



Military Stays in Bosnia; Vaccinates for Anthrax

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Opposition to Law Officers Having Unfettered Access to Medical Records

All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.

Hippocratic Oath

UNLIKE PHYSICIANS, many of the great and increasing number of people who now have access to medical records have taken no oath to protect either the privacy or the well-being of patients. Reports of egregious misuse of patient information—and concern over the potential for even greater abuse made possible by the nation's move toward computerized records—has led Congress to consider legislation to protect the confidentiality of patient records.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required US Department of Health and Human Services (DHHS) Secretary Donna Shalala, PhD, to submit detailed recommendations for protecting the confidentiality of patient information. On September 11, 1997, Shalala submitted her recommendations. Congress now has until August 21, 1999, to pass the required legislation, and if it fails to do so, the DHHS secretary will be authorized to promulgate protective federal regulations.

The secretary's recommendations (accessible via the World Wide Web at <http://aspe.os.dhhs.gov/admsimp/pvcrec0.htm>) are drawing fire from clinicians who object to allowing law enforcement agents and members of the US intelligence community carte blanche access and use of patient information. Among the leading critics is the American Psychiatric Association (APA), which argues that unfettered access to medical records by law enforcement and intelligence officials poses a serious threat to the welfare of patients, especially those with mental illness.

At the 13th Annual Rosalynn Carter Symposium on Mental Health Policy, at

the Carter Center in Atlanta, Ga, APA President Herbert Sacks, MD, issued "a call to action" for the National Alliance for the Mentally Ill, the National Association of Mental Health, and others to join the APA's 42 000 members in leading a citizen's coalition to support legislation that would require law enforcement and government intelligence agents to get court permission before they can view patients' records.

The symposium, Privacy and Confidentiality and the Appropriate Use of Mental Health Information in an Era of Managed Care, focused on the 2 major factors that are increasing concern over the threat to patient privacy: the rush toward managed health care and electronic information technology. "Managed care certainly has played a role," said former First Lady Rosalynn Carter in addressing the symposium, "but it would be unfair to attribute the growing concern about security and accuracy only to that. The electronic storage of patient information on computers that are linked throughout the country is making this information more easily accessible to people who do not have legitimate need for access."

Although Shalala's recommendations seek to remedy many of the problems posed by the managed health care and electronic information juggernauts, they fall far short of addressing the concerns of many clinicians and civil libertarians. While law enforcement officials throughout the United States need a warrant to search or remove records from a person's property, in many jurisdictions they are free to search through that person's medical records without legal process. The DHHS secretary recommends keeping it that way:

Law enforcement agencies need access to health information for many purposes. We recommend that providers and payers and those receiving information under the provisions of the legislation . . . be permitted to disclose health information without patient authorization . . . upon request of a law enforcement official who states that the health information is needed for a legitimate

law enforcement inquiry, and that the request complies with all applicable law; or upon request of the US Intelligence Community . . . who states that the information requested is needed for a lawful purpose. We recommend that the Intelligence Community and law enforcement agencies which receive information under this provision not be subject to restrictions on its further use or disclosures except as provided by other law.

We recognize that new issues are raised by the search capabilities of computerized records, and that there are arguments in favor of new restrictions to address these possibilities. However, until more experience is gained with the uses of computerization of these records, and the types and frequency of requested searches, it is premature to change existing law in this area.

'Morass' of Existing Laws

According to Robert Gellman, a Washington, DC-based privacy and information policy consultant and one of the symposium speakers, "patchwork," "erratic," and "morass" are words that can be used to describe existing medical privacy laws. "No general federal statute regulates the privacy of health records," he said. "Federal laws cover drug and alcohol abuse treatment records maintained by any institution that receives federal funds, but relatively few health records fall under the protection of these laws. According to a recent survey of state laws, most but not all states impose a duty to maintain confidentiality on physicians. Fewer impose a similar requirement on other health care providers; 9 have confidentiality requirements for employers; and only 4 impose duties on insurers."

