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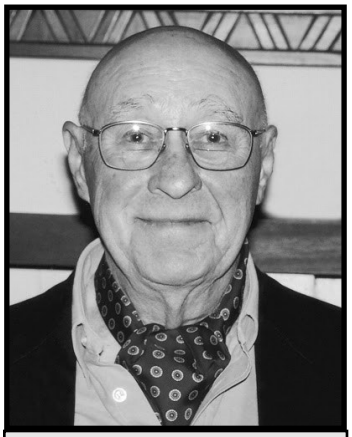
In Memoriam: Jonas Rappeport, MD


Jonas Rappeport, MD

by Bruce Hershfield, MD

On September 8, 2020, Dr. Jonas R. Rappeport, President of the MPS in l965-66 and founder of the American Academy of Psychiatry & the Law in 1969, died in Cockeysville at age 95. Acknowledged as the dean of not only forensic psychiatry in the Baltimore area, but as one of the leaders in the country, he trained many of the practitioners in the field. As the obituary in the Baltimore Sun of September 9th stated, "He was credited with lifting forensic psychiatry from the stature of a judicial sideshow to that of accepted medical specialty".

Born in the Baltimore area, he graduated from both college and medical school at the University of Maryland–-sandwiched around his service in the Army in Europe. As a teen, he babysat for the family of Dr. Manfred Guttmacher the Chief Medical Officer of the Supreme Bench for Baltimore City who later became Jonas' mentor. He did his psychiatric training at the University of Maryland and Sheppard Pratt, then joined the staff at Spring Grove, where there was a forensic psychiatric unit. He opened a private practice in 1959 and also became the psychiatrist for the Baltimore County Circuit Court, which was a part-time position. He was named the chief medical officer for the Baltimore City Supreme Bench in 1967 and held that position until he retired in 1992.

Because of his reputation, he was asked to advise at several important trials. He prepared to testify for the trial of John Hinckley, who shot President Reagan, but was not called by the prosecutor.

After his retirement, he continued to actively participate in the psychiatric community until he was into his nineties. For example, he helped found and then actively led a group of psychiatrists who met monthly for lunch for many years. He was a person with many interests, including woodworking and fishing and gardening, and was generous in sharing his gifts with others.
John Buckley, MD interviewed him in 2008 as part of the Oral History project. Here are a few of his comments:

"In high school I was a drum major. I was a drum major at College Park that first year, for the drum and bugle corps. I twirled the baton. Once I threw the baton up in College Park and it landed right smack on the goal posts–an impossible thing. People thought I had done this on purpose, which I couldn't have done, but that was fun.

After the war we were in Austria and I had transferred to the medical division of our battalion. I was discharged in around May of '45 and came home and wanted to be premed at College Park, so I did that for 2 or 3 years. You could then do 3 years of college and one of medical

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In This Issue

MARYLAND PSYCHIATRIC SOCIETY

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Send all correspondence to:

Maryland Psychiatric Society, Inc.
1101 St. Paul Street, Suite 305
Baltimore, MD 21202
Phone: (410) 625-0232; Fax: (410) 625-0277
Email: mps@mdpsych.org
WEB:http://www.mdpsych.org

(Rappeport continued)

school.

My interest was in OB/GYN or Psychiatry, even in med school. In Maryland, this was when Jake Finesinger came, in '50, and I graduated in '52. That was when they built the Psych Institute.

"I had known Sam Novey and he was sort of a mentor when I was in my residency and then, when I was in practice, I bought supervision from him. Along about somewhere in this interval

Sheppard Pratt had supplied the psychiatrist in the juvenile court in Baltimore County every Saturday morning. Sam and Chief Judge Contrum had decided that we really ought to have a half-time person like the city did and so they decided to set up the office of court psychiatrist. Sam recommended me. Eventually, I had one of the first fellowships, at the county courts. It was my program and I only had one Fellow in 5 years.

The APA had a division of Law and Psychiatry. Manfred Guttmacher knew I was coming to the meeting. He asked me what I thought about an issue and I didn't know what the hell they were talking about, but, boy, they were just so wonderful to me! Then I met a whole bunch of other fellows in the area and that eventually became our network and that eventually became the core of the founding of the American Academy of Psychiatry & the Law. I think we had about 35 people at the first AAPL meeting, in Baltimore, and Joan and I had a big dinner for them at our house. I was the first president and did that for 2 years. Then I became the Medical Director eventually and supervised until about 1995, when I retired.

I think I was most privileged to be a physician. I did research, I published many papers. My main area of research accomplishments, which has been surpassed greatly, was in dangerousness of the mentally ill. I published some of the early seminal papers on the subject. I did my research, my publication, and my administration, and I did my clinical work. I did all the things that I could ever hope to do. I feel that I was horribly privileged and fortunate to have a wonderful career."

Dr. Jeffrey Janofsky, who is a leader in teaching forensic psychiatry in our community, commented, "Jonas was a founding father of AAPL and was its first President and first Medical Director. He was an important figure to many of us. He was my teacher, mentor, and friend. After AAPL announced his death I received anecdotes from all over the world describing how he was important in helping others in their professional and personal lives."[1]

Dr. Leonard Hertzberg, a forensic psychiatrist in the

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Rappeport

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Baltimore area, commented, "Jonas was not only a wonderful teacher and forensic psychiatrist, but a knowledgeable mentor who gave generously of his time. His achievements in our field are vast and Maryland psychiatrists are not the only ones who benefitted. His wisdom, dedication, and hard work were instrumental in the success of the American Academy of Psychiatry and the Law (AAPL), the professional organization for forensic psychiatry. He left a rich legacy. Most of all, I will miss his kindness and friendship. "

Dr. Thomas Allen wrote that, "Jonas was the Director of the Maryland Foundation for Psychiatry from 1996-2015; he then was an Honorary Director until his death. He was its President from 1998-2000, then from 2004-2015. He was strongly committed to making people aware of what Psychiatry had to offer and to encourage them to get the help they needed. He was very knowledgeable about the field and loved working with people. He was a wonderful raconteur, fisherman, cook, and camper and enjoyed art, music, and the outdoors. He had an engaging sense of humor. He was an accomplished woodworker. Everyone loved to be around him."

I met him shortly after I moved to Maryland in 1974 and he and his wife were very welcoming, as they were to so many others. He inspired many of us to be better, by his example and by the advice he gave. He was exceptional in many ways–-unusually friendly and warm and delighted that he had found so many ways he could profitably spend his time. Even many years after he retired, with his wife-- who died in 2007-- and then with his companion, Alma Smith, he continued to actively contribute to our psychiatric community. Throughout a long life, he showed how much one person can do to make the lives of others better.

1. Janofsky JS & Tellefsen, C: "Jonas R. Rappeport, MD: Founding Father of the American Academy of Psychiatry & the Law". JAAPL. Sep2007, 35 (3), 290-293.

100 Days of COVID: Musings from Psych Overflow

by Andrew Angelino, MD

Andy Angelino, MD

"Dr. Angelino, the blower at this end of the hall has stopped working. The entire nurses' station has lost pressure and is contaminated."

That was about 3 weeks in. But I'm getting ahead of myself.

I was on vacation with my family, skiing in Colorado, when COVID "hit" the US. Our vacation was almost over when the toilet paper was no longer available in the stores, and luckily we had about 3 small bottles of hand sanitizer in our carry-ons, so we wiped our seat areas down on the plane and tried to hold our breath for 3 hours.

By the end of my first week back to work, there were two one-hour phone calls a day on the COVID updates for the hospitals, with about 3 hours of phone calls in- between, dealing with panicked employees. By April, we had masks and plans for keeping patients distanced from each other, but there were reports of inpatient psych units having to manage outbreaks in other parts of the world.

I've worked in the infectious disease world for over 20 years now. I understand well how patients with psychiatric illnesses are vulnerable to HIV and hepatitis because they have trouble following the rules. However, to get those illnesses, you have to do something -- have sex or shoot drugs. To get COVID, all you have to do is breathe. So, it's less like the vulnerability for our patients to HIV, and more like the vulnerability of our patients to TB, which runs through settings where people are living in close proximity, like rehabilitation programs, group homes and prisons. And, as we've seen, so does COVID. So, patients with serious psychiatric illnesses are vulnerable from the double-whammy of often living in such settings and not following the behavioral prescription of wearing a mask and staying distant from others.

