THE
MARYLAND PSYCHIATRIST
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MPS President: Mark Ehrenreich, MD


Mark Ehrenreich, MD

My family moved to a northwest suburb of Baltimore when I was very young. I left to attend college at Wesleyan University. I graduated with a joint major in biology and psychology, perhaps an indication that I was destined to be a future psychiatrist. I postponed my application to medical school by one year in order to spend six months at Brandeis University's Jacob Hiatt Institute in Jerusalem.

After graduation from college, I worked for a subcontractor to the National Cancer Institute in Rockville while applying to medical school.

I attended the University of Maryland School of Medicine. I was drawn to the school for two reasons. It gave me the opportunity to pay in-state tuition and to matriculate into the Combined Accelerated Program in Psychiatry (CAPP). I came here with the expectation of becoming a psychiatrist.

I did my residency at University and then joined the faculty. The bulk of my professional career has been in consultation liaison psychiatry; I ran the division for approximately 25 years. As the division director, I created a number of our specialized consultation services. These included programs in HIV psychiatry, psycho-oncology, and transplants. We set up a consultation service to endocrinology, vocational rehabilitation programs, and our medical crisis counseling center. In addition, I created our fellowship program in psychosomatic medicine/ consultation liaison psychiatry. However, what I am most proud of during this time was my ability to recruit wonderful faculty members. I really enjoyed working with so many excellent fellows, residents, and medical students. I became the director of residency training for the combined University of Maryland/Sheppard Pratt psychiatry program and the chief of education for the Department of Psychiatry in 2012. It has been truly rewarding to recruit medical students into the program, watch their initial steps as PGY1 residents, their developing expertise as PGY2 and PGY3 residents, and the consolidation of their skills as PGY4 residents. What a pleasure it has been to see them graduate and to watch their careers develop afterwards!

One of my major goals as the incoming MPS President is to seek ways to engage our residents, fellows, and early career psychiatrists. We are a vibrant district branch, but to move forward we need to ensure they participate in our society. I am particularly anticipating working with our residents and fellows committee and our early career psychiatry committee so we can better serve their needs.

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MARYLAND
PSYCHIATRIC SOCIETY

A District Branch of the American Psychiatric Association

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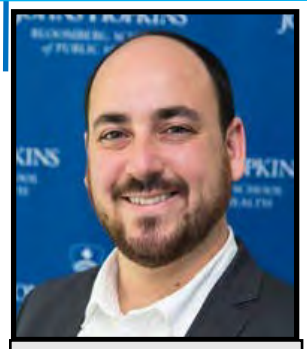
Masking Safety

by Paul Nestadt, MD



Paul Nestadt, MD

I do not think that I have COVID-19. I can't be sure, because studies have found that anywhere between 20% and 80% of cases are asymptomatic. Of course, even fatal cases are present and infectious, several days or a week before making themselves known.

However, I am optimistic that I did not catch it today. I had been worried. This morning, a CNA ran over to warn me that a patient I had just examined had suddenly spiked a high fever.

This patient, as with most on our dual diagnosis psychiatric unit, came from an unstable housing situation. Most of our patients come from the streets, group homes, or jail. These are settings which, like the hospital itself, have relatively high rates of infection due to close quarters and inadequate resources. A recent study of a Boston homeless shelter found that 36% of residents tested positive for COVID and of those, almost 90% had no symptoms. Two weeks ago, the New York Times crowned the Cook County jail as the nation's top virus hotspot. This week, Ohio's Marion Correctional Institution reported that 80% of their 2,500 inmates had tested positive.

Our patients are, by definition, too psychiatrically ill to be safe outside of the hospital. In many cases they cannot understand the need to socially distance, to wash hands or wear masks, to not hug or spit. Half of my patients this morning were under 'constant observation'-- a staff member must stay close at hand in order to be able to stop them if they impulsively attack others or themselves. A few more 'active' patients also needed a security detail as back up. Our patients do not wait patiently in bed to be visited. Their rooms do not have phones or TVs, and we strongly encourage them to be out and about. The treatment process relies on their participation in the unit milieu, interacting in the common area, eating in a family style, and attending group therapy throughout the day. We are not designed for infection control, with our communal patient phone, open floor plan, and day area couches.

When I was told that my patient was febrile, I flinched. I had done my best to maintain as much distance as possible, as I have done throughout the pandemic, though I had examined his sore knee. I was wearing my mask. It is a paper disposable one that the hospital provided along with two brown pa-

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per storage bags, for reuse indefinitely. Usually we are supposed to use these once, never for more than a few hours because they lose filtration efficacy and because they readily become petri dishes for everything that lands on them. Virus is notably detectable on surgical masks for 7 days-- longer than any other surface. Before March, reusing a disposable surgical mask could cost the hospital its accreditation.

I was given this one in late March and instructed to ask for a replacement only if it was torn or visibly soiled. Not that it matters, since surgical masks are designed to prevent the wearer from transmitting virus, but do very little to prevent the wearer from contracting it. If today's patient had been infected, I would be infected. My family would follow. I would put all of my other patients and coworkers at risk until symptoms manifested to trigger my self-quarantine. This logic has led some hospitals to provide N95's for all clinical work. It led China to require much more than that. It is why I got in touch with PPE suppliers early in this pandemic. I learned that FDA registered N95's are readily available, but cost $2.63, whereas surgical masks are $0.39 each. That cost difference may be why many hospitals still rely on surgical masks, which provide minimal protection from infection. That difference may be why health care workers make up 1 in 5 cases of COVID-19 in the US.

My patient did not have a fever. He had enjoyed a hot cup of coffee minutes before his temperature was checked. A great relief. But we do not know who is infectious, regardless of symptoms. We draw from high risk populations. We work in close proximity on open, interactive units, with disorganized, mentally ill patients, sometimes requiring physical holds and rarely able to maintain safe distances. It is no coincidence that one of the first COVID clusters in Maryland was in a psychiatric hospital, or that New Jersey's psychiatric hospitals have become the newest battlefront. Psychiatrists are accustomed to treating the most vulnerable of patients, and this vulnerability to COVID is no exception.[11]

Without adequate protection, we are the ones putting these patients, and ourselves, at risk.

Jesse Hellman, MD Wins Lifetime of Service Award

"What It Means to Me"

Jesse Hellman, MD

Dr. Irvin Cohen, a former Assistant Medical Director at Sheppard Pratt, died on April 14th. While there were numbers of people who helped my development as a psychiatrist, it was Irv who had the greatest impact. I had interviewed at Sheppard in 1970 — those were the days of Frieda Fromm-Reichmann and "I Never Promised You a Rose Garden" — during my medical internship at Rhode Island Hospital in Providence. I was, however, seriously considering cardiology as an alternative and was full of questions (doubts, really) about pursuing a psychiatric residency, particularly doing so south of the Mason-Dixon line. "If you come to Sheppard for training," Irv told me, "I think you will never want to leave Baltimore." As in many things, he was completely right. Irv's humanity and kindness shaped his intelligence and knowledge/

In 1975 I returned to Sheppard after two years in Germany as a psychiatrist in the U.S. Army. Irv strongly encouraged me to become involved with the MPS. It was he who so brilliantly summarized his concern that medical decisions were becoming overly influenced by legal and financial considerations: "Philosophy follows funding!"

Being involved with the MPS and its Peer Review Committee, and Med-Chi's Physician Rehabilitation Committee, were perhaps my most important experiences beyond being a Service Chief at Sheppard, my own analysis, and private practice. I was fortunate enough to serve on the MPS Council as Chairman, Co-Chaired the Managed Care Committee, and became President in 1990-91. Additionally I worked with *The Maryland Psychiatrist* and the *MPS News*. Our field requires much more than skill and intelligence alone: the importance of empathy and judgment cannot be over-stated. There were (and are) many thoughtful and kind people associated with MPS who influenced me immensely (as I write this Thomas Lynch jumps to mind). I was particularly fortunate in this regard to work closely with Bruce Hershfield, Art Hildreth and Tom Allen. It was when we were working together that the MPS decided to hire Heidi Bunes. It was one of our best decisions ever!

Just as in our field we try to understand feelings, actions (and inaction), and symptoms, my

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participation on the MPS Peer Review and Med-Chi Rehabilitation committees helped me to explore and understand what had occurred clinically from multiple perspectives. Working on these committees helped me appreciate the different emphases of psychiatric training at Sheppard, Hopkins, and the University of Maryland, rather than leading me to become polarized.

I am very pleased to have been honored with the Lifetime of Service Award.

The "Nurse Practitioners as Medical Directors" Law

(SB 1122/HB 944)

by Kim Jones-Fearing, MD

Kim Jones-Fearing, MD

Nurse practitioners are being supported by various organizations, including the Black Mental Health Alliance, and by large nursing educational institutions such as the University of Maryland, and rural counties such as those on the Eastern Shore. This is having an impact on how psychiatrists work. We need to do something to organize how to deal with it.

The legislature recently supported several bills allowing them to take jobs previously meant for psychiatrists. In the last session, multiple bills were put in place to study the problems regarding mental health care access. All of them failed. Instead, laws were passed to allow nurse practitioners to take the place of psychiatrists in telemedicine. The exact same bills put forth last year --for *psychiatrists* to expand Telemedicine as medical directors-- all failed. Senate bill 1122 passed in early April, allowing nurse practitioners to work as medical directors for outpatient mental health centers in Maryland. Addie Eckardt is the legislator who first sponsored several of these bills. The rationale was that "psychiatrists are moving away from working in the public sector".