"Each state has a statute addressing the confidentiality of general health care information," reported John Petrila, JD, chair and professor, Department of Mental Health Law and Policy, at the Louis de la Parte Florida Mental Health Institute, University of South Florida College of Medicine, Tampa. "Most states also have a separate statute defining the confidentiality of mental health and

Protecting Research as Well as Patient Privacy

SOME OF the legislation for protecting the privacy of patient records under congressional consideration would make it difficult for epidemiologists and other medical researchers to conduct many of the studies commonly done today. The legislation would block investigators from having access to patient information without patient consent. US Department of Health and Human Services Secretary Donna Shalala's recommendations to Congress, however, would permit disclosure of medical information to researchers without patients' consent if it would be impracticable to conduct that research without the data that identify the patient and if the research project is approved by an institutional review board.

"Research is essential to our health care," the secretary wrote Congress. "Federal law should permit use of information for research without consent under carefully defined circumstances, and should also include safeguards, including restrictions on redisclosure, to ensure that individual subjects are not harmed. Federal requirements should include a determination by an institutional review board that the research does not involve more than minimal risk, that the absence of consent will not harm the participants, and that the research would be impracticable if consent were required."

On the other hand, legislation proposed by Rep McDermott and Sen Leahy's draft would require consent of subjects before protected health information could be disclosed to researchers. "The question of access by researchers is an important one, particularly given the split between the proposals on the issue of consent," said John Petrila, JD, chair and professor, Department of Mental Health Law and Policy at the Louis de la Parte Florida Mental Health Institute, in Tampa. "It should be noted that a provision requiring consent of each individual before protected information may be disclosed would have a significant impact on many research projects in both general and behavioral health."

States also have been considering adopting legislation to bar researchers from obtaining data about patients without their consent. "Despite the absence of documented abuses related to approved research projects, legislation has been passed in Minnesota that restricts access to medical records for research purposes," wrote L. Joseph Melton, MD, of the Department of Health Sciences Research, Mayo Clinic, Rochester, Minn, in the *New England Journal of Medicine* (1997;337:1466-1469). While acknowledging that misuse of patient information by some insurers and employers has justifiably heightened public concern over the confidentiality of medical records, Melton warns that laws that prevent researchers from conducting observational outcome studies based on medical records may endanger the public's health. Requiring that patient consent be obtained each time before a medical record could be used for research would make it impossible to do most retrospective studies that are vital for assessing health and disease trends and for conducting long-term studies of treatment outcomes. "Such studies often involve thousands of subjects who may have last been seen many years ago," Melton said.

In addition, such laws have the potential to strongly bias studies that can be carried out, because they would be based on data that come only from patients who give permission. The exclusion of data from patients who died or those who are less disposed to provide permission would likely introduce selection biases that may make the studies useless or the results harmfully misleading, Melton said.

The privacy rights of patients can be protected without jeopardizing research that is vital to promoting public health with legislation that permits institutional review boards to waive the requirement of informed consent for important studies in which the risks of adversely affecting the welfare of patients is minimal, Melton concluded.—A. A. S.

substance abuse treatment records and information. All states also have separate statutes providing confidentiality of information regarding individuals infected with [human immunodeficiency virus]."

These multiple standards often create practical difficulties for clinicians who treat people with co-occurring disorders for which different confidentiality rules apply, Petrila said. The need for more

uniform and rational legislation to protect the confidentiality of patient records has long been a concern to the health community and others. "The current Congress is the third consecutive one in which health privacy has been on the agenda," Gellman said. "Future prospects for legislation remain highly uncertain. Previously, health privacy legislation was considered during 1979 and 1980. Despite support for legislation

from the Carter administration and from both House and Senate committees, the effort failed and was not revived until 1993."

Congress now is considering a number of legislative proposals in addition to the DHHS secretary's. They include proposals from Rep Jim McDermott (D, Wash; HR1815), Rep Gary Condit (D, Calif; HR52), and Sen Robert Bennett (R, Utah; S1360), and one that Sen Patrick Leahy (D, Vt) is expected to introduce. Leahy's pending proposal, which is supported by the APA, provides patients with the most protection against unwarranted searches and seizures of their medical records by law enforcement officials, Petrila said. Leahy's proposal would require law officers to obtain a court order under nearly all circumstances to access protected patient information and would have to demonstrate "clear and convincing" evidence of lawful need before they can disclose that information.

Courts Champion Privacy

The DHHS secretary's recommendations for law official's unfettered access to patient records are "horrendous," said Marcia Kraft Goin, MD, PhD, clinical professor of psychiatry and behavioral sciences at the University of Southern California School of Medicine, Los Angeles. Although the secretary called for the enactment of stiff penalties for anyone convicted of misusing patient information, Goin argued at the symposium that punishment will not likely reassure the public. "People don't feel safe in their homes [just] because their state has enacted the death penalty," she said. "Similarly, public trust in protection of medical information privacy will not be supported by the enactment of harsh punishments for the misuse of patient information."

