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Jill Rachbeisel, MD Appointed Chair at University of Maryland


Jill Rachbeisel, MD

On February 12th the Dean of the University of MD School of Medicine, Dr. E. Albert Reece, announced that Dr. Jill RachBeisel, who has served as Interim Chair of the Department of Psychiatry for the last two years, has been appointed as Chair. On March 18, 2021 she was invested as the Irving J. Taylor Endowed Professor and Chair. Dr. Reece commented in announcing the appointment that, "She is highly respected across our academic community and has demonstrated unwavering and effective leadership throughout the years. Her gift for building partnerships between researchers and clinicians to create innovative and highly successful initiative is remarkable and highly desirable."

After earning first an RN certification and then a BS in Chemistry and Mathematics, she went on to receive her MD degree from Penn State University and completed her psychiatric residency at the University of Maryland Medical Center. Dr. RachBeisel has been on the faculty since 1989 and has served as Division Director for Community Psychiatry, Chief of Clinical Services and then Vice Chair of Clinical Affairs before assuming the interim chair position in 2019.

Dr. RachBeisel worked with Dean Reece to set up a Vice Chair of Research and named Gloria Reeves, MD to be the first one to hold the position. The Department of Psychiatry received grants worth $43 million for fiscal 2020. In 2019 Dr. RachBeisel helped open two new units––an adult inpatient psychiatry unit and an adult day hospital program that is located at the U of MD Medical Center Midtown Campus. In the Fall of 2019, she established the Department's first Diversity, Equity, and Inclusion Committee and in July 2020 launched an annual 5-part grand rounds Diversity lecture series that runs through the academic year. To recognize the ongoing work and resources necessary to make the needed cultural changes she appointed Dr. Anique Forrester as the first Chief of Diversity for the Department.

Dr. Mark Ehrenreich, MPS President and Chief of Medical Education in the department, commented, " The Department of Psychiatry is excited and thrilled that Dr. RachBeisel has been appointed as the permanent chair of Psychiatry. She is a superb clinician and administrator who has worked tirelessly over many years on behalf of our patients, our trainees, our faculty, our institution, and our community. We look forward to a bright future with her at the helm of our department."

"I am honored and humbled to be the Department of Psychiatry's first woman Chair" said Dr. RachBeisel." My first priorities include building teams and collaborations to understand and discover novel treatments for mental illness and substance use disorders, deliver top evidenced based care to our community and to support the education of the next generation of clinicians. To accomplish all of this, supporting my faculty, who are the building blocks of our Department, is my highest priority."

by Bruce Hershfield, MD

In This Issue

MARYLAND
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Virtual Meetings to the Rescue

by Laura Gaffney, MD

Laura Gaffney, MD

It has been almost a year since we have had to isolate ourselves from others because of the pandemic. I found myself feeling down about the loss of social contact. Fortunately, friends of mine started using Zoom to get together virtually. I had also missed talking to colleagues, so I signed up for Zoom meetings and have been having monthly meetings with fellow psychiatrists. The topics have ranged from psychiatry cases and private practices to culture and world events. For me, it has eased the feeling of social isolation and hopefully for others as well. I hope to continue these meetings after the pandemic ends. What I have learned is that virtual meetings are a great way for people in different parts of Maryland to get together and talk. I have been able to meet with more people than before.

The pandemic has been awful in so many ways but it has led to improvements in virtual technology. And I don't have to wear shoes for virtual meetings. It is also fun to try different filters and backgrounds for virtual meetings. However, I would caution about the use of certain filters or you could end up like the lawyer who turned himself into a cat.*

* (Lawyer tells judge 'I'm not a cat' after a Zoom filter mishap in virtual court hearing - CNN)

Getting Ready for the Second Wave

by: Harsh K. Trivedi, MD, MBA, president and CEO, Sheppard Pratt &
Todd Peters, MD, VP and chief medical officer, Sheppard Pratt

Harsh Trivedi, MD

Todd Peters, MD

COVID-19 has continued to wreak havoc on our country, our state, and our local communities.

Yet, we know the numbers tell only part of the story. We have already begun to see the impact on mental health. The pandemic has only exacerbated the mental health crisis that already existed. In a recent CDC report, 10% of respondents reported having seriously considered suicide in the prior 30 days. Only 4% of respondents in a relatively similar study considered taking their own lives in 2018—and, in that year, 48,000 died from suicide. Rates of suicide, which were already alarmingly high pre-pandemic, are expected to increase. In that recent study, almost 41% of respondents reported at least one mental health concern. The Maryland Opioid Operational Command Center reported an overall 9.1% jump in drug-related overdose deaths in the first half of 2020 compared to the same period in 2019, which it attributed to the COVID-19 pandemic.

Stephanie Durruthy, MD

Sheppard Pratt takes care of some of the most vulnerable in Maryland, which makes us an important part of the COVID-19 response. As an organization with more than 380 sites and more than 160 programs in 16 Maryland counties, and with 5,000 employees, it is in a unique position to lend its support to the vaccination efforts.

At the end of December, we turned our conference center in Towson into a vaccine clinic. We provided vaccinations to our eligible employees across the state, including our psychiatry residents/fellows, as well as vaccinating others in need of our services. We also created satellite clinics in locations around the state to reach employees who might not be able to get to Towson, as well as vaccinated our clients who are in behavioral health group homes.

We know that patients with schizophrenia are especially vulnerable to dying from COVID-19. We must vaccinate this high-risk population and have staunchly advocated it receive the vaccine early in the state's tiered distribution plan. We have held vaccine clinics in Frederick, Gaithersburg, White Marsh, and Baltimore to ensure we do our part. Our pop-up clinic in Baltimore vaccinated nearly 300 people, of whom 60% were from minority communities. We know that they have faced longstanding health disparities and have disproportionately been impacted by COVID-19.

We also saw it as imperative that Sheppard Pratt lead the way to help secure vaccine access for the broader community of mental health practitioners. We recognized that many may not have access to the vaccine if they were not associated with a hospital or health system, yet they are also on the frontline. In January, we contacted the MPS as well as some other local provider associations to offer access to our vaccine clinic to ensure psychiatrists and other mental health practitioners were vaccinated. On January 14 and 15, at our Towson campus, we held a clinic that served many members of the MPS. We vaccinated more than 350 people. It was a great opportunity to see colleagues in-person after so many months. Likewise, it made "mental health parity" real, ensuring that psychiatrists were treated equally with members of every other field of medicine--integral to frontline efforts during COVID.

And now begins the hard work.

Many of our patients may have been stable pre-COVID-19 but are struggling today. Those with years of sobriety may have relapsed. There are also reported increases in domestic violence and child abuse cases. Unemployment, increased anxiety and financial stress, and a lack of community resources have set the stage

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Second Wave

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for this to get worse. Many victims have found themselves isolated in violent homes, without access to resources, or friend and family networks. For many, the restrictions and social isolation of the last year have disrupted their access to care, which could profoundly impact their mental health.

Throughout the past year, we have responded to the increased need for access by implementing telepsychiatry across our network of programs and services—inpatient, partial hospital programs, urgent psychiatric care, and outpatient programs. Our scale of growth-- and the ability to roll it out and impact the health disparities in our communities-- was a "game changer" for those struggling to access care. We launched our Virtual Crisis Walk-In Clinic a year ago as an alternative for those seeking emergency psychiatric care. It provides those in crisis with an online mental health assessment and connects them with the next level of appropriate care. From April – December 2020, we provided more than 300,000 telehealth visits across all our programs.

All of us have a critical role to play in helping our communities to recover. By each of us doing our best, we can all get through this together.

Angela Nduaguba-Ezumba, DO

Awaiting Brood X: Revisited

by Dinah Miller, MD

Dinah Miller, MD

I remember very little of what was going on in the world in the Spring of 2004. One thing I do remember about 2004, however, is that I wrote an article for *The Maryland Psychiatrist* called "Awaiting Brood X" about the coming of the cicadas.