We met with various stakeholders and legislators about our concerns over the summer of 2019. We were able to convene on September 3rd with the MPS leadership, Dr. Anne Hanson and several other MPS and WPS members. We were able to review the hearings and discuss possible future steps, including how to receive full support from our lobbyists at the MPS and Med Chi, and from legislators. We were able to meet with State Senator Brian Feldman, Senator Clarence Lam, Senator Katie Fry-Hester,, and Delegate Terri Hill. Delegate Dr. Terri Hill agreed to assist in writing and to support a corrective bill.

Many concerned Maryland psychiatrists attended the Med Chi House of delegates meeting held November 2n. The keynote speaker was Dr. Patrice Harris, the first African American president of the AMA. During the House of Delegates meeting, resolution 24-19 was presented as a corrective remedy to the above Nurse Practitioners law. Details of Med Chi resolution 24-19 can be reviewed on the Med Chi Medical Society web site under the Events, House of Delegates, and Resolutions Tabs. The resolution entitled "Outpatient Mental Health Clinic Medical Directors states that "…the Medical Director of an Outpatient Mental Health center should be required to be a licensed and appropriately trained physician."

On March 11th, our testimony was heard in the State House of delegates. Though we are unsure of the final outcome, I would say that we were successful in that we were able to bring this quality of care issue to the attention of the legislature. Our group of psychiatrists accompanied by our bill sponsor, Delegate Dr. Terri Hill, convened and were heard by the Health and Government operations committee. The delegates asked many questions. We were successful in teaching them that Maryland is not considered a shortage state at all for psychiatrists. It is 10th in the number of psychiatrists, both per capita and overall. The problem is really an access to AFFORDABLE care due to lack of enforcement of federal mental health parity (non-quantitative limits) and "business of Medicine", priorities, which favor low cost rather than safety and meeting "quality of care" benchmarks. We made the point that nurse practitioners and other non-physicians are trained to work as part of an integrative team of professionals, not on their own. " Integrated" care is not the same as "Interchangable" care.

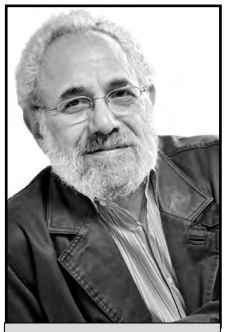
We were a diverse group of psychiatrists from multiple backgrounds and ages. We were the very last bill supporters to be heard by the House of Delegates on March 11th. The very next day, we got word that the state capital was closing early due to the coronavirus pandemic. That is the first time the state capital has closed this early since the Civil War!

I want to thank Delegate Dr. Terri Hill and the co-sponsor, Delegate Haynes, and our group of psychiatrists who took the time to give compelling testimony in support of this corrective bill. It is more important than ever for all psychiatrists to continue to show up for these legislative meetings, to express opposition to bills that worsen access to quality mental health care and that damage our profession.

The Psychological Fallout of the Pandemic As Illness and Death Increase

By: Michael B. Friedman, MSW and Steven S. Sharfstein, MD

The psychological fallout of the pandemic will change when illness and death become more widespread. We will have more direct experience of the hard realities of the pandemic. Increasingly, we will know people who are sick (perhaps including ourselves), and increasingly we will know people who have died (perhaps the people we love most in the world). As the reality of this hits home it is likely that more people will experience abject fear of death (call it "existential anxiety"), and more of us will be in grief, perhaps repeatedly.



Michael Friedman, MSW

How will we cope with this? Will mental health professionals be prepared to help?

Typically, spiritual leaders help us come to terms with mortality. But houses of worship are closed. Will using telecommunications to stay in touch with congregants and even to conduct services provide adequate solace?

Typically, people prepare for imminent death by gathering at deathbeds in homes or hospitals. This mostly will not be possible. Will vigils via video conference become the norm?

And, typically, people deal with grief in public ceremonies—funerals, memorial services, burials with friends and family in attendance, wakes, visits to the home of the bereaved. These critical ceremonies are now being stopped. How will people process grief when bodies pile up in makeshift morgues and then are dumped in mass graves? Also via video conference?

What can mental health professionals do? Fortunately, laws and regulations have been changed to permit and to pay for treatment via telecommunications. So—in theory--mental health professionals—psychiatrists, psychologists, social workers, and mental health counselors, especially grief therapists-- can help people to weather the emotions stirred up by imminent death, including grief.

But it will be a challenge to provide adequate comfort via telecommunications. Being physically present is its own kind of comfort. Will a talking image on a screen provide adequate solace? We will find out.

Will mental health professionals ourselves be prepared to deal with the existential anxiety and grief of the people we hope to help, especially when we too may be devastated by personal loss and fear of death? Do most of us have the skills we need?

In addition to directly treating patients via telecommunications, mental health professionals have been helping communities to help neighbors who are living in isolation, connecting volunteers with them via telephone and video conference. Mental health professionals help by training volunteers, by helping them process their experiences, and by providing clinical backup. This will require volunteers to learn how to have hard conversations that most of us shy away from— about mortality and grief.

Mental health professionals are also trying to help people cope with the psychological fallout of the pandemic by providing information—tip sheets—about how to cope. Mostly, it has been good advice, at least for educated people who are not overwhelmed by having lost their jobs and their savings. But it will need to be modified to reflect the changing realities. Now, for example, we are advised to get sleep. There will need to be advice for growing numbers of people who wake up in the middle of the night afraid that they are about to die or in tears as they remember those they have lost.

Steven Sharfstein, MD

Mass tragic experiences—wars, forced migrations, economic depressions, pandemics, and the like—are psychologically devastating. There are elevated rates of PTSD, depression, anxiety disorders, substance abuse, and suicide among people who live through them.

But in terrible times many people discover new strengths, new levels of courage, new reserves of compassion, and new sources of meaning. Hopefully, that will be true of us mental health professionals as we face these challenges.

Ed.'s Note: Michael B. Friedman, LMSW was the Founder and Director of the Center for Policy and Advocacy of The Mental Health Association of NYC and taught at Columbia's School of Social Work prior to retiring. Most of us already know of Dr. Sharfstein's long history of service to our community.

How COVID-19 Is Affecting Us: What Can We Do?

By: Shobhit Negi, MD

Shobhit Negi, MD

The recent outbreak of COVID-19 has gripped the world with apprehension. Our brains are on overdrive. We are constantly dealing with an invisible threat because we don't know who is infected. Anyone could infect us. We don't know how bad it will get or how long it will last. It's a global threat; no community is safe. Many amongst us are reckoning with individual losses, such as illness and death-- or loss of employment as a result of economic upheaval--or communal grief as we watch our healthcare, education and economic systems destabilize. All this is changing the way we see and perceive threat.

Princeton's Angus Deaton, winner of the 2015 Nobel Prize for economics, coined the term "deaths of despair," referring to fatal consequences associated with unemployment. He blamed the recently increased rates of suicide, drug overdose and alcohol-related liver disease on the changing economic situation. Every 1% increase in unemployment leads to a 3.5 % increase in opioid addiction. With the ongoing pandemic, we are seeing alcohol and drug use on the rise. Because the virus attacks the lungs, it poses a serious threat to those who smoke tobacco or marijuana; aerosols harm the lung and diminish the ability to respond to infection. COVID-19 endangers people with opioid use disorder and methamphetamine use disorders. Having a respiratory disease while abusing opioids increases the risk of overdose, due to diminished lung functioning. Methamphetamine constricts the blood vessels in the lungs, compounding the damage caused by the virus.

The gift of olfaction is one of the joys of life, which most of us take for granted. Food is more than just fuel; it is also one of the greatest pleasures in life. The madeleine memories triggered by taste are involuntary. Losing one's sense of smell and taste—as can occur with COVID-19—can be a huge emotional loss.

The American Academy of Otolaryngology-Head and Neck Surgery recently proposed that anosmia (loss of smell) with resultant dysgeusia (change in taste) be added to the list of screening tools for COVID-19.

The link between acute respiratory infections and mental disorders has been known since at least the SARS epidemic a few years ago. A year after that occurred, more than 40% of the survivors had mental problems, even though their physical symptoms had improved. The survivors experienced symptoms related to PTSD, depression, somatoform pain disorder (chronic pain due to psychological factors), and OCD.

It is sometimes necessary to deprive people of their liberty for the wider public good, but this is often contentious. "Quarantine" was first used in Venice in 1127 with regards to leprosy. People who are in quarantine may experience confusion, anger, boredom, and loneliness. Being quarantined in the company of a household member exhibiting symptoms, such as cough and fever, can worsen anxiety. Akin to stigma once associated with leprosy, COVID-19 has exacerbated xenophobia, hate and exclusion.

The global medical community is experiencing unbearable stress, knowing many COVID-19 patients die alone. Sadly, when patients infected with COVID-19 enter, the hospital, dies, and get transferred to a make-shift morgue, almost no relatives can be with them. Patients, day in and day out, beg to say "goodbye" to their close relatives, while gasping for air. COVID-19 has killed over 100 doctors and nurses around the world. Some healthcare workers have died by suicide. Some have had no time to process emotions due to the escalating number of cases. Some dread acquiring the virus while working in dangerous settings. Some are frightened of having to decide who gets a ventilator or an ICU bed. Some are being asked to live on less money despite increasing work demands. Many are putting the health of their own families at risk, and are being shunned by others for fear they are contagious. All these factors, and others, are emotionally burdening our health care workers.

