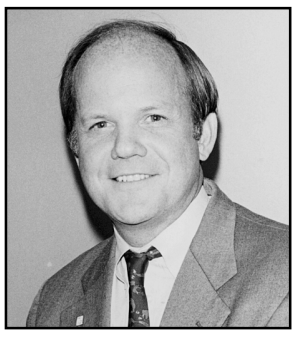
Medical Privacy and Your Prescriptions

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

On April 14, 2001, new federal privacy regulations developed by the Department of Health and Human Services under the Clinton administration last year will go into effect. These privacy regulations establish for the first time a national standard for protecting patient confidentiality including a special provision regarding psychotherapy notes. Under the regulations, psychotherapy notes, if maintained separately from the medical record are afforded substantially greater confidentiality protection. The government has provided for a second comment period until March 30, 2001, for additional responses on the final regulations.



Jim Nininger, M.D.

The APA has prepared a response focusing on several concerns including the use of personal health information by providers for marketing and fundraising, provisions allowing patient's to sign blanket consents at the outset of treatment before the patients know what their records might contain and concerns regarding the possibility that psychiatrists will need to keep two sets of records in order to benefit from the new protections afforded psychotherapy notes.

An article "Medical Data: Privacy's Guarded Prognosis" in the *New York Times* (March 1st) described a physician's surprise at being presented by a pharmaceutical representative with a print–out of his pre–menopausal patients on estrogen-replacement therapy. Doctors' prescribing practice information is often made available to pharmaceutical houses by pharmacy chains for a price. Your "SSRI profile" is probably no mystery to the drug representative in your office. Some psychiatrists have even received mailings from prescription drug management companies listing every patient and their medica-

[See **President's Message** on page 8]

NYC Sets the Scene for the Seventh Annual Picnic for Parity

New York continues to be among an increasingly smaller minority of states that does not have a parity law. Ever pertinent is the need to continue to address publicly the demystification of mental illness, and the disparity that individuals and families encounter when they seek treatment for a mental illness. The Surgeon General has issued two reports in the last year, highlighting the need for better psychiatric services for all, and particularly for children.

And even in victory, we must remain alert and vigilant. A recent review of how the Parity law for federal employees was actually being implemented, revealed many discrepancies between third party payers. Our efforts for parity must continue, and all willing shoulders are welcomed at the wheel.

For all these reasons, and more, the Picnic for Parity will again be held in Bryant Park, in the heart of New York City and across New York State. It will be held on May 11th, 2001, between 12:30 and 3:30 pm. Like in previous years, all those interested in the issues of mental health will gather to get to know each other, discover new services at the information fair, and discuss mental health topics with all assembled in the park. Ever expanding our coalition building efforts, there will be participants from the pharmaceutical industry at the information fair. This year there will also be a major focus on the mental health of children and of the elderly, through campaigns promoted by the New York City Department of Mental Health, and the New York Coalition for Children. But also, it is a place for all of us to meet, fraternize, and create a moment, a tradition for ourselves, where our place as citizens is ours, like everyone else's. We hope to see you there. For information call 212-942-8500 and ask for Wilfrid Raby, or 212-989-8460 and ask for Molly Finnerty. ■

7TH ANNUAL PICNIC FOR PARITY
BRYANT PARK, NYC
MAY 11, 2001
12:30 TO 3:30 PM

As We Go to Press… APA Election Results are In!

By Herbert Peyser, M.D.

The Committee of Tellers met on March 1, 2001, and reviewed the results of the 2001 election.

The Committee reported that 11,447 paper and online ballots, representing the votes of 36.3% of the eligible voting members, were returned. Of these, 7.2% of those who voted, did so online. The candidates elected (with the percentage of votes) were as follows:

President–Elect:
Paul S. Appelbaum, M.D. (72.4%)

Vice-President:
Michelle B. Riba, M.D., M.S. (60.5%)

Secretary:
Pedro Ruiz, M.D. (59.4%)

Trustee–at–Large:
Patrice A. Harris, M.D., M.A. (57.5%)

Member–in–Training Trustee-Elect:
Susan L. Padrino, M.D. (56.2%)

Area 3 Trustee:
Roger Peele, M.D. (63.6%)

Area 6 Trustee:
Maurice Rappaport, M.D., Ph.D. (56.1%) ■

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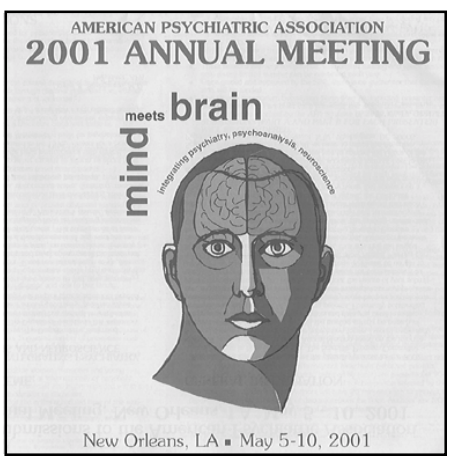

Dole Wins Award: Pioneer in MMTP Honored

By Michael Scimeca, M.D.

Dr. Vincent P. Dole was presented with the American Psychiatric Association's Warren Williams Award for his pioneering work in understanding opioid agonist effects and creating methadone maintenance treatment.

Dr. Dole was presented with the award December 9, 2000 in Washington D.C. The award was offered by the APA Assembly and the New York State Psychiatric Association to honor the work, both of Dr. Dole, now an emeritus professor at The Rockefeller University in New York City, and his late wife, Dr. Marie Nyswander, a psychiatrist. Together they performed the elaborate and rigorous research that led to the creation of methadone maintenance programs that combined both pharmacologic and psychosocial treatments. This research opened the way for the understanding of brain receptors and receptor chemistry.

In the 1960s, Drs. Dole and Nyswander responded to an unprecedented crime wave in New York, where more than half of the nation's narcotic addicts lived and were completely untreated. In 1963, six "hard-core" heroin addicts, who had been unresponsive to any psychological or social treatment attempts, were admitted to the Rockefeller Institute Hospital. Drs. Dole and Nyswander realized that heroin addiction relapse occurred because of intolerable and persistent craving for the drug. They theorized that methadone, with its long–acting opioid agonist properties, could be a treatment. They soon saw that patients ceased suffering cravings and were not "high."

