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Holiday Greetings & Year In Review: From The President

by Virginia Ashley, MD


Virginia Ashley, MD

Holiday Greetings from the executive committee and staff at MPS. We hope all of us can celebrate in our own special ways.

At MPS we are grateful for surviving the second year of pandemic issues. Committee meetings and MPS Council are taking place on a regular basis, by zoom. Thanks to Heidi and Meagan, we have adapted to it. It has the advantage of not requiring us to do any travel or to look for a place to park on busy work nights. However, most of us do miss the socialization benefits of in-person meetings. We are working on what future MPS meetings might look like and we are suspecting we will have a hybrid of in-person and Zoom.

We have been working on membership recruitment this year, especially with younger members. We added a medical student category, which may facilitate students to become psychiatrists. If any member would like to mentor a medical student, please contact us. The Hopkins Residency Program has decided to start funding residents' memberships in MPS. The University of Maryland- Sheppard Pratt Residency program currently pays for theirs. We are very excited about our younger members.

We have had several successful CME meetings by Zoom. The Maryland Foundation for Psychiatry funded the free CME on Racism in Maryland Psychiatry program. We also had a CME program about Psychiatry and Legal Interventions in November.

We are hoping for a healthy hybrid year in 2022. Happy Holidays and Happy New Year from the MPS!

In This Issue

MARYLAND
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All BUT the Credentialing

by Kim Jones-Fearing, MD

Kim Jones-Fearing, MD

Have any of you been hired for jobs, but told that the only remaining issue is credentialing? You are then given endless portals, passwords to reset, user names and multiple credentialing applications. One set is for the recruiting agency, another set for the hiring authority, the facility, hospital etc. This duplication of information is NOT normal and is contributing to a shortage of psychiatrists in Maryland.

There are 2 types of credentialing in the health industry. One type is where the hiring facility does the credentialing on your behalf. This is called "delegated credentialing". The entity doing the credentialing has "skin the game" because it is tasked with getting your credentialing correct. The other type is "non-delegated credentialing", where you are essentially spending hours of what I call "Do it yourself credentialing." This starts with filling out 60 pages of a uniform credentialing form, then going to numerous portals where you are entering the same information multiple times. It takes hundreds of hours of hands-on time to do. It is demoralizing. It is unnecessary. You can go through weeks and months of daily logging into portals, resetting passwords--only to find out that the PIN for your position has just been closed. The new position was just given to a nurse practitioner!

Insurance credentialing for behavioral health in Maryland has NOT been following government guidelines. This was recently addressed by our insurance commissioner, Kathleen Birrane, in a town hall meeting in July. You can watch it on the Maryland Insurance Administration website. I was the panel member representing the MPS. One citation that was excluded was my statement about the statistic that the average psychiatrist nationally works 2.4 jobs. For many of us, this means we have a private practice and we may also work with a clinic or hospital or correctional facility as a "rendering provider." When the insurance credentialing system is corrupt and chaotic, with no way of streamlining information flow, it leads to a corruption of multiple other processes. Provider directories and provider panels are often inaccurate. Hundreds of thousands of potential patients have no idea of how to find us. If you decide to watch the Credentialing town hall, you will hear a patient advocate's testimony first-hand. Lack of fair and consistent outpatient credentialing standards for behavioral health directly caused her grandson's first psychiatric hospitalization.

If you have noticed this chaos, please share your comments on our Listserv. There is strength in numbers. We have a few friends in the legislature now. Things can change. The barriers to our employment are artificial and structural. We need to stand up and do something about it. If we don't, NP's are waiting to be handed our jobs.