This year--unlike 2004-- I am very much aware of our news cycle. As we rush to vaccinate every American over age 16, we are either headed toward the end of what has been a remarkable pandemic year, or into a fourth wave of despair. The US Capitol has been attacked twice this year, and tens of thousands of unaccompanied children have crossed into the USA from Mexico. The country looks very different than it did a little over a year ago, when we came and went freely and Donald Trump was Tweeting.

The cicadas come up from the ground every 17 years, when the soil temperature reaches 64 degrees. I was told in 2004 that it would sound "louder than 10 lawn mowers." I had no idea how loud that was, but it did not sound pleasant. I was warned they would be "everywhere," that dogs would eat the shells and get sick, that you couldn't sit outside. Someone else said there would be a few bugs; you'd bat them away and move on. In that article, I wrote about the anticipation of Brood X and intermixed it with the anticipation of a yearly episode of mania in a patient I had been seeing for a long time. I wondered what that patient -- someone whose life and illness were both quite memorable in my career-- had to do with cicadas!

I love the spring-- when the clocks change and the days get warmer, when the ice melts and the world stops feeling treacherous, when the neighbors emerge and when color explodes everywhere. My joy starts with the arrival of the crocuses, and, as I write, my windows look out on daffodils, forsythia, and cherry trees. The tulips will bloom any day now, and then the azaleas will, in red, pink, purple, and white.

While I love spring every year, springtime 2021 has been special, as we emerge from a terribly dark, difficult, and isolated winter. It's been a time of fear and of political division. We've stayed indoors in our bubbles and we've communicated with our

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Brood X

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friends, family, and patients using our computer screens set on Zoom. To suddenly have color, warmth, renewal, and vaccines has been absolutely miraculous.

In 2004, I wrote about buying an air conditioner for my bedroom to drown out the noise of the cicadas. In 2021, they are (almost) the last thing on my mind. If it wasn't for a neighbor who posted a question on a listserv asking if they would ruin an outdoor wedding, I'm not sure I would even remember they are coming. In the original "Awaiting Brood X," I discovered that the cicadas were not as bad as the hype. They emerged as big, black bugs with golden-veined wings and small orange eyes. As more and more emerged, they became louder, producing background noise that was musical and a bit haunting. They shed crunchy, glistening, black shells, and my dog had no interest in either the occupants or their encasements. I'll have to see what my current dog thinks--in his dotage he has gone blind and I imagine the cicadas will be a perplexing addition to a world he has learned to navigate quite gingerly. And I can't help but wonder if that patient from so long ago continues to have such remarkable episodes of mania now that she would be in her 70's.

For this spring, I just want to be hopeful. As we wait for what comes next---for how to negotiate whatever our 'new normal' is-- I am not worrying about Brood X, about what noise they will make or what mess their crunchy shells will leave. Instead, I'll bank on the prospect that our vaccines will release us from this difficult year and hope that when the cicadas do arrive, we can safely keep our windows closed.

Pharmacy Benefits: NOT What they Taught us in Medical School

by Robert Herman, MD

Robert Herman, MD

Every week on the MPS email list there are several messages from our colleagues, expressing frustration and exasperation at medication denials by insurance companies. There are many types. One of them is when we have a patient who has been stabilized on a particular medication and is doing very well; we suddenly get a letter saying that the medication is no longer covered by the insurance plan. Other denials involve patients for whom we wish to choose a particular medication, only to find that they are required to fail several other medications before being allowed to get the one that we feel is appropriate. Our colleagues on the e-mail list express sympathy and make suggestions like calling the medical director of the insurance plan or writing the state insurance administration or writing to our congressman. But it seems that these problems continue to plague us and may be getting worse.

If we do call the insurance company, we go through an irritating phone tree, and then are asked by somebody who speaks very slowly the patient's identifying data and the name of the prescription and other basic information. The folks on the other line seem to be trained to speak very slowly, to ask us to repeat everything 2 or 3 times, to take up as much of our precious time as possible.

Many of us have learned to deal with some of these problems by using a company called CoverMyMeds. If the pharmacist is cooperative and starts the process, we get an e-mail from CoverMyMeds and complete an electronic form. If we do this according to the rules our patient will usually be allowed to get the medication that we prescribed. But not all pharmacists cooperate with this. CoverMyMeds is a company based in Ohio that is funded by the pharmaceutical industry, as they want to make it easier for patients to get what we prescribe.

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Yet, even when we use this and send correct and relevant information, the results are not always in our patients' favor. It appears to me that those making the decisions are ill- informed and lack basic psychiatric and medical knowledge. For example: a patient of mine with bipolar disorder who was severely depressed and had failed to respond to quetiapine was not allowed to get lurasidone because that was only approved for bipolar I depression and my diagnosis was bipolar type II. I discovered that the medical director of the company who made this decision was a physician in his mid-70s who has practiced his entire career as a radiologist in Pennsylvania (and is not licensed to practice Medicine in Maryland.

In another case a patient who was on suboxone developed swelling of his lips and tongue, which his internist and I agreed was due to hyper-sensitivity to naloxone, one of the two components of the medication. Those of us who use this medication know that this is not common, but it does occur. We then prescribe sublingual buprenorphine, which does not contain naloxone. But, when I prescribed this, the pharmaceutical benefits manager denied it, even after my appeal. In his written denial letter he stated incorrectly that it is impossible for a patient to develop hypersensitivity to naloxone because it is not absorbed sublingually. His statement contradicts the information in the prescribing information for the product. He was simply wrong. I later discovered that this medical director was a pediatrician in Chicago

What is this all about? It is not actually the insurance company that is denying the medication; it is a little-understood intermediary company called the pharmacy benefit manager (PBM). These are companies that arose in response to growing pharmaceutical costs. But they have morphed into behemoths that themselves are taking an increasing percentage of health care dollars, with little evidence that they actually improve quality of care or even control health care costs. They do generate profits for themselves--and frustration for doctors and patients.

PBM's, as intermediaries between insurance companies that pay for medication and pharmaceutical manufacturers, are generally paid by insurers, with the promise they will control drug costs. But controlling drug costs will not necessarily reduce health care costs. For example, if a PBM will not pay for a first medication that is more effective in keeping patients well and out of the hospital, the "cheaper" medication may lead to more side effects, noncompliance, and decreased effectiveness. This leads to worse outcomes for the patient, as well as increased cost of a possible hospitalization. It is clear that coverage decisions by PBMs do not take these factors into account, but are merely based on relative cost of the drug-- and the profit the PBM can make from the transaction.

These business practices are largely hidden, but are a product of negotiations between pharmaceutical manufacturers and PBM's. A manufacturer may, for example, pay a large "rebate" (essentially lowering the cost of the drug) in exchange for classifying the drug as "Preferred" on the "Formulary" (list of drugs allowed by the insurer). These rebates may not benefit the patient or the insurance company, but may in fact increase the profit of the PBM. A bill to require disclosure of these rebates was passed in the U.S. House, but died in the Senate (H.R.2115 - Public Disclosure of Drug Discounts and Real-Time Beneficiary Drug Cost Act116th Congress (2019-2020).

These "deals" are typically negotiated annually, so that at the beginning of the year patients may discover that a drug that they have been doing well on for many years is no longer on their formulary. They must then either switch to a different drug or pay cash. It is hard to describe how deleterious this is in the lives of our patients. Many have struggled for years, finally finding stability on a particular medication, then learning that their insurance company will no longer pay for it because of a new "deal" their PBM struck with a particular manufacturer.