Serious breaches of patient privacy are widely being reported in newspapers and magazines, Goin said. Readers are being advised not to file for reimbursement from their insurer and to go to practitioners or druggists who agree not to report results to their insurer or employer. But that solution is a luxury that most US patients cannot afford.

"Secretary Shalala's recommendations are directly antithetical to this increasing jurisprudential recognition at the highest levels of a personal right to confidentiality," said Goin. "The courts appreciate the benefit to the public of maintaining patient privacy. The legislature, caught up with problems of cost containment and law enforcement, fails to realize the loss to the public when mental health professionals are steered away from their role of healing by demands for policing."

Recently, the Seventh Circuit Court stated: "Effective psychotherapy depends upon an atmosphere of confidence and trust, and therefore the mere possibility of disclosure of confidential communications may impede development of the relationship necessary for successful treatment. . . . The privilege also serves the public interest, since the mental health of the Nation's citizenry, no less than its physical health, is a public good of transcendent importance" (*Jaffee v Redmond*, 64 USLW 4490 [Sup Ct June 13, 1996]). In upholding that decision, the US Supreme Court commented that the fear of losing information important to police investigations is specious, because a patient who knew there was no confidentiality would not disclose such information, Goin said.

"Legislators need to match their concerns and efforts with those of the courts and listen carefully to the recent decisions of the justice system," she concluded. "The needs of personal privacy and the impact of continued erosion of these rights far outweigh the perceived public need to know."

Health Care's Achilles' Heel

"Technology is the right arm of health care and its Achilles' heel," said Richard Harding, MD, medical director of Richland Springs mental health center at Richmond Memorial Hospital, Columbia, SC, and a member of President Clinton's committee to develop legislation for protecting the confidentiality of medical records "Without trust, the patient may be reluctant to give the clinician complete and accurate information. Also, a sympathetic clinician may be reluctant to write down the diagnosis of a sensitive disease or will conspire to omit crucial data from the medical record. It may not be long before the data needed for quality assurance, outcomes studies, and economic analysis will be tainted, rendering outcomes studies meaningless at best and misdirecting at worst."

"The mental health professional is bewildered about what to write in the medical chart," Goin said. "There is a recognized need to maintain a careful record in order to ensure quality care. An accurate record is crucial to properly treat a patient in the absence of the regular caretaker. The record also provides a means of quality review. However, increasingly records are being written to primarily answer claim reviews rather than to provide quality care. In the service of protecting their patient's confidentiality, many clinicians will omit vital information. . . . There are profound dangers in diverting the medical record from its primary purpose as an instrument useful in the provision of quality health care. As it is forced to act as a resource for claims review and criminal investigations, it will be less and less potent as a useful tool in quality care."

The stigma and shame associated with some illnesses, and especially with mental illness, are well known and often complicate or compromise patient compliance with treatment. Patients turn to physicians when they are suffering, both physically and mentally, and therefore are in a condition of extreme vulnerability.

"In this state, they pour out their hearts, telling life stories which they believe will be kept in confidence," Goin said. "This storytelling is important for the therapeutic process, especially in psychiatric practice . . . the clinician has a unique burden of responsibility to keep in confidence the private information entrusted to him or her in the course of a patient's treatment."

Will Technology Help?

Considering whether technology will help or hurt the struggle to protect patient privacy, Gellman said, "Technology will not provide a direct solution to the major privacy problems facing the American health care system. Technology will provide partial or total solutions to some problems, will exacerbate oth-

ers, and will create entirely new problems, all at the same time.

"More widespread use of computers and networks will threaten privacy because patient information may be more readily available to more users," he said. "At the same time, the technology may improve patient care and lower costs. Computers may also enable us to manage patient information so that we can profit from its availability in ways that do not impinge further on individual privacy interests. Well-managed computer systems can also provide greater security protections. All of this can be done, but it remains to be seen if they will be done in a safe and effective way."

The real danger of technology, Gellman concluded, is that "technological familiarity breeds acceptance." As in the past—such as with the introduction of handheld cameras and more light-sensitive film around the turn of the 19th century, which allowed photographs to be made without the subject's consent—familiarity with new technology is sure to change the way society views privacy. "Once we get used to technology, it grows more difficult to argue that the technology violates our expectations of privacy," he said.