MPS Seminar on Psychiatry & Legal Interventions

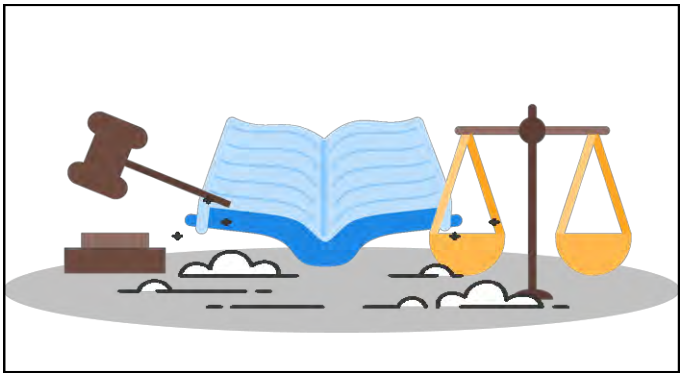
Drs. Deb, Lewis & Means Discuss Ways to make Dangerous Situations Safer

by: Bruce Hershfield, MD

Bruce Hershfield, MD

On November 10th, the MPS held a webinar chaired by Dr. Paul Nestadt concerning how we can intervene to prevent tragedies. This was done as a result of a tragic incident on May 8th in which 4 people died at the hand of Everton Brown.

Dr. Arkaprava Deb, whose letter to the Baltimore Sun brought this incident to the attention of so many, began by describing what happened. He told us that since 2015 there have been 1400 fatal police shootings of people who had psychiatric diagnoses. Of course, he added, psychiatric disorders are not responsible for all crime. He went on to describe what can be done. Emergency petitions can be requested of a judge by anyone and are valid for 5 days afterwards. They can also be issued by MD's, psychologists, peace officers, and others and these do not expire. He said that 62% of them result in admission to a hospital (mostly voluntary). Since 2018 we have had access to "extreme risk protective orders" (which are now in 19 states plus DC). A judge who issues one can temporarily remove firearms during a crisis or until treatment has begun. It does not require a psychiatric diagnosis. The application can be filled out by a "petitioner", including a professional who has examined the person. In CT, the number of suicides decreased by 5-10% after this was implemented.



He then told us about the development of "mobile crisis teams" that provide 24/7 availability for face-to-face intervention by a professional on-site. Each county in Maryland has one. They do evaluation, triage, and referral and have been shown to increase the percentage of admissions that are voluntary.

Dr. Cynthia Lewis, who is in charge of psychiatric ER services at Johns Hopkins Hospital, then lectured from the perspective of the ER physicians. Some of the changes in the Baltimore area came about because of a consent decree with the Federal government in 2011. Although it is generally not advisable, the professional who is examining a person can transport the evaluee to the nearest facility. That person must be examined within 6 hours and cannot be kept in an ER for more than 30. If admitted to a hospital, the person must be seen by a psychiatrist within 24 hours. Maryland is only one of three states that does not have "Assisted Outpatient Treatment". She went on to give an update on laws governing seclusion and restraint.

Dr. Ronald Means then spoke about Behavioral Health Crises in College & University Settings. He said that most of these schools do provide clinical services to students who are complaining of stress, typically by psychologists and social workers. The clinicians are not usually experienced in handling patients who have serious conditions. Often, the only ones who can respond to a crisis are police and safety officers. It is not clear how the policies apply to students who are in "remote" locations, or to staff. A pilot program at Johns Hopkins is pairing a mental health professional with a security officer, 24/7, in order to provide "bridge care" until the person can get to see someone who can provide treatment on a longer-term basis.

The lectures were followed by an interesting Q & A session, including some discussion of whether our community would be better served if Maryland provided for outpatient commitment.

Tribute: Dr. Harold Eist (1938-2021)

by: Bruce Hershfield, MD

Harold Eist, MD

Harold Eist, MD a past president of APA and longtime friend to many of us, died December 16th at age 83 of complications of hip surgery.

He was a major figure in psychiatry.

Originally from Edmonton, he attended the University of Alberta and did his psychiatric training at the University of Minnesota and his analytic training at the Washington Psychonalytic Institute. He was director of a mental health clinic for many years, earning it a Gold Medal from the APA and being personally named the Washingtonian of the Year in 1979. A Clinical Professor at Georgetown, he wrote more than 100 articles. For many years he practiced child and adolescent psychiatry and adult psychiatry in Bethesda. Active in psychiatric organizations, he served as President of the APA and was the North American Rep on the World Psychiatric Association board. He served three terms as President of the Washington Psychiatric Society, was an affiliate member of the MPS, and also was active in the Southern Psychiatric Association.