One tool that PBM's use is called "prior authorization". Typically, this involves only approving a drug for a certain indication and not others. PBM's may use a list of FDA- approved indications in order to decide if they will pay for a medication. But medical knowledge is constantly evolving and we often use medications that are approved for one condition to treat others. For example, lamotrigine was approved in 1994 for epilepsy, but until 2003 we used it "off label" to treat bipolar disorder, until it was finally FDA-approved for that. Every clinician knows examples of medications that are FDA-approved for one indication, but are quite helpful for others

Another tactic is called "step therapy". This means that, before we treat patients with a medication that we think is appropriate, the patient must go through a number of other medications we "should" use first. These "fail first" protocols are

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often illogical and ask the patient to try medication that is either not indicated or for where there is no evidence for its effectiveness. For example, certain antipsychotics are effective for depression in bipolar disorder, but many are not. These patients are often severely depressed and at risk for hospitalization or suicide, but their treatment is delayed because of these business practices.
PBMs often require a periodic reauthorization of medication even if the patient has a condition that is chronic and not expected to change. For example, patients with ADHD may be required to get their treatment reauthorized, although that is considered a chronic condition. Are patients with non-psychiatric conditions like diabetes also required to have their treatment re-authorized once a year? If not, this may be in fact a violation of the parity law.

These business practices are becoming increasingly complex. PBM's are charging more to insurers and paying less to pharmacies, getting more and more "rebates", and continually increasing their profits. Many of these practices are poorly regulated, or not regulated at all.

What can be done about this? The first step may be transparency --requiring PBM's to disclose their agreements with pharmaceutical manufacturers so that we can see their incentives to promote certain drugs and discourage others.

Federal legislation is unlikely to address these issues in the foreseeable future. Our best hope for legislative solutions may come from the states, where legislatures are working on many bills to regulate the practices of pharmacy benefit managers. Most of these appear to mandate transparency, trying to force them to reveal ways they are making hidden profits by manipulating prices and double-dealing. Our own state last year passed the Maryland Competitive Pharmacy Benefits Manager Marketplace Act, which attempts to force more competition among PBM's, using a "reverse auction" to get them to bid against each other in an effort to reduce costs.

So far, there has been little attempt to reform the practices of PPM's from the clinical end, making policies regarding authorizations and formularies that are consistent with standards of good clinical care. We are all licensed by the state and must get continuing medical education. It should be assumed that we are competent, and that the decisions that we make regarding our patients' treatment are generally appropriate. We—along with our patients--should be the ones making these decisions.

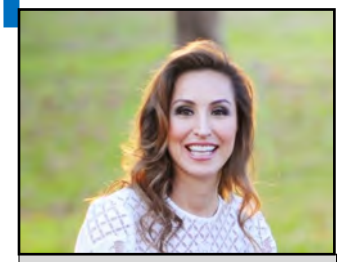
We could improve this situation by insisting on credentialing their medical directors--physicians who make decisions regarding formularies and prior authorization protocols. They should be experts in the specialty that is relevant to the decision, with clinical experience in treating these patients. Ideally, they should be working clinically at least part of the time, and only part of their time for the PBM. This would protect them from undue pressures from the PBM's to make decisions contrary to their clinical judgment.

If those decisions are to be "second guessed" by PBM's, they should make them based on data regarding comparative effectiveness of treatment alternatives, not just costs. They should follow established treatment guidelines by recognized experts and professional organizations, and these guidelines and rules should reflect new knowledge and be continually revised to reflect current professional opinion. Those who are second guessing our clinical judgment should know more than us, not less.

Patients by definition are ill, and therefore are vulnerable, and can find it hard to understand and negotiate this maze of treatment. Psychiatric patients are particularly vulnerable, as they are dealing with illness of the brain. We as psychiatrists are in a unique position to understand the importance of timely and effective treatment for our patients, including effective medications that we are in the best position to choose. We should therefore speak out on behalf of our patients and let our voices be heard at every opportunity. It is a part of our sacred oath as physicians.

Memoriam: Amanda Cook-Zivic, MD

by: Annette Hanson, MD



Amanda Cook-Zivic, MD

On December 23, 2020 staff members of Clifton T. Perkins Hospital Center were saddened by the sudden and tragic death from coronavirus of a valued colleague, Dr. Amanda Cook-Zivic. A graduate of the University of Maryland psychiatry residency program, where she later completed a forensic psychiatry fellowship, she had been on the Perkins medical staff since 2007.

She was a zealous advocate for her patients and a meticulous forensic evaluator. Her colleagues and friends often described her with identical adjectives: beautiful, funny, warm, very creative, and always willing to defend and fight for others. Early in the COVID pandemic she brought homemade cloth masks for the hospital staff that she had sewn herself, using her grandmother's hand-me-down sewing machine. She didn't hesitate to volunteer for extra on-call coverage when needed and also bought pizza for patient parties.

As one fellow forensic psychiatrist, Dr. Sameer Patel, recalled: "We were having a hard time getting staff to attend our meetings. So for the next two years, we alternated going to Dunkin Donuts every Tuesday morning to bring donuts and coffee for the staff... And of course, it worked and we had almost all free staff attend our meetings and contribute to the management planning. Amanda was always looking for ways to integrate staff into treatment decisions and made everyone feel like they were part of the team."

Dr. Magda Riega, a co-resident and close friend of Dr. Cook-Zivic's, treasured their time together planning Halloween parties for the residents and sharing their hopes during long nights on call: "Amanda always fought for what she believed in, no matter the consequences. At the same time, she was open and welcoming and willing to listen. She was a hard worker and so proud of her heritage. Every December I looked forward to her Holiday card, filled with pictures of her family and updates about their life. She loved her husband, Mike, and her children Jackson and Kensington so much. She had a way of making things beautiful. She was a mother, a wife, an artist, a healer, a doctor, a forensic psychiatrist and my friend. She will be greatly missed and never forgotten. May she rest in love and may her family feel the love her friends had for her."

The New OCD Program at Sheppard Pratt

by: Michael Young, MD

Michael Young, MD

The Retreat at Sheppard Pratt has been an established therapeutic community for going on 20 years, with a continuum of care spanning residential treatment to comprehensive outpatient care. Its philosophy has been to integrate multiple clinical viewpoints. In addition to biomedical interventions (including TMS and ECT), psychotherapy is a significant focus of treatment. The core services include at least 3 hours per week of intensive individual therapy with the attending psychiatrist and an additional 6-8 hours of individual treatment with other clinicians. There are also over 30 hours of group therapy and family therapy sessions throughout the week. Specialized treatment tracks have been developed for substance use disorders. Residents have the option to step down to a Retreat group home, Ruxton House. A second Retreat group home, Magnolia House, is scheduled to open this spring and has a specific focus on occupational therapy and helping residents develop life skills

In March, we started accepting patients into the new OCD Program at The Retreat. It is designed as a residential treatment program that combines evidence-based specialty care for severe OCD and related disorders with the other treatments we have been providing. It is designed to help patients who are not benefiting from outpatient treatment, when multiple treatments have not led to symptom improvement, when co-occurring psychiatric illnesses are complicating the treatment, or when they are seeking a consistent treatment environment away from home.

In addition to the core Retreat programming, patients admitted to its OCD program receive 4 weekly individual sessions with a trained OCD specialist, including psychoeducation, cognitive therapy, mindfulness training, and exposure and response prevention (ERP). Daily dedicated ERP sessions (1-2 hours per day) are guided by a combination of OCD specialists, trained licensed clinical social workers, and trained Retreat nursing staff who can also provide 24/7 help in resisting compulsions. Weekly group therapy for OCD, and a weekly support group that includes outpatients so that residential patients can learn from others with OCD at different stages of treatment, are also of-

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New OCD Program

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fered. Mindfulness training, already built into our core programming, has also been expanded so that there are now 2 -3 weekly group sessions available. Weekly family therapy is an important part of the program. The approach to ERP is designed to combine a habituation approach (reduced distress through repeated gradual exposure to the triggers) with an inhibitory learning model (emphasizing distress tolerance and generalization for long-term benefits). The approach also emphasizes the importance of identifying and eliminating mental rituals--not only the overt physical behaviors that are more noticeable to outside observers.

We aim to help people who suffer from severe OCD, in a compassionate and validating way-- beyond just reducing their symptoms-- to help them lead healthier lives.