My department was talking daily about keeping our patients and staff safe in the hospitals. We eventually proposed, and then implemented, universal testing for SARS-CoV-2 prior to psychiatric admission. The question was, however, what to do about patients who tested positive, but were not symptomatic. They had no medical reason to be admitted to medical floors; moreover, medical units often are not ideal for treating psychotic patients. Fortunately, at Howard County General, we had just opened a new psychiatry unit and had moved into it in January. That meant we had an old psychiatric unit that was standing idle. Within 48 hours, our engineers had made the entire old unit a negative pres-

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sure space. So, we were able to have 6 beds on an inpatient psych unit, with all the ligature safety needed and common spaces where patients could walk and do activities.

While many psychiatrists were developing telepsychiatry skills, and our consult and emergency services were getting trained on how to see patients in isolation on iPads and such, I was working on donning and doffing a personal respirator. On April 21, we opened the unit with our first patient, and I began my days on what is now called "psych overflow."

I was worried about my staff. We were taking on the isolation unit for the system, and several times staff told me that I was responsible for them having to take these patients and to work in a bio-unit. I knew I would have to attend on the unit personally to keep the charge going, but as I did, I became more and more worried for them. I decided I needed to do everything I could to protect them, even if it meant working every single day so fewer people had to.

The mechanical failures–- like the blower failing and thereby putting the entire nurses' station at risk-- comprised only one of the little things that could go wrong and expose people. Most troublesome is the doffing process-- the inconsistent practices of people removing PPE when they are coming off the unit. We're dealing with psychotic patients who can, and have, "gone off" and become violent, while a staff member is wearing a paper gown and a thin hood with a blower pushing purified air through it.

I have been a hospital psychiatrist, in charge of things, for more than 20 years. I am chronically sleep-deprived. So much so that if lie flat, any time of the day, for more than 10 minutes, I will fall asleep. Sometimes in a chair if I'm writing notes for too long and haven't had coffee. I laugh derisively when asked to fill out my "effort form" for my institution, listing the percent of time I spend on activities. Nowhere does it allow me to list how much time I spend answering phone calls in the evening or at night. Not much keeps me from falling asleep. But having staff members tell me that I am responsible for their lives does ring the bell on that one

So, here we are. 100 days. No days off.

I went to a Catholic medical school. A retired priest taught ethics. I learned that "taking dominion" meant that you had responsibility for not only your decision, but for any and all possible outcomes anywhere and on anyone else. According to the priest, only God could have dominion, because only God could see all the future and be responsible for it. Taking dominion from God is a great sin because man cannot do what God does. And yet we do it in Medicine all the time, making decisions for others' lives, practicing oaths to be constant advocates for our patients and to do no harm to them. We do the best we can.

As the old joke goes, "It only takes one psychiatrist, but the lightbulb really has to want to change." I can only be responsible for myself and my actions, using whatever persuasion I have to get others to try a different option with hopes it will improve their function and quality of life. I might be wrong. My interpretation of the problem may be incomplete. I can't see everything. The blower might break down, the respirator might fail, the patient might tear the gown, someone might get sick.

So, I get up. I shave. (I lost the beard so I can wear the mask.) I check my temperature. I get dressed in scrubs. (I am working in pajamas after years of training and being told I have to wear a tie and white coat.) I put on gear, go on the unit, and see patients. I ask the staff if they're OK today. Maybe I bring in snacks. I check the blowers and the respirators. I ask if we have spare supplies. I wash my hands tend to the dermatitis on my nose from the mask, change clothes in my office, and go home. I take my shoes off in the garage, strip in the laundry room, and wash my scrubs and the clothes I drove home in. I then take a shower. I smile when I come out to see my family.

In a week, I have to go take my daughter to her new school in Vermont. I have to ask another faculty member to cover for me. All of them have small children at home. They haven't practiced doffing their gear much – I've been doing it for everyone. Because I'm all I can control and I have dominion, whether I wanted it or not.

Unfortunately for this lightbulb, it doesn't really want to change badly enough. But that's why I'm writing. My idea that I have to keep everyone safe and help all the sick and do anything it takes, is one that is, at least in part, in every one of us. I've never been more powerless, and never been more grateful for the things that matter.

No one was infected when the blower quit. We got it working and decontaminated the nurses' station. In fact, no one has become infected from working on the unit. And we've helped dozens of patients from all over Maryland. I'm an expert nasopharyngeal swabber now. Every day, I say "I need someone to tie me up and turn me on" when I'm getting the gear on. They moved the hospital's medical COVID isolation unit next to mine and I am now the "Mayor of COVID Corner," having adopted the nursing staff of that unit and baking for them as well as for my own nurses.

And I smile at my family and friends every day.

Remembering Dr. Patricia Newton

By: Annelle Primm, MD, MPH

Patricia Newton, MD

Dr. Patricia A. Newton, an internationally recognized African American psychiatrist who served as the CEO and Medical Director of the Black Psychiatrists of America, died on September 28, 2020 in Baltimore at the age of 75.

An influential thought leader, Dr. Newton was a clinician, educator, scholar, media personality, and entrepreneur whose life's work centered on uplifting the mental health and emotional well-being of black people. Dr. Newton was a proponent of integrating African spirituality and black mental health. This was fostered by her role as a queen mother, female king, and divisional chief in Ghana, West Africa. In association with this honor, the traditional name of Nana Dr. Akosua Akyaa was bestowed upon her, making her an official Ashanti royal in the Kingdom of Agogo.

Born and raised in Tuckerman, Arkansas, she was determined from an early age to become a physician. She graduated from high school at the age of 15, completed her undergraduate studies in pre-med at the University of Arkansas at Pine Bluff. and graduated magna cum laude from the George Peabody College of Vanderbilt University, where she earned a master's degree in molecular biology. She attended medical school and completed her psychiatry residency at the Washington University School of Medicine in St. Louis.

She then came to Baltimore, where she completed a master's degree in public health at what is now the Johns Hopkins Bloomberg School of Public Health. In addition to her formal medical, psychiatric, and public health studies, Dr. Newton was an extern at the National Institute of Mental Health, where she reviewed and analyzed grant proposals and learned grantsmanship. These skills proved to be valuable for her future professional pursuits.

In 1977, she joined the medical staff at Provident Hospital, a black hospital in Baltimore, where she served as Chair of the department of psychiatry. In this role, which she held until 1985, she established numerous innovative programs involving diagnosis, treatment, and rehabilitation.

Entering private practice in 1983, Dr. Newton founded and served as president and medical director of Newton & Associates, PA. Her areas of professional focus included trauma treatment and public health issues related to human trafficking, substance use disorders, affective disorders, and epigenetics. She worked nationally and internationally to coordinate systems of care between traditional healers and western-trained health care professionals. In addition, she fostered the integration of mental health into global medical care through the Royal Circle Foundation, a non-profit organization she co-founded and served as Secretary-Treasurer. She was also president of Newton-Thoth Inc., an international meetings and events management company.

Dr. Newton received numerous awards and honors. She was recognized as Essence Magazine's Woman of the Year in Health & Medicine in 1985. She was designated as one of Baltimore Magazine's 100 Most Influential Women in Baltimore and a Distinguished Black Marylander by Towson University. In 2019, she was selected as the recipient of the Solomon Carter Fuller Award from the APA..

In addition to her role as CEO and Medical Director of the Black Psychiatrists of America, she was a former president of it and served as a member of its Council of Elders. Her expertise as an international meeting planner facilitated the wide reach of Transcultural Conferences of the Black Psychiatrists of America which were held in the USA, the Caribbean, Africa, South Asia, and the Middle East.