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HOW COVID-19 IS AFFECTING US

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Times like these evoke a variety of reactions within us; many of which are natural responses to difficult situations. Displaying resilience- -the ability to bounce back, cope with adversity, and endure during difficult situations- -is ordinary, not extraordinary. For centuries, people have demonstrated this ability. The world has survived several notable pandemics, including the Black Death and the Spanish flu. Using supportive resources to address stress is a critical component of resilience.

Psychological first aid (PFA) is a crucial early intervention that focuses on mental health of the affected survivors by providing psychosocial support during outbreaks. The Johns Hopkins PFA tool consists of the 'RAPID' model. It is an acronym standing for Reflective listening, such as paraphrasing with empathy; Assessment of the current presentation, primarily assessing cognitive capacity, affective expression, social adaptability, interpersonal resources and readiness for intervention; Psychological triage, prioritizing attending to severe versus mild reactions; Intervention, using cognitive and behavioral interventions to mitigate acute distress; and Disposition, consideration of next steps, including facilitation of access to ongoing care.

We need to take adequate care of ourselves because that is the only aspect of life we can truly control. Because we are being constantly bombarded with news we need to be mindful of the source. We should develop a routine—writing down our worries, talking through our fears by challenging those that are irrational, and using grounding techniques (like the 5-4-3-2-1 one for anxiety), communicating with our loved ones by phone, text, social media or video, utilizing meditative practices (like guided meditation or listening to calming music), staying physically active while practicing social distancing, etc.

It is tempting to develop "mental myopia" during stressful times, allowing one major facet of today's reality to occlude our view of what is going on. At this vital moment in history, we can either let the pandemic-induced stress make lyrics of a Pink Floyd song, Time, "shorter of breath and one day closer to death" come true, or adopt a stress-is-enhancing mindset, which can have positive consequences for our health and our work performance.

Coping With Insurance Networks

By: Robert Herman, MD

Robert Herman, MD

In February I attended a meeting with two of our state delegates—Bonnie Cullison and Ariana Kelly-- and representatives of other mental health professional organizations, including psychologists, social workers, counselors and occupational therapists. It concerned how private health insurance networks are functioning. The discussion was very spirited. The delegates were very interested and seemed genuinely surprised at some of the things that we told them about our experiences.

Our experiences with private health insurance companies remind me of the old joke about bad restaurants; the food is not very good and the portions are too small. Health insurance companies do not reimburse mental health providers well, and the administrative burden of getting paid is enormous and time-consuming, so that accepting private health insurance does not work financially for many of us. We often are in solo practice or in small groups so we have little bargaining power against these enormous companies. It's often too expensive to hire professional billing staff who are able to collect the money that we are due. Insurance companies pay practitioners of different medical specialties different rates for the same procedure codes. They also pay clinicians in the same specialty differently—for example, if they are solo practitioners versus members of large groups. We are not able to compare notes because reimbursement rates are confidential and protected by antitrust laws and confidentiality agreements. We heard examples of clinicians who left large groups to form small practices; their rates were cut substantially for exactly the same procedure codes done by the same person.

Insurance companies make it more difficult for psychiatrists, compared to other physicians, to become members of their networks. Their credentialing process is onerous-- and more complex than for other physicians. Insurance companies typically will credential "any willing provider" for most medical specialties, but will only allow a limited number of psychiatrists, psychologists, etc. to become credentialed, then will close their panels and not let others sign up. Their lists of participating providers are often out of date and patients spend many

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COPING WITH INSUANCE NETWORKS

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hours calling them, only to find they are no longer in the network or are not accepting new patients. Insurance companies may change their polices without informing everyone what they have done.

Patients are caught in the middle in this war between mental health practitioners and insurance companies. if they try to find a provider who accepts their health insurance, they often have to wait months for an initial appointment. This is often impossible for families who are in crisis. Many of them therefore must go out of network and pay a provider directly, so they are paying insurance premiums to the insurance company, which can then pocket the money, and they are also paying fees to get the care they need. Insurance companies make it very difficult for patients to get reimbursed for out-of-network care.

The need for mental health care is continuing to grow. Rates of suicide are increasing. The opiate crisis is not going away.

Is there any solution to these problems? It will require efforts on the part of insurance companies, professional organizations, individual providers, and legislators. It is unlikely that clinicians who already have full practices of self-paying patients will be tempted to participate in insurance networks. Younger psychiatrists may perhaps be convinced to sign up if reimbursements are increased and administrative burdens are reduced. Forming larger group practices, with more negotiating power with insurance companies and competent administrative staff that can collect from insurers, may also be part of the solution.

The meeting ended with the two delegates thanking us for our participation and indicating that they plan to communicate with health insurers to see if there are legislative solutions to these problems. We and our patients and their families need to help propose solutions to give our patients better access to affordable mental health care.

The True Purpose of Medicine:

Advice for Medical Students

By: Margaret Chisolm, MD

Margaret Chisolm, MD

(Ed's Note: This is a version of the article published in Public Discourse—the Journal of the Witherspoon Institute—on August 28, 2019.)

As you enter the medical profession, I encourage you to "start with the end in mind" by studying the Hippocratic Oath. It articulates the true aim of medicine, guiding physicians to provide treatments that align with its purpose and so are right for a doctor to do, and to refuse to provide treatments that go against it and are wrong for a doctor to do.

Someone once asked anthropologist Margaret Mead, "What is the first evidence of civilization?"

She answered, "A healed femur." She pointed not to a grinding stone or a religious artifact or a weapon, but to a healed thigh bone found in an archaeological site that was 15,000 years old. Why? The femur is the longest bone in the body and takes about six weeks of rest to heal. To survive a broken femur, this early human would have needed someone to provide food and drink, shelter, and physical protection for many weeks. Thus, the first indication of civilization is the provision of care over time for an injured person.
As medical students, you are entering into a profession that has its origins in the very beginning of civilization. In the ancient world, only four occupations were considered professions: teachers, lawyers, priests, and physicians. These are characterized by a fiduciary relationship--the professional is in a privileged position relative to the other party. All required a public promise—a *profession*—in the form of an oath. In a few short years, you will also profess an oath to a vocation of healing and comforting. Regrettably, the oath you will profess will almost surely not be the one written by Hippocrates, which for millennia described the noble purpose of medicine and guided its practice.

Nevertheless, I encourage you to "start with the end in mind" and study the Hippocratic Oath. He is the best guide you can have in your journey. The oath continues to capture the essence of what it means to be a doctor and will teach you how to act toward your teachers (and later your own

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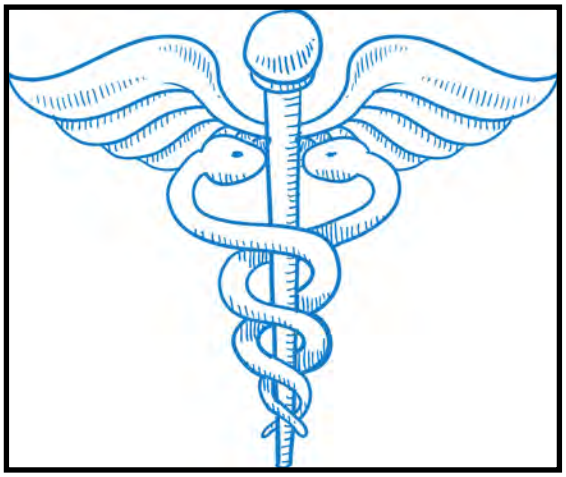
students), as well as your patients and their families. It guides physicians to provide treatments that align with the purpose of medicine and so are right for a doctor to do, and to refuse to provide treatments that go against this purpose and are wrong for a doctor to do.

So, what is the purpose of medicine? Physician and scholar Leon Kass has suggested that it is neither the gratification of the patient, nor the improvement of personal virtue or public order, nor the alteration of human nature, nor the prevention of death. Rather, it is simply the pursuit of health, defined as the "well-working of the organism as a whole."

You will need to consider whether what you are being asked to do, either by your teachers or by your patients or their families, is oriented toward this purpose. Your work is a calling, and it is a sacred one: "to cure sometimes, to relieve often, to comfort always." In seeking to cure, you will need to ask yourself if the side effects of the proposed treatments are disproportionate to the benefits or, in seeking to relieve suffering, if the measures are properly oriented towards well-working.



You may be asked to do things that are morally wrong. Freedom means you can live in accordance with what you think is right (and wrong) and so to take conscientious actions. It is central to your well-being. Because you can conscientiously object, you can choose to take only conscientious actions. Doctors refuse things that patients request all the time—antibiotics for viral infections, growth hormones for mildly short stature, opioids beyond an amount necessary for pain control—without any professional censure for these actions. Therefore, refusing to provide a medical service that you think is wrong almost always represents a dispute about the purpose of medicine. So, again, study the Hippocratic Oath! The only way to know that you are not cooperating with a corruption of the duties of a doctor is for you to know the purpose of Medicine. Are your actions oriented toward pursuit of the patient's health?