Memoriam: Lutz von Muehlen, MD

by Bruce Hershfield, MD

Lutz von Muehlen, MD

Dr. Lutz Heinrich von Muehlen, a long-time MPS member, died on February 9, 2021, at the age of 91.

Born in Dresden, he lived his youth in Berlin and Goehren, Germany; then in Paris and Basel.

He attending medical school in Germany and Austria. He immigrated to Baltimore in 1959 and did his internship at St. Joseph's Hospital and his psychiatric residency at the University of MD Psychiatric Institute. He taught residents there until he retired at age 70.

He practiced at University, St. Joseph's Hospital, the VA hospitals in both Baltimore and Perry Point, and at Fallston Hospital. He maintained a private practice in Baltimore until 1978, when he moved to Havre de Grace. He later practiced in Havre de Grace and Bel Air.

Throughout his life he had an active interest in philosophy, art, language, world history, politics and photography and enjoyed conversation with friends and family on these topics

Zoom! The Maryland General Assembly in Remote Control

by Annette Hanson, MD

Annette Hanson, MD

At the time of writing this article there are only 6 weeks left in Maryland's 2021 legislative session, and the MPS's legislative committee has reviewed 56 of the 3,056 bills that were filed. The 27 supported jointly by the MPS and the Washington Psychiatric Society involved increased access to mental health services for veterans, students, and law enforcement, along with preservation of reimbursement for telehealth visits. Suicide prevention bills are now under consideration--- safe gun storage laws and the creation of a suicide mortality review board. Modification of emergency petition procedures and civil commitment standards are also under consideration, but have not passed out of committee. A final legislative report will be available for members after the session ends, on April 12th.

This year's legislative efforts were particularly rewarding due to the many new members on the legislative committee. Members reviewed bills in advance and were prepared to discuss them during weekly conference calls. They also helped prepare written testimony, drafted amendments, provided talking points for the MPS lobbyist, and were available for oral committee testimony. There was active involvement and representation from the Washington Psychiatric Society and support from the executive committees of both DB's. The pandemic prevented the annual in-person Advocacy Day in Annapolis, but oral testimony was easier because all hearings were held remotely and livestreamed on YouTube.

A summary of the bills reviewed, as well as positions taken, can be found at https://mdpsych.org/legislation/session-recaps-laws/2021-session/.

Members interested in getting involved in next year's general assembly efforts can join the legislative committee by contacting the MPS office.

Cheers From The Chair

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

Jimmy Potash, MD, MPH

Ed's note: this is a version of a column Dr. Potash sent to his faculty several weeks ago.

And so it was I entered the broken world
To trace the visionary company of love, its voice
An instant in the wind (I know not whither hurled)
But not for long to hold each desperate choice.--from *The Broken Tower* by Hart Crane, 1932

Today Hopkins is marking the one-year anniversary of our entry into the broken world of COVID-19. As I look through the 80 emails that I sent on March 12 last year, I see a response to a message from Department Administrator Beth Ambinder telling me that Maryland public schools are closing for two weeks, and that we will have to accommodate staff who will have childcare needs. There is also a response to Amber Thomas, of Hospital Epidemiology and Infection Control, who wrote that neither staff nor patients will be allowed to eat meals or snacks together in groups. Residency director Graham Redgrave and I went back and forth about making the Friday morning resident teaching session—Service Rounds—a virtual experience rather than a live one. I also responded to my son, who had sent me the stanza of the Hart Crane poem above, which served as the epigraph for the funeral program of a recently deceased English Professor and literary critic.

Death has very much been with us over the past year, in the world, in the nation, and at Hopkins, which has been leading the world in tracking the grim trajectory of this heavy toll. Within our system, we have lost several hundred patients, and fewer than 10 employees. On March 12, 2020, it did feel like desperate choices needed to be made within the department. There were choices about how to handle what was then relatively scarce personal protective equipment, whether to convert double rooms to singles, whether to allow visitors on the unit, and whether to allow staff to opt out of patient care. We soon moved to questions about whether to COVID- test all prospective patients before admitting them, and how to handle those who tested positive. The choices seemed desperately important because it was clear that getting them wrong could have lethal consequences.

With the help of extraordinary leadership from the institution, and Herculean efforts from leaders in our department, we have fared remarkably well. First and foremost, we have successfully fended off the Grim Reaper. As far as I know, neither a single patient of ours nor a single member of our department has died of COVID-19. Thank God. Or thank goodness. Or, more importantly, thanks to all of you.

One unique element of our COVID response was the establishment of the COVID-positive psychiatry unit at Howard County General Hospital by Dr. Angelino. This has truly been a heroic effort, because of the workload involved and the willingness to take on personal risk at a time early in the pandemic when there were still many uncertainties. Dr. Angelino had plenty of help from people like Drs. Crystal Salcido and Ashley Bone, social workers Anika Holland and Scott Walsh, and many others. We recently learned that the whole team has been chosen for an Innovations in Clinical Care Award by the leaders of the Johns Hopkins Medicine Clinical Awards program, which will be presented at a ceremony on April 6.

At another award ceremony not long ago, Dr. Leslie Miller described the kintsugi metaphor, in which broken pottery is repaired using golden seams that make it beautiful again in new ways. Today the world feels markedly less broken than it has over the past year. Johns Hopkins has distributed more than 100,000 vaccinations. And President Biden said last night that vaccines will be open to all adults by May 1. Last week, I didn't get a chance to send out a Cheers from the Chair email because I was presiding over the annual meeting of the American Psychopathological Association, as this year's President. We focused the meeting on the mental health aspects of the pandemic, and we heard many distinguished speakers describe increases in distress, anxiety, depression, and substance use during the past year. But we also heard about silver linings that have emerged, perhaps most notably the rise of tele-mental health, with its ability to connect people, far-flung though they may be, to care with such ease.

When I mentioned kintsugi in Cheers last month, Beth Wellmann, a Senior Grants and Contracts Analyst for our Divisions of Behavioral Medicine and Behavioral Biology, emailed me with a link to one of her favorite songs, *Broken and Beautiful*, by Kelly Clarkson. Thank you, Beth! It couldn't be more apropos: https://bit.ly/2NasnOz.

Family, Friends & Fines

Why the Road to Board Sanctions is Paved With Good Intentions

by: Barry Goldstein, Esq. & Michelle Dian, Esq.
Waranch & Brown, LLC

Barry Goldstein, Esq.

Michelle Dian, Esq.

Ed's Note: Attorneys Goldstein & Dian have offered to start a regular column on how psychiatrists can avoid legal pitfalls. Waranch & Brown is located in Lutherville, MD

It's an all-too-common scenario: you're enjoying yourself at a family function when, suddenly, your aunt approaches you. "Your cousin has been going through some tough times this year. He could really benefit from some professional help. Can you talk to him?"

And there it is -- the potential to cross the line from a family relationship to a formal doctor-patient one. You want to help, because helping people is what you do. That's why you went to medical school, right? And you took an oath to help others! But most importantly, you love your cousin. It seems innocent enough --one evaluation and you can provide a prescription to help your cousin address the problem. But should you do it?

We recently represented two health care professionals in similar situations.

The Risk of Treating Family Members

The first psychiatrist thought she was being helpful in evaluating and treating a family member. She diagnosed anxiety and prescribed Xanax. Then it escalated: this family member became more demanding and started requesting more medications. Because of their relationship, the psychiatrist felt compelled to help . And then an anonymous complaint was filed with the Board of Physicians.

As required, the Board investigated this complaint and requested the patient's chart. Upon review, it found insufficient documentation for the medications being prescribed. The Board then charged her with "unprofessional conduct in the practice of medicine" for her treatment of her cousin and insufficient documentation to justify the medications prescribed.

Ultimately, she entered into a Consent Order, which placed her on probation, required her to take a medical ethics course, and charged her a fine. A copy of the Consent Order was posted on the Board's website. Her patients' insurance companies saw it and advised her that they would no longer reimburse her for treating their insureds. The revenues of the practice started to decrease.

