ple dosing than would recurrence. Pascual's triptan per-attack study verifies this idea.⁷ His results indicate that rizatriptan, with its large response rates, has a significantly lower incidence of attacks treated with multiple tablets than does sumatriptan, zolmitriptan, and naratriptan in spite of relatively high recurrence rates.

Simply, recurrence is a poor endpoint. We would recommend that studies not report recurrence rates; instead, they should use 24-hour sustained pain relief or 24-hour sustained pain free to indicate the long-term efficacy of acute medications.

Like recurrence, adverse events were not included in the original analysis because they do not clarify or alter the cost-effectiveness of the medications. In addition, it would not have been statistically valid to include the measure in our analysis. No published triptan study has measured adverse events as a primary outcome. Although it is certainly possible to pool such data as exists in order to define a "number needed to harm,"⁴ inconsistent recording of adverse events and very wide confidence intervals mean that these findings are of limited value when comparing alternative treatments.

Triptans are consistently well tolerated.^{8,9} Most adverse effects are mild and have no related costs. Even the once-feared side effects of neck and chest tightness do not trigger cardiac evaluation as they once did. These side effects are not thought to be related to cardiac events.

There seems to be no correlation between the adverse effects and safety of triptans, nor is there any evidence of safety differences among triptans. The impact of side effects on cost is inconsequential compared to migraine disability considerations.

To conclude, we chose the 2-hour pain-free data because it was the industry standard,¹⁰ matched the desires of patients,^{11,12} mirrored 24-hour sustained pain-free results,⁶ and minimized the risk of introducing bias into our conclusions.⁴ Including recurrence rates and adverse events in the analysis would not have significantly altered the results, only added complicating factors.

Again, we thank Dr. Silberstein for his comments.

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Provider Perspective on HIPAA

Dear Editor,

I had some thoughts about the Health Insurance Portability and Accountability Act of 1996 (HIPAA) subsequent to the recent article¹ and editorial¹ in the *Journal*. There are real and presumably unintended consequences of the HIPAA statute and regulations.

I was looking for a new car. I decided to be patriotic and avoid German cars—the Russians and French long ago sinking into the oblivion of instant lemons—due to the antiwar stances being taken by our former enemies/charity recipients/allies. However, before I could leave the office, I had an inch-thick pile of HIPAA compliance policies and forms to review and frantic administrators calling in panic and fear about the impending invasion of trial lawyers and bureaucrats looking for HIPAA compliance gotchas over which to sue. Also, in the local paper, Los Angeles County announced it was closing a dozen or more primary care clinics to save money, while, in another article in a trade rag, there was mention of the fact that L.A. County had just announced it had signed agreements with consultants totaling \$16 million to prepare the county for HIPAA. The more I thought, the more angry I became over the fed's heavy-handed, dogmatic, and ignorant approach to confidentiality.

Here we are with literally hundreds of years of experience with the doctor-patient relationship and its spillover, and relatively stringent laws in almost every state governing the use and release of patient information, panicked over HIPAA. We have a government of know-nothing technocrats who are blindly marching to the drum of regulations that ignore the reality of medical practice, with providers left to wonder about the costs and aftereffects of the federal mandates. Suddenly, I had a little empathy for the Germans. While I agree with our stance toward Iraq, I can't help thinking that the Europeans' complaints about Bush's foreign policy sound all too familiar when walking the

hospital and health plan hallways. Unfortunately, we providers don't have veto power over HIPAA at the United Nations.

While we chafe at the dictatorial approach of HIPAA, try to put HIPAA in perspective. In most states, HIPAA changes are bothersome, but they don't need to be the huge and expensive problem some consultants are making it out to be. All HIPAA does is formalize what is being done, hopefully, in practice. Yes, it adds some costs and bureaucratic and unnecessary steps to the health care process, but common sense should still prevail. I think HIPAA really only requires a written notice of privacy practices that is available to patients, on the Web and in the facility or office or store; some kind of acknowledgment from the patient in writing, like signing a log book; care in the use of medical information and tracking its disclosure outside regular health care operations (meaning sending a bill to a payer is not trackable); and patient access to his or her record, with the right to request the ability to alter or comment on the record, which the provider doesn't have to agree to.

There are stupid sides to HIPAA, like requiring a provider to obtain written privacy agreements from vendors who obtain protected information. They are already required to keep the information confidential, but we will waste millions of dollars nationwide in legal, printing, and postage costs just to comply with this make-work, unnecessary requirement. I guess I should get over it and feel sorry for the thousands of people in Los Angeles who have lost access to primary care while the county fattens the pockets of consultants and feels that it has somehow done something to protect patients' privacy. I am sure that the sick who show up at shuttered clinics will suddenly be cured knowing that if they can find a provider, their information will be protected.

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■ HIPAA on the Edge

Dear Editor,

My job takes me to many different types of health care settings. I have been painfully watching the HIPAA evolution in the places I visit. It spurs me to share a few stories.

Last month, I was in a local hospital. The hospital was challenged to figure out how to dispose of their used IV bags. Each IV bag is labeled with the patient's name. Evidently, the local hospital association sent this hospital a news-flash informing them that they would be in violation of HIPAA if they simply threw the empty IV bag in the patient's waste paper basket—a practice that has been done forever. Emptying the trash 3 times a day is simply not adequate anymore—absolute paradise for a HIPAA consultant!

Last week, one of my friends told me of a heated battle he observed in the academic medical center. Legal counsel had informed the medical staff that all specialists, unless they were the admitting physician, could not look at a patient's chart until the patient had given informed consent. Yes, another potential HIPAA violation. Can you imagine a teaching hospital full of specialists who can't look at a chart until the patient provides informed consent? HIPAA on the edge!

Closer to home, I am coordinating a 40-site, 4,000-patient benchmarking study. It involves a retrospective review of the patient's medical record and data collection by a clinician who works in the study site. No patient-identifying information is transferred to me to perform the benchmarking—no name; no geographic subdivision of the patient's address smaller than a state; no elements of date (birth, admission, discharge, initiation of therapy, etc.); and no identifying numbers (social security, medical record, prescriber number, etc.).

I coordinated a conference call earlier this week, and one site (and I am thankful it was only one) inquired about locating patients who had previously been discharged from the hospital to obtain informed consent to retrospectively review their medical record. The reason cited—HIPAA. Eeeeks, I quietly thought, HIPAA on the edge again—it has finally happened to me!

Quickly, though, I discovered the valuable HIPAA consultants—those other pharmacists on the conference call. They profoundly dismissed the notion that this practice would constitute a HIPAA violation. Their logic was as simple as one...two...three: (1) no patient identifying information, (2) the hospital's own staff collecting the data, (3) therefore, no need for informed consent. Patient privacy can be a good thing—but not on the edge!

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