While CEO and Medical Director, Dr. Newton focused on the importance of healing black people from trauma they have suffered throughout the diaspora. In addition, she collaborated with colleagues involved in organizational psychiatry, such as the APA and the National Medical Association, to expand the number of black psychiatrists to help address the unmet mental health needs of the community. She created a welcoming and safe space for black psychiatrists who felt excluded or blocked from opportunities in other organizations. As a result, the Black Psychiatrists of

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Newton

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America became an incubator of and served as a springboard for leadership opportunities among early career, mid-career, and senior psychiatrists. She was a leader in setting up the Black Psychiatrists of America biennial program, *The Mental Health Status of Black America Capitol Hill Forum*. Convened in collaboration with the late Congressman Elijah Cummings of Baltimore, these concentrated on issues such as civic mental health and post-traumatic stress disorder. She also established, on behalf of the Black Psychiatrists of America, a series of Faith Community Mental Health outreach in-person and virtual programs to inform faith leaders about mental health issues for their congregations and themselves.

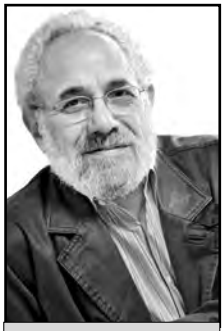
Other examples illustrate her timely initiatives and continuing dedication to addressing racism and mental health issues. In recent months, driven by the killing of George Floyd and racial disparities in coronavirus infection and death rates, Dr. Newton spearheaded an initiative to declare racism a public health crisis. Starting in April, she hosted the weekly radio show, "Mindful Moments with Dr. Pat" (WSYP 95.1 FM Sankofa Radio), during which she highlighted critical mental health-related issues and interviewed prominent guests, such as Dr. Altha Stewart, first black president of the APA. She also wrote "Drama of the Trauma: Mitigating Historical Epigenetic Effects of Racism," which is slated for publication in 2021.

The significance of her career and accomplishments is in stark relief at this time. given recent vivid illustrations of the impact of racial injustice on mental health and well-being of people of color. She was way ahead of her time. She was unapologetic about actively promoting a grounding in African-centered cultural beliefs and practices that are important components of healing from trauma and systemic racial injustice. Dr. Newton's legacy of professional excellence and leadership will live on through the work of her colleagues and the many young psychiatrists who have been inspired by her dynamism and by her scholarship.

Annelle Primm, MD, MPH

The Psychological Fallout of the Pandemic of Older Adults

Michael B. Friedman, LMSW
Chair, AARP Maryland Brain and Behavioral Health Team



Michael Friedman, MSW

The pandemic has created and revealed vast psychological needs in our society, for older adults as well as for younger ones.

It surprises some that young adults are more likely to be experiencing emotional distress than older ones. This reflects ageist perceptions of older adults in our society, including that they need a lot of help during disasters-- perhaps even more so during the current pandemic because they are its primary victims.

But the emotional adaptability of older adults is no surprise to those familiar with the literature. Most are not frail and disabled and do not need assistance. Seniors have weathered difficult life experiences, have developed coping skills that only come with age, and are less likely than younger adults to have substance use disorders.

However, older adults and their families face a range of troublesome issues that are somewhat different than those faced by younger people and that contribute to significant emotional distress. For example, they are at the highest risk of serious illness and death due to COVID-19. It is important to note that the highest risk is for those in nursing homes and assisted living facilities (who are not included in community surveys regarding mental health).

In addition, social isolation is a significant threat. Because they are more likely to live alone (by 85, about half do), older adults sheltering in place are more likely to suffer from profound loneliness, particularly if they do not have or cannot use advanced tele-communications to stay in touch.

Social isolation is also a great threat to those who are living in long-term care facilities. Infection control measures often result in lock downs; during them, residents must remain in their rooms, often without access even to telephones. Family contact is cut off, which can be a great loss.

Other issues that affect the emotional well-being of older adults include:

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Psychological Fallout of the Pandemic

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- Problems accessing food
- Limited availability of needed in-home supports
- More limited access to health care due to greater difficulty using telehealth
- Increased risk of inactivity and boredom including loss of paid and volunteer work, and of access to houses of worship and senior centers
- More limited contact with family, especially grandchildren
- Increased stress on grandparents who are caregivers
- Increased tension in the home and consequent elder abuse
- Increased stress for caregivers
- Triggered memories of traumatic experiences
- Loss of access to spiritual support especially in times of grief.

Public Policy Implications

Telehealth: Access to physical and behavioral health care during the pandemic has depended on emergency legal and regulatory provisions to pay for tele-health. Retaining these provisions on a permanent basis will be a major advocacy challenge in the coming year.

We need to address limitations of tele-health, including lack of broadband in some areas, lack of affordable equipment for some people, and—particularly for some older adults—inability to use the technology.

The pandemic has revealed longstanding faults in America's long-term care system. We need to develop stiffer requirements and enforce them and to increase adequate levels of trained staff.

The impact of social isolation, economic hardship, trauma, racism, etc. on mental health has become clearer and clearer during the pandemic. Still, our nation invests too little in addressing the social determinants of poor physical and behavioral health.

The pandemic has also highlighted inadequate planning to meet behavioral health needs, especially of older adults. We are now nearly a decade into the "elder boom" that will double the population of older adults and make them a larger portion of the population than children under 18. We still have not prepared to meet the behavioral health challenges that are unfolding.

We need to develop a comprehensive, data-based, multi-year plan.

Now.

MPS Holds Virtual Annual Meeting

By: Bruce Hershfield, MD

Bruce Hershfield, MD

On October 8th, the MPS held its annual meeting—which always takes place in the spring—but by "zoom". There were 58 participants.

Marsden McGuire, the outgoing president—whose term ended in May, but who has played a vital role in keeping the MPS on-track during the pandemic—began by going over the MPS finances. The fiscal year ended with a surplus of $1000. Membership is up to 731—largely because of increased membership by residents and fellows in the University/Sheppard Pratt training program. We held 3 successful scientific programs and reviewed 85 legislative proposals. Our APA Assembly Reps introduced 2 position papers. We formed a health policy advisory group and have 10 new "interest groups".

The Maryland Foundation for Psychiatry then gave its anti-stigma advocacy award to Janice Lynch Schuster for her op-ed piece in the "Sun" on 10/14/19—"People are not defined by their diseases". She spoke movingly about her son, who died in 2017. She stated she had been offended by patients being referred to as "junkies" As she said of her son, "He was a gracious soul" and "was far from being a 'junkie'".

Dr. Jennifer Coughlin then announced the winners of the Best Paper awards for Residents & Fellows—Jooyoung Lee—and ECP's—Paul Nestadt and T. Avi Gerstenblith. The winner of the Best Poster Award was Mark Kvarta, but special recognition was also given to other finalists—Raina Aggarwal and Rachel Dillinger.

It was then time to give the 2020 Lifetime of Service Award to Jesse Hellman, MD. You can read his remarks, plus a sonnet he wrote that he says was inspired by Dr. Don Ross's comments, on page 8.

Dr. McGuire thanked last year's Council and Committee Chairs and announced we have 9 new Distinguished Fellows, 12 New Fellows, and 11 New Life Members.

He then turned the gavel over to Mark Ehrenreich, MD, our new President, who commented about how Dr. McGuire was always "thoughtful, kind, considerate"—"always measured in

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MPS Holds Annual Meeting

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dealing with difficult circumstances". Dr. Ehrenreich, who is in charge of the psychiatric residency at University/Sheppard Pratt, said that because of his background he wants to engage the younger members of the MPS. He has been involved in our efforts to increase social justice and to combat racism. He has specifically directed our committees to increase inclusiveness and to be diverse and free of racism.

It was then time to announce the door prizes.

These are difficult times, but we do have each other to help us get through them and it's clear that our leaders—including our excellent staff—are competent and are determined to do just that.

A SONNET for OUR TIMES
by Jesse M. Hellman, MD

Winner of the 2020 MPS Lifetime of Service Award

Abandon Hope

The blessed Dante, safely back from Hell,
Sang tales of tortures that should ever quell
The smallest hope of those whom God should send
To be with others with like sins condemned.
But for this man the Lord has found
A special Circle where forever bound
He'll dwell alone without his throngs
Of sycophants to beat the gongs
Of Praise for which he ever yearns.
He values gold, but simple kindness spurns.
No Circle this for all the *hoi polloi…*
But this Fate leads to unrestrainèd joy:
A *special* Circle *just for me*!
Great glory for eternity!