As you work to provide the best possible medical care for patients, know that there are a great number of protections for healthcare professionals. The Health and Human Services' (HHS) Office for Civil Rights now has a division of Conscience and Religious Freedom, dedicated to restoring enforcement of protections against coercion or religious discrimination for any entity that receives HHS funds, such as Medicare and all residency training programs that receive HHS funds. Protecting the pursuit of health—and life—for your patients may not always be easy, but it is essential. Your patients need to trust that you are dedicated to preserving and restoring them to health, and not dedicated to intentionally hastening or assisting in their death. This trust is the cornerstone of the doctor-patient relationship.

You are also entrusted with grave responsibility by society, which will have invested about $2 million in your education and training. You will be expected to be available to attend to a sick patient irrespective of their personal characteristics, treating justly all who seek your care; this may include rapists, bigots, and enemy soldiers. You will join a community whose members hold one another responsible for their actions. This can become problematic when doctors become more concerned with the secondary goods—money, prestige, honor—of medicine.

You will be introduced to the human body via an encounter with a dead body—a cadaver—in gross anatomy lab. Even so, you must remember that health is a functional capacity and not merely a structural one. Starting medical school by studying a dead body may convey a false notion of the purpose of medicine and your role as a doctor. It suggests that the purpose of medicine is the maintenance and repair of a physical object—the body—rather than the pursuit of health, and that the role of a doctor is one of a technician rather than a professional.

You have each received a privileged gift, one that is meant to be used in the service of others. Become aware of the legal protections available for you to act according to your conscience. Understand that you are being trusted by your patients and society to use your gifts—in combination with a balance of science and charity—to be the best clinician *for* the world. And remember that the pursuit of health itself, although an excellent purpose, is not the greatest good. The greatest good, for both our patients and ourselves, is leading a moral and worthy life.

The author thanks Drs. Farr Curlin and Aaron Kheriaty for their contributions to these ideas on the purpose of medicine, as discussed at the recent Medicine as Moral Practice conference sponsored by the Zephyr Institute.

Cheers From The Chair

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

Jimmy Potash, MD, MPH

Ed's Note: Edited excerpts from two recent columns—among many—Dr. Potash sent to Hopkins faculty.

4/3/20

When in April the sweet showers fall

That pierce March's drought to the root and all

And bathed every vein in liquor that has power

To generate therein and sire the flower...
--Geoffey Chaucer, *The Canterbury Tales*, 1400

In Chaucer's time and in ours, April has typically been a "sweet" month, one in which the showers fall, the flowers bloom, and life is regenerated and reinvigorated. It didn't feel that way to T.S. Eliot, writing in the wake of the disaster and carnage of World War I, when he composed the oft-quoted first line of *The Waste Land*: "April is the cruellest month..." This year, while we smell the sweet scents of the daffodils and the cherry blossoms in the wind, we also worry that the cruel virus might be floating through the air.

Some people see disaster and run towards it. One of them is Dr. Crystal Salcido, who graduated from our residency two years ago and is currently a post-doctoral fellow. In July she is scheduled to start a clinical position at Howard County General Hospital, while continuing research in a part-time role. Last night, she reached out to me and to Howard Chair, Dr. Andy Angelino, asking if she could obtain clinical privileges early so that she could be of help.

There is a field of disaster mental health, which I learned about in 1988 when I took a course in the Hopkins School of Hygiene and Public Health (the word "hygiene" is clearly making a major comeback!). Dr. Bruno Lima, taught it, and he was a community psychiatrist in our department, whose research focused on emotional distress following disaster in Ecuador and Columbia. Sadly, he died at an early age, and the APA's award in disaster psychiatry is now named after him.

Another of our psychiatrists who ran towards disaster was Dr. Mickey Kaminsky, who went to Louisiana with a team from Hopkins to help respond to Hurricane Katrina. Dr. Kaminsky also joined forces with psychologists Lee McCabe and George Everly to publish a number of papers in the *International Journal of Emergency Mental Health* on preparing for the psychological aspects of disaster. Drs. McCabe and Everly co-authored one paper in particular in 2009 that is especially relevant to our situation today: "Preparing for an influenza pandemic: mental health considerations." In that paper they refer to "the types and distribution of psychological ramifications that will likely attend such a crisis—one-third of the population [emotionally] unaffected, one-third hyper-vigilant, and one-third immobilized." They also point out that "the psychological wellbeing of healthcare workers is crucial to a successful response to such a crisis. If it is ignored, those whose services that are needed the most at that time may be unavailable." One of the elements facilitating this wellbeing is "feeling well-equipped and protected." In that vein, I am so pleased that Johns Hopkins Medicine announced that, effective today, "all employees will be required to wear a surgical, procedural or cloth face mask while working across any of Johns Hopkins Medicine healthcare facilities." This is just what the doctor ordered in terms of morale in our department, and many others.

There is some sweetness in the air, though it may be hard to detect with our face masks on. Not all of us will be people who run towards disaster, but let us all at least stand our ground. Let us be like the April rain, infused with power, and life giving.

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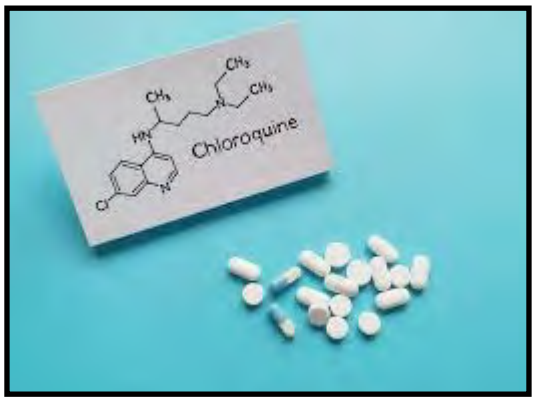
4/10/20

I took chloroquine for two years when I lived in Senegal in the 1980s, and I remember my fellow Peace Corps volunteers talking about having unusually vivid dreams, which they attributed to the drug. Some of my friends were concerned about this mind-altering effect, though most considered it a small price to pay for staving off the potentially lethal effects of malaria. Later, as a Peace Corps doctor, I would learn more about the neuropsychiatric side effects associated with this medication, which was first systematically shown to be effective in preventing and treating malaria in the 1940s. Then, as a psychiatrist, I took care of a patient who had earlier suffered a chloroquine-induced psychosis while overseas. This type of side effect has been described since the 1960s in journals like the *Lancet* and *JAMA*. Similarly, the closely related drug hydroxychloroquine, used to treat autoimmune diseases, has also been reported to cause psychosis and other psychiatric side effects.



Most of us in this department and at Johns Hopkins understand the difference between enthusiasm about a potential treatment, and strong evidence that a treatment works. In fact, Hopkins Medicine was founded on the idea that scientific rigor was essential to the advancement of the field and to the provision of high-quality care. With regard to chloroquine, its efficacy was demonstrated in a 1947 study in which "volunteers" were infected with the malaria parasite, and then the medication was given to one subset, while two other antimalarials were given to the others. Chloroquine treated the malaria, and cleared the parasite from the blood more quickly than did the other drugs. I will note that the "volunteers" were drawn from Stateville Penitentiary near Chicago, and it is hard to imagine that they all freely chose to participate in this study. The important step of creating Institutional Review Boards to protect the rights of people who engage in research studies didn't come until the 1970s.

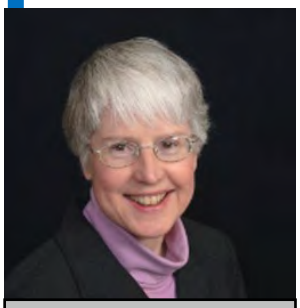
Good clinical ideas have to be tested before we can pass judgment on them. One such idea is prone ventilation, the idea of turning patients on ventilators over, so that they are lying on their stomachs, as a way to improve oxygenation in Acute Respiratory Distress Syndrome (ARDS). Our Director of Nursing, Kelly Caslin, recalls the first time she flipped a patient. She had great trepidation, but it worked—the oxygenation level rose. Meta-analyses of controlled studies have shown this reduces mortality when applied for at least 12 hours a day. This approach is likely helping as JHH manages patients who have COVID-19. Fifteen of them who have required ventilator support have now come off of it and are recovering. As Associate Professor Joe Bienvenu has shown in studying patients with ARDS, about half of these patients will experience anxiety, depression, and PTSD symptoms over the next several years. Associate Professor Karin Neufeld has also done work on how best to detect these symptoms in patients like this. Dr. Adam Kaplin will be providing psychiatric support to the Pulmonary team that has set up a clinic for patients who have recovered from severe COVID-19 illness.

My closest friend in Senegal, Beydi Ba, was a neighbor and work partner in the rural village I lived in. He had grown up in a tiny village with no electricity or running water, living in a mud hut with his material wealth amounting only to a horse and wagon, and a few sheep. Beydi had never learned to read or write. Yet he was smart and insightful, and had an uncommon level of wisdom. Disaster had befallen Senegal a few years before I arrived, in the form of drought, which had resulted in people going hungry in this farming-based economy, and in parents desperate to feed their children. As we discussed what it had been like during this crisis, Beydi said to me: "You think you understand people's character. But you actually don't. Not until you see how they respond when things get truly difficult. That's when you learn what people are r*eally* made of."

I have been learning a lot about what so many of you are really made of. And I am immensely impressed by it. Thank you all for being the kind of people who respond to crisis with the qualities that have always distinguished this department and this institution--with reason and rigor, with compassion and caring, and with grit and good nature. You are a true dream team!