Drs. Dole and Nyswander developed methadone maintenance for the management of heroin addiction. Administered in daily oral doses, methadone acts to block the frequent and extreme mood shifts characteristic of heroin addiction so that patients stabilized on methadone are able to lead normal and productive lives. Following pilot studies at The Rockefeller Hospital, methadone maintenance was adopted in hundreds of programs worldwide. "In the year 2000, there are still people doubting the effectiveness and success of methadone maintenance at the same time that a new opioid, buprenorphine, will be entering everyday practice to block heroin addiction. In psychiatry, we talk every day to our patients about serotonin levels, brain receptors and the role of medication in addressing a 'chemical imbalance' as part of the standard treatment of mental illness. We honor today Dr. Vincent Dole, whose pioneering work set the stage for an understanding of neurochemistry, opioid receptors and the true bio-psychosocial treatment of psychiatric illness," Dr. James Nininger, presenter of the award and president of NYSPA, declared at the Washington ceremony. ■

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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: (845) 398-5595
Fax: (845) 398-5483
e-mail: citrome@nki.rfmh.org
http://www.nyspsych.org/bulletin

Thomas E. Gift, M.D.
Howard Owens, M.D.
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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: centraloffice@nyspsych.org
http://www.nyspsych.org

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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.

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

From the Editor's Desk… Get Ready for a New Marketing War


Leslie Citrome, MD, MPH

The antipsychotic medication market is heating up. Pfizer announced on February 5, 2001 that the FDA has approved the new atypical antipsychotic ziprasidone. The drug is expected to be launched by the time you are reading this. In a press release from February 14, 2001, Lilly announced that the FDA Advisory Committee recommended approval of an intramuscular form of olanzapine for the control of agitation associated with schizophrenia, bipolar mania, and dementia. The next day, Pfizer issued its own press release, stating that the FDA Advisory Committee has recommended approval of an injectable form of ziprasidone for the control of agitated behavior in patients with schizophrenia and schizoaffective disorder. It is not yet known when the injectable forms of ziprasidone and olanzapine will be launched, but it is likely to be before the end of the year. A depot formulation of risperidone is in active clinical trials. In addition, two new atypical antipsychotics, aripiprazole and iloperidone, are in the final stages of testing prior to their being evaluated by the FDA for approval.

All this is good news for patients. Greater choice and the possibility of better effectiveness are most welcome. Many patients with schizophrenia and other psychotic disorders do not respond optimally to currently available medication regimens, or have difficulties with the adverse effects. Noncompliance, either covert or overt, is often driven by the lack of perceived benefit or intolerance to adverse effects. Having more choices should bring additional hope that something may work out better.

The competition for market share is fierce, and along with greater choice we can expect an intense marketing war on the part of the pharmaceutical industry. My mailbox is already flooded with invitations to CME events in all sorts of nice places, usually free or heavily subsidized by industry. I expect the exhibition hall at the APA Annual Meeting in New Orleans in May to be busier than ever. I do wonder, though, whether the marketing plans will accentuate the positive, or will be replete with the "negative campaigning" that has become the hallmark of recent advertising blitzes.

As a psychiatrist, I have never before been targeted to receive as much information about non-psychiatric disease as I have today. I welcome information on cardiac conduction, obesity, diabetes mellitus, liver and pancreatic disease, and prolactin levels — it is important to be on top of this. Trouble is, the information is coming from companies of competing products that have an axe to grind about the other guy's product. When charts and tables are presented comparing the various antipsychotics, you can identify the company producing the table by seeing what characteristic is missing or downplayed. On the exhibit floor it can get downright nasty — I recall funhouse mirrors at one exhibit that showed psychiatrists what they would look like if they gained weight. This negativity appears unseemly, and casts an unflattering image of the industry as a whole.

New and exciting data are emerging that demonstrate the advancements that atypical antipsychotics are delivering. Keep in mind that these agents have only recently become available in the past few years and that clinical research has a significant lag time (often several years) from conceptualization of a study, to funding, implementation, analysis of data, and publication. Hopefully as more data become available about benefits, less time will be spent accentuating the negative. ■

COMMENTARY

Is the Triplicate Prescription Really in Its Death Throes?

By Herb Peyser, M.D.

The era of the despised triplicate prescription is almost over. It is to be transformed into a single serial script that the pharmacist will transmit electronically to the NYS Department of Health (DOH), Bureau of Controlled Substances (BCS). No more will pharmacists have to mail copies of the prescriptions into Albany. No more will the BCS have to have people punch the information into storage banks there. No more will physicians have to buy triplicate prescriptions books and keep copies of prescriptions for Schedule II controlled substances and Schedule IV benzodiazepines. (Although they will most certainly have to pay for serial scripts.)

I say the era is "almost over" because there's one major snag — privacy. So don't get rid of your old triplicate prescriptions books. And if you're running out you may have to buy more. And don't hold your breath where Albany is concerned for its movement tends to be glacial. The Medical Society of the State of New York (MSSNY) and NYSPA have been working on this with DOH and following it for years, but the law wasn't passed until 1998. Now we are working to get the regulation that implemented it last November cleaned up regarding the privacy issue.

Background

Almost three decades ago Governor Nelson Rockefeller launched the triplicate prescription as one of his weapons, along with mandatory sentencing, etc., in his "war" against narcotics. Most of his weapons proved useless except to fill the prisons, and the heroin epidemic flourished. DOH, however, embraced the triplicate in its "war" against the unqualified, uncredentialed "pain and stress centers" freely handing out Qualudes, barbiturates and other sedatives, and against the "fat doctors" indiscriminately handing out stimulant anorexiants, thyroid, etc.

A number of addiction specialists and some other physicians supported the idea, but most of the medical community opposed it. They felt there were far better procedures that would be less intrusive into the doctor patient relationship, less burdensome to physicians' practices, and would not create an additional fee, another tax on doctors. MSSNY, supported by the pharmaceutical houses, sued DOH and took it up to the U.S. Supreme Court. The Court ruled for DOH. Attempts to pass a law revoking the program failed.

BCS began collecting data and sending it to County Medical Societies whose committees reviewed the reports, spoke with the doctors involved, and advised BCS. Some high prescribing was legitimate, so let it go; some doctors were uninformed, needed education; some seemed venal. BCS acted on the committees' advice and recommendations.

In the 1980s the Commissioner decided to add Schedule IV benzodiazepines to the list of medications requiring triplicate prescriptions. He was motivated to do this by the Department of Social Services that was at that time administering Medicaid and complaining about the "Medicaid mills". Some were doctors' offices at subway stops; some were pharmacy storefronts with signs in their windows, "Doctor Upstairs". The "patient" went upstairs, said a few words to the doctor who wrote a quick note and signed a prescription for benzodiazepines; the "patient" went downstairs, filled the prescription, which was paid for by Medicaid, and went out and sold the drug on the street. It was ripping off Medicaid.

Again the doctors protested — more intrusiveness, burdens, and taxes; there were other, better ways. Again MSSNY sued. Again it went up to the U.S. Supreme Court. Again the Supreme Court ruled for DOH. Again attempts to change the law failed.