2020 Lifetime of Service Winner: Remarks

By: Jesse Hellman, MD

Jesse Hellman, MD

Thank you, and thank you to everyone involved with MPS. I started at Sheppard as a resident in 1970 and then after two years in the army returned in 1975, meeting Art Hildreth and Tom Allen. It was their influence that brought me to MPS, where I joined the Peer Review Committee, and worked at Med-Chi with Physician Rehabilitation. On the MPS Executive Committee I think the most important thing I did was to help bring Heidi Bunes onboard. It is hard to imagine what MPS would be like without her.

Earlier in life my multiple interests led to great uncertainty! Would I be a surgeon like my father? Before I went to medical school I considered graduate work in English literature, and during medical school not only took the law school admission test but almost jumped ship to a PhD program in English. Psychiatry saved me: it is the medical field that unites my interests. It is unique, combining the latest advances of medicine with the eternal values of the humanities; the intertwining of our emotional and cultural worlds with observable experience and the provable data of research. Empathy and kindness are its bedrock values.

Virginia Ashley is coming in as MPS President. When I think of Ginger, of course, I think of Lisa Beasley, who was such an asset to MPS and whose loss is still so acute. As is Irvin Cohen, who was my most valued mentor. It is perhaps now with Covid and our political crisis that we are all so aware of loss and uncertainty in so many areas of our lives: the political conflict affects nearly everything and everyone. Very little is just as it was. Recently I finished writing an essay about the effect on the playwright Bernard Shaw of the death of his timid older sister Agnes, who died shortly before her 22nd birthday. While he almost never spoke of her, her death strongly influenced his works throughout his entire life — he repeatedly wrote of a young woman being educated by an older man. Consider that as Shaw got older, in his mind Agnes would have always stayed the age she was when he last had been with her. Complicated and unresolved grief is often unspoken, over-looked, and especially important in

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Lifetime of Service: Remarks

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our country today. Being a psychiatrist gives us a different way of listening, a greater sensitivity to how childhood events can affect us all our lives.

Six years ago I returned to literature, uncovering the text of a play written in 1897. The following events contain a coincidence that beats almost unfathomable odds: *Nelson's Enchantress* tells the true story of a beautiful but poor young woman, living on the streets in London, taken in and educated by an older man, whom she eventually marries. She later falls in love with Horatio Nelson: it is the famous story of Emma Hart, who became Lady Hamilton. The play was reviewed by Bernard Shaw, failed and closed after one month. Could it have helped inspire Shaw's vision of Eliza Doolittle and to write *Pygmalion*? The author of *Nelson's Enchantress* used the pseudonym "Risden Home". The internet helped uncover that she was Augusta Matilda Paterson De Lacy Lacy and that her great-granddaughter is Araminta Hippisley-Coxe, to whom I wrote but she did not answer my emails. I had no idea where she lived.

In 2015 I wrote to Araminta again, telling her that I was to present in London at a meeting of the Shaw Society. Would she be able to come? After some delay she wrote back, agreeing to meet at a nearby restaurant, showing up with with a large package. "Dr. Hellman, when you told me that my great-grandmother Augusta wrote a play that may have influenced Bernard Shaw, I thought 'This American must be a bit nutty'. But when you said you were presenting at the Shaw Society I wrote to my cousin Linnet in Connecticut, whose brother-in-law, Thomas Allen (!!!), is a physician in Baltimore. She asked him if he knows of this Jesse Hellman, and was told he has known him for forty years! Hearing that, I then went to my attic and in a trunk that had been untouched since Augusta died in 1917 found this cutting book filled with information on the play." Araminta's cutting book was exhibited both at the National Maritime Museum in Greenwich as well as at the Victoria and Albert Museum. And how did her great-grandmother Augusta come to have her play produced at the Avenue Theatre in London, with the heroine being played by Mrs Patrick Campbell and Lord Nelson by Forbes Robertson? Augusta's husband Charles was Oscar Wilde's physician!

And to add a little bit of spice to this story, Shaw had fallen in love with Mrs. Patrick Campbell after seeing *Nelson's Enchantress*, and she, at the age of forty-seven, created the first Eliza Doolittle in *Pygmalion* in London seventeen years later!

What I've Learned

By Brent C. Pottenger, MD, MHA

Brent Pottenger, MD, MHA

A year ago, I reflected on "What I've Learned" during the first half of my psychiatry residency at Johns Hopkins (see p. 11 of *The Maryland Psychiatrist*, Fall 2019, Vol. 43, No. 2). Now, as I complete my final year of psychiatry residency training, I appreciate that I have learned a lot.

(1) Prescribe hope;
(2) There are always options; and,
(3) Be consistent.

Dr. Karen Swartz at Johns Hopkins shares with trainees: "I prescribe hope. Hope. And lithium." She exemplifies this lesson in her care of patients, role-modeling how to "prescribe hope" from the moment we meet our patients. Simple opening statements such as, "We are glad that you are here for care. We are hopeful that you can get a lot better," can start this process. I will integrate a "prescription of hope" message as part of my psychotherapy work with patients.

Prior to entering psychiatry, I trained in physiatry at Johns Hopkins. As a physiatrist, I learned how to instill hope for physical recovery in patients through the rehabilitative process, aiming to restore function in a limb after a stroke or regain mobility after an extensive hospitalization for a severe illness like sepsis. At the time, I did not appreciate how skillful psychiatrists are in communicating hope to patients, and now I respect how psychiatric training teaches us to be beacons of hope for our patients.

Secondly, a corollary to prescribing hope is educating patients that there are always options. These provide hope. Dr. Glenn Treisman at Johns Hopkins shares with patients: "I'm not out of bullets. I have many more bullets. If this doesn't work, we have options to try next. There are always options." Patients tend to speculate about how the future will be based on how the immediate past has been for them. For instance, a patient with depression and co-morbid chronic pain who has not yet improved after trials of three antidepressants may catastrophize and think that "nothing will ever work." Validating the patient's

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What I've Learned

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difficult experience thus far, while simultaneously offering a better perspective--"there are always options"--is valuable.

As a physiatrist, I grew frustrated by the limited options available for me to offer patients suffering from chronic pain. Now, thanks to my psychiatric training, I have expanded my armamentarium extensively. Moreover, by learning how to formulate a case using *The Perspectives of Psychiatry*, I am better prepared to understand the patient's situation, diagnose co-morbid mental illnesses, and then choose treatment approaches that address all these factors in an individualized fashion.

Combining these lessons requires consistency. Patients are more likely to buy into the "prescription of hope" if I am consistent in delivering this message over time, both in the words I choose and the ways I behave. I intend to keep working on it for years; I think it will make me a better doctor.

In Memoriam: Mayer C. Liebman, MD

2008 Lifetime of Service Award Winner

By Bruce Hershfield, MD

Mayer Liebman, MD

Dr. Mayer C. Liebman died on November 18th at age 86.

He had a long record of helping the MPS. For many years he served on the Legislative Committee, including as its Chair; these included much of the time when we were struggling to achieve parity and to contain managed care. He chaired the MPPAC in 2003-2004 and served on its board for many years. He was a member of the Board for the Maryland Foundation for Psychiatry and served as the MPS Rep to the Med-Chi House of Delegates. For these and so many other services he did for the MPS, he received its Lifetime of Service Award in 2008.

He also was President of the Baltimore County Medical Association in the early '90s and was Chair of its Legislative Committee during the time when Med Chi brought about tort reform in the legislature. He led the BCMA in this effort.

Dr. Liebman trained in Psychiatry at NYU and worked at Sheppard Pratt after coming to the Baltimore area. While he was there, he ran the NORCOM community mental health clinic in Towson and supervised the hospital's outreach to local universities. A graduate of the Baltimore/Washington Psychoanalytic Institute, he had a private practice in Baltimore County for many years.