On Being Disposable

By: Annette L. Hanson, MD



Annette Hanson, MD

According to the Maryland legislative calendar, April 6th BC (Before COVID-19) was supposed to be Sine Die, the last day of the legislative session. That means to adjourn "without assigning a day for a further meeting or hearing." It's the legislative equivalent to saying, "Hasta la vista, baby!"

Sine Die takes on a darker meaning in the days of a global pandemic. When there is no definite future date to meet, there is the sense that we all may or may not see other again. This is a feeling I've had frequently lately, usually right after a video chat with friends or family. Being in what one some people tactfully call a "high risk age group," I find myself mentally calculating not only the risk of infection, but also the risk of dying from it.

I work in two state facilities where the outbreak has already taken hold. My private practice colleagues ask me if I'm still going in to work, and why I don't transition to telehealth like the rest of the psychiatric world. There is an implication that I somehow see myself as either invulnerable, irreplaceable, or indispensable.

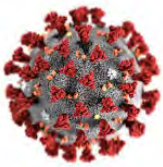
None of those adjectives apply. Some psychiatric care can only be provided in certain settings, and under certain conditions, that require a personal touch. My inpatient hospital colleagues need support. With staffing shortages, some of my colleagues are now performing non-physician patient care duties like supervising fresh air breaks and meal distribution. Within the prison, no infrastructure exists for direct face-to-face evaluations through telehealth.

In both settings, there is a shortage of personal protective equipment. The little equipment that exists is being distributed on an as-needed basis, with instructions to make it last as long as possible.

From what I've learned from out-of-state colleagues, this is the situation in many state institutions where public health measures seem to be the last thing on the government's to-do list, particularly when the patients involved are some of the most marginalized members of our community. Advocacy groups like the ACLU have successfully lobbied for the release of older prisoners and those with underlying health conditions, but states are simultaneously threatening to incarcerate people who violate stay-at-home orders. There is no arguing with this kind of government logic.

Fortunately, I know I have the backing of my friends and "family" in the MPS. In a letter to Governor Hogan, our organization outlined specific interventions that will decrease my personal risk as well as the risk of all institutionalized people. In return, MPS received a personal response from the Secretary of Public Safety, Robert Green, which listed a point-by-point response to our concerns.

No one will feel entirely comfortable again until the pandemic is over. Until then, it's good to know that the MPS is willing to step up to remind government agencies that no one is disposable.



Delivering Critical Care During COVID-19

by Harsh K. Trivedi, MD, MBA, President & CEO &
Todd Peters, MD, VP & Chief Medical Officer, Sheppard Pratt

The COVID-19 story that's emerging is a shared experience for physicians throughout the state, region, and country. We rely on each other to provide the care and services to meet the needs of those we serve, to share knowledge about what we are learning each day, and to help us shape public policy. COVID-19 has presented new and unique challenges daily. We begin by thanking our incredible team of doctors, nurses, therapists, and multi-disciplinary care teams across the state.

Harsh K. Trivedi, MD, MBA

With the need for behavioral health services greater than ever, we recognize the importance of remaining open and providing access for those who need our care and services. Sheppard Pratt has more than 380 sites across the state, more than 160 programs in 16 Maryland counties, and 5,000 employees. We need to support everyone on our team so that patients and clients continue to receive the care they need.

Maintaining Access to Life-Saving Care

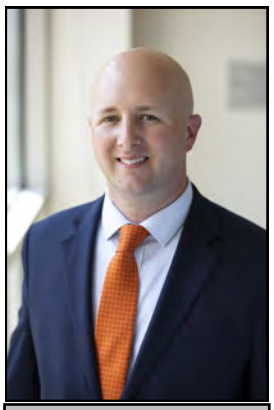
From running treatment teams, to managing groups and therapeutic environments, we have had to innovate and reimagine what our care and services look like, in order to maintain access and ensure the highest quality care.

In our hospitals, we have looked closely at managing our therapeutic environments to maintain social distancing—from rearranging and eliminating furniture to changing the size of our therapy groups. We have also developed a personalized approach that differs from patient to patient. To maintain contact and communicate with families and to conduct family therapy, we are utilizing video/phone. Our providers are currently utilizing a modified staffing schedule of 7 days on/7 days off, with one provider on a unit at a time and another provider that is supporting off-unit via telehealth.

Most of our community-based program sites remain open for in-person appointments and walk-ins, though some of our day programs are not. We have redeployed those staff to check on clients in their homes, and to help them manage food, shelter, and medications. For our clients who are unable to leave their residences and community locations, we are providing in-home medication administration and injections. We are also now producing breakfast and lunch at each of our day program facilities and distributing meals—13,000 per week-- in our communities to our most vulnerable across 200 supportive housing locations. We are certain that we are keeping thousands of people with serious mental illness alive and helping them remain safe. A meaningful victory thus far has been preventing any outbreak of COVID among our many elderly and medically frail SMI individuals.

Expanding Access to Care

Telehealth has expanded across the state and country in response to COVID-19. We see it as a critical component for mental health care. All of our mental health and addiction services are now virtual, including our intensive outpatient services. We have increased our telehealth services to support some of our most vulnerable populations during this time and to meet them where they are. This week will mark the completion of 25,000 outpatient telehealth visits.



Todd Peters, MD

We also launched our Virtual Crisis Walk-In Clinic as an alternative for those seeking emergency psychiatric care. It provides those in crisis with an online mental health assessment and then connects them to the most appropriate level of care and services. This can help decrease the volume of psychiatric patients in emergency rooms, which is integral when hospitals are taking care of patients with COVID-19. In the first three weeks since its launch, our virtual crisis clinic provided over 350 crisis evaluations and urgent follow-up appointments for medication management or psychotherapy.

The Retreat, our premier program for mood disorders and substance use, is now offering a virtual program in light of the COVID-19 pandemic.

The continued uncertainty surrounding COVID-19 has caused many people to evaluate the impact of anxiety, OCD, and related disorders on their daily lives. Now more than ever, there is a need for dedicated programs and expertise that treat OCD and anxiety. The OCD and Anxiety Center of Greater Baltimore re-

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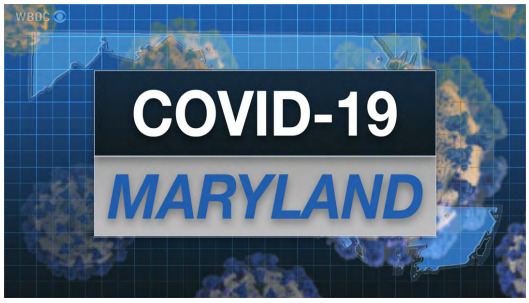
cently joined Sheppard Pratt to help more people get the specialized and compassionate care they need. It reduces the barriers to getting treatment for OCD and anxiety disorders.

We have also hired more than 50 psychiatrists within the last year to help ensure greater access to care, which is crucial. Our new colleagues will help augment our in-person and virtual care services across all of our service lines, including our coverage of our school-based services, inpatient and day hospital services, OCD-related services, eating disorder service line, Retreat-based services, and our Crisis Walk-In services.

Supporting Staff in Uncertain Times



As we adapt to the changing circumstances of COVID-19, it's important to ensure our employees have timely and accurate information. Our executive leadership team has been hosting daily calls with more than 200 leaders in our organization to share information, in addition to conducting regular communication with all employees. This current situation is a marathon, not a sprint. It's important for everyone to remain calm, to work as a team, and to support each other.

We are also encouraging all of our employees to look after themselves and to pace themselves, as our COVID-19 response will likely last for weeks or months to come. We have provided numerous self-care resources for employees and their loved ones, are encouraging use of our Employee Assistance Program as well as setting up new telehealth counseling resources for our staff, and are offering free groups for employees, led by Dr. Michael Young. We have also provided our leaders access to coaching resources to help them lead and to support their staff.

Advancing Our Field and Sharing Our Knowledge

We are focused on advancing our field and sharing our knowledge with professional colleagues in many ways. We have participated in several webinars with the APA, the American Hospital Association (AHA), National Association of Behavioral Health (NABH), and National Council to provide information on how we've re-engineered care processes and adapted and innovated our treatment programs. We have also re-launched virtually our grand rounds, known as the Wednesday Lecture Series, with Dr. Gonzalez-Heydrich of Harvard Medical School discussing "The Future of Pediatric Psychopharmacology: Insights from Pediatric Psychosis and the Genome." Our lecture series is open to all and will utilize our e-platform for registration, pre- and post-tests, and to receive free CME credits.

We are also contributing to the broader field by advancing psychiatric knowledge. We are putting the finishing touches on the next edition of the APA Textbook of Hospital Psychiatry, which will compile the latest trends, issues, and developments in the field of hospital psychiatry. Our research portfolio continues to grow with the announcement of Dr. Scott Aaronson, director of clinical research, leading three new Sheppard Pratt clinical trials involving psilocybin.

In addition, we have created a virtual "Lunch & Learn with Sheppard Pratt" series via Facebook Live to provide tips and resources to the general public during May's Mental Health Awareness Month. We have also participated in a "Community Conversation" webinar with *Baltimore Magazine* to discuss how people can cope with anxiety, depression, and isolation.

When the pandemic subsides, it will be more important than ever that mental health and substance use programs are open and accessible. We must all be there to support those who may be facing mental health challenges made even greater by the fears, uncertainties and self-isolation of COVID-19. Our collective services are needed now more than ever.