The 1970s suit had brought up the privacy issue, and the U.S. Supreme Court reviewed the mechanism. The Court determined that privacy was adequately maintained; the material in the mailed-in prescription copies was punched into a storage database in the BCS in Albany and kept in a locked, secure room with adequate safeguards. The Fourth Amendment against unlawful search and seizure was not being violated, the Court ruled (*Whelan v. Roe*, 1977), but it specifically avoided deciding the question regarding "a system that did not contain comparable security provisions," such as an interconnected computer system.

MSSNY turned to the single serial script and electronic data transmission of the prescription by the pharmacy directly to the BCS, and worked with DOH on this system, which was being used by some other states. It took

[See **COMMENTARY** on page 8]

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

Medicare's War on Family Therapy: A Psychiatrist's Ordeal

By David S. Goldman, M.D.

Dr. Goldman is in private practice in New York City. What follows is a first person account of the Empire Medicare review process. The manuscript has been edited to conform to Bulletin word limits. –Ed.

Since the spring 1999, Empire Medicare has waged a steady war on psychiatrists submitting claims for Family Therapy. Their tactics are so capricious, unvarying, non–responsive, and diversionary as to require a tremendous expenditure of time and energy in supplying documentation about sessions, and inevitably writing 10-12 page explanations similar to a lawyer's brief to justify medical necessity, citing relevant policy decisions and the psychiatric literature, and arguing against draconian limits that would make any treatment a farce. From such tactics, a member doing family therapy under Medicare needs the active support and guidance from Edward Gordon, M.D., past president of NYSPA and currently on the Medical Advisory Board at Medicare, and from Seth Stein, Esq., the Chief Counsel and Executive Director of NYSPA.

The Saga Begins

In the spring of 1999 Empire Medicare requested documentation on five sessions where I had seen a depressed patient with her husband, after she was diagnosed with malignant breast cancer. She was greatly frightened by the diagnosis, became more depressed, and worried about the impact this would have on her conflicts with her husband. These sessions helped stabilize her, improve her depression, reduce the conflicts that the couple was experiencing, and mobilize the husband's support for her. In a few weeks, Medicare approved the claim. I thought this was simply one of its periodic audits, and thought nothing further about it.

In treating a second couple a few weeks later, I ran into a demand for my entire record for the first six sessions after I submitted a claim for them. Unlike the first case where I provided detailed summaries, here I was asked for all my notes, phone records, medical tests, etc.

Rules Change

I became aware that Empire Medicare was changing the rules when I received an identical request for complete documentation on the next six family therapy sessions. I called Medicare and was told by customer service that "certain parameters were being applied to family therapy" but could not provide further information. Nineteen pages of session notes were sent in response to the request, only to result in rejection notices. This was in the form of a regular Medicare Remittance Notice that rejected all six sessions with a simple code designation CO-50, for which a single explanatory line read "These are non-covered services because this is not deemed a "Medical Necessity" by the payer."

The Plot Thickens

While I started to make inquiries as to how such capricious reviewing could occur, it all came together when I read Seth Stein's November 22, 1999 "Special Medicare…Alert" in which he described Empire's virtual embargo against family therapy. I was also startled to read at this time that one colleague had close to 570 claims denied. Seth also discussed meetings with officials of HCFA, the federal agency that finances and administers Medicare through local carriers (like Empire) who process claims. Seth also appealed to individual psychiatrists to submit their negative experiences with Empire to him so that appropriate legal action could be planned.

Getting the Policy

I wanted to gather the appropriate policy statement concerning family therapy that Medicare presumably was basing its rejection on. When I phoned Empire customer service, I was told that they do not have a written copy of the family therapy policy guidelines, and that it was not available to doctors in any form as far as they knew. I was given the names of two psychiatrists who were on the Medicare Medical Advisory Board, one of them being Edward Gordon, M.D. Dr. Gordon was helpful, clear and informative when I asked him for advice. He pointed me to the website where I could get the full policy statement <http://www.empire medicare.com>.

References Obtained; Case Made

I also reviewed the APA's *Guidelines for the Treatment of Patients with Bipolar Disorder*, Mildowitz and Golstein's, *Bipolar Disorder: A Family–Focused treatment Approach*"and Glick and Kessler's *Family Therapy*. Twenty–nine additional references were obtained to document the relevance, necessity, duration, type and effectiveness of my treatment. In ten typed pages, I challenged the rejection on several grounds. In February 2000 Empire upheld my appeal for the wife, but stated they needed more time for the husband. Nine months had passed between submission and upholding of the appeal. By that time I had sent Empire 34 pages of typed clinical notes (reduced from 120 pages of verbatim notes), three cover letters, a ten–page brief, a six–page bibliography, and direct quotes from 29 references that supported my treatment approach. Never at any point was it indicated what kind of review my submissions had received. The reviewer was always hidden behind the description of an "Independent Person." I doubted that a psychiatrist ever looked at my original submission of clinical notes.

No single patient treatment problem or completing a scientific paper had forced me to be so repeatedly and continuously preoccupied. For amounts between $700 and $1400 in reimbursable treatment fees, I had to spend time reviewing 270 pages of patient notes, transcribe over 40 pages of clinical sessions, submit 26 pages of briefs, and spend a month's work of weekends.

The Evil Empire

In this Kafkaesque situation, Empire Medicare revealed itself as an

enemy of responsible psychiatric care for senior citizens needing family therapy. In a cold and unfeeling manner, Empire does not hesitate to throw every conceivable obstacle in the way of the treating psychiatrist. While they may have the laudatory aim of analyzing family therapy practice problems, they are now the major agency for demoralizing and wearing out both patients who seek family therapy and psychiatrists who try to ethically and professionally provide it.

The only way we can control and eventually end Empire Medicare's abusive practices against family therapy is to consult with our Chief Counsel and Executive Director, Seth Stein, and to provide him with copies of our appeals to Empire Medicare. Further legal action is being planned. With your help, we can score a court victory. ■

MediComment: Coding Q & A

By Edward Gordon, M.D.

Ed Gordon, M.D.

Q: What code should we use to bill for seclusion and restraint evaluation? Is it possible to bill twice for the same patient if he ended up in S/R twice in 24 hrs? Could we bill this as a high medical complexity consult?

A: This question is especially timely now that HCFA has published and JCAHO has endorsed new rules requiring closer psychiatric attention to patients placed in seclusion and restraint. There are several scenarios, depending on whether the patient has been seen earlier in the same day, and for what kind of service.