Her desire to help her cousin ended up costing her professionally, personally, and financially. We are seeing more and more physicians facing this scenario when they prescribe medications for their family members.

The Maryland Code does not *specifically* preclude physicians from treating family members. Nonetheless, the Board takes these complaints seriously. When it finds any discrepancy or issues, the Board charges them with "unprofessional conduct" pursuant to Md. Code Ann., Health Occ. § 14-404(a)(3)(ii). When charged, they face sanctions from a reprimand (the minimum sanction) up to license revocation.

Most physician associations, including the AMA, agree it may be unethical for physicians to treat or write prescriptions for family members. There are many reasons why treating family may not be wise. For example:

- Physicians may face competing personal and professional expectations from their family members;
- Physicians' personal feelings may unduly influence professional medical judgment and interfere with providing objective care;
- Physicians may fail to probe sensitive areas when taking the medical history, or may fail to perform intimate parts of the physical examination; and,
- Physicians may be inclined to treat family members for issues that are beyond their expertise.

The Risk of Treating Employees

This same logic applies here. The second psychiatrist we represented began treating one of his office employees and prescribed medication. After a while, she started asking for *additional* medications. The psychiatrist/employer wanted to help her as a friend. Moreover, he wanted her to be productive and to appear for work as scheduled. He was concerned that, if he declined, she might stop coming to work consistently—or upset the congenial office environment he had worked so hard to develop.

Because of these concerns, he lost his medical objectivity and began prescribing the requested medications, without documenting a medical indication in her chart. As one can imagine, other employees found out, and someone filed a complaint with the Board. It placed him on probation, required him to take an ethics course, and issued a hefty fine. Ultimately, his choice to treat her created havoc in his office and lots of stress for him.

We know it is tempting to treat family members and employees. But this personal relationship can cloud your judgment as a physician – or your family member/employee's judgment as a patient. Before bringing someone like this on as your patient, consider the potential ramifications. **We suggest you help them by referring them to another psychiatrist. It is just not worth the risk!**

John Campo, M.D.

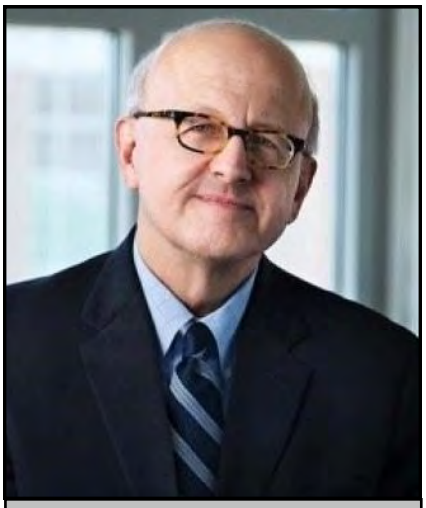
New Director of Child and Adolescent Psychiatry at Johns Hopkins

by: Elizabeth Wise, MD

Elizabeth Wise, MD

Since the fall of 2020, Dr. John Campo has been the Leonard and Helen R. Stulman Professor and Director of Child and Adolescent Psychiatry at Johns Hopkins. He is also the VP of Psychiatric Services at Kennedy Krieger Institute (KKI) and Vice Chair of Hopkins' Department of Psychiatry and Behavioral Sciences. He comes to Baltimore by way of Morgantown, West Virginia, where he spent two years as assistant dean for behavioral health, chief behavioral wellness officer, and professor of behavioral medicine and psychiatry at West Virginia University and the Rockefeller Neuroscience Institute.

As the VP of Psychiatric Services at KKI, Campo "is committed to delivering excellent clinical care for children and adolescents with neurodevelopmental disorders," says psychiatrist Roma Vasa, who is director of education and training there. Campo "is a visionary with an approach that is both compassionate and collaborative."



John Campo, MD

Raised outside of Scranton, PA he was a first-generation college student who graduated from Lafayette College and completed medical school at the University of Pennsylvania. He initially wanted to train in internal medicine and specialize in hematology/oncology. During his pediatrics rotation as a third-year medical student, however, he realized he could be "an internist for kids" and went on to complete his pediatrics residency at Children's Hospital of Philadelphia (CHOP). He had always been interested in psychiatry, but had a hard time giving himself "permission" to enter the field. It was not until a friend suffered a severe melancholic depression during residency that Campo decided to set aside notions and pursue psychiatry. After completing his pediatrics residency at CHOP, he trained in an integrated adult/child and adolescent psychiatry residency at the U of Pittsburgh. Campo spent 15 years on the faculty at Pittsburgh: creating and running a med-psych unit for children/adolescents, leading a practice-based research network on the management of early onset mood and anxiety disorders in primary care, and building a network of pediatric practices with integrated mental health services.
He next spent 12 years in Columbus, Ohio, first as Chief of Child and Adolescent Psychiatry at Nationwide Children's Hospital and Ohio State University, and then as Chair of the Department of Psychiatry and Behavioral Health at Ohio State. In Columbus, Campo created a Crisis Assessment Linkage and Management (CALM) service to manage behavioral health crises; this intervention led to the reduction of emergency department length of stay and inpatient admissions.

In addition to access to care, Campo's research and clinical interests include the integration of mental health services within medical settings, suicide prevention, and the relationship between somatic symptoms and psychiatric disorders. Of note, his first research grant, a K award while at Pittsburgh, was a clinical epidemiological study of children with functional abdominal pain who presented to primary care settings.

Campo has received the American Academy of Child and Adolescent Psychiatry Simon Wile Leadership in Consultation Award and the National Alliance on Mental Illness Exemplary Psychiatrist Award. He co-edited the *Handbook of Pediatric Psychology and Psychiatry* and has authored over 120 papers and book chapters.

Now having relocated to Baltimore – where one of his daughters also resides and attends Johns Hopkins Carey Business School – Campo is tasked with the challenge of integrating a fragmented division of child and adolescent psychiatry at Hopkins, where the different sections (Bayview, Children's Mental Health Center on the East Baltimore campus, the Children's Center on the East Baltimore Campus, and Kennedy Krieger) each have their own administrative mechanisms, priorities, and budgets. "A lot of other places would be envious of what we have," Campo says, "but it's 'Hopkins,' and from my perspective, our aspiration isn't to be good or pretty good, it needs to be great." Campo's goal is to develop a unified, internationally preeminent division of pediatric psychiatry and behavioral health by improving its training program and better integrating "into the fabric of the Children's Center and pediatrics in general."

Unreasonable Barriers to Care Threaten the State System

by: Kim Jones-Fearing, MD

Kim Jones-Fearing, MD

Ed's Note: This is a version of a letter sent to the Baltimore Sun

When I learned on November 24th that Optum was refusing to pay mental health claims to Maryland's CMHC's for the past year I was outraged. But, I was more shocked to see that the government had done nothing to stop this flagrant abuse despite federal and state laws.

During the last legislative session, a mental health parity law was put in place to strengthen protections such as "non-quantitative" limitations--rules put in place by insurance companies that indirectly result in limiting care. Prior authorization for medication, pre-authorization for clinic visits, first- fail protocols, and patient-improvement criteria are all examples.

I have been seeing ridiculous reasons given for medication prior authorizations. These took an average of 9 non-reimbursable hours for the doctors and staff to complete. Examples included brand-name mood stabilizers that patients had been stable on for many years. Some were patients with addictions who simply needed Strattera for attention deficit disorder. These prior authorization requests arrive in the fax machine at random times and may not reach the attention of the clinician until days later-- when patients have already missed several doses. This drives a wedge between patient and doctor and often results in patients dropping out of treatment or seeking meds on the street from drug dealers

It did not really surprise me that Optum has been doing this. It is a subsidiary of United Health Care. In 2019, United Health Care's subsidiary, United Behavioral Health, was found guilty in federal court of mental health discrimination for using flawed algorithms to illegally deny treatment to more than 50, 000 claimants with mental illness. According to the federal law, passed in 2008, mental health criteria for treatment selection cannot be any more restrictive than they are for general health care. The flawed algorithms that United Health Care used were based on internally company-generated data and not those used in the federal government guidelines. This resulted in far more patients being denied treatment than is acceptable.