He was particularly important in warning us about how business practices could corrupt the ethics of our profession if the two got too closely intertwined. Brian Crowley, who recently served two terms as the Area 3 Trustee in the APA, commented, "Roger Peele called Harold 'Churchillian' for his frequent warnings about the rise of managed care, with its interference in the doctor-patient relationship and greed in taking money from the healthcare system. One aspect of Harold's activism in organized psychiatry and daily life was his emphatic support of being inclusive, and his antipathy to prejudice of all kinds, including those based on color, gender, sexual orientation, religion, and social position."

He also fought hard for many years to protect the privacy of our patients. He was the sort of man who was willing to pay whatever it took for standing up for what is right.

Dr. Steven Sharfstein recalls the APA election in 1994 when Harold and he traveled the country and debated no less than a dozen times in various district branches. That year, over 15,000 psychiatrists voted--a record--with Harold winning the APA presidency by a few hundred votes. Steven and Harold bonded over that time, when real issues could be discussed and debated. (These days, only a few thousand psychiatrists vote in APA elections.) Steven commented, "We all shall miss Harold's energy and deep commitment to the profession. I will especially miss his friendship."

Many of his admirers spoke movingly of how much he had influenced them when they learned of his death. William Thornloe, MD from Georgia captured one aspect of Dr. Eist particularly well:" He was a giant among us. We will all miss his ability to have convictions and to have actions based on those."

In his remarks on receiving the 2015 Distinguished Alumni Award from the University of Alberta, Dr. Eist said, "We have to try to make it more. My patients inspired me to work hard, to learn and to constantly challenge myself to find more creative ways to help." He went on in that generous way he had, "My wife, Ann, has been with me for almost 56 years. She is my best friend, loving, nurturing, trustworthy, beautiful, and reliable. She is my alpha and omega—the first and the last, a clearheaded assistant and companion. As Churchill said of Clemmie, 'We have traveled ceaselessly over endless seas.'"

Dr. Crowley, who was close to him for more than 50 years, said," I'd known Harold as a good friend and worked with him in WPS and APA matters for so many decades, and those many rich, unforgettable memories temper the real sense of loss."

The Future of Psychiatry: A Look Back to Where We Were

by: Steven Daviss, MD


Steven Daviss, MD

In April, I was asked to develop a presentation at a conference as one of several speakers on the subject of "The Future of Psychiatry." We would each speculate on what the practice of psychiatry would look like in the year 2075. This is 54 years from now. I rounded that up to 55 years, so let's call it 2076. That is, of course, the year the United States celebrates its 300th birthday.

I do not actually know what the field of Psychiatry will look like in 55 years, when I am 114 years old. But I can make an educated guess about what it might look like then. How did I educate myself about the future? By looking at the past. I looked back 55 years, to 1966. And to 1911. And to 1856. I looked at a narrow slice of data every 55 years, leading up to 2076. This article will explain a few of my observations about psychiatry's past and how that might inform what the predicted future will bring. But those observations are made through this narrow lens -- a lens that is solely focused on psychiatry at 55-year increments, as told by the authors published in the *American Journal of Psychiatry* in April (or May) of each of these years.

Across this span of 220 years, there are many repeating themes, but they are using different words that evolve over time - - starting with the name of the Journal. The first issue of the *American Journal of Psychiatry* was in 1844, when it was then called the *American Journal of Insanity*. What is now the APA was then called the Association of Medical Superintendents of the American Institutions for the Insane.

Words become heavy with age, weighed down by definitions and meanings that get added to them over the years. Asylum becomes Institution. Lunacy becomes Insanity. Insanity becomes Psychiatry. What will "Psychiatry" be called in 2076? Will the APA then be the American Mental Health Association? Maybe that one is taken. American Mental Wellness Association? Nah, AMWA already owns that acronym, and the name sounds so 2020's. I've got it. Perhaps the American Neuromics Association. "Neuromics" could be the new "psychiatry," going all in on the interplay among neurons, circuitry, genetics, genomics, proteomics, endocrinology, and immunology, among other related fields.