He was a friend and mentor to many of us. Dr. Erik Roskes commented on our e-mail list on hearing of Mayer's passing, "This is sad indeed. He was a role model for me as a kid, when I knew him in Shul. Very kind man."

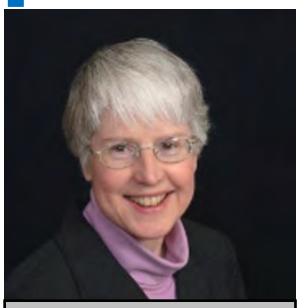
Dr. Mark Komrad said on the e-mail list, "It was an honor to have been one of the people who was part of Mayer's medical team. Mayer was a cherished colleague, a model of what it means to be a doctor and a human being. His memory will guide my own steps in my work and my life."

Thomas Allen, MD remembered, "His life was dedicated to helping his patients and the broad community of physicians and psychiatrists. He was gracious and well regarded."

Mayer befriended and guided me when I first came to this area, as he did so many others. He had a gentle, southern style and was generous in helping others. He was an exceptionally kind and wise man who, by giving of himself, showed what it means to be a friend and healer.

Uncertainty Marks Next Legislative Session on Police Reform Bills

By: Annette L. Hanson, MD



Annette Hanson, MD

The news broadcasts have recently been filled with scenes of violent protest and civil unrest. The public is understandably frightened, and many are calling for reform of both the criminal justice system and the police. The Maryland general assembly has already been active in this area through work groups and task forces to study police misconduct, racism, the civil immunity of law enforcement, recruitment and hiring practices, oversight, and training. The upcoming legislative session is destined to be filled with bills on these topics.

Traditionally, the MPS rarely comments on bills specific to criminal sentencing or law enforcement unless there is a direct relationship to the treatment of people with mental illness or the practice of psychiatry. I would like to give a brief overview of reform legislation that the MPS has already acted upon.

In 2018 we supported a bill that created the Behavioral Health Crisis Response Grant Program, which established competitive funding for local behavioral health authorities to establish and expand this type of crisis response. These programs serve seriously ill patients who require prompt community-based care through mobile crisis teams or walk-in services. They also provide temporary crisis beds, serving to divert people away from the correctional system and emergency departments. The bill required the state to provide up to $3 million in services.

During the 2020 legislative session we supported the Crisis Intervention Team Center of Excellence bill, which built upon that grant program. It creates a committee to provide technical assistance and resources to local law enforcement agencies to create model programs.

The coronavirus pandemic stymied some efforts to address police reform issues this year because the legislative session ended in early March--shortly after the first COVID death in the state. We supported legislation to reduce potentially deadly conflicts between police and people with mental illness. We supported House Bill 1470, "First Responders Mandatory Mental Health Training." This bill was drafted in response to concerns expressed by the parent of a child with mental illness who was also a person of color. Although the testimony was generally favorable, the bill did not come to a floor vote because the legislative session ended before the relevant committee voted. Similarly, House Bill 736 was another coronavirus-induced "bill death." This would have required all law enforcement agencies in the state to provide access to employee assistance, including mental health care, to all police officers at minimal cost to them. It was based upon the concern that as many as 12% of police officers in a national survey reported that eventual suicide was either very or quite likely for them. The bill passed the House unanimously, but did not come to a vote in the Senate due to the early end to the legislative session.

Plans for the 2021 general assembly session are under discussion now. We will continue to monitor and provide written testimony on legislation, but there may be limits on direct access to legislators, depending upon requirements for social distancing and limitations on public access. Committee hearings may limit in-person oral testimony, which means that much of our usual deliberative processes will be handicapped.

In the upcoming session, direct involvement by MPS members will be even more important than usual. The legislative committee will be providing regular updates to the MPS e-mail list regarding the bills that we are reviewing. In order to represent our membership most effectively, I would ask members to review these posts and the draft legislation they mention. Advocacy is most effective when members can tell legislators how the legislation directly affects their practice and their patients. We also welcome proposed language for bill amendment and improvement. We encourage all members, regardless of any "official" MPS position, to make their opinions known to their elected officials through phone calls, emails, and traditional "snail mail". Member involvement crucially helped us in the last session in our efforts to defeat bills related to scope of practice and other issues. The legislative committee welcomes member engagement on so many issues that are important to our practices.

Cheers From The Chair (Part 1 & 2)

By: Jimmy Potash, MD, MPH
Chair, Johns Hopkins Dept. of Psychiatry & Behavioral Sciences

Jimmy Potash, MD, MPH

Part 1: What a great honor to be recognized in the *U.S. News & World Report* 2020 Best Hospitals issue, as **#1** in the country in psychiatry!

In our general psychiatry services and in our many sub-specialties, like mood disorders, eating disorders, schizophrenia, dementia, substance use disorders, chronic pain, and child psychiatry, all of you--clinicians, researchers, and staff--dedicate yourselves every day to making a difference for patients, and their families. All of our work rests on a strong foundation of caring. And we build on that with our rigorous standards and our commitment to harnessing the power of biomedical research to discover new mechanisms driving mental illness and new approaches to treatment.

This is ostensibly a clinical ranking. It is based on reputation, determined by the answer psychiatrists give to a single question: "where would you send a difficult-to-treat patient?" The truth is that we have long been THE place to send difficult-to treat-patients, because our comprehensive approach to assessment, systematic approach to formulation, and intense dedication to patients' wellbeing, make us the gold standard for clinical excellence. Our clinical prowess hinges on great psychiatrists, psychologists, residents, fellows, nurses, social workers, occupational therapists, therapists, and administrators. But the *other* two parts of our mission *reinforce* the clinical mission, and add substantial luster to it. Our efforts aimed at making new discoveries that will lead to better treatments give patients hope that we can make a difference for them, now and in the future. Our focus on training the next generation in how best to carry these important efforts forward help establish us as standard setters in the field. So, this honor belongs to *all* of us.

We were #3 in this *US News and World Report* clinical ranking last year and #4 the year before that. This is not the first time we have been #1. Many of you will remember that we held that distinction in 2011 and 2012. The methodology regarding who is surveyed has changed since then. It felt pretty good last year to win a bronze medal, but there is nothing like winning the gold! Baltimore's Michael Phelps better watch out, as we are hot on his trail. J

In the 1950 movie, *All About Eve*, the character Margo Channing, played by Bette Davis, famously says, as a large party is getting under way, "Fasten your seatbelts, it's going to be a bumpy night." Perhaps a comparable warning should have been issued to all of us at the beginning of the bumpy year of 2020. We have been dealing with the challenges of COVID-19, and that has been nothing to party about. Yet our celebration of this singular recognition by *US News and World Report* will acknowledge the uniqueness of our current situation. We will be giving out COVID-fighting facemasks, with the Hopkins logo, that say "Johns Hopkins Medicine, Psychiatry #1, USN&WR 2020-21." I hope you will wear them with prudence and pride.

Part 2: Things fall apart; the centre cannot hold;
Mere anarchy is loosed upon the world…
--*The Second Coming* by William Butler Yeats

Yeats wrote the above lines in 1919, with World War I having just ended, the Irish War of Independence beginning, and his wife recovering from a nearly fatal bout of influenza. This verse has been quoted often during the tumultuous year we are in.

With the events of 2020 in mind, I spoke last week in Grand Rounds about how the things that feel overwhelming around us ultimately get inside of us, changing our molecular makeup. Depression often arises in the context of a combination of a genetic vulnerability and stressful life events, with these experiences leaving an imprint that affects how our bodies, brains, cells, and genes work. The epigenetic mark known as DNA methylation—a chemical change that influences the action of genes--has been shown to be altered, sometimes enduringly, by traumas like childhood abuse and combat exposure, in ways that lead to changes in the brain, and increased risk of depression and anxiety disorders.