In Maryland, our death rates from treatable conditions such as depression, stress, drug overdoses and suicide have risen dramatically over this past year--partly as a result of this systemic lack of access to care. During the darkest part of the pandemic, when death rates were rising the most, the entire country was on lock-down and we were advised by scientists and infectious disease experts to avoid all in-person contact, Optum and other insurers were actively denying claims for telemedicine. This was while it was just about the only safe way to interact with patients.

There have been many consequences, including lay-offs, clinic closings, rapid turnover of health care professionals, and overall poor access to care. Clinics and other out-patient practices are unable to take in new patients. Most likely this is due to fear that treatment criteria will not be met. Another reason is the rejection of prescriptions for medications that, in most cases patients have been stable on for many years, due to lack of "authorization" by the insurance company.

Now that we see the blatant abuse of health resources, what will we do as an organization? What can we do as individuals?

Update: The Maryland General Assembly voted unanimously to hold Optum responsible for the disastrous mismanagement of Maryland Medicaid. You can read about it here.

Curbside Conversations Update

New information for Curbside Conversations is posted online. Over 20 topic areas with limited participation have been added! Curbside Conversations facilitates member connections related to specific practice areas. Members with in-depth knowledge chat informally with other members seeking information. The discussions are not formal consultations, but rather a collegial resource offered voluntarily to others in the MPS community. Click for details.

Meet the Behavioral Health Challenges of The Elder Boom

by: Michael B. Friedman, MSW
Chair, The Brain and Behavioral Health Advocacy Team of AARP Maryland


Michael Friedman, MSW

Recently, AARP Maryland established an advocacy group focusing on brain and behavioral health. In part, we did so because of the clear psychological fallout of the pandemic. But we also did so because of significant unmet behavioral health needs of older adults that existed prior to the pandemic and that will exist afterwards. To meet these needs, AARP of Maryland, with support from the MPS and other organizations, has called on the state to develop **a data-driven, multiyear plan to meet the behavioral health challenges of the elder boom.** A mandate to do so has been included in the state budget for 2012-22.

The elder boom began a decade ago. It is gathering force and will continue to do so as the population of older adults--as well as the population of older adults with cognitive and behavioral health conditions—doubles in the next few years.

This should be a matter of major concern. About 25% of people 65 and over have diagnosable cognitive and/or behavioral disorders. Even more of them experience emotional challenges that have significant negative impact on quality and length of life. Troubling conditions include:

- Dementia
- Other psychiatric disorders such as psychosis, depression, and anxiety disorders
- Substance misuse, particularly overuse of alcohol and of medications
- Co-occurring physical and cognitive disorders
- Disturbing emotional reactions to catastrophic events

Difficult developmental challenges of old age including:

- Retirement and other role changes
- Decreasing social connections and increasing social isolation
- Dealing with grief
- Declining physical health
- Living with chronic illnesses and pain
- The increasing possibility of dependency
- The inevitability of death

These conditions result in substantial human suffering. In addition, they are major contributors to premature disability and death. In part, this reflects the high rate of suicide among older adults. In larger part, it reflects the negative consequences of co-occurring disorders, which are a major driver of the very high costs of health care in the United States.

The mental health of older adults should be a matter of major social concern, especially for:

- People with long histories of mental and/or substance use disorders
- Socially isolated older adults
- Victims of economic hardship
- People of color, who will become a much larger portion of the population in the coming years and currently suffer from health disparities
- Older veterans
- Victims of elder abuse
- Family caregivers

Sadly, most older people with cognitive and/or behavioral disorders do not get adequate care and treatment:

- There is an inadequate continuum of behavioral health services
- There are too few clinically, culturally, and geriatrically competent health and behavioral health professionals and paraprofessionals.
- There is over-reliance on primary health care providers without adequate expertise.
- And, even though the vast majority of older adults with cognitive and/or behavioral disorders live in the community, there is still over-reliance on long-term institutional care, largely due to:
  - (1) Inadequate support for family care givers, who are at high risk for "burn out"
  - (2) A shortage of supportive housing as an alternative to institutional care.

It is important to note that mental health is a critical component of well-being in old age. Contrary to the ageist perspective of our society, it is possible to age well. Older people can not only achieve considerable personal satisfaction; they can be, and are, contributors to society. Older adults are not, as the ageist perspective has it, only people in need of help; they are people who can give help. Promoting lives of connection, engagement, belonging, and meaning can result in a vastly stronger society.

(Continued on p. 15)

Elder Boom

(Continued from page 14)

To address the behavioral health needs and opportunities of older adults, AARP of Maryland believes there needs to be a multi-year, inter-agency plan that draws from sound data regarding demographics, epidemiology, service provision, and financing.

It will need to address a broad range of issues including how to:

- Help older people with cognitive or mental disorders to live where they prefer
- Support their family caregivers
- Provide housing alternatives to institutions
- Increase the capacity of, and access to, home and community-based services including tele-health
- Improve the quality of both community-based and institutional services
- Enhance integration of physical, cognitive, and behavioral health services and of health and aging services
- Build a larger and more clinically, culturally, and geriatrically competent behavioral health and long-term care workforce
- Provide public education regarding their problems
- Address social determinants of behavioral disorders, including isolation, economic hardship, food insecurity, dangerous living conditions, and systemic racism
- Include older adults as part of the effort to meet the needs of their peers
- Re-organize financing so that funding structures align with service needs

The behavioral health challenges of the elder boom are vast and difficult, but meeting them is critical to the health and well-being of older adults. With the enactment of this mandate, we can now take a major step forward.

Calling All Members!
2021-2022 MPS Opportunities

Engage, Network, and Make a Difference in How Psychiatry is Practiced in Maryland

The annual MPS leadership cycle begins again this month with the installation of Ginger Ashley, M.D. as President. The MPS offers multiple ways for members to connect with the organization and each other, including volunteering for committees or joining an email interest group. This is your organization representing your profession. Your energy and ideas can help the MPS effectively focus on issues that are important to you - this is your chance to help shape it! To review member opportunities and sign up for those of interest, please click here.

Barbara Young:
Turning Anguish Into Beauty

by Jesse Hellman, MD

Jesse Hellman, MD

Psychiatrist and psychoanalyst Barbara Young celebrated her 100th birthday on November 27, 2020. Barbara was born in Chicago. Her father was a Congregational minister, her mother a teacher of Latin, Greek, and German. She learned very early she need not be meek. She grew up in a family that stressed strong communal values, helping others, and sensitivity to the beauties of nature and humanity. There was also the eternal blend of expectations and complexity. Talking with her sister was invaluable, but at times it led them to be told that their conversations were bothering their mother, who was in another room in their house.

When she was quite young Barbara told her grandmother that someday she would be a nurse. The response was transformative: "Why don't you be a doctor?" This encapsulates her drive to both follow her dreams, to help people, and not be held captive by the expectations and boundaries women have long faced. Dr. Young went from college to medical school at Johns Hopkins, becoming a psychiatrist and psychoanalyst who has helped many explore their own dreams and expand their own boundaries.

What Dr. Young is truly known for, however, is her work as an artist. She was a pioneer in color photography becoming recognized as art, her work in the permanent collection of some of the most prestigious museums in the nation: The Museum of Modern Art and Metropolitan Museum of Art in New York, the Baltimore Museum of Art, and the Walters Art Museum. Particularly striking is how her art encapsulates and express the emotions and sensitivities which drew her to psychiatry and psychoanalysis.