REMEMBRANCE:
Joseph Bierman, MD

By Bruce Hershfield, MD

Joseph Bierman, MD

Dr. Joseph Bierman died on May 17th at age 93. Originally from St. Louis, he attended medical school at Washington University, interned at Maimonides Hospital in Brooklyn, and did his first two years of psychiatric training at Washington University-Barnes Jewish Hospital. He then came to the University of Maryland to finish his residency because he also wanted analytic training. He studied adult and child psychoanalysis at the Baltimore-Washington Institute, where he then became a training analyst. He worked at University's Child Study Center and was also a consultant to the Family and Children's Service from 1959-82.

He practiced in the Baltimore area for many years. Through his teaching and supervision, not only at the Institute but also at Hopkins and University, he had an important influence on our psychiatric community.

Jay Phillips, MD commented, "Joe Bierman was a leader of the Baltimore-Washington Institute for Psychoanalysis, with a unique stature as a child and adolescent analyst. He was a careful and rigorous thinker, who encouraged students to think first for themselves about what their patients were struggling with in clinical moments, and what they were trying to communicate with symptoms of all kinds. He modeled an analytic stance of accepting the patient's point of view as the starting point of every encounter, believing deeply that working to understand the elements of patients' problems was the best way to help. As a mentor, he was unfailingly kind and generous. He understood that the private emotional life of the therapist would always influence what could be understood about a patient and how well understanding could be conveyed. He showed us the value of trying to reach the highest standards of clinical sophistication."

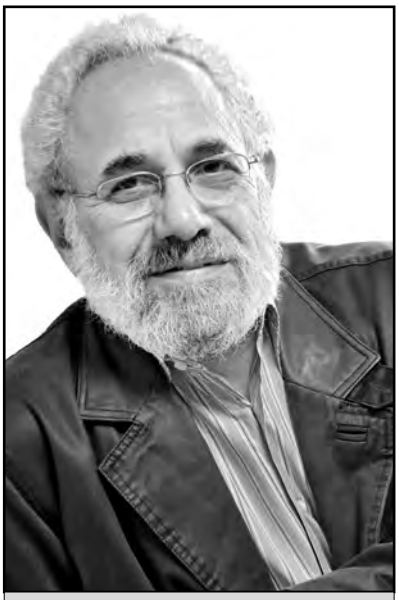
William Wimmer, MD commented, "Dr. Joseph Bierman served as my advisor, teacher, and supervisor during the years I was a candidate in the Adult and Child programs of the Baltimore-Washington Psychoanalytic Institute. Until my graduation from both programs we were 'Dr. Wimmer' and 'Dr. Bierman'. Following my graduation, we became 'Bill' and 'Joe' and I learned of his warmth, compassion, and passion for promoting the welfare and mental health of children and adolescents.

Joe's organizational skills and attention to detail were extraordinary. I remember fondly when he recruited Allan Gold, Bob Lessey, and me to explore the effects of movies on young children. We cobbled together a program, during which we showed clips from the likes of 'Nightmare on Elm Street', 'Gremlins', 'Bambi' and 'Lion King', followed by discussion. Eventually, thanks to Joe's commitment and encouragement, we published a paper entitled "Effects of movies on children's emotional health." The article is just as timely today as in 1996.

Perhaps Joe's most important contribution to Psychiatry and Psychoanalysis was his unwavering devotion to truth and absolute integrity in all things. He will be sorely missed."

Put Ideological Differences Aside:
Unity to Improve The Mental Health System

by Michael B. Friedman, MSW



Michael Friedman, MSW

Vituperative ideological divisions among mental health advocates impede us from achieving major improvements in our mental health system.

Some advocates would limit the rights of people with serious mental illnesses for their own good and for the safety of society. They believe in expanding the use of coercive interventions, especially involuntary outpatient treatment, which they usually refer to as "assisted outpatient treatment." They also generally believe that deinstitutionalization went too far and that many people with serious mental illness would be better off in hospitals than in jails and prisons or homeless on the streets. They, therefore, advocate for increasing the use of both short and long-term psychiatric hospitalization.

Opposing advocates argue that to protect people with serious mental illness from homelessness, we need more housing, and that to keep them out of jails and prisons we need extensive criminal justice reform. These advocates maintain that there would be little need for coercive interventions if there were expanded outreach and engagement efforts. In addition, they often point to the horrendous history of abuse that occurred in state hospitals and argue that if more "recovery oriented" and "person-centered" community-based services were available, fewer people would need inpatient services.

No doubt, both perspectives are well-meaning and have some merit. Unfortunately, in the battles to get major legislative changes, advocates with these different ideological convictions neutralize each other. At best, we end up with incremental improvements. Often, we get window dressing—such as new administrative structures—or compromises that are largely self-defeating—such as getting expanded Medicaid coverage of psychiatric hospitals, but only for relatively short stays. Major change is rare.

Despite the ideological divide, there is a remarkable degree of agreement among mental health advocates about needed improvements.

What do we agree about?

•Fewer than half of the people with mental or substance use disorders get treatment that might be beneficial. We need to increase both service capacity and improve access to service.

•Most people who get medical treatment for psychiatric disorders get it from primary care physicians, who provide "minimally adequate care" less than 15% of the time. Those who get treatment from mental health professionals get treatment that is minimally adequate-- let alone, of high quality—less than half the time. We need major improvements in quality of care.

•"Fragmentation" within the mental health system and among mental health, substance abuse, and physical health providers is unfortunately common. We need, and frequently call for, improved integration of care.

•Hundreds of thousands of people with serious mental illness languish in jails or prisons. We need extensive criminal justice reform.

•Hundreds of thousands of people with serious mental illness are homeless. They need housing and support to remain securely housed.

•People with serious mental illness have lower life expectancy, poorer health, and less access to medical services. Mental health policy needs to address physical, as well as mental, health.

•Suicide is on the rise. Comprehensive measures are needed to reduce its incidence.

•The so-called "opioid epidemic" also requires a comprehensive response.

•Many people with long-term psychiatric disabilities do not get the supports that they need to have satisfying lives in the community. Greater investment in community support services is essential.

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Put Ideological Differences Aside

(Continued from page 16)

•Much housing and care for people with psychiatric disabilities is provided by family caregivers, who do not get the support they need. They need more support services—such as respite--and more benefits—such as tax relief.

•Despite the large growth of minority populations, mental health services are often not "culturally competent". We need to build culturally competent service systems that include effective outreach, public education, and empowerment of minority providers.

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•Little has been done to prepare for the "elder boom". In a few years, older adults will outnumber children. It is time to build a "generationally" competent behavioral health system for older adults.

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•There is a vast shortage of mental health professionals, particularly those with expertise with children, with minorities, and with older adults. We need a far more effective effort to build an adequate professional, and paraprofessional, workforce.

•

•In addition, improved financing is absolutely critical. This includes both increased funding for behavioral health services and substantially redesigned funding mechanisms.

This is a daunting list. None of it will be easy to achieve. The political divide in America, the debates about how to structure and finance our health care system, and the sheer lack of interest in mental health issues all make it difficult to bring about meaningful change.

But the great ideological division among mental health providers makes it even more difficult to achieve anything other than pitifully small steps.

It is time for advocates to put these differences aside and unite to work for goals we all agree on.

How I Help Patients Sleep

By: K. Hogan Pesaniello, MD

K. Hogan Pesaniello, MD

Difficulties with sleep are common in psychiatric practice. Due to the emphasis on short term use of hypnotics, and concerns about long term effects of anticholinergics, as well as importance of deprescribing as patients age, I've been interested in any non-medication techniques I can use to minimize use of CNS depressants to accomplish sleep onset.

I encourage exercise, coach patients in eyes-open relaxation skills, train them to use progressive relaxation and breath strategies, and teach them to eliminate blue light in the evenings. I discuss and encourage sleep hygiene measures (same to-bed and rising time each day, not doing other activities in bed --like reading, avoiding caffeine after morning, having a bedtime ritual, etc.). I evaluate for mood and sleep disorders in case primary mood disorders or sleep apnea need to be addressed, or a sleep study ordered. It is also important to consider medical problems interfering with sleep. (GI or bladder issues, hypothyroidism or menopause, for example.) And it is essential to assess and address psychological issues contributing to over-arousal, like unprocessed trauma, and as needed, consider the z-hypnotics or other psychotropics like amitriptyline or --rarely-- neuroleptics or benzodiazepines for short term use. When weaning the Z-meds, I usually wean down part of the dose one night every three nights for a few weeks, then two nights every three nights for a few weeks, then stay on the lower dose for a few weeks. Then I have patient wait to take the med until they have given themselves 30 minutes to fall asleep, as described below. These are common practices for most psychiatrists.

Even when we have done all the above approaches, patients still may need to learn to consciously calm themselves and shift their state in preparation for sleep. Without these skills, some patients will be prone to continue to rely on medications to get them to sleep. As I attempt to wean them off hypnotics or other psychotropics that have been helping them sleep, I know it is important to make sure patients actually know how to quiet their mind and encourage the slow waves of pre-sleep and sleep to dominate. Patients are often fearful about weaning off medications that help with sleep, and that anxiety can interfere with sleep onset. One option is to encourage patients that they CAN take

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their "sleep medication,' but delay taking it a bit. If they are not sleeping in 30 minutes, THEN they can take it if they want. They can keep it by their bed but begin to practice every night for some period the mindful practices below before taking it. And eventually see if they can wait at least 30 minutes before taking their pill. Eventually they may well be able to fall asleep increasingly and skip the sleep medication more and more nights, and naturally wean themselves, with your guidance.