Here are some of the titles in the 12th volume of the *American Journal of Insanity* in the April 1856 issue:

1. Considerations on the Reciprocal Influence of the Physical Organization and Mental Manifestations
2. Suicide and Suicidal Insanity
3. Reports of American Asylums
4. Education of Idiots at the West
5. Insanity in Relation to Crimes
6. Summary

The first article relates to how physical conditions impact the mental, and vice versa -- particularly focusing on the female reproductive system. Data are presented from asylums to suggest that the reproductive organs cause the insanity in 25% of the residents.

> Whether the primary cause in these cases had its seat in the cerebral or the generative system, is a question no less interesting than difficult of solution.
>
> Hence all the diseases which affect the female generative system have, at one time or another, been brought forward as causes of insanity. Even its most natural function, that of gestation, does, in some cases, by the peculiar change wrought in the female economy, and the train of inexplicable nervous symptoms which result, give rise to insanity.
>
> The changes which take place in the mental and moral faculties about the time of puberty, are in both sexes very interesting, particularly so in the female. ... 'The mind,' says Dr. Copland, ' acquires extended powers of emotion and passion, and the imagination be comes more lively. If, on the other hand, the uterine organs continue undeveloped, and the menstrual discharge does not appear, the mind is dull, weak, or de pressed, and the emotions and passions are imperfect or altogether absent.

(Continued on p. 6)

(*Continued*) The Future of Psychiatry: A Look Back to Where We Were

This article examines these "reciprocal influences," speculating on cause and effect, and the line between physiological and pathological.

The second article summarizes a French treatise on suicide and insanity by Dr. Brierre de Boismont, splitting the various causes of suicide into predisposing and determining causes. The former includes "hereditary tendency" (a nod to genetic risk), sex, age, education, and economic status; while the latter includes insanity, individual unfortunate circumstances, and "unconquered passions."

> Suicide risk is higher among the most highly educated and in areas with advanced industry, which de Boismont "proves, by authentic and exact statistics, that the number of suicides is in direct proportion with the advance of civilization.

After reviewing suicide notes from many cases, he distinguishes written content from those who appear sane and those who appear insane. He acknowledges that suicide can be a rational act born of desperation and desolation.

> [Of the sane,] "it is found that the motives which they assign in explanation of the act are the results of the passions, the inordinate desires, -- in a word, of all the common incentives to action in life". [Of the insane,] "the tendency to suicide is determined by hallucination, illusions, and other morbid conditions. With those of a sane mind who commit suicide, reason remains undisturbed; but with the insane it is in a state of perturbation."

He also discusses suicide prevention…

> Imitation, which is a species of moral contagion, contributes to increase the disposition to suicide; therefore nervous, impressible persons should avoid conversations and books relating to this subject. Threatening punishments are, at the best, good only for uncivilized nations; but actual punishments for certain vices -- such as drunkenness, for example -- would diminish the number of suicides.

…as well as treatment.

> In the state of insanity, the treatment of those disposed to suicide differs from that for those who are sane. More frequently is it necessary to resort to seclusion, to coercive measures, and to therapeutical agents--such as long-continued baths; shower-baths also are found serviceable in the acute stage of this malady. Cold affusions and antispasmodic preparations and tonics may be employed with great success; also external irritation, such as friction of the skin, and likewise depletion and blistering, may prove beneficial. It is some times necessary, in cases of prolonged refusal of food, to introduce nourishment into the stomach by means of the oesophagus tube. The administration of morphine appears at times to be useful in the treatment of suicidal insanity.

We don't use cold packs, blistering of the skin, or morphine as treatments for suicidality anymore. But it makes one wonder how some of today's treatment would be viewed by our colleagues in 2076, armed with the evidence and knowledge that accumulates over the next five decades.

Part 2 of this mini-series from Dr. Daviss will continue in the next issue.

Dr. Daviss was MPS President in 2004-2005, is immediate past President of the Maryland-DC Society of Addiction Medicine, and is interim chief medical officer for Optum Maryland.
drdaviss@gmail.com

Interview: Ronald Means, MD
MPS Ethics Committee Co-Chair

by: Bruce Hershfield, MD

Ronald Means, MD

Q: "Please tell us about your role as Co-Chair of the MPS Ethics Committee. What is it like and what advice can you give us?"