If you are required to see a patient to evaluate the need for S&R, or to review the continued need for S&R, the most appropriate code to use would be an E/M code. The codes for subsequent hospital care (99231-99233) would most commonly be used.

If the subsequent hospital care codes are used, the note provided should provide a description of the reason for the restraint (an interval history), an examination as appropriate to the patient's situation, and the decision reached as to the need for restraint. The level of coding would depend on the complexity of the situation, or, alternatively, the amount of time involved. For example, if the history provided is an expanded problem focused interval history, and the medical decision making of moderate complexity, the service provided might well be 99232. Repeat visits to evaluate and reorder S&R will involve additional service. Only one E/M code can be normally billed on a single day. Additional services involve at the very least, additional time. As a result, the coding might well be upgraded to 99233 after another visit to certify S&R.

Where time predominates, the level of coding is driven by the time, and not by the usual History, Examination and Medical decision–making.

CPT describes the situation as follows: "When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face–to–face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility) then time may be considered the key or controlling factor to qualify for a particular level of E/M services."

It continues: "The extent of counseling and/or coordination of care must be documented in the medical record." Typical times for these services are: for 99231, 15 minutes, for 99232, 25 and for 99233, 35 minutes.

If substantially more time is required, and the medical necessity for this is documented, then the use of inpatient Prolonged Services codes are warranted. These codes, 99356 and 99357, are used when prolonged service, in excess of 30 minutes more than the underlying E/M code, is required. 99356 is used once for the first additional hour beyond the 30 extra minutes, and one unit of 99357 for each additional half–hour beyond that.

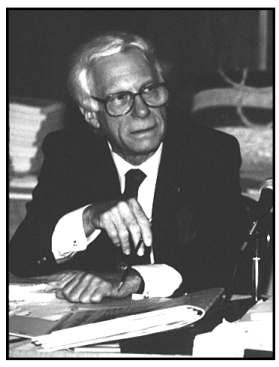
For example: if the prolonged service time provided is 105-134 minutes during a 24–hour period as a result of multiple visits to certify S&R (time includes floor time as well as face–to–face time), you would bill one unit of 99356 and 2 units of 99357 (30 minutes each). The use of these codes requires that the underlying E/M code be billed also. Less than 15 minutes is not billed.

This is an example of permissible billing of more than one service per day, where service of unusual intensity is provided. Cardiologists utilize the codes, for example, for

[See **MEDI-COMMENT** on page 6]

Rolling With the Punches

by Herb Peyser, M.D.



Herb Peyser, M.D.

In the interests of taking the Board to the members and the members to the Board (and reporting my votes) let's consider:

MEDEM.COM

July '99 Medical Director Steve Mirin presented APA with joining AMA and five specialty societies in a for–profit website offering high quality medical information. (Ninety million visitors in 1999 searched the Net for health information from healthcare websites often lacking credentialed authority; the number one disease searched was depression.) Concerned that psychologists, family practitioners, etc. might take that on, the Board unanimously voted $250,000 for an APA seat on the board controlling Medem and its content.

Websites were offered to physicians, free if permitting advertising, a fee if unsponsored ($30 per month beginning June 2001 with 90 day notice of change). Medem hoped eventually to provide practice management (primarily traffic and administrative, prescription renewals, appointments, possibly help with claims forms, but also clinical information, patient interaction, secure messaging, and online consultations). That would, however, require significant capital from advertisers, investors, mergers and acquisitions, not yet available, and healthcare content alone was not attractive enough.

In October '99 a $750,000 second round was requested to increase APA's shareholdings, longevity on Medem's board, and influence. Three of us, myself included, opposed that. It didn't seem fiscally prudent, seemed somewhat risky and not really necessary. APA had limited resources and serious budgetary problems and was already on Medem's board. We three, aware of APA's lack of business expertise, were also concerned with APA's increasing involvement in unsure for–profit financial aspects of what was primarily a public, member and profession service–oriented initiative. The Board disagreed, voted it. Thirteen other medical and specialty societies later joined Medem, not as investors but contributing subscribers and "eyeballs."

Collapse of the Dotcom

March 2000 saw, as we feared, a collapse of dotcom (particularly content dotcom) financial valuation and loan markets. Also, only a little over 500 APA members had developed active Medem websites, and psychiatry did not have advertisers (Medem had Ortho-McNeil, Nestle Carnation, WebMD). Other dotcoms offered competitive websites. These matters were discussed at the December Board meeting with the Medem CEO and others, and the enterprise reviewed.

The Board unanimously felt Medem's value to the public, members and profession was still strong and APA should go ahead with it. Further attempts with direct mailing would be made to show website value to members, increase subscribers and patient "eyeballs", and aid further search for advertisers and investors. The Board voted $41,000 for that. I and another, while supporting Medem's public, member and profession service-oriented commitment, felt for–profit Medem should finance it, not APA, and voted against that. (It also seemed more cost–effective just to use e-mail; psychiatrists not online would be less likely to use the Net.)

A problem emerged involving the Board's fiduciary responsibility and need for knowledge of Medem's financial details versus Medem's need for secrecy of proprietary information as it competed in the loan markets. The Medical Director found himself in conflicting roles on Medem's board and finance committee: (1) representing and with fiduciary responsibility to APA's Board; (2) sitting in his own right with fiduciary responsibility to Medem. The problem was resolved, at my suggestion, by APA's Board developing a Medem Oversight Committee to be closely involved with Mirin and Medem, with confidentiality but reporting to the Board.

Circles of Influence

The Board is no monolithic entity but rather concentric circles of influence, even more so when its Executive Committee is created (required by the 501[c][6] reorganization). Officers and Trustees, aware of not being elected to the Presidency, tend to defer to him/her. Some Trustees are rather peripheral despite their fiduciary responsibility. Some Presidents work closely with Presidents–Elect, others not. The one–year President's influence diminishes after his/her first three trimesters.

All this strongly augments management's role. The Board, with only four working meetings a year, greatly relies on the Medical Director. Some Presidents work closely with, sometimes defer to management; others enter into more of a dialogue. Presidents come and go, Board members have varying degrees of influence, the Medical Director continues. What is the proper balance between governance and management here, and between central APA and the DBs?

Perhaps the overall organizational structure should be reviewed: possibly longer Presidential terms, less centralization, and stronger roles for members, DBs, state organizations, Area Councils, the Assembly, certainly closer governance contact with the Medical Director (e.g., governance must oversee management to ensure that Medem makes money, pays for itself, and isn't burdensome for APA with its other budgetary concerns). Perhaps a Business Advisory Board of neutral business experts, separate from management, should be created to advise governance.

