TRENDS & Ideas

INFORMATION SUPERHIGHWAY

Dealing with Cyberhate

The information superhighway is becoming potholed with hate-mongering files. But because no governing body oversees networks such as the Internet, any sort of censorship raises practical and legal questions, writes Richard Z. Chesnoff in *U.S. News & World Report*. This has not stopped groups like the bigot-exposing Wiesenthal Center from sending a massive dossier it has compiled on cyberhate to the U.S. Federal Communications Commission (FCC), which recently passed on the dossier to the U.S. Justice Department.

How the FCC and the Justice Department will handle evidence of and complaints about hate-mongering on the Internet remains to be seen. But a question these bodies must answer, reports Chesnoff, is whether the Internet is more akin to a public broadcast system (and thus subject to control) or to the mail (allowed greater freedoms).

Users can block any files they wish, says attorney Mike Godwin of the Electronic Frontier Foundation, a public interest group in Washington, DC, which advocates cyberspace freedom. He states, "I can't conceive of any constitutional controls," unless civil liberties are directly interfered with.

Some people, such as Vancouver resident Ken McVay, are taking advantage of these same freedoms to quash the cyberhate that is plaguing the information superhighway. He has established a server list of responses to extremist statements. "It's the only way to answer these liars," says McVay.

And one commercial network, Prodigy, is even trying to rid itself of hate-mongering bigots by issuing voluntary norms. "But guidelines may have little effect in a freewheeling venue such as the Internet," Chesnoff points out.

Whether such guidelines make a difference today, people like McVay and Los Angeles–based Wiesenthal Center Associate Dean Rabbi Abraham Cooper are not willing to sit idly because, Cooper points out, these advocates of violence and hate have "far easier access to two things they have never had before: a mass audience and the attention of young, unsuspecting users."

Sim Gellman

PERINATAL CARE

When Insurance and Access Are Not Enough

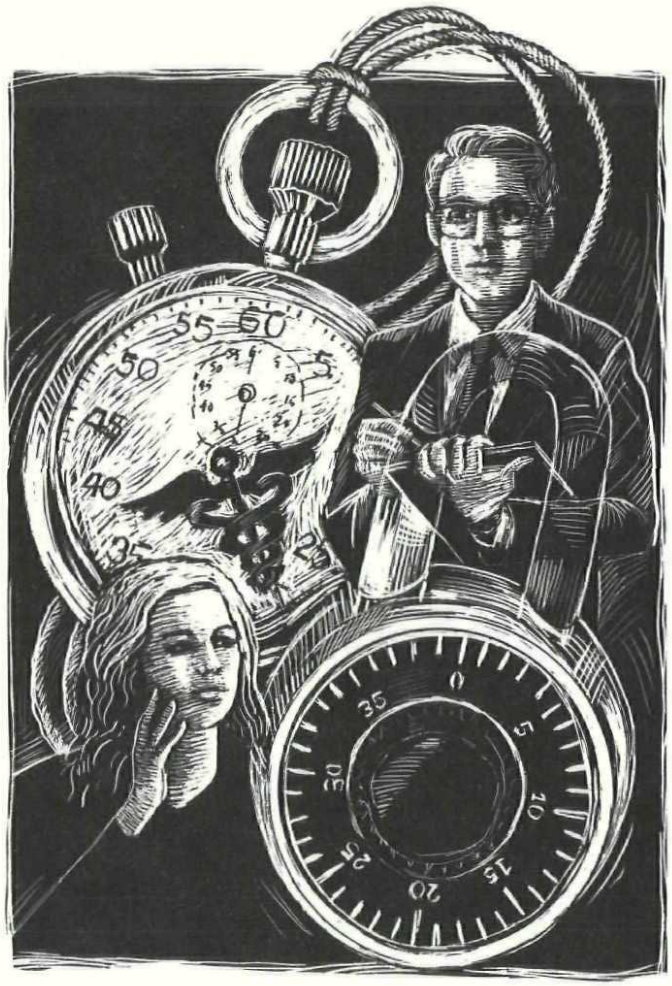
Having health insurance and regular access to healthcare does not in itself ensure that Mexican-American Medicaid enrollees will make adequate use of services for pregnant women and infants, according to a recent study.