Dr. M: "Joanna Brandt and I have been Co-Chairs for several years. The primary responsibility of the committee is to investigate complaints regarding conduct of MPS members. Usually, we get that information through Board complaints—-the consent orders. We usually take additional steps to see if APA standards have been violated. I think my forensic training has helped me in these types of investigations. The goal is to make sure that everyone understands what is ethically correct. If necessary, we try to get the member to get up to speed about what the violation was, so as to avoid future problems."

Q: "Any advice about how to avoid getting in trouble?"

Dr. M: "Most of the violations involve boundaries. For whatever reason, we sometimes cross those limits. I suggest always reaching out if you have questions. We are there not just to investigate possible violations, but to offer advice. If you are wondering if something is becoming a violation, please ask. I also strongly encourage peer supervision, especially for those of us in private practice. That way you can get an objective perspective about the standards we are trying to abide by."

Q: "How did you decide to become a forensic psychiatrist?"

Dr. M: "I am from Michigan, where I went to the University of Michigan. I am somewhat unusual in that I always knew I wanted to be a psychiatrist-—even a child psychiatrist. Even in high school I was interested in the mental health field. Because I wanted to do all of the aspects of mental health care, I decided to become a psychiatrist. I always liked working with kids and felt some desire to work with under-served populations. I went to medical school at Case Western. Maybe I got swayed a little bit to look at other potential fields, but stuck with Psychiatry. As a medical student, I did some research at looking at child victims of domestic violence or witnesses to community violence. It was a great opportunity to ensure that what I planned to do fit well with what I loved. One of the most well-known forensic psychiatrists, Dr. Phil Resnick, teaches there. I had the opportunity to learn from him and to do a forensic rotation with him as a 4th year student. At that time, he was preparing for the Andrea Yates trial and I helped him get ready for that. So, after doing that, I found the field to be incredibly interesting. It would satisfy my inquisitive nature while also working in Community Psychiatry, which I knew was my primary love and passion."

Q: "How did you come to Maryland?"

Dr. M: "I came here to do my adult training at the University of Maryland/Sheppard Pratt. I did a couple of years of child training at Johns Hopkins and then returned to University for my final year, in the forensic program. I didn't intend to stay here—-I thought I would go back to the Midwest. But, after 6 years in Baltimore, establishing connections, I decided to stay. Baltimore has been 'home' ever since."

Q: "Tell us about what you are doing now."

Dr. M: "I do a number of things. After I finished training, I worked half-time at Clifton T. Perkins, doing forensic evaluations—-criminal responsibility and competency to stand trial. I also immediately started working for Catholic Charities of Baltimore. Initially, I was a staff psychiatrist, working in the crisis program it runs for youth in Baltimore. So, I split my time, initially, and I also began to develop a private practice that was focused on forensic consultation, with lawyers or agencies. As time passed, I took on more administrative work. I stopped working at Perkins and took an Assistant Medical Director position at Catholic Charities. For the past two years, I've been the Chief Medical Officer for Catholic Charities of Baltimore. I help to oversee all the mental health services Catholic Charities administers throughout the state."

Q: "What does Catholic Charities do?"

(Continued on p. 8)

Dr. M: "It provides a number of services. A senior services arm focuses on housing for vulnerable seniors—-nursing home care, assisted living, as well as housing options. A community services arm works primarily with shelter home populations, like Our Daily Bread, Weinberg House, My Sister's Place. It includes "head start" programs and the Esperanza Center for the immigrant population. Then there's my part--family services, focusing on mental health services for children and adults. For example, we have a residential treatment center for youth and a therapeutic school, in Timonium, and we have 8 outpatient mental health clinics around the state. We treat kids, adults, families, with almost any diagnosis, including substance abuse. We continue to manage the crisis program for youth in Baltimore. We also have a developmentally-delayed arm that provides day programs, housing etc. for adults who require special services.

Many people know the individual programs, but might not know they are all housed under Catholic Charities."