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Cheers From The Chair

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This week I was thinking about the most outstanding accomplishments in our department's history, and this led me to Dr. Horsley Gantt, who ran our Pavlovian laboratory for 35 years, and won the prestigious Lasker Award in 1946. One of his greatest scientific contributions was his demonstration of how the external environment could shape the internal functions of the body, especially the heart, which he found responded more quickly than any other organ. In 1943, he published a book called *Experimental Basis for Neurotic Behavior: Origin and Development of Artificially Produced Disturbances of Behavior in Dogs*. In it, he described experiments with three dogs, whom he named Fritz, Peter, and Nick. He trained the dogs to differentiate two tones, rewarding them for their success. Then he made the tones more and more similar, to the point that it was impossible for the dogs to hear the difference between them. In this setting, Fritz and Peter were relatively unperturbed, but Nick's heart rate rose, as did the pace of his breathing. He became restless, and began whimpering and crying. Afterwards he wouldn't eat. Other experimental stressors produced comparable results, and the conclusion Gantt drew was that Nick had constitutional instability that was brought out by the challenging conditions. Reviewers of the book drew parallels to the predicament of soldiers suffering mental breakdowns following experiences in the war.

Assistant Professor Liisa Hantsoo has been interested in how adverse childhood experiences (ACEs), such as abuse or chronic stress, leave marks that persist into adulthood and promote changes in the makeup of moms during pregnancy. A couple of years ago she published a paper showing that multiple ACEs are associated with changes in the composition of the gut microbiome—the vast array of diverse species of bacteria in the gut--during pregnancy. She showed that these changes might contribute to alterations in the response of the body's inflammatory and hormonal systems to stress. Dr. Hantoo's study also found intriguing preliminary evidence that the more omega-3 fatty acids the moms consumed, the milder were the effects of ACEs on inflammation during pregnancy.

Recently, she secured a grant from the NIH for $200,000 to extend these observations in a sample of African-American women, who, on average, have higher rates of ACE exposure and greater physiologic vulnerability to the inflammatory impact of stress than white women. She will examine the links from ACE to gut microbiome to inflammation, determine whether the altered microbiome passes to the offspring during delivery, and more robustly assess whether maternal diet during pregnancy influences the gut microbiome and inflammation. Just this week, a paper from UCLA appeared in *Nature* providing evidence that the maternal gut microbiome plays a role in shaping how the fetal mouse brain develops, strengthening the case for a bacteria-brain connection, and suggesting Dr. Hantsoo is on a promising track.

If you are having trouble staying centered in these stressful times, consider this timeless wisdom from nineteenth century writer and philosopher Henry David Thoreau: "Time is but the stream I go a-fishing in. I drink at it; but while I drink I see the sandy bottom and detect how shallow it is. Its thin current slides away, but eternity remains. I would drink deeper; fish in the sky, whose bottom is pebbly with stars."

In Memoriam: Gladys Arak Freedman

2008 Lifetime of Service Award Winner

By Bruce Hershfield, MD

Gladys Arak Freedman, MD

Gladys Arak Freedman, a Life Member who joined the MPS in the mid- '80s, died on November 5th.

After she graduated from the State University of NY in 1967, she trained in General Surgery at Pacific Medical Center, then trained in Pediatrics and Internal Medicine before doing a residency in Psychiatry at the University of MD and then a fellowship in Child & Adolescent Psychiatry there.

For many years she maintained a private practice in the Pikesville section of Baltimore County. She treated patients until the day she died.

Steven Warres, MD commented, "Dr. Arak was remarkably dedicated, serious, and sincere. She cared about her patients and never let anything slide by without thoughtful consideration. Patients knew she was deeply involved in ameliorating their situations---not just with them for 15 minutes but with them for the long-haul work.

Decades ago, as Gladys' service chief on the Child Inpatient Unit at Sheppard Pratt, I was well aware of her devotion to her patients, her individualism, her subtle sense of humor, and her great capacity for critical thinking. Gladys pushed us to be better."

Why is Women's Mental Health A Specialty?

By: Nicole Leistikow, MD

Nicole Leistikow, MD

When I completed residency at Johns Hopkins and was looking for my first job in Baltimore, I joined the University of Maryland to be part of their Women's Mental Health Program where I see patients in several clinics and teach and supervise residents. I also recently started a private practice specializing in treating women. When I tell people I am a reproductive psychiatrist, many respond, "I didn't even know there was such a thing." Why do we need psychiatry that focuses on women when, for many of us, the majority of our patients are indeed women, not a niche category by most standards. Shouldn't all adult psychiatrists be capable of treating women?

Unfortunately, while women make up the majority of those seeking psychiatric treatment, men have historically been defined as the default patient. For decades, women were excluded from medical research; It wasn't until 1991 and 1993 that the National Institutes of Health changed course and started requiring studies to include women or justify their exclusion. Women are still routinely advised (although admittedly less frequently), by family members, pharmacists, OB/GYNs and even psychiatrists, to stop all psychiatric medications in pregnancy and while breastfeeding without thought to the effects of untreated psychiatric illness on the mother and baby. The FDA pregnancy categories for drugs, although phased out in 2015 in response to criticism of their misleading nature, which privileged newer medications with less information available on their reproductive safety, are still routinely referenced when selecting potential antidepressants. I still encounter women of child-bearing age who are being prescribed valproic acid without adequate rationale when the European Union restricted its use in this population in 2018 due to the mounting evidence of teratogenicity and other fetal effects. These are only a few illustrations of the point that there remains much work to be done.

The short answer is, of course, that all adult psychiatrists should be adequately trained to treat women across the reproductive life cycle, from menarche, through pregnancy, lactation, the post-partum period or after pregnancy loss, and through perimenopause. These hormonal transitions, now understood to represent times of increased risk for exacerbations of most mental illnesses as well as new onset illness, including flares of anxiety, depression, bipolar illness and schizophrenia, are still routinely ignored by clinicians not versed in what is a growing reproductive psychiatry research literature. When was the last time you asked your female patients about the regularity of their periods and whether they have noticed any pattern in mood symptoms, sleep, anxiety or irritability relative to their cycles? The odds are, depending on when you completed residency, you were never trained to do so.

As a PGY3 rotating through the Johns Hopkins Women's Mood Disorders Clinic on Thursday afternoons, I didn't realize at the time, that by treating this population under the guidance of Drs. Jennifer Payne and Lauren Osborne, two world class experts, I was racking up more hours of training in reproductive psychiatry than is offered by the vast majority of residency programs. In a 2017 survey, only 40% of U.S. psychiatry residency training directors felt general adult psychiatry residents should be competent in reproductive psychiatry and only 60% of residency programs required residents to have any training in this area. To give an example from a specific subject area, only 6% of surveyed programs required that residents have at least 5 hours of exposure to psychopharmacology in pregnancy across all 4 years (1). Although there are at least 12 U.S. Women's Mental Health fellowships currently, the Accreditation Council for Graduate Medical Education (ACGME) does not accredit any of them (2). Suicide is a leading cause of preventable maternal deaths and treating maternal mental health has been recognized as "treating for two," an intervention that has additional payoffs for child and family mental health. Yet, both inpatient and outpatient services that accommodate mothers caring for infants and young children, while starting to be built, remain strikingly rare.

Today, we know so much more than we did even 10 years ago about the effects of medications in pregnancy and breast-feeding, as well as the effects of a mother's untreated illness on her and her children. When I teach residents about treating mental illness in pregnancy, we talk about having a risk (of treatment) versus risk (of illness) discussion rather than a risk versus benefits discussion to refocus attention that has been historically lacking on the very real threat of untreated maternal mental illness. Although in many circles, depression in preg-

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nancy or postpartum has been accepted as a legitimate illness deserving treatment, it is still not on a par in everyone's mind with "real" illnesses like epilepsy, which has been triggering risk versus risk discussions in pregnancy for decades. We are also learning more about how many of the medications we prescribe are metabolized during pregnancy, reducing drug levels for many but not all women, thus frequently requiring an increase in dose across the second and third trimesters rather than the non-evidence based taper that many clinicians and women seem to intuitively prefer as delivery approaches. Imagining that lowering antidepressants in pregnancy may decrease a baby's risk of side effects does not make it so, but it does make women more vulnerable as they head into postpartum, the time of greatest psychiatric risk.