Patricia Moore, RN, and Joseph T. Hepworth report in the *Journal of the American Medical Association* that a study of 620 mothers in Maricopa County, AZ, showed that pregnant Mexican-American women had fewer medical visits than non-Hispanic whites. (The former made an average of 8.6 visits, the latter 10.2.)

Mexican-American infants also made fewer visits than their non-Hispanic white counterparts (8.2 versus 9.8) and received fewer immunizations.

Because all the women were Medicaid enrollees, Moore and Hepworth discount economic factors in explaining the differences in care. Almost 95 percent of the Mexican Americans spoke English, so the authors do not see language as a serious barrier either.

Moore and Hepworth find that Mexican-American women *do* have more children, more problems with transportation, and less help from their support systems than non-Hispanic whites. These factors, the authors say, may explain the disparities. They conclude that Mexican Americans might benefit from expanded outreach and care coordination activities.



MANAGED CARE

Depressed Mental Health Benefits

Managed mental healthcare has proven to save many employers mega-dollars on their healthcare bills. However, some patients, mental health professionals, and benefits experts believe this practice may in the end be more costly–in terms of employee stress, litigation, and financial resources.

"We're asking how much savings can we get purely in terms of medical expenses, but the other side is what's the effect on worker productivity, and that should be a huge concern," Edward Anderson, executive medical director at Bell Atlantic Corporation, told Carol Hymowitz and Gabriella Stern of the *Wall Street Journal*.

Because they are often limited to conducting a specific number of counseling sessions with each patient, many mental healthcare professionals are trying quick fixes such as prescribing medication for depression instead of helping employees keep mentally healthy, write Hymowitz and Stern. Deborah Coady, a Boston legal secretary whose therapist has prescribed antidepressants, told the reporters, "[I would like] very much to do some therapy so I could see how to avoid this depression dance."

Distressed workers' poor productivity is not the only expense. Many corporations are facing lawsuits, charged with denying or interfering with mental healthcare, report *Business Week*'s Joan O'C. Hamilton and Michele Galen.

Such lawsuits are forcing a few improvements in managed mental healthcare plans. Partly in response to a class action suit initiated by therapists and patients, Bay State Health Care, offered by Blue Cross/Blue Shield of Massachusetts, will take steps to give patients more provider choice and increase the number of visits allowed.

But large corporations, which are often self-insured, are immune to liability through the 1974 Employee Retirement Income Security Act (ERISA), report Hamilton and Galen. The act exempts such corporations (and now managed care companies operating on the self-insured's behalf) "from state laws providing for punitive and other damages for companies found negligent." The reporters point out that plaintiffs who lose must pay the company's legal fees, making it virtually impossible for most employees to file suit.

This situation may be rectified soon, however. Recent rulings reflect the frustrations courts feel over ERISA, and there are bills in Congress intended to amend the act. One "would let beneficiaries sue employers and collect punitive and other damages for improperly denied claims," state Hamilton and Galen. They add that providers are urging states to better administer managed care plans, including those for mental healthcare.

MEDICAL TRAINING

Wanted: Fewer Specialists

Managed care, which demands more primary care physicians than specialists, is clearly the wave of the future. Nevertheless, about 73 percent of U.S. medical students continue to choose specialist over generalist training. Where are the needed generalists to come from? asks *Networking*, the newsletter of the California Association of Catholic Hospitals. And what, in the long run, is to be done with the surplus specialists?

Perry Pugno, MD, vice president of graduate medical education for Mercy Healthcare Sacramento, says hospital systems like his have decided to "grow their own" primary care physicians, rather than wait on medical schools to change priorities. Indeed, Mercy Healthcare Sacramento hired Dr. Pugno with a mandate to develop a family practice residency for the system.

Other programs retrain specialists as generalists, an expensive process that usually lasts about three years. Some specialists don't like the cost and length of retraining. And there is another problem. Thomas Day, MD, program director for the Duluth Family Practice Residency, Duluth, MN, notes that retraining "may be somewhat of a challenge to the ego" for specialists.

The issue is complicated by disagreement about who is and who is not a primary care physician. James Weinlader, director of the residency review committee of the Accreditation Council on Graduate Medical Education, says, "The government definition of a primary care physician is family practice, internal medicine, and pediatrics."

But in California some systems and health plans consider gynecologists and obstetricians to be primary care physicians. State regulations permit OB/GYNs to be designated as primary care practitioners; they do not require it, however.