Barbara Young, MD

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Uffizi Landing, 1963

In perhaps her most famous work, a photograph which she took after leaving the Uffizi Gallery in Florence, we see two small boats. There is a large expanse of water above the boats. Originally one could see the opposing shore. She cropped that shore out. Ned Rifkin, head of photography at The Baltimore Museum of Art, explained that by so doing she was making "modern art." By doing so, she created a sense of the larger of the two boats being like a parent protecting a child against the great unknown. Her photographs show contrasts between death and life, the changes and turmoil one faces in life, and more. They are modern art in a most progressive sense, combining much of what she experienced in her religious home with her academic and progressive parents, facing the inevitabilities of death and loss. Importantly, Barbara fought the IRS for 6 years, successfully, to establish the right for a professional to deduct the expenses of pursuing her art.

The Blue Room,1973

Glen McNatt wrote in *The Baltimore Sun* that "Young, a psychiatrist, was one of the pioneers of color art photography." Howard Spiro, Professor of Internal Medicine at Yale University and director of the Yale Program for Humanities in Medicine from 1983 to 1999, said of Dr. Young that "the only person I can compare her to is Beethoven. I envy her ability to turn anguish into beauty." Barbara writes in *Looking Back*, a work of biography and photographs she published last year, "In Zurich I visited Rosselina Bischof, the head of Magnum Photo... She gently caressed "Stream Bed 1960" and "Jumbay Seedlings 1963," likening them to Buddhist gardens where nature is arranged to represent various life forces. She felt that my work showed an attempt to integrate forces in a manner similar to assisting patients to integrate themselves."

It is not at all unusual for those in our profession to make use of their interest in people, entwined with the skills and experience gained in medicine and psychiatry, in creative ways in the arts and humanities. Barbara Young exemplifies this to a most unusual degree. Barbara is now living at Symphony Manor, a retirement community in Roland Park. Reading about her and speaking with her has been inspiring and led me to write this sonnet, which she asked I include here:

For Barbara Young at 100

Her father a pastor, her mother taught Greek.
With a minister's morals and courage galore,
She learned very early she need not be meek,
Pursuing all truths yet still searching for more.
"I shall be a nurse! That will be a good start!"
Her grandmother countered with barely a pause,
"Why not a doctor? Go: follow your heart!"
Psychiatrist, analyst, she garnered applause,
An artist expressing emotions sublime:
The beauty of sand waves caressing a beach,
Extended hands show the passage of time,
How life slips away -- yet hope stays within reach.
Her upbringing taught her that come health or strife
Our mothers' embraces support us through life.

Interview: Geetha Jayaram, MD

Professor, Johns Hopkins Department of Psychiatry and Behavioral Sciences, Public Health & Nursing

by Bruce Hershfield, MD

Geetha Jayaram, M.D.

March 8, 2021

Q: "Please tell us what you have been doing recently."

Dr. J:" I have been involved with the Rotary movement since I was a teenager—doing humanitarian services, here and across the globe. This year, I am the District Governor-elect, which is a position that covers 62 clubs in the Maryland/DC area. The idea is to provide leadership and training to the presidents of those clubs and to motivate them to fulfill the mission of Rotary. In my year the theme is to Serve to Change Lives.

We spend a great deal of time working together, trying to figure out how to do bigger projects—bigger in scale and with a broader reach. During the pandemic there were about 7 clubs, including mine, in Howard County that worked together to deliver about $55,000 worth of PPE to area nursing homes and assisted care living homes.

Rotary International has 7 areas of focus now. For my year, we will be choosing Maternal and Child Health, as part of my strategic plan, for which we will be giving out grants. So we essentially do millions of dollars-worth of humanitarian service."

Q: " What else have you been doing?"

Dr. J: "I last worked on the inpatient unit last April. Now I am just mentoring and teaching. I'm working with the School of Public Health and the School of Medicine to provide outreach; mentoring young people who want to do outreach or who want to work in public health. There is a lot to do and I volunteer my time to help. I attend the Johns Hopkins Academy of retired faculty. They have interesting programs monthly.

I also serve as a consultant for patient safety to many hospitals and individuals. Either they have read my book or have read about my patient safety initiatives. I retired from that American Psychiatric Association committee this past year, after having served on it for 17 years. That's a long time! I still work in some capacity with the Association of Women Psychiatrists and I am on the Council for the American Association of Psychiatric Administrators. We review applications for awards, we try and build our base and we try to network with one another."

Q: "It sounds like you have plenty to do."

Dr. J: "Yes I do. I have expanded support for mental health initiatives via Rotary grants to many parts of the world. We forged a fellowship of Rotarian doctors across 6 continents. We are about 400 members who work around the globe, together. We worked on suicide prevention in Lithuania. The whole country went through a massive effort to try to reduce suicide because its rate was 4 times that of the USA. The age group 15-25 was most affected. We worked together for a couple of years and applied for a global grant that was funded by the Rotary Foundation. They launched a massive effort to educate everybody in the country—caseworkers, community care providers… I made sure they linked it with the Vilnius University School of Public health, which is apparently the oldest university in Europe. They worked with law enforcement, mayors, educators, everybody in the country to reduce suicide and they were very successful.
In Kenya, where I am working now, I am using the community mental health model I used at Hopkins and duplicated in India. Once our grant application goes through we plan to launch a similar initiative in Kenya."

Q: "How did you come to Hopkins and get involved with this?"

Dr. J:" During the Carter administration there was a dearth of physicians in the USA and they called for highly qualified people to come here if they could pass their boards. At the time, it was easier. If you passed your medical boards you were given a green card. I took the exam in Paris and became a naturalized citizen. You had to land on American soil before January 9, 1977. The deadline was set at short notice. You just had to get your stuff together and get here. As soon as I arrived, I was looking for residency programs. I applied to Hopkins in both Medicine and Psychiatry. I had done a couple of Internal Medicine years in India. I had a child—I had been the first person in my class to marry and to have a child. I looked at the rigors of being a Medicine resident; I simply would not have had any time for a child at all, so I decided I would take Psychiatry because the call was every 4th day instead of every other day.

And I loved it. I loved the teaching, I loved Paul McHugh's direction, his leadership, his mission,

(Continued on p. 18)

and his ability to inspire people. The reason I stayed at Hopkins was that he is a phenomenal teacher and also an inspiring person. He is one of the brightest people I have ever encountered in Medicine. He also recognized there was a need for someone strong in Community Psychiatry. He encouraged me to be the Director of the clinic when Bill Breakey ran the program. The clinic got the Community Psychiatry "gold medal". That was the first time we got it—because of the development of services under the umbrella of Community Psychiatry at Hopkins. I loved working with the inner-city poor; that was what I wanted to do. Eventually I went to run the inpatient Community Psychiatry unit with Jeff Janofsky. We shared an attending psychiatrist role for over 21 years. I believe we made an enormous difference in teaching and in developing the kind of clinical care patients ought to be getting. "

Q: "What influenced you the most?"

Dr J: "The first principle is that each person requires his or her own approach. There's no one approach that fits everybody. What we have always been taught in Psychiatry is to meet the patients half-way and to try to understand who they are and what they are about and what really pains them. What brings them to the inpatient service? Why do they suffer? That is what Paul McHugh taught us—using "The Perspectives", getting to know who the person is what matters the most, then thinking of making the patient safe. When clinicians fail it is because they try to have some ready-made formula.

With regard to safety, I have done a lot of research in the area and know there are certain things that predispose to violence, for example. Like someone who is withdrawing from drugs or who has grown up in a violent environment. With a splendid nursing staff, we were able to control that to a point where no-one was hurt significantly in over two and one-half decades! It was because we tried very hard, as a team, to work with the patient."

Some of my earliest supervisors had a big impact. Jerome Frank was my supervisor for group and individual therapy. He and Lex Smith, who was a terrific supervisor, persuaded me to start my own private practice. So, in addition to working at Hopkins, where I was "limited full-time", I had my own private practice." Others who supervised me in other areas of outpatient care were Bill Battle and Bob Ward, both excellent teachers.

Q: "That can change one's perspective."