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

Dr. M: "I continue to enjoy my private practice, where I provide forensic consultations. It's a different kind of activity and I get a chance to use a different part of my brain. I never thought I would be the administrative type—-I always thought I would be the clinician, seeing kids for the rest of my career. But, along the way I have enjoyed analyzing systems of care and helping to make them better. I expect I will be doing a lot of that in the future."

Q: "You can influence a lot more people that way."

Dr. M.: "That's true, but there's nothing better than working one on one with somebody to have a direct impact, as well."

Q: "What else are you doing these days?"

Dr. M: "I'm married and I have children who are 14 and 11. They keeps me pretty busy, with all their activities. I like to read. I like to run a lot.
I have enjoyed having adjunct faculty appointments at University and at Hopkins. I love when Residents or early-career psychiatrists reach out to me and ask me questions. They challenge me and give me ideas about what I might do to help in delivering mental health services. I hope to see even more of that kind of stimulating conversation, to help me do the best work I can."

MPS Best Paper Awards Deadline January 31

To recognize outstanding scholarship by young psychiatrists in Maryland, the MPS established annual "best paper" awards in 2013. Previous winners are listed here. The Academic Psychiatry Committee is currently soliciting nominations for the 2021 Paper of the Year Award in two categories:

Best Paper by an Early Career Psychiatrist Member (ECP): Eligible psychiatrists are ECP members who are first authors of papers published or in press in 2021. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2022.

Best Paper by a Resident-Fellow Member (RFM): Eligible psychiatrists are Resident-Fellow members who are first authors of papers that were written, in press, and/or published in 2021. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2022.

Scholarly work of all kinds (e.g., scientific reports, reviews, case reports) will be considered. If you would like to nominate a paper and author, please email or mail the paper as indicated below by **January 31**. Please include a brief explanation of why you believe the work is worthy of special recognition.

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IN MEMORIAM: Ira A. Liebson, MD

by Bruce Hershfield, MD

Ira Liebson, MD

Dr. Ira A. Liebson, a former long-time MPS member, died from complications of a fall on October 25th.

Originally from Passaic, NJ, he switched to pre-medical studies at Columbia after graduating with a degree in English from Muehlenberg College. He completed his pre-medical studies at Columbia and then graduated from NYU Medical School. He came to the Baltimore area to do a medical residency at Johns Hopkins and stayed until 2013, when he and his wife, Marian Thomas (also a psychiatrist; they met while in psychiatric training at Johns Hopkins) moved to Cambridge, MA.

For many years, he worked at what is now called the Johns Hopkins Bayview Medical Center, where he treated patients and studied addiction in the behavioral pharmacology research unit. He co-authored at least 100 articles and textbook chapters. An Associate Professor at Johns Hopkins, he also worked at the counseling center on the Homewood campus and on disability claims for the Social Security Administration.

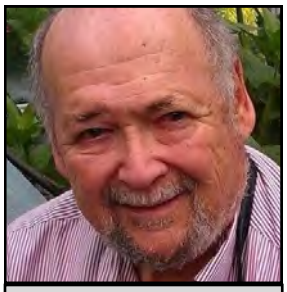
He loved music and traveling and as late as age 88 he went to Germany to attend the Leipzig Bach Festival. He admired Samuel Johnson and James Boswell and in 2010 he lived for a week in Boswell's house in Scotland. He worked on sabbatical in Munich, England, and the USSR, and was conversant in German, Italian, and French.

Dr. Eric Strain, Director of the Behavioral Psychology Research Unit, commented, "Ira was a wonderful guy and I always enjoyed his perspective and wisdom. We lost a BPRU friend, colleague and family member …But a little bit of him remains with those of us who got to know him, in our memories of him and in the part of him that has lodged in our hearts."

I knew Ira because I worked with his wife. They were both lovely people and I always enjoyed seeing them. He was, as Dr. Paul McHugh commented in the Baltimore "Sun" (from which this biographical information is largely taken), "A splendid psychiatrist and a wonderful person… He made a personal connection with his patients, who felt they could call him at any time…He took the time to know his patients."