Funds Under Choke Hold

The budget is the tightest I've seen. Budgetary prioritization (especially the Information Service) has not been completed; the budget has been put off until the March meeting. It is difficult because of large unavoidable expenses and many valuable competing projects, each with its own constituencies. Much concern was expressed over the Board's apparent overspending on itself (as opposed to major cuts to the Area Councils and Assembly). A controller function with strict reporting has been put in place. I'll report on this.

Unavoidable expenses include the unexpected bankruptcy of an APPI book wholesaler, and heavy legal fees associated with the insurance company sale, Medem, the corporate reorganization, and the Ritalin lawsuit. The IS has had heavy expenditures but now seems to be slowly moving along, not complete as yet but improved. There is a database, and an online membership directory will be developed. A membership and networking IS was purchased from the Maryland DB and will be tried out as a pilot project for the DBs.

Major cuts in Components meetings will be made by the Joint Reference Committee. There was some resistance; some of us were unhappy with cuts that decrease member participation in governance, and the Components are where most of APA's work is done to carry out its clinical mission (e.g., DSM, Practice Guidelines, etc).

Dues are now only 21% of APA's revenue, leading to concerns over increasing direct or indirect reliance on pharmaceutical money. A committee was appointed to develop strict guidelines governing APA's relationship with industry.

Other Matters

The corporate reorganization continues. APA is beginning the development of DSM-V, to mesh with ICD. The Assembly recommendation to have APA advocate against private sector carve–outs was approved. The Assembly's position supporting legal recognition of same sex unions with associated rights, benefits and responsibilities was approved. Jim Krajeski was reappointed Editor of *Psychiatric News*.

The Board approved funding recommendations from the Commission on Public Policy, Litigation and Advocacy to the Oklahoma, New Mexico and Hawaii DBs for help with scope of practice issues in those states. It approved in principle the Commission's request to give money to the Joint Commission on Government Relations to (1) poll and conduct focus groups in target states on that issue, and (2) conduct a study re lobbying Congress regarding non-physician Medicare coverage.

The Task Force on Non–Dues Revenue Sharing will continue, to monitor and evaluate the process. Carolyn Rabinowitz's candidacy for the AMA Council on Scientific Affairs was supported. The Ad Hoc Workgroup on the IS that I got set up will continue to work with them. The Commission on International Members will seek outside funding to continue and expand its work. ■

Albany Report

By Richard Gallo, NYSPA Legislative Consultant

Martin A. Luster - New Chairman Appointed

In the opening days of the 2001 Legislative Session, Assemblyman Martin Luster was named the new chair of the Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities.

First elected to represent the 125th Assembly District (Tompkins, and part of Cortland) in 1988, Assemblyman Luster has had 142 bills signed into law including a Practitioner Placement Law intended to encourage physicians to establish practices in under-served areas.

When I met with Assemblyman Luster on January 22, he expressed his strong support for insurance parity for mental illness and chemical dependency. He is expected to introduce a comprehensive parity MANDATE bill (which NYSPA is working on with others) at a press conference in Albany tentatively scheduled for February 12th.

Parity: Out of MEND, FIT is Born

There is a new face and focus for the coalition of organizations supporting health benefits parity coverage for mental illness. First of all, the Mental Health Equality Not Discrimination (MEND) Campaign has changed its name to the Fair Insurance Today (FIT) Campaign. Secondly, a new bill is being crafted with the intent to MANDATE equal coverage for mental illness and chemical dependency in all group health insurance and group HMO plans delivered or offered for delivery in New York State.

As noted above, Assemblyman Luster has embraced a new, stronger and more comprehensive approach to parity in New York State and has already secured co-sponsorship interest from twenty-eight members of the Assembly Majority, including: co-prime sponsorship from Assemblyman James Brennan (outgoing MH Committee Chair and lead sponsor of the Assembly parity bill for the past four years); Alexander (Pete) Grannis; Insurance Committee Chair; Sam Hoyt; Alcoholism & Substance Abuse Chair; Dick Gottfried, Health Committee Chair; and Steve Sanders, Educational Committee Chair.

On the Senate side, we have a clear expression of interest on the part of Senator Thomas Libous (lead sponsor of parity in the Senate in recent years), regarding sponsoring the new bill in the upper house. The introduction of identical bills by majority party members of both houses will be a giant step forward for parity because it bridges the "different bills in different houses" gap of prior years, providing instead a unified parity proposal around which to rally.

Governor's Executive Budget

On January 16 following the Governor's Executive Budget presentation, James Stone, Commissioner of the Office of Mental Health, and his staff held a budget briefing for advocacy groups, which I attended for NYSPA. The Commissioner's January 16 presentation and his testimony a week later at the OMH hearing before the Senate and Assembly Fiscal Committees can be obtained on-line at the following URLs: <http://www.omh.state.ny.us/omhweb/aboutomh/omhbudget.htm> and <http://www.omh.state.ny.us/omhweb/aboutomh/bughear.htm>.

Also, <http://www.state.ny.us/dob/pubs/executive/executive.html> will bring you to the web page of the Governor's Division of the Budget where you will find the full text and proposed appropriations for the entire budget. It is a relatively easy surf to locate the various sections dealing with health, mental health, MR/DD and alcoholism and substance abuse.

The Executive Budget recommendations include $6.6 million on a full annual basis to fund an additional half-year of the Community Mental Health Reinvestment Act of 1993. This amount will be provided at a 50 percent phase–in for FY 2001-02, and is based on a projected closure of 100 non–geriatric beds at an average "savings" per bed of $65,500 per year. The funding provisions of the current Reinvestment Act will sunset on September 30, 2001.

The Community Mental Health Support and Workforce Reinvestment Act has been proposed to strengthen the existing system of county and voluntary–operated mental health services by instituting a multi–year plan to fund a Medicaid fee increase and a three–year COLA for certain community–based services. The funding for these increases would come from savings directly attributable to adult inpatient bed closures and facility relocations and closures. The plan calls for the closing of two State operated psychiatric centers (Hutchings and Middletown) and the relocation of four children's facilities (Western NY, Rockland, Sagamore and Queens) to the grounds of nearby or adjacent adult psychiatric centers.

NYSPA is still reviewing the Executive Budget request for Mental Health and related services and expects to present a written Position Statement to the Senate and Assembly very soon. ■

Eli Lilly ad

Outpatient Civil Commitment in New York – An Update

By Tracy L. Benford, M.D.

Tracy L. Benford , M.D. is a Fellow in Forensic Psychiatry at the New York University School of Medicine. –Ed.

Tracy L. Benford, M.D.