Dr. J:" What you gain, besides business skills, is a deep appreciation for how hard it is for people to approach you for help. It's not an easy thing to do. Whereas on an inpatient service people are brought in because they are so ill, in an outpatient practice people often want to come to you, not because someone is forcing them, but because they recognize they have a need. So, it's a very different approach and it helps you become a better psychiatrist. "

Q: "What are your plans for the future?"

Dr J:" I love humanitarian work. I think it helps me grow as a person. It transforms you---to be able to go and to sit down in an 8X8 foot house, the floor covered by packed mud and cow dung paste to keep out the ants. To sit on the floor on a bamboo mat with someone who has severe bipolar illness, whose bedroll is in one corner, a little shrine where she prays in another corner, one faucet that is used for a bath as well as for a kitchen water source, and a makeshift clay oven. That is somebody's house. This person has a tremendous appreciation for what you are doing. She is scrambling around, trying to borrow some sugar from her neighbor, some milk, so she can give you some tea because you are this very prized visitor to her little house. When you observe the dignity and the courtesy with which they treat you—this in Kenya, in India, in other parts of the world where I have been—you realize the gift that this woman is giving you is far larger than anything material that you are providing for her. They are willing to talk about the most intimate details of their lives with you. And they trust you to do the right thing for them even though they don't know you from Adam. That gives you a profound sense of gratitude and accomplishment, but it also reminds you of how insignificant you are in the big scheme of things. "

Q: "How can the psychiatric community help?"

Dr. J: " I would love to form a satellite club of professionals who want to do humanitarian work. I put a lot of effort, with Jim Harris and Cathy DeAngelis, into writing a proposal for a global mental health section of our department because there are many residents who apply, and medical students, who ask for it.

We have essentially three different schools of global health. One is an Institute for Global Health, there is a division of mental health in the School of Public Health, and then we are here in the Department of Psychiatry. Over and over, I have tried to get these three groups to work together. This year, the Provost has given permission to start something called the Hopkins-India Health Initiative. I have been approached by a Professor in the Center for Global Health who has been working with HIV patients in the Mumbai area, to see if we can help Hopkins launch an India health initiative. The idea is to see how Hopkins can facilitate the growth of medical services in India for underserved populations".

Q:" What has given you the most satisfaction?"

Dr. J: "I love teaching. The biggest gift I got among all awards was being elected to the Distinguished Teachers Society of Hopkins two years ago. They only elect 5 every year, so I was very pleased!"

Why Psychiatrists Should Follow "Goldwater"

by: Annette Hanson, MD


Annette Hanson, MD

Now that the presidential election and inauguration have passed, it may be safe to re-address psychiatry's role in politics and, in particular, the Goldwater Rule. More appropriately referred to as Section 7.3 of the Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, it states:

"On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization for such a statement."

This principle was publicly re-endorsed by the APA in press releases during the Trump administration because some psychiatrists felt compelled, in the name of national security, to speculate upon the president's personality traits and psychodynamics.

What some people may not realize is that the psychopathology of prominent elected and appointed federal officials has been well documented throughout history, and these disabilities have not made them categorically unqualified to hold office.

Consider the Supreme Court:

One of the earliest Supreme Court justices, appointed by George Washington, was John Rutledge, who had attempted to drown himself. He was rescued, then attempted suicide again a day or two later. He not only served on the Supreme Court, he helped draft the first Constitution.

Justice Henry Baldwin was hospitalized for what was called "incurable lunacy" and missed the entire 1833 term. He promoted a method of constitutional interpretation that remains influential today.

By age 92 Oliver Wendell Holmes was showing cognitive decline and was frequently drowsy on the bench or during conferences. During his record-breaking tenure on the court he wrote the majority opinion for many key First Amendment cases.

Justice Frank Murphy was hospitalized several times during 1946 and 1947 due to dependence on Seconal (and later on Demerol). By 1948 some of his closest acquaintances were convinced that he was regularly purchasing illegal drugs. He deputized other judges to cast votes on cases on his behalf.

Other justices were equally influential, yet flawed. In 1962 Justice Charles Whittaker was admitted following a suicide attempt, but still supported a unanimous court opinion to oppose racial discrimination in voting rights. There were two attempts to impeach William O. Douglas based upon alleged character defects because he had been married four times and was possibly hypomanic at baseline. Chief Justice William Rehnquist was once admitted to the hospital for treatment of delirium due to Placidyl dependence.

If psychiatrists speak out in the name of public safety or national security, they would be wrong more often than right. As the last election and tumultuous inauguration proved, our nation and Constitution are sound. When psychiatry steps into the political arena it runs the risk of being used as a political cudgel rather than a clinical tool.

Medical Student Mentors Needed

The MPS is looking for members who would like to serve as mentors for our our new medical student members. As a practicing psychiatrist, you will help guide them throughout their medical school journey and help with their growth both personally and professionally. If you feel you would make a good mentor, please email mfloyd@mdpsych.org.

LETTER FROM THE EDITOR
My Tie

by: *Bruce Hershfield, MD*

Bruce Hershfield, MD

On July 1, 1971 I started my training and met most of the other 1st year Psychiatric Residents at UNC. It was a sale day called "Hot Diggity Day", so several of us went to the local Belk-Leggett store, where I bought a tie for $3.50. I still wear the tie and I am still learning about psychiatry and my fellow psychiatrists, almost 50 years later.

Dr. Young (see the article on p. 15) has been doing it longer.

Time has passed at different speeds in my career, but the most dramatic change has occurred in this past year of the plague, with its peculiar sameness of weekdays and weekends.

Learning has also changed, as I 've realized by doing without in-person meetings. Now, I can learn more in a couple of hours in front of a computer than in any entire meeting. It came just in time, as our knowledge has gotten too big to handle at meetings and with books and journals. But there are aspects of psychiatry that have nothing to do with facts and can be absorbed best by in-person conversations with colleagues. We are missing out on that, like the kids have been missing out on a well-rounded education by doing "virtual school".

The biggest changes I have seen in Psychiatry have included the dominance of medication as the centerpiece of what we're known for doing, the adoption of a business model for how we're paid, and the recent advent of telepsychiatry for all.

The first has led to "med chex", with some of us already being replaced by nurses who are comfortable writing prescriptions. This is a result of reductionism—that all psychiatric problems are "brain disorders"-- and the over-sold idea that pills will solve all problems. It is clear to me that we have given up the status of being the experts in treating OCD and personality disorders and it is happening for panic disorder, as well.

The "alliance" of Psychiatry with "big business" has led, predictably, to the bigger entity swallowing the smaller. This created a ton of paperwork. Money that could be spent on patient care is instead going to a whole class of administrators and clerks. The attempt to overlap two ways of viewing people—as sufferers (patients) to be helped or as consumers who have resources to spend—threatens our whole system of ethics.
The sudden and almost-total advent of telepsychiatry may change our relationships with patients forever, decreasing the warmth of our interactions with them and our chances of establishing the kinds of relationships that can save lives in a crisis.

At an APA annual meeting a few years ago, I heard someone from the PA attorney general's office talk about her concern that older physicians tend to suffer from cognitive decline. It is clear they require more time to learn the new technologies. They may resist changes that really do need to occur. However, they may make fewer mistakes, having learned from the ones they have already made (and have seen others make). There doesn't seem to be much evidence that the theory Maintenance of Certification is based on is true--that clinicians right out of residency practice better than ones who finished training years ago. They just practice differently. Certainly, people who are looking for psychiatrists are not demanding they see inexperienced ones.

As in 1971, we still have a lot of work to do. The more I do this, the more I realize how little I know—like why some get ill and others don't. But the only way I can see us having a chance of answering these questions is for us to work together, in the MPS, the APA, and our allied organizations. Together, we can be hopeful. If we are divided, we have no chance.

I plan to wear that tie this week. The fashions come and go—wider to narrower, silk to poly, colors muted or louder—but I think it was made right and it still has a few good days ahead.