"In interpreting the Fourth Amendment's protections against unreasonable searches and seizures, the Supreme Court looks in part at the expectations of individuals and society. This test is tautological: privacy is only protected when people expect it to be protected. As professor Paul Schwartz has written, 'this circular approach ignores the silent ability of technology to erode our expectations of privacy.' It remains to be seen whether the growing gap between privacy and technology will create a consumer backlash or the requisite pressure for legislation. Evidence of a backlash exists, but it does not appear to pose either a real threat to computerization at this time or a sufficient force to drive legislation through Congress," Gellman said.

—by Andrew A. Skolnick

Could Virulent Virus Be Harbinger of 'New Flu'?

MORE THAN 1 MILLION chickens and other food fowl were slaughtered in Hong Kong, China—an event fraught with difficulty—late last month in an attempt to stem the spread of a new antigenic strain of influenza virus originating in birds. The virus emerged to infect at least 16 humans in Hong Kong and, as this issue of *JAMA* went to press, 4 of those infected had died (see also p 263).

A major concern is the possibility that the new strain could be passed from hu-

man to human, which would herald the likelihood of a pandemic.

While it is not clear how the virus is being transmitted, most of the cases so far seem to have occurred as a result of contact with chickens. "However, not all of them have been directly linked to exposure to birds. That's one of the questions we still have to answer," said a spokesman at the Centers for Disease Control and Prevention (CDC), Atlanta, Ga. But, pointed out the influenza expert, "Hong Kong is one big bird market."

The virus has been identified as an H5N1 (hemagglutinin 5 neuraminidase 1) strain of influenza A. Because humans have not been exposed to this antigenic variant and the shift in the hemagglutinin antigen represents a major change, the possibility exists that, if the virus is transmitted through human contact, it could be the cause of a pandemic. Serum specimens are being taken to test for the presence of antibody to the virus.

"There is no evidence so far that the infection has spread widely in the com-

munity or that there has been human-to-human transmission," said Daniel Lavanchoy, MD, head of the World Health Organization (WHO) Division of Emerging and Other Communicable Diseases Surveillance and Control, who went to Hong Kong to assist in the investigation. CDC scientists who are also in Hong Kong agree. They are continuing their efforts to determine how those who have become ill were infected, whether other persons in Hong Kong and Southern China are infected with the virus, and whether there is evidence of person-to-person transmission.

A CDC spokesperson who is in Hong Kong stresses that "so far there is no clear evidence that a major outbreak is likely."

Began Last Spring

The first person known to have become infected with the new strain—in May 1997 in Hong Kong—was a 3-year-old boy. The child died during an acute respiratory illness that subsequently was determined to be caused by H5N1 influenza type A. However, he died of Reye syndrome, apparently the result of being treated with aspirin.

Subsequently, a serum specimen obtained from the physician who cared for the child has been identified as positive for the H5N1 virus. The physician is reported not to have developed any respiratory symptoms nor does he appear to

have infected others, an indication that the virus may not be readily transmitted among humans and—even when it is transmitted—may not result in severe illness. Investigators from the CDC and the Hong Kong health department have reported that of 502 serum specimens from persons believed to have had contact with the initial patient, 9 were positive for the virus but only 1 person had mild symptoms of influenza.

The second case involved a 2-year-old boy who developed fever in early November and was admitted to the hospital. Although he recovered, a nasopharyngeal aspirate taken during his hospitalization was positive for influenza A H5N1. The identification of the virus in both cases has since been confirmed independently by the WHO's Influenza Collaborating Center at the CDC, the National Influenza Center in Rotterdam, the Netherlands, and the National Institute for Medical Research in London, England. To date, there have been 7 other cases and 2 more deaths.

Preparing for Worst Scenario

Since there is no evidence that a pandemic is imminent, "the cases so far reported are not regarded as an emergency, but we are acting as if it were," said a CDC spokesperson. In short, the authorities are preparing for a worst-case scenario while hoping it does not eventuate.

Initial steps have been taken to characterize the virus and develop a vaccine. One problem is that this virus is so virulent it kills the chick embryos on which it is cultivated for vaccine production. So scientists are trying to get a surrogate strain for H5N1, and the current strategy is to look for another chicken H5, said Edwin D. Kilbourne, MD, a research professor in the Department of Microbiology and Immunology at New York Medical College, Valhalla, NY.