In the spring of 1999, an article by Dr. Howard Owens appeared in *The Bulletin* describing the outpatient civil commitment program in New York. At that time the program was in its early stages, following a three-year pilot program at Bellevue Hospital. The outpatient civil commitment law, popularly known as "Kendra's Law," is the basis for the Assisted Outpatient Treatment (AOT) Program that is now in operation throughout New York State. The purpose of this article is to provide a brief update about the AOT Program and how it has evolved over the past fourteen months, with the focus on procedures used in New York City.

"Kendra's Law" is intended to enhance the supervision and treatment of the mentally ill in community based settings. The law allows outpatient civil commitment of an individual if the court finds that he or she:

1. is at least 18 years of age and suffers from a mental illness; and
2. is unlikely to survive in the community without supervision, based on a clinical determination; and
3. has a history of non–compliance with treatment for mental illness which has led to either two hospitalizations for mental illness in the preceding three years, or resulted in at least one act of violence toward self or others, or threats of serious physical harm to self or others, within the preceding four years; and
4. is unlikely to accept the treatment recommended in the treatment plan; and
5. is in need of AOT to avoid a relapse or deterioration that would likely result in serious harm to self or others; and
6. will likely benefit from AOT.

Referrals for AOT may come from a variety of sources, including a parent, spouse, or adult family member; an adult roommate; the director of a hospital in which the person is hospitalized; the director of an organization, agency, or home in which the person resides and receives mental health services; a psychiatrist who is either treating or supervising the person's treatment; or a parole or probation officer.

Once a referral is received, the AOT team assigned to the area where the patient lives does an initial screening in order to determine if the patient is appropriate for AOT. This screening process often includes an interview with the referred individual, conversations with the referral source, and review of past records. If it appears from this initial screening that the person does in fact meet the criteria for AOT, a formal examination of the person is arranged with a psychiatrist on the AOT staff. This exam is done with a lawyer from Mental Hygiene Legal Services present on the patient's behalf. A petition demonstrating that the person meets criteria for AOT is then filed, accompanied by the affidavit of the examining physician. The affidavit must show that the physician examined the person within ten days of the filing of the petition, and that he or she meets criteria for AOT.

The court is then required to set a hearing date that is no more than three days after the court receives the petition. At the hearing, the court will hear testimony of the physician whose affidavit was filed with the petition, and may also consider testimony of the petitioner and the subject of the petition. If the court then determines by clear and convincing evidence that the criteria for AOT are met, and a written treatment plan has been filed with the court, an order for assisted outpatient treatment is issued. Once granted, the initial order for AOT is effective for up to six months. The order can later be extended for successive periods of six or twelve months if the court approves such extensions in subsequent hearings.

Treatment plans are specified to the needs of each individual patient and generally involve either supportive case management (SCM), intensive case management (ICM), or an Assertive Community Treatment (ACT) team. These case management services are an essential component of successful Assisted Outpatient Treatment and represent a spectrum of services of varying intensity, with SCM's providing the least intensive case management and ACT Teams providing the most intensive services. The case managers act as the linkage between the patient and the AOT team after the court order has been granted. This allows appropriate ongoing follow-up and a mechanism for alerting AOT staff to any later interventions that might be necessary.

Treatment plans may also include medication management, outpatient psychiatric services, day treatment programs, substance abuse treatment, or other services deemed appropriate by the examining psychiatrist. If a person does not comply with the terms of the court order, that person may be transported to a hospital and retained for up to 72 hours to determine if inpatient treatment is necessary at that time. This process has been referred to as a "removal" since the person is forcibly removed from their place in the community and brought into the hospital for evaluation.

The total numbers of referrals, petitions filed, petitions granted, petitions denied, and petitions withdrawn for each program are listed in Table 1.

These figures reveal that in all jurisdictions there have been many more referrals for AOT than there have been petitions actually filed with the courts. Two factors contribute to this result: first that the AOT teams have the obligation to exercise discretion in screening out patients who do not fit the clinical and legal criteria specified by the law; second that there is a backlog of cases that have been referred but not yet presented in court. Once a petition has been presented, however, very few cases have been rejected by the courts. Here the most parsimonious conclusion is that the courts almost always accept the recommendations contained in the testimony of psychiatrists.

Table 1. Assisted Outpatient Treatment - Summary Report as of 1/12/01

	Bellevue Hospital Center	Rikers Hospital	Woodhull Hospital	Elmhurst Hospital Center	North Central Bronx	New York Sttate OMH	TOTAL FOR ALL PROGRAMS
Referrals to AOT	796	148	314	400	338	352	2348
Petitions filed	230	32	189	79	114	71	715
Petitions Granted	198	24	161	57	109	63	612
Petitions Denied	3	0	11	6	2	3	25
Petitions Withdrawn	17	5	8	8	0	3	41

As Dr. Owens pointed out in his previous article, there are a number of potential problems with the implementation of "Kendra's Law." One problem noted by Dr. Owens is that "the law has no teeth." In other words, there is actually no mechanism in the law to enforce patient compliance with the treatment plans set forth in the court orders. Failure to comply with the treatment plan is not in and of itself grounds for involuntary hospitalization. If a patient does not comply, he or she cannot be detained beyond the 72–hour evaluation period (unless the patient meets the standard provisions of Article 9.27 and 9.39, requiring dangerousness to self or others). Because this standard for involuntary detention existed well in advance of the outpatient civil commitment law, essentially not much has changed with regard to involuntary hospitalization.

Dr. Owens also expressed the concern that psychiatrists could "be left holding the bag" — expected to provide workable treatment plans and to testify about how they would be implemented, but lacking the resources to implement the treatment and unable to hospitalize the patient involuntarily. In terms of the lack of community resources in some areas, this concern has already been proven warranted.

In New York City the Intensive Case Management services have been saturated by the number of referrals they have received. Their already thin resources have been stretched even thinner by the heavy demands of AOT Programs. At Bellevue, for example, this has led to obstacles in proceeding with some of the current cases under investigation since case management services are required to be in place *prior to* conducting an official examination for AOT. The clinical heart of AOT lies in the provision of good case management; limited resources for case management represents a roadblock to the implementation of the law. AOT teams, which had to be organized and staffed over a short period of time have at times found themselves overworked and overwhelmed with the volume of cases.

Despite these notable issues, as the current forensic fellow working on the AOT team at Bellevue, I can say that thus far, the resources in the community have been excellent in terms of providing the expected support services, once the court issued its order. Furthermore, from my own experience, the clinical staff at community agencies have felt that AOT has been very beneficial to their clients who are involved in the program. These staff members have been extremely willing to work in concert with the AOT team. In my opinion, therefore, psychiatrists have not been "left holding the bag." Rather, the effect of AOT so far has been well–coordinated, comprehensive treatment for the chronically mentally ill who so often have been overlooked by mental health care systems in the past. ■

Medi-Comment

Continued from page 3

continuous observation of unstable patients.