IN MEMORIAM: Carl Segal, MD

by Bruce Hershfield, MD



Carl Segal, MD

Dr. A. Carl Segal, a Distinguished Life Fellow of the MPS who practiced for many years in Columbia, died on December 2nd at age 87.

Originally from Philadelphia, where he attended the Temple University School of Pharmacy and then Jefferson Medical College, he served in the Army as Psychiatrist in Chief at Ft. Benning, reaching the rank of Lt. Colonel. He was Director of the Howard Co. Community Mental Health Center and one of the founding physicians at Howard County General Hospital. He practiced in Columbia until the week before he died.

Dr. Andrew Angelino described him as "a staunch patient advocate, beloved by his patients". Emile Bendit, MD said he was "a wonderful person, a caring, gentle soul who believed in the community, working with police and the schools." Dr. Douglas Heinrichs commented, "He has been a central figure in the Howard County psychiatric community… He was a superb clinician, and especially gifted at the long-term management of chronically fragile and disturbed patients… He did this with a combination of a therapeutic optimism and energy quite remarkable for someone of his years …He was a kind and nurturing man to both his patients and his colleagues and will be profoundly missed."

Healthcare practitioners who prescribe CDS must do so electronically OR apply for a waiver by January 1, 2022!

All requested waivers will be granted for calendar year 2022 only.

MDH compliance actions will be delayed until January 1, 2023.

To apply for a waiver, visit the Office of Controlled Substances website, Quick Links, Electronic Prescribing Waiver Request: *https://health.maryland.gov/ocsa/Pages/Electronic-Prescribing-Waiver-Request-form.aspx*. **The deadline is January 1, 2022**.

CLICK HERE FOR MORE INFORMATION

Dr. Jennifer Payne Departs Hopkins For UVA

by: Elizabeth Wise, MD

Elizabeth Wise, MD

Dr. Jennifer Payne, a leader in the field of women's mood disorders and reproductive health, has left Johns Hopkins for the University of Virginia, where she is now Vice Chair of Research of Psychiatry.

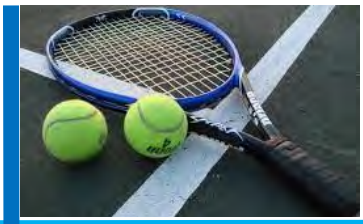
She founded and led the Women's Mood Disorders Center at Hopkins – now renamed the Johns Hopkins Center for Women's Reproductive Mental Health – in 2004. She treated multitudes of women during times of hormonal transition, established a robust research program and recruited others into the field of reproductive psychiatry. Through her NIH-funded research, she, along with Zachary Kaminsky and others, has discovered epigenetic biomarkers that are predictive of postpartum depression.

She grew up in West Virginia and received her bachelor's degree in biology from Davidson College. She was awarded a scholarship to attend medical school at Washington University in St. Louis. She completed her residency in psychiatry (serving as chief resident during her final year) at Hopkins and a fellowship in mood and anxiety disorders at the NIMH before returning to Hopkins, where she was on faculty from 2003 until her departure this year.

She is known for her "amazing ability to make reproductive psychiatry understandable to people who are not reproductive psychiatrists and demystify the field of perinatal psychiatry," explains Lauren Osborne, MD, who now leads the Hopkins Center for Women's Reproductive Mental Health. Dr. Osborne remembers that after they gave a talk at the APA a few years ago, multiple audience members excitedly came up to Dr. Payne to meet her. Indeed, she - -and her work within the field of reproductive psychiatry - - were the main reason Dr. Osborne came to Hopkins in 2014. Moreover, Dr. Payne holds leadership positions within two organizations in her field: she is president-elect of both the International Marcé Society for Perinatal Mental Health and its regional branch, Marce of North America.

Although she is now in Charlottesville, she still has strong ties to Baltimore, with ongoing scientific and intellectual partnerships with Drs. Kaminsky, Osborne, and other collaborators. "Although I'm sad to leave Hopkins and the Women's Mood Disorders Program that I've built, I'm excited to concentrate on building research in reproductive psychiatry and other programs at the University of Virginia," Dr. Payne said. She added that she and Dr. Osborne "plan to continue our long-term collaboration and expand our studies into multi-site studies so that we can continue to influence the field of reproductive psychiatry. This isn't an ending so much as an expansion!"