Speaking of post-partum, the treatment of sleep deprivation is vastly underappreciated in my experience. I teach residents to ask about sleep after delivery in great detail, recording when the baby is first put down at night and by who, when the patient first sleeps and is first woken up, how long it takes her to go back to sleep after each feeding and so on until the absurd post-partum sleep schedule is laid bare for all to see. The next step is to look for unappreciated sleep opportunities and to let/request others in the household take over some of the nighttime feedings, even if it means their own 8 hours are disrupted. "Even if I pick the perfect antidepressant for you at the perfect dose, if you are not sleeping, it won't work," I tell my patients. We spend a long time on this discussion because in protecting my patient's sleep, I am, for the most part, working against society's expectations, the expectations perhaps of the patient's family, and of the patient herself, all of whom typically see no problem in intentionally and cavalierly disrupting the sleep of a woman with a history of severe depression, anxiety or even bipolar illness. The role induction, as my wise Hopkins attendings would put it, from mother who must sacrifice herself for her family at the cost of her mental health to mother who can care for her family by protecting her mental health, is an important part of treatment.

These are a few of the ways I do things a little differently as a reproductive psychiatrist. The principles, however, are widely applicable. The risk of treatment versus risk of illness discussion, a focus on the timing and quality of sleep, even an exploration of how doing for others at the cost of our own mental health is a zero-sum game that ultimately makes us less able to care for our family. All of these practices translate well to treatment of any patient, even…men. Specialty training in how to take into account the various risks and needs of women at different reproductive stages of life could make us more thoughtful psychiatrists for all of our patients. But how to get it?

Thankfully, the community of reproductive psychiatrists is generous and open to proselytizing. For several years now, I have been part of a miraculous effort by the National Curriculum in Reproductive Psychiatry (NCRPtraining.org), led by Lauren Carpenter, to bring together volunteer experts to create free online modules that allow psychiatrists (and others) to learn about important women's mental health topics and the relevant research literature and also to teach trainees within their institution by using guided case discussions. In addition, there are other important resources like the Massachusetts General Hospital Center for Women's Mental Health blog (womensmentalhealth.org). This summarizes and puts into context the latest research and the website mothertobaby.com run by teratology information specialists who offer clinician consultations and easy to understand patient handouts on a wide array of medications and supplements. Finally, the APA will be publishing a textbook on women's mental health across the reproductive life span, written by leaders in the NCRP, within the next year.

The tide is turning and evidence-based treatment recommendations for women are beginning to shape the latest crop of psychiatric residents as more of them begin to get training on how to treat women at all times of life. Should women's mental health be a subspecialty? Perhaps, if we do our job right, eventually it won't have to be.

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Interview: Robert P. Roca, MD

Vice Chair for Clinical Business Development
Johns Hopkins Dept. of Psychiatry and Behavioral Sciences

by Bruce Hershfield, MD

Robert Roca, MD, MPH

November 9, 2020

Q.:" Tell us about your new job."

Dr. R.: "When I was preparing to leave Sheppard Pratt after 26 years, I began looking at what else I might do. As I approached the point when I was going to retire. I went to talk to Jimmy Potash, the Chair at Hopkins. He had been my medical student in the '90s at Bayview. I asked him if there was something I could do that would be helpful. He asked, 'What about something like Vice Chair for Clinical Business Development?' I was surprised that the idea occurred to him, apparently spontaneously, but it turns out this is a position that has been created in a number of other departments at Hopkins in recognition of the need to find ways to expand the clinical enterprise in a financially viable way. I was extremely delighted that it worked out. So, my job is to help the department develop high quality and financially strong clinical programs that give more patients access to care at Hopkins at a time of tremendous need. "

Q: "So this is a new position not only for you, but for the department."

Dr. R: "Yes, but there are similar positions in the departments of Neurology & also in Medicine and perhaps others."

Q: "What had you done that made it possible for you to do all this?"

Dr. R: "I was on the leadership team as vice president and medical director at Sheppard Pratt during a time of explosive growth during Steve Sharfstein's tenure. I arrived in 1993 on the heels of a fundamental reorganization after Steve took the helm. At the time, Sheppard Pratt was principally a free-standing private psychiatric hospital. Over the next two decades it blossomed into a comprehensive mental health system with inpatient units on two campuses, five day hospitals, community mental health programs around the state, and residential treatment centers for adolescents with special needs. So, I had the great privilege of serving on a wonderful leadership team at a time of tremendous growth. The system thrived during those years and I learned a lot about how to create programs that met needs and were financially sound in the context of the entire system. Also along the way I got an MBA at the Hopkins Carey School of Business."

Q:" What are you working on now?"

Dr. R: "As you know, the Hopkins department of psychiatry was rated as the best in the country in 2020. It deserves that reputation. It has a very talented faculty, deeply committed to patient care, research, and training. There is a real drive to be on the frontier. Faculty members have been involved in trials of esketamine, so we launched an esketamine clinic. Faculty members have been involved in trials of brexanolone, so we are in the process of bringing up a program to provide that. Of course, there is also the Center for Psychedelic and Consciousness Research. While it's early to predict what the therapeutic uses of psychedelics are going to be, it's an intriguing new direction. Overall, it's exciting to be at a place that's on the cutting edge of research focused on finding new approaches to the conditions we treat."

Q: "Are you still seeing patients?"

Dr. R: "Yes. One of the things that impresses me about Hopkins is that everybody is expected to work as a clinician. The Chair of the department does inpatient attending and sees outpatients. So, this year I am going to be the inpatient attending on the geriatric unit for a couple of months. I see geriatric outpatients and I also spend about 1 1/2 days per week in the community psychiatry clinic. Whatever else you are doing, seeing patients keeps you grounded. It's really hard to be effective in program development or administration if you don't understand clinical care in a first-hand way."

Q: "Tell us about your work in the APA. I understand you are the Chair of the Council on Geriatric Psychiatry."

Dr. R: "Perhaps the greatest advantage of being in organized Psychiatry is the personal relationships you develop with people you otherwise wouldn't get to know. On the Council there is a wonderful cadre of people from all over the country. We have members from the east coast, the Midwest, the far west, and even Hawaii. The core function of a Council is to be a resource to the APA administration and leadership. So, when geriatric issues come up for which the APA needs to have an advocacy position or respond to the media, we are respon-

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Interview: Robert Roca, MD

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sible for creating position statements that can be adopted as official policy. We are also allowed to create our own agenda in many respects. Because a number of our members are interested in diversity, a couple of years ago we put together a book entitled "Culture, Heritage and Diversity in Older Adult Mental Health Care." It was a great experience and hopefully resulted in a useful product. Buoyed by that experience, we are now putting together a book on COVID and the elderly, with a focus on the implications of COVID for older adult mental health care. I think the final product will be useful. It has been a terrific honor and a joy to be in this role as Chair of the council."

Q: "That's quite a lot for someone who 'retired' a couple of years ago!"

Dr. R: "A lot of us really love what we do and it's hard to stop doing it. Over time, you winnow away what you do not want to do, and you spend more time doing what you do want to do. Psychiatry is a tremendous field and there is a tremendous demand for our services. I serve as the Alternate Delegate to the Med-Chi House of Delegates, and I attended the first virtual House of Delegates meeting this past weekend. There was a presentation by a fellow from Merritt Hawkins, which is a physician staffing company. He gave a presentation about the results of a survey of physicians. I was astonished at how frequently Psychiatry came up in his discussion. He made a point of talking about the psychiatric impact of COVID on physicians. He called attention to the demand for psychiatrists in the community. They use an "index of demand", which is basically demand divided by the number of people available to provide services. By that index, psychiatrists are second only to oncologists in terms of the magnitude of the need. I took away the sense that if there was ever stigma about having psychiatric needs or being someone who treats people with these needs, it seems to be falling away. There is increasing respect for what we do and for those of us who do it."

Q: "I remember that when I met you when you were a resident, you had already trained in internal medicine. Are you happy about how your career has gone?"