"There are many specimens in [researchers'] refrigerators that don't have the virulence of this particular strain," said Kilbourne, who is the developer of a technique for making recombinant influenza viruses that carry the desired antigenic strain to stimulate immunity while possessing the good growth characteristics needed for vaccine production. "Until a surrogate strain is selected, there isn't much I can do about making a recombinant," he said. "What I am pressing for is that we don't spend time looking for an exact match. Something is better than nothing."

Two years ago, public health experts started to make plans to respond to an outbreak of pandemic influenza. At the time, they agreed that it was not a question of "if" a pandemic would occur—it was a matter of "when" (*JAMA*. 1996; 275:179-180). What officials hope is that "when" has not already arrived.

—by Charles Marwick

Military Stays in Bosnia; Vaccinates for Anthrax

MILITARY MEDICINE—like the peace-enforcement effort that it supports—now has an open-ended commitment in the former Yugoslavia.

After previous extensions of US forces' stay in the war-torn Bosnia-Herzegovina region, the Clinton administration has now said withdrawal should be determined by progress toward lasting peace rather than by any deadline date. Previously, the administration had announced US troops would leave next June.

As 1998 begins, the United States is contributing slightly more than 8000 troops to the 34 000-member North Atlantic Treaty Organization (NATO) force seeking to prevent resumption of the bloody 3½-year civil war among Serbs, Croats, and Muslims in what was the nation of Yugoslavia.

Little Illness or Injury

At the annual meeting in Nashville, Tenn, of the Association of Military Surgeons of the United States (AMSUS), speakers noted that—in the absence of

combat—the illness and injury rate for US forces deployed to Bosnia has been the lowest in history.

Ronald R. Blanck, DO, a US Army lieutenant general and current AMSUS president, said the illness and injury rate in Bosnia is 76 cases per 1000 US service members per year. Blanck, who is the US Army's surgeon general, said this rate compares with 153 cases per 1000 during the 1990 and 1991 Desert Shield/Desert Storm deployment against Iraq and 419 cases per 1000 annually during the conflict in Southeast Asia during the 1960s and early 1970s.

According to the US Department of Defense (DOD), before US service members are deployed for NATO's Operation Joint Endeavor in Bosnia, they undergo comprehensive medical screening, collection of blood samples that are stored for future reference, and education about health risks (and preventive measures to be taken) in the region.

To protect US service men and women once they join NATO's stabilization force, surveillance of the environment and any

unusual incidence of disease is being conducted, according to the DOD. For the former, more than 112 000 analyses of soil, water, and air samples from Bosnia have been done. For medical surveillance, laboratories have been set up where US troops are based to provide immediate on-the-spot diagnostic support.

According to DOD officials, these environmental and medical surveillance efforts resulted in early detection of the threat of tickborne encephalitis in the region. Prompt vaccination has helped prevent the development of this type of encephalitis among US forces deployed there.

US military commanders in Bosnia also must work with military physicians to assure that the troops' medical records are kept up to date and any potentially health-related events are recorded. When US military personnel complete their tours of duty in Bosnia, they undergo additional comprehensive physical and mental health screening and serum collection before leaving or within 10 days of reporting to their new assignment.

The Pentagon has been criticized for the quality of some medical records maintained for US personnel during the war in the Persian Gulf 7 years ago. This in part has prompted the DOD's "force medical protection" effort now under way.

Force medical protection (which in turn is part of the so-called revolution in military affairs affecting future US military doctrine, capability, and operations) includes monitoring of immunizations.

Anthrax Vaccination Increased

The DOD is ordering all of the approximately 1.5 million men and women (unless pregnant) in uniform (who make up an all-volunteer force) to be immunized against anthrax as a precaution against a possible terrorist biological attack. Researchers

working in military laboratories and uniformed personnel in the various branches' biological and chemical warfare units or special operations forces already are receiving the anthrax vaccine, according to DOD officials. Six injections are required over an 18-month period, with an annual booster. Some recipients experience mild localized reactions.

Some (state) Army and Air National Guard personnel, who may be designated by the DOD to respond if there is a local terrorist attack using biological weapons, are expected to be immunized against anthrax. Selected other military reservists, certain DOD civilian workers, and perhaps a few others might also be immunized if they are likely to be sent to high-threat areas, according to officials.