Below, I will describe how I approach sleep onset / interruption issues with a supportive psychotherapeutic approach. (These are mindful approaches to quiet the "busy mind" that interferes with sleep onset or getting back to sleep in over-aroused patients.)

I have found these simple instructions can help patients learn to improve their brain regulation so that they can learn to shift themselves into a state that helps induce sleep. I am providing this information in a format that you can share with patients:

MINDFUL FOCUS FOR INDUCING SLEEP or DEEP RELAXATION:
Focus gently -- but intently and exclusively-- on one or more of these very relaxing mindful activities, resisting the impulse to stop focusing on them when your mind starts to wander. If bored or wavering, shift to another focus or add another while maintaining the one you are getting bored with. As the brain becomes more relaxed, thoughts can become less linear, and more "drifty". At this point, make sure you resist the drift toward active thinking by refocusing a little longer on just these:

RELAX ALL OF YOUR BODY like you are floating on water…Let go with all joints, let your body from head, neck all the way down to your toes, be loose. Imagine the "letting go" of your body that you do when floating on your back in water…. Maybe imagine the sounds of the water, the feel of water below and air above… Your body rising slightly and falling slightly as your breath comes in and out. Some time when you are in a pool or lake or ocean, study the floating so you can remember it when trying to fall asleep.

SLOW YOUR BREATHING like when you practice the coherence technique of doing Heart Rate Variability (HRV) biofeedback training…. "Heart focus"(Imagine your heart in the middle of your chest.), "Heart breathing" (Imagine your breath flowing in and out through your heart.) and "Heart feeling" (Putting your mind on something that gives you an inner smile.)…and remember to let your breath be soft, quiet, just a very slow trickle – You hardly need much air when you are lying down- - Breathe as slow and soft and long as you comfortably can. How slowly, softly, and gently CAN you breathe? You may be able to slow it down to two or fewer breaths per minute, if you really let it slow to a mere trickle. Remember, you don't need to move a lot of volume, you don't need a lot of air when resting like this. Slow your breath WHILE relaxing like floating….

WARM YOUR HANDS AND FEET: Imagine feeling warmth on your hands and feet. Imagine the actual sensation of heat as if your hands were pointed toward a nice fire, or healing glowing heat waves are coming from your hands and feet, or imagine the sensation of putting your hands and feet in warm sand on the beach, or into a nice hot bath…Imagine them getting hot and even sweaty, heavy and full with the warmth…During the day, you can practice doing this with a hand stress thermometer ($25 online from AMAZON), until you can raise the temperature with biofeedback, but biofeedback is not necessary. It just can help you learn this skill efficiently.

PUT YOURSELF IN A SAFE PLACE for the night: A safe, uncomplicated place, like on a rock by a stream, in a favorite room or library, in God's hands (no worried prayers, just in God's protection for the night, if that works for you), in a safe protective bubble of favorite soothing color…

SEE IN YOUR "MIND'S EYE" A RESTFUL HYPNOTIC IMAGE: Watching snow fall outside through a large picture window on a quiet night…feel the hush and watch the snow swirling and the blanket of snow collecting. Or imagine wind blowing over a prairie of grass, or through a large tree. Or watch the waves of the ocean. Imagine watching clouds on a starry night, lying in a cozy tent. Raindrops falling into a pond or puddle, or a downpour observed from a cozy couch from dry inside…

Now the KEY to using these mindful focus ideas for quieting your mind and lowering your arousal is to KEEP YOUR ATTENTION ON THESE FIVE STEPS ONLY. If your mind starts to wander to busy itself on other topics, or drift to negative topics, imagine sending those topics to a box or bulletin board for some other time, and return to focus entirely on one or two of these steps…You can change what you pay attention to, but only to one of the other steps…or try to do all four at one time….and as your mind starts to drift, try not to stop the slow breathing and letting go….you might even say "Stay awake!" to yourself and try to do it for one more minute before falling asleep…Just note its's starting to work as you start getting drifty. At that drifty point it is easy to stop keeping your mind on what is working…try to stay on it long enough to drift on to sleep. And trust that even if you stay awake, this is one of the best ways to rest, almost as good as sleeping….and you just may drift off to sleep….Zzzzzzzzz

REMEMBRANCE:
Irvin Cohen, MD

By Bruce Hershfield, MD

Irv Cohen, MD

Dr. Irv Cohen, who practiced in the Baltimore area for many years and influenced many of us because of his skill in administration and teaching, died April 14th at age 96.

Born in Baltimore, he was adopted by an aunt and uncle after his mother died in an accident when he was 3 months old. He graduated from Johns Hopkins and then got his M.D. degree at the University of MD. After serving in the Army, he helped set up Sinai Hospital's psychiatric unit, then served as Director of Training and Associate Medical Director at Sheppard. He joined the MPS in 1958, served as our President in 1972-73, and was active on the Ethics Committee till 2004. He continued doing disability reviews for many years and was still very active when he was awarded the MPS Lifetime of Service Award three years ago.

His down-to-earth approach to life and Psychiatry were evident in a July 2010 interview he did with Dr. John Buckley and Ms. Carol Allen for the "Oral History Project":

"During internship at Sinai…Guttmacher probably got me and George Winokur interested in a residency at Seton Psychiatric Institute, which was then a brand-new operation. It had been a retreat …Guttmacher and Muncie, Wendell Muncie, were very central to getting a group together to create this place. It was approved for 2 years of training and it sounded alright to me. ..It was a lovely place to be. Of all those places I've been, those two years at Seton and a large chunk of my years at Sheppard Pratt, maybe the year at the surgeon general's office in Washington, were the most productive and instructive and interesting to me. The happy times."

"Seton was only approved for 2 years. The third year I went out to Perry Point , the VA Hospital, so I had some exposure to the VA system."

"When I came back from the Army I was director of residency training at Spring Grove state hospital. That's the first full-time director of training in the state system (though there had been a director at the main office level, director of training and research.)"

"I also worked in the private hospitals…I was part of the group that opened the department of psychiatry for Sinai Hospital."
"Sam Novey decided to leave analytic practice, keep a small group of patients, and become director of training at Sheppard Pratt. He talked me into going there and joining and heading up the liaison activities with Grater Baltimore Medical Center. I did and unfortunately Sam died within that first year. I then inherited his job."

"The time I liked best was as director of training because I was treating people too along the way. This was my main focus and I supervised for years along with Lex Smith (in a psychotherapy program at Hopkins)."

"I wrote a paper once called "Managing to Redefine Psychiatry"—about the early stages of managed care. They redefined Psychiatry! They'd kid me at Sheppard about it: "Cohen's Law": "Philosophy follows funding".

He was admired by many of us. When his death was announced to the MPS e-mail list, several people commented:

Jesse Hellman said, "Irv was a wonderful, compassionate man who was a model to so many of what a psychiatrist could be."

Laurie Orgel wrote," He was a careful and empathic psychiatrist as well as a pragmatic thinker. I feel fortunate to have had him to encourage me in my career. In these later years his wit and wisdom were both a help and a delight."

Charles Peters, who was the one who told us about Irv's passing, added, " In my years in this field I have never known anyone who was as perspicacious , empathic, and genuinely humble as Irv… Wonderful man. Dearly missed"

Interview:
Jill Rachbeisel, MD

Interim Chair, University of Maryland Department of Psychiatry

By: Bruce Hershfield, MD

Baltimore, April 29, 2020

Q.: **"How is the department handling the COVID-19 crisis?"**

Dr. R: "Our Department is working hand in hand with the entire medical center. We are fortunate to have an impressive team of infectious disease specialists and other leaders, some with military training, who are thinking about and planning for the worst and hoping for the best. We have followed the algorhithms. The UMMS Behavioral health has led the way in many areas. The system includes 14 coordinated hospitals and I have the pleasure of co-chairing the behavioral health COVID-19 response team for the University of Maryland Medical System. As behavioral health leaders, the group meets twice per week to organize a planned response to the crisis. This included mandatory admission testing for psychiatry. Long before most hospitals started testing for all admissions, we mandated COVID-19 testing for all persons needing psychiatric admission. We wanted to keep our beds open so we were very aggressive, very early and implemented a care model to protect staff and patients. Universal masking, social distancing on units, reducing treatment interventions to very small cohorts and reducing all semi-private rooms to single occupancy were, and continue to be, part of the management in acute areas. The Department of Psychiatry also worked with our facility engineering team to design a COVID-safe behavioral health unit for asymptomatic patients needing acute care. Fortunately, although we are prepared to stand that unit up if necessary, we have not needed to do so. All of the psychiatric units in the UMMS network have agreed to conduct care similarly. As a result, we went from a capacity of 182 beds in the system to 120. Simultaneously, ED volume has been modest in many facilities, keeping demand for beds manageable.