Dr. R:" I suppose I am at the far end of my career arc, and I have never had second thoughts about my choice to do Psychiatry. I had always been interested in psychiatry, but when I graduated from medical school I wasn't ready to commit to it. So, I did an internal medicine residency because it seemed the best way to learn the most about the most things. But toward the end of the residency, as I was contemplating what to do next, I remembered what drove me to become a physician in the first place. So, I actually looked at pulmonary fellowships and psychiatric residencies at the same time. I know I made the right choice. "

Esketamine for Treatment-Resistant Depression

By Robert Herman, MD

Robert Herman, MD

In March, 2019 the FDA approved eskatamine (brand name Spravato) as an adjunct to treatment with an antidepressant. It uniquely treats depression in several ways. It appears to interfere with glutamate signaling and to increase levels of brain derived neurotrophic factor. Of course, like most drugs we use, its exact mechanism is unknown.

Current models of brain function center around feedback loops, whose neurons employ neurotransmitters to communicate with one another. We can affect these circuits with different agents that affect different locations within them. Esketamine appears to work more quickly than traditional antidepressants; improvement in mood at times occurs within hours. This also suggests that its mechanism is different.

A number of requirements in its labeling and regulation make it challenging to use. The patient has to be monitored for two hours after it is given. Because of the potential for abuse, it must be delivered to the clinician's office and stored securely. Patients are not permitted to drive for the remainder of the day. When it was approved I did not see it as something I would be able to use in my practice. Circumstances changed, however, in the summer of 2019, when my group practice moved to a larger suite of offices, where an unused office was available. I am also in a relatively large group practice, with support staff available to help me. This is not something one can do alone!

One of the first patients I treated was a 60- year-old who had been depressed for at least 15 years and who had spent most of his time in bed or lying on the couch. He had been treated with multiple antidepressants, including MAO inhibitors, without benefit. I started treating him in March, 2019, after his prior psychiatrist retired. We began twice-weekly esketamine in December, 2019. I noted a slight degree of improvement after one month. He then began to improve rather rapidly, achieving full remission from depression (by rating scales and by reports from him and his wife) in mid- March. I now treat him once a month, and he has remained in full remis-

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Esketamine

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sion . Our plan is to continue esketamine monthly until November-- about nine months after achieving remission-- and keep him on his oral antidepressant regimen indefinitely.

I have treated a total of seven patients to date. Most had been depressed for many years and had failed multiple treatments. Two failed to respond to electroconvulsive therapy. All have responded to the drug; the majority of them are in remission or are responding rapidly.

There have been many logistical and clinical challenges. It is expensive and getting insurance approval has been a challenge. A number of patients came to me seeking treatment, and then have not followed up for a variety of reasons. Its long-term effects are unknown, as it has only been in clinical use for 18 months. Yet it does seem to offer some patients relief from debilitating depression when many other treatments have failed

In Memoriam: Kay Koller, MD

By Jesse Hellman, MD

Kay Koller, MD

On September 26 Kay Pak Koller, a much-beloved child psychiatrist who worked at Sheppard-Pratt, died of cancer at the age of 90. It was a loss for all who knew her and had the pleasure and benefit of working with her. Her personal story is remarkable in terms of her courage, fortitude, and vision. It shows her to have used her personal strength to overcome cultural taboos that had stifled many others. Her story and accomplishments are remarkable from any perspective.

She was born in Pyongyang, Korea to an ancient and titled family. She was the grand-niece of Empress "Myung-Sung", who died in 1895. Myung-Sung was the wife of the first emperor of Korea. If one had expected that one--and especially a woman--who came from such a lineage would be retiring and unassertive, Dr. Koller would greatly disappoint. The eldest of six children and raised by her maternal grandmother, she was a woman of courage, independence, vision, and determination.

Jacques Kelly wrote in an obituary in the Baltimore Sun that "Dr. Koller recalled in a memoir that she had an idyllic childhood where she ran with butterflies among cherry blossoms. She also said the happy days did not last. At age 14 she left Pyongyang for Seoul, where the rest of her family were living, during the end of World War II."

"She was a graduate of Bai Wha High School in Seoul and began to learn English during her final year there, after U.S. occupation forces arrived in Korea. 'I enjoyed school work and was competitive,' she wrote in a speech about her days in Korea. 'I was a precocious child in every way. I was reciting a speech in Japanese when I was six years old.'" Her daughter, Kim Thiel Koller McClung, said that her mother "was raised by her maternal grandmother, who made her the strong woman she became."

Dr. Koller recalled that her father had cut her off financially when she started pre-med studies, believing that women should not be educated: their place was in the home. "He mercilessly told me to leave the house," she said. After she emigrated to San Francisco she went to Baltimore, where she trained at Union Memorial Hospital. It was there that she met her future husband, E. Curtis Koller, who also became a psychiatrist. After beginning her psychiatric residency at Sheppard-Pratt in 1968 she joined the staff, later working at Sinai and also at Franklin Square Hospitals.

Mr. Kelly also noted that Dr. Koller "taught English at the Korean Anglican Church of Baltimore and served on the vestry and as treasurer. She rode horses as a young woman and played tennis throughout her life. She enjoyed ballroom dancing, knitting, and opera."

Child psychiatrist Meena Vimalananda, who worked with Dr. Koller at Sheppard-Pratt, recalled her warmly, touching on the personal aspects that made her so beloved: "Kay was very gentle and had an optimistic view/perspective and a quiet sense of humor with her patients as well as colleagues. She was an elegant dancer and loved ballroom dancing as a fun way to relax. Her every move felt as graceful as a dance. I will miss her laughter and love of life and family."

LETTER FROM THE EDITOR
A Memorable Day in a Memorable Year

By: *Bruce Hershfield, MD*

Bruce Hershfield, MD

I learned today that the Presidential race is over. People are celebrating in the streets of some major cities. But I know that some psychiatrists are not celebrating--because they see politics very differently than I do. We can disagree without being enemies. I hope we can join forces now to fight our common enemy—COVID-19.

The virus has changed what it's like to be a psychiatrist more this year than anything else has in the 49 years I've been seeing patients. I don't see them in person any more, which I miss. I also miss seeing friends and colleagues.

I am upset that anything—let alone a medical problem—is afflicting millions and killing hundreds of thousands of us. People are losing their jobs, are mourning their relatives and friends without even being able to go through the rituals that would comfort them, and are surviving with damage to their bodies that may never go away. We are just beginning to see the expected surge in psychiatric and neurological problems that are likely to follow the first stages of an epidemic. Even if psychiatrists and other professionals who care for people are not "burning out" in large numbers yet, we may see that more and more as the pandemic spreads.

We have had to adapt. More patients keep their appointments. When they forget, it's easier to fit them in because they only have to use their smartphones or computers instead of their cars. Many people are spending less on gas; the roads are less congested and the air is cleaner. Snow and ice are no longer valid excuses for cancelling appointments. I can sit outside on nice days and get a clearer signal on the app I use. (Just about everyone I know prefers to be outside instead of indoors on a nice day.)

I have come to appreciate the sacrifices that psychiatrists like Dr. Angelino (see p. 3) are willing to make to treat inpatients. It is clear that some of my colleagues will do whatever is necessary when they are called upon.

I am reassured when I see how so many leaders, like the Dean and the Chair at Hopkins, are handling crises with honesty, resolve, and self-sacrifice. They report the facts, ask for questions and give honest answers—or they admit they just don't know. Also, I am impressed by the staffs of our professional organizations, like the MPS and the Southern Psychiatric Association. The virtual meeting these two groups held jointly in Baltimore in September was not as socially enjoyable or as highly sophisticated as others I've attended (like the one in 2015). But anyone would be impressed by what they delivered under the circumstances.

I remind my patients that I don't know the future, so I don't know when they can come to my office again. If some of the HIPAA rules are enforced again or Pennsylvania, only 25 minutes away, insists I get a license there to continue seeing their residents, the current situation could change in a hurry. (It did in March.) I am counting on the APA to continue to convince the federal government and the legislatures to be flexible.

I remember hearing family stories about the "Spanish flu" of 100 years ago and about studying the post-encephalitic Parkinson's that some patients had 50 years later, when I was in med school. I am sure that we will always remember this year, like my elderly relatives did, so long afterwards. I am hopeful--on a memorable day in a memorable year---that we and our profession will come out of it not only different, but stronger.