Pentagon officials have said that at least a dozen nations are capable of producing anthrax spores and incorporating them into biological weapon delivery systems.

The concern, discussed with increasing frequency in recent weeks as Iraq resists United Nations inspection of potential weapons development and storage sites, is that a rogue state might be tempted to use such mass-casualty weapons for terrorist purposes.

A major theme of the AMSUS meeting was the possible use of biological weapons and its challenges for medicine. Anthrax is one of the potential biological weapons that was discussed in Nashville by researchers and clinicians studying these spores and possible countermeasures.

—by Phil Gunby, JAMA contributor

Miscellanea Medica

Richard A. Rifkind, MD, chair, Sloan-Kettering Institute; director, Sloan-Kettering Division, Cornell University Graduate School of Medical Sciences; and head of the DeWitt Wallace Research Laboratory, has been named chair of the Board of Governors of the New York Academy of Sciences, New York, NY.

Charles E. Kahn, Jr, MD, associate professor of radiology, has been named to the newly created position of associate dean and medical director of clinical informatics at the Medical College of Wisconsin, Milwaukee.

David W. Barry, MD, chair and CEO, Triangle Pharmaceuticals, Durham, NC, has been elected chair of the Inter-Company Collaboration for AIDS Drug Development, an alliance of pharmaceutical companies.

At its recent annual meeting, the Radiological Society of North America bestowed its highest honor, the Gold Medal Award, on the following physicians: **Daniel H. (Stormy) Johnson, MD**, Metairie, La, immediate past president of the American Medical Association; **Wallace T. Miller, Sr, MD**, University of Pennsylvania School of Medicine, Philadelphia; and the late **Derek C. Harwood-Nash, MB, ChB**, of Toronto, Ontario. The RSNA awarded honorary membership to **Gerard D. Hurley, MD**, Federated Dublin Voluntary Hospitals, Dublin, Ireland; **Harvey Picker**, former head of Picker

Corporation, Camden, Me; and **Hans G. Ringertz, MD, PhD**, Karolinska Institute, Stockholm, Sweden.

Jon Mukand, MD, PhD, Southern New England Rehabilitation Center, has received the American Heart Association's Special Service Award for his service on the AHA's board of directors and contributions to education about stroke rehabilitation.

Gerald A. M. Finerman, MD, University of California, Los Angeles, School of Medicine, has been appointed chair, UCLA Department of Orthopaedic Surgery.

Walter H. Ettinger, Jr, MD, MBA, has been named director of the J. Paul Sticht Center on Aging at Wake Forest University Baptist Medical Center, Winston-Salem, NC. Ettinger is the author of the book, *Fitness Over 50, It's Never Too Late to Start*.

Paula Traktman, PhD, Cornell University Medical College, New York, NY, has been named chair, Department of Biology, Medical College of Wisconsin, Milwaukee. She succeeds **Sidney Grossberg, MD**, who was chair for more than 30 years.

Paul Friedmann, MD, Tufts University School of Medicine, Boston, Mass, has been elected president of the Council of Medical Specialty Societies. He succeeds

Carden Johnston, MD, University of Alabama-Birmingham School of Medicine. **Robert L. Replogle, MD**, University of Chicago Pritzker School of Medicine, Chicago, Ill, is president-elect. Secretary is **Bruce E. Spivey, MD**, president and CEO of Columbia-Cornell Care, and treasurer is **Leon Reinstein, MD**, Sinai Rehabilitation Center, Baltimore, Md.

David A. Hamburg, MD, president emeritus of the Carnegie Corporation of New York and a pioneering investigator of the relationship between physiological and behavioral factors, will receive its most prestigious award, the Public Welfare Medal, from the National Academy of Sciences at its annual meeting in April.

Neopito L. Robles, MD, of Thomas-Davis Medical Centers in Tucson, Ariz, has become president of the Pima County Medical Society.

Alan Ducatman, MD, director of the Institute of Occupational and Environmental Medicine at West Virginia University's Robert C. Byrd Health Science Center, Morgantown, has been named chair, Department of Community Medicine.

Editor's Note: Miscellanea Medica normally appears in the Medical News & Perspectives section several times each month. Items submitted for consideration should be sent to Marsha F. Goldsmith, editor, Medical News & Perspectives.