Consultation codes, 99251-99255, might be used, for a single evaluation, but would be unlikely to capture the nature of the service provided, especially since repeat assessments may well be required. Follow up consultations, 99261-99263, cannot be billed on the same day as an initial consultation. Additional consultations by different covering psychiatrists would be denied.

The use of these codes is described in more detail in the CPT book. You will be well advised to buy the CPT book from the AMA and learn to use it. The AMA number is 1 800 621-8335. Ask for the 2001 CPT book and minibook for medical specialties, sold as a package. ■

Look for more Medi–Comment Q&A in future editions of The Bulletin!

Goldstein and the Insanity Defense: An Interview with Angela Hegarty, M.D.

by Martha Crowner, M.D.

Martha Crowner, M.D. interviewed Angela Hegarty, M.D. on September 9, 2000. Dr. Hegarty is Director of Forensic Services at Sagamore Psychiatric Center. –Ed.

On January 3, 1999, Andrew Goldstein, a man with a history of multiple hospitalizations for psychiatric illness, pushed Kendra Webdale to her death in the path of an oncoming subway train. He pled not guilty by reason of insanity. A mistrial was declared November 2, 1999, but a second trial resulted in his conviction. He was sentenced to 25 years to life.

The crime and the ensuing court case were widely publicized. The course of Mr. Goldstein's illness and of his contact with the local mental health care system were also publicized. On May 23, 1999 a story in the *New York Times Magazine* opened with, "Maybe they should have just stenciled it in large letters on Andrew Goldstein's forehead: TICKING TIME BOMB. SUFFERS SCHIZOPHRENIA. IF OFF MEDICATION, RUN FOR COVER!" The author wrote that Mr. Goldstein had suffered repeated episodes of psychotic decompensation due to medication non–compliance. He sought out care and was repeatedly hospitalized, but could not obtain the support he needed after discharge, because social services were inadequate.

The Webdale family lobbied for passage of New York State's Assisted Outpatient Treatment Law, which became known as "Kendra's Law."

Angela Hegarty is a forensic neuropsychiatrist in private practice and Clinical Assistant Professor of Psychiatry at New York University School of Medicine. She was retained by the prosecution to evaluate Andrew Goldstein and testified in both trials. My interview with her follows.

When Mr. Goldstein was found guilty, when his insanity defense failed, residents would ask me, "How could this be?" I couldn't explain it. I hope you can.

Many psychiatrists don't know that there is a distinction between a diagnosis of schizophrenia (or other mental illness, for that matter) and the legal standards for the insanity defense. Here's the legal standards: In order for a defendant to be found not responsible by reason of mental disease or defect, the defense has to prove by a preponderance of the evidence that, at the time of the offense, he (or she) was suffering from a mental illness, and as a result of that mental illness, failed to know what he was doing, the consequences of what he was doing, or that what he was doing was wrong.

All three are required?

No. The idea is that mental illness interferes with the defendant's capacity to fully think through what he (or she) is doing. It could be that someone knows what he is doing, but lacks the capacity to know and appreciate the consequences or wrongfulness of his behavior. Under such circumstances he might be found not legally responsible.

So it seems that the current standard is purely cognitive. Its requires that the defendant didn't KNOW what he was doing, didn't KNOW the consequences… It doesn't take into account the defendant's affective state or ability to control his or her own behavior. These may all be affected by mental illness.

Yes. As I understand it, the standards for a "insanity defense" in New York are purely cognitive. There was a time when the "irresistible impulse" criterion was also part of the standards, at least in some, if not all, jurisdictions. But in recent years this has largely been abandoned. Historically, the standards for an "insanity defense" became more restrictive in response to the findings in the Hinkley case.

That was the case in which President Reagan was shot?

Yes.

What was your job in the Andrew Goldstein case?

In insanity cases, the defense counsel's job is to bring out the aspects of the psychiatrist's evaluation that support an insanity defense. The job of the prosecution attorney is rebuttal of the defense expert's position. That's the job of the attorneys.

I was called in as a forensic psychiatrist to evaluate Mr. Goldstein. Psychiatrists do the same evaluation no matter which side retains them, the defense or the prosecution. Sometimes a psychiatrist is retained and performs an evaluation, but the conclusions are not helpful to the retaining counsel's case. In those cases, you are not asked to testify and often, are not even asked to write a report.

In this case, the first thing I did was to review all the data we had about Mr. Goldstein and all the data about the crime. I reviewed the psychological test results. I interviewed Mr. Goldstein. Between the two trials I spent about 20 hours with him, face to face. Then I looked at all the data and tried to understand what Mr. Goldstein was thinking and feeling when he pushed Kendra Webdale to her death. My job was to understand the mental illness and to understand the crime. Obviously, I did not agree with the conclusions of the defense experts.

I'd like to ask you more about Andrew Goldstein and his case, but how much can you tell me?

The case is under appeal, so I can't comment on the details. However, I can comment on its coverage in the media.

It seemed to me that the media coverage of the case equated severe mental illness and violence. This concerned me because it promotes stigmatization of the mentally ill. Advocates for the mentally ill have worked long and hard to counter the stereotype of the mentally ill as unpredictably violent. Most mentally ill people are never violent. And when they are, they are usually violent for the same reasons that the rest of us are.

The law presumes that the majority of mentally ill people are not violent. The law presumes that they are both competent and responsible until proven otherwise. This presumption forms the basis for the civil rights of the mentally ill. The public's perception that the mentally ill are neither competent nor responsible is a substantial obstacle for those who advocate for their rights.

Some advocates for people with severe mental illness have written that capitalizing on public fears of violence may be necessary. That is, necessary in order to get laws passed to ensure that people with mental disorder get the treatment they need. In my opinion, this hurts the literally millions of people with serious mental illness who are struggling to find acceptance in a community that is already leery of them.

I'll tell you a story. I have a friend whose son has a diagnosis of schizophrenia. The young man has lived with his father in the community for many years and has never been violent. The father told me that after the neighbors in his apartment building read the *New York Times Magazine* article (the one you mentioned earlier) for the first time they expressed concern about his son's ability to control himself. They had suddenly become afraid of him! They worried that he, too, was a ticking time bomb, simply by virtue of his mental illness!

Some of the details of the case are already public. They were reported in the press.

I was surprised that a journalist had apparently been given access to Andrew Goldstein's entire psychiatric record. This is extremely unusual, even in cases that are covered extensively in the media. Of course, any material entered into evidence or testimony at trial is part of the public record. Forensic psychiatric evaluations are not confidential in the way that treatment evaluations are confidential. But even in forensic settings, it is general practice to protect as much patient confidentiality as we can.