Jill Rachbeisel, MD

Q. **"What about the outpatients?"**

Dr. R.:" Our adult and child day hospitals are closed. We are using both spaces for staff support areas.
Our ambulatory services remain open and we continue to see new patients. They have a choice of being seen in-person or we have the tele-mental health services to offer them. We feel strongly that in this time people need to have access to mental health services. Our model of care in ambulatory programs has also changed to reduce risk of exposure to everyone. Anyone coming in the building is fully screened, including with temperature checks. This includes staff. Anybody with a temp over 100 goes home. We mask everybody—patients and staff. We are seeing patients at least 6 feet apart. We make sure we are maintaining social distancing. The vast majority of routine visits are converted to tele-health visits and, interestingly, no-show rates are down and overall our clients are pleased that they remain connected and cared for."

Q.: **"It sounds like you are being flexible."**

Dr. R.:" Absolutely. This crisis response takes people out of their comfort zone of the standard face-to- face visit. We started providing most therapy via telehealth, including groups in our rehabilitation programs. I have been pleasantly surprised by the flexibility of many people who are willing to step up—-to practice safely even when they initially didn't feel comfortable."

Q.:" **How did you learn how to administer such a large Department?"**

Dr. R.: I have learned by watching and being mentored by those who do this work so well. We do have a very large Department with 7 major clinical and 4 large research divisions and there are many things to manage. In these times, everybody wants to know how they can help. Unfortunately, in this unprecedented situation, the right answers aren't always known. I have worked to pull people together and work as a team! I have told all my faculty and staff that we are going to figure this out together. This pandemic has challenged our medical and research teams in ways not anticipated. Keeping everyone safe and minimizing risk are paramount. A recent example was when we went to mandatory testing; there were no exceptions. So, the ethical, legal, and safety issues that arise with an involuntary, uncooperative person waiting for admission was quite uncomfortable for all of us. The nasopharyngeal swabbing is minimally invasive, but momentarily uncomfortable. Together we explored the issues of patient rights and safety. With the assistance of our system council, we settled the 'great good approach' that everybody was comfortable with maximizing safety for all.

Q.: **" What other responsibilities do you have?"**

Dr. R. " Even during a pandemic, the department's wheels keep turning. We have started to plan for the recovery phase for both our clinical programs and our research pro-

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grams. Revenues are significantly down because of the reduction in services and all our research has been on complete restriction. It is my responsibility to look ahead and start our recovery planning.

Q.**:" What have you learned about leadership?"**

Dr. R.:" Leadership in a crisis calls for a number of things. Maintaining connection, open communication and frequent recognition of those who go above and beyond. Communication involves meeting more frequently with people, Twice a week I have a large clinical virtual meeting. Anybody can join. We have a standard agenda, but can change it to meet the situation. We do "surge planning" together. I keep everyone informed about where we are headed and at what pace. We get input as we approach difficult tasks, such as redeployment of faculty so that, as we surge, individuals are aware of the plans and not surprised when it happens. It's also important when handling a crisis to acknowledge those individuals who go 'above and beyond' and are using their creativity and flexibility to problem-solve. The next issue of the newsletter focuses on those who have given their all. That's how you keep spirits and morale up.

I also meet with the Departmental research leaders and teams. Along with Dr. Gloria Reeves, my vice-chair of research, we have started a research recovery committee and are gathering the resources for COVID research. Researchers are robustly working on submitting more COVID grants. We have a division of psychiatric services research and they are implementing a study, approved by our IRB--surveying patients and staff on the impact of COVID and social isolation. We are looking at the impact of virtual, distant treatment on patients, including how they are responding to it and how they feel about it. My approach has been: 'We are in this. What are we going to learn from it? How are we going to be able to re-tool ourselves to be able to move forward?'"

Q.:" Tell us about your career and what you did before you became Interim Chair."

Dr. R.:" I completed my psychiatric residency here at the University of Maryland Medical center and then joined the faculty. I have been here for 30 years and have gradually worked my way up. I am always seeking things that are exciting and challenging to me professionally while building strong effective teams. I started my career in acute care, emergency and addiction services. After about 10 years I had the opportunity to direct the Community Psychiatry Division and found myself again challenged and intrigued. For the better part of 20-22 years, I have identified myself as a community psychiatrist. My research is centered on the treatment of the severely mentally ill. Another interest of mine is women's mental health and looking at perinatal and post-partum illness and their impact on families and children. I am often asked what keeps me here. My answer never changed: I am here because of the people with whom I work and the populations we serve. We have an incredible, vigorous and dedicated faculty and a wonderful community with which to partner." .

Q.:" What can the psychiatric community do to help you?"

Dr. R. "I believe we all need to pull together and advocate for enhanced mental health services and broader coverage. Payors need to consider regular coverage for tele-mental health services even after this crisis is over. But that will take a collective effort.
This all ties into our next challenge: Figuring out what the 'new normal' looks like. I predict it is going to be very different. I strongly believe the psychiatric community should push hard for more use of tele-mental health, making it easier to access mental health services and structuring it in a more client-centered fashion. Many are being seen via audio-visual technology and they have been more engaged and they are incredibly grateful for the flexibility. I often hear: 'Are we going to be able to continue this kind of treatment?' Many people may not feel comfortable coming out of their homes, at least right now. I look forward to shaping what our 'new norm' looks like.

Another challenge is to consider how we going to deliver acute care moving forward. We cannot return to how we provided care pre-pandemic. Many hospitals still have double room occupancy in Psychiatry. For safe, personal and respectful care, we need to have single rooms. What should our group modalities look like? We have learned many ways of delivering good care through this crisis and carrying these lessons forward is critical.

Another consideration is in how to provide addiction services. While we are in a state of emergency, the federal government has relaxed the criteria for eligibility for methadone take-homes. So programs have been able to give more take home medication over longer spans of time. Turns out, this new 'temporary practice is a more humane, personalized and sensitive way to provide care rather than mandate a disruption in people's lives by extended periods of daily visits. Prior to COVID-19, not only was this not possible, it wasn't conceivable. I think that after this there is going to be a strong argument to redefine addiction/methadone management services. But we have to look at the data and ask important questions: How many people are relapsing and how many are staying engaged longer during this unique time?

We have such incredible talent across our Maryland community. We also have lots of silos and natural competition. There is an old saying—'You can go faster alone, but farther together.' I hope we can bring our mental health community together and go a much longer way!"

LETTER FROM THE EDITORS
This Spring

By: *Jessica Merkel-Keller, MD*

Jessica Merkel-Keller, MD

There is something special about spring evening air. Its moisture is gravid with possibilities, as new growth emerges and takes form. It is a time of transition. We watch delightful parts of the life cycle play out, from budding into pollination.
This spring is like no other in our lifetime. While there is still a growing and a transformation of the natural world, there is also a loss inflicted by the pandemic. Every one of us has been placed more directly into a position of contemplating our mortality. Out of this collective vulnerability, we have brought out the best in each other. There is more courteousness, more sharing, more acts of kindness, and, with it, a sense of community.

In our own community as psychiatrists, our messages and tools of healing are being disseminated in novel ways across digital media and telehealth. Much of the administrative red tape-- especially the double-edged sword of HIPAA that protects patient information, yet makes it harder to connect with patients and their families-- has been lifted. We are learning about reaching people and practicing our healing art in non-traditional ways.

What we learn about facing challenges will continue to have relevance even after the pandemic has passed. Our shortage of mental health professionals is magnified by the new practice climate. Nevertheless, we are rising to the challenge by using technology and coordinating care with colleagues like never before. There is a true joy in practicing what matters most. Our missions are clear: Benefit the sick, get people well so they can achieve their potential, and decrease the burden of suffering.
The leadership in our psychiatric community has handled the crisis well. Look at the article by Drs. Trivedi and Peters, the columns by Dr. Potash, and the interview with Dr. RachBeisel. MPS staff members Heidi Bunes and Meagan Floyd have worked tirelessly to support us and keep us informed. Our collective actions under strong leadership and support have helped save lives and have connected us instead of leaving us isolated. Our members have a sense of community; we are all in this together. We press on. We can confidently address whatever is likely to come.

It has been a pleasure to work with Dr. Bruce Hershfield as co-editor of The Maryland Psychiatrist these last three years. He has inspired me greatly, as we both have enjoyed the support of readers, members of Council and the MPS Executive Committee. I am stepping down as co-editor as I transition to the Secretary – Treasurer role. A very special thank you to Ms. Meagan Floyd, who does lovely layouts and facilitates the meetings of the Editorial Advisory Board.

To everyone who has written for TMP: Thank you for supporting our community. We really need you always, but especially now, in this spring.

Member Updates and Survey

The MPS sent member information update forms and the 2020 member survey in May. Please watch your US mail and return your information promptly!

Member Update Form
The MPS membership directory will be published in late Summer. Please ensure that your information on file with MPS is up to date. If you opt in, this data is also used for the online Find a Psychiatrist and the telephone patient referral service. Please indicate all insurance networks where you participate in-network. You can also log in to your member account on the MPS website to directly enter updates. **The deadline for directory changes is July 31**.

Member Survey
Please help guide how MPS committees, Council and staff will work for you in the coming year by completing the survey. **INCENTIVE:** Three respondents who complete the entire survey and include their names will be chosen at random for a **$100 credit** that can be applied toward MPS dues or an MPS event. **CLICK HERE** to start – this should take less than 5 minutes!

Special Member Rate for 2020 MPS Directory Ad

MPS members can advertise their practice, new office location, specialty, new book, etc. for a special members-only rate of $100 for 1/3 page in the directory. The 2020-2021 directory will be out in early fall 2020, so order soon! For details, email Meagan at mfloyd@mdpsych.org.