It seems that some people, at least some journalists, were trying to argue that the mental health system failed Andrew Goldstein.

The issue of Andrew Goldstein's state of mind at the time of the offense and the issue of the adequacy or inadequacy of the mental health system are separate questions.

It is one of the cornerstones of our system that defense counsel provide as vigorous a defense as possible within the limits of the law. Sometimes defense counsel have been known to bring up red herrings in order to do the best they can for the client.

Still, I can't understand it. To throw a stranger in front of a train seems crazy. To do it to your spouse, someone you've been fighting with for years, that I could understand. If he were thoroughly intoxicated, that I could understand, but he wasn't. At least I never read that he was.

Not crazy, senseless. There's a difference. Legally sane people commit horrible, senseless crimes every day. Many crimes are senseless. Most homicides are not committed in cold blood, for logical reasons. Usually people get emotional, they loose their temper, then they do things they regret later on. Many of us have bad tempers. The law is part of what keeps us from acting on our tempers.

Will Mr. Goldstein get treatment in prison?

Yes. The New York State Office of Mental Health provides mental health services for prisoners throughout the system. ■

Call For Nominations

Area II Trustee to the APA Board of Directors

The Area II Nominating Committee is soliciting members who are interested in being considered for nomination as a candidate for election as Area II Trustee. The current three–year term of office for Area II Trustee expires in May, 2002, and candidates for this office will be included on APA 2002 ballot.

NYSPA members interested in being considered should contact Edward Gordon, M.D., Chair of the NYSPA Nominating Committee no later than June 15, 2001.

CLASSIFIED ADVERTISEMENTS

Rates for classified ads are $60 (minimum) for the first three lines, $10 per line thereafter. NYSPA members receive a 50% discount on the minimum rate. All ads must be prepaid. Contact Donna Sanclemente for pricing of your copy and payment arrangements: 732-438-0954 or email donna@ptofview.com.

Commentary

Continued from page 2

Albany a while and finally the law was passed in 1998, but now a serious problem arose. Such a system enters data into a computer network interconnected to a plethora of other computers. All along the line of communication and storage between pharmacy and the BCS there would have to be strong protection against unauthorized access.

APA and NYSPA were alerted to this problem by the American Psychoanalytic Association's privacy hawk, Dr. Paul Mosher. Consultation with MSSNY revealed that they were working on it. Although BCS Director Jim Giglio had reassured MSSNY's Drug Abuse Committee Chair that encryption and security was in place, MSSNY's Division of Governmental Affairs had communicated its concerns to DOH and was waiting for the regulation. It emerged in November 2000 and was felt to be inadequate, and NYSPA wrote a strong letter to DOH, as did MSSNY.

The MSSNY letter reviewed the regulation and concluded that "the proposed regulation does not appear to provide for any greater efforts to ensure against unauthorized access than those provisions that already exist in statute and in regulation." They asked "that the Commissioner [of DOH] use her broad powers under Public Law 3308 to take steps to provide greater assurance that the information maintained in the computer system will be free from unauthorized access."

MSSNY's letter also reviewed Whelan and noted that MSSNY was "concerned that this expanded risk of unwarranted disclosure could cause a court to view this new law as unconstitutional." It emphasized that "there is some risk that this statutory mechanism could be deemed to be unconstitutional if adequate patient privacy is not maintained." These comments seem to indicate the possibility of legal action from some quarter if the regulations were not improved.

MSSNY also asked that the regulation allow physicians to use their old triplicate forms for at least six months following implementation of the system, that the money saved by BCS not needing personnel to punch in the data be used to defray the cost of the new forms, that "terminally ill" be defined to aid in prescribing for hospice patients, and that the BCS review the entire program and its "success … in reducing the inappropriate use of controlled substances, compared to the efforts of other States." In this MSSNY was questioning "the continuing need for physicians to share certain sensitive patient information with the State …"

The NYSPA letter quoted Justice Brennan in Whelan: "the Constitution puts limits not only on the type of information that state may gather, but also on the means it may use to gather it. The central storage and easy accessibility of computerized data vastly increase the potential for abuse of the information …" NYSPA asked DOH to "defer further action to implement this new system until it discloses for public review and comment the means that will be employed to protect the confidentiality and integrity of the new system …"

We'll see. ■

President's Message

Continued from page 1

tion and urging the psychiatrist to change the prescription to another medication. Some communications have included a printed prescription form with the doctor's name, the patient's name and medication being "pushed" by the drug plan.

There have been some hearings on the subject in the past year in Manhattan and Albany, and Mark Green and Congressmember Carolyn Maloney have expressed concerns over the issue. We will be planning to meet with Congressmember Maloney to discuss possible legislative initiatives in this area.

As mentioned, exemptions in the new federal regulations soften associated safeguards in protecting medical data. An article in the *Washington Post* (January 16th) by staff writer Robert O'Harrow, Jr., summarized some pros and cons of the new privacy rules: Foundations affiliated with hospitals continue to have access to patient names, addresses, and phone numbers for fundraising activities. Patient advocate groups do applaud that when the rules fully take effect in 2003 patients will have the right to access their records. Employers will be prohibited from receiving personal health data except for administrative purposes, and those who misuse private records could face fines or prison. Any health care provider or service wishing to use medical records must notify the patients as to how they are being used, and the patients may opt out of having their records used for marketing or fundraising purposes. Patients, however, must be contacted at least once by any given entity to refuse, and cannot provide a blanket rejection of such requests.

As medical data including prescription information and laboratory test results are increasingly digitalized, hazards arise. While patients can benefit from having timely comprehensive information immediately available to their doctors, that same information in the wrong hands can be damaging. With hospitals, pharmacies, and insurance firms increasingly carrying such information in computer databases, medical data can be used to deny insurance coverage or employment and social security numbers and birth data accessed in identity theft. As the access and transfer of records electronically becomes more efficient, unexpected or unintended intrusions into privacy become more frequent.

The task of improving the transfer of information to benefit patient care while at the same time protecting medical records is complex. We must hope that the extent of the exemptions in the upcoming federal regulations does not undercut the desired gains in patients' rights and the protection of private data. Robert Gellman, a lawyer and privacy consultant in New York, has studied the regulations and described them as full of "virtual rights," authorizing behaviors that were once viewed as unethical or improper.

Psychiatrists must be in the forefront of speaking up for the appropriate protection of confidential information and the proper use of medical data. Next time your pharmaceutical rep asks you how often you use their product, ask yourself how you feel knowing that the rep may have a more accurate answer than you! ■

New York State Psychiatric Association
Area II Council - American Psychiatric Association
100 Quentin Roosevelt Blvd.
Garden City, NY 11530