Jennifer Payne, MD



Tennis Anyone?

by: Sue E. Kim, MD

Sue E. Kim, MD

I began playing tennis regularly when I came to Buffalo for my psychiatric residency in 1985. The apartment complex had one tennis court, which was always available. I attended group lessons at a local high school. The instructor's name was Bob and I remember him as "Buffalo Bob". Occasionally, I played at the University of Buffalo Amherst campus. There were many courts, and they were very pleasant. In the neighborhood, several women played together after work, usually once a week. Good matches with appreciative players in glorious summer days in Buffalo; this memory fills my heart with delight.

I met Roberta when I went to play as a substitute at an indoor facility. She and I became lifetime friends. She came to my citizenship ceremony. She was happier than I was. She remembered that her grandparents came from Ireland. She suggested that she and I celebrate t this anniversary together every year.

In Baltimore, I played at a large tennis club at the Green Spring Station. Jobe also played there and he and I became life partners. He had come to this country as a college student, then learned to play tennis. At the same club, I met Dr. Mahmood Jahromi, who invited me to join his private practice group. Somehow, I began private practice, which opened up new horizons. I am grateful to Dr. Jahromi for opening a path for me to be in private practice. I saw him often on the tennis court. Now, I see him on the monthly MPS zoom social.

I had many memorable games over the years. You experience beautiful feelings at the time of magnificent plays and magical moments. Both triumphs and defeats are worthwhile when everybody plays by the same rules. When you lose, you know that you will have an opportunity to win next time. I draw on what I've learned from tennis when times are rough.

When COVID came, tennis stopped. I used to run in and out of my office a few times a week in order to play women's doubles tennis. No tennis, no more travel to the office, or to any place, everything is done at home, time feels different. I experimented by getting up and getting out to play tennis first thing in the morning, with Jobe. It worked well.
Though he and I stayed away from playing singles for a few years because it is so strenuous, we resumed it under the new circumstances. Both of us were surprised that we could play it again, and every day, and we kept getting stronger and better. Last year, I was the senior women's singles champion. This year, nobody signed up in that category. Josh, the tennis pro at the club, was sweet to say "Everybody is afraid of Sue!"

For many years, tennis has been a staple in my life. I either played or watched games on TV, or both. There are excellent tennis matches somewhere in the world every day. Many countries produce world class players. Jobe and I traveled to visit them. We ate their food, listened to their music, danced with their people, tried on their clothing, held their babies and learned to speak a few words. We saw their accomplishments and struggles. We were touched by each country we visited. I echo Mark Twain, who said that travel is toxic to prejudice.

Two years ago, we went to Wimbledon. We entered the grounds in a long, winding line, which is a Wimbledon tradition. When we got there the first time, people showed us how the line worked. The next day, we were the guides for the first timers. Staff invited us to play on the lawn court which was built on the side to entertain people in line. That is how I played at Wimbledon!

One day this fall, Jobe and I were playing at our club on a beautiful afternoon. I asked him, 'Did you know that your life would be this good when you came to this country?' We owe much gratitude to those who welcomed us to be a part of their families and to be their friends. We, immigrants from Korea and southern India, were provided with love and kindness. I feel that it is perhaps my duty and privilege to be here in this critical time in this country-- lifting up our voices to preserve and promote what is important to us all. That includes our games—especially tennis!

What Catholic Charities Does

by: Ronald Means, MD

Ronald Means, MD

As I was finishing my training 14 years ago, I began searching for a job. In addition to finding something that would further hone my forensic skills, I wanted a child and adolescent, community psychiatry position. I stumbled upon Catholic Charities of Baltimore, which needed a psychiatrist to help lead its BCARS program – a crisis program for youth in Baltimore City. I accepted the position, as well as arranging to do some outpatient clinic work. At the time, I had no idea about the larger variety of services offered by Catholic Charities. It took years for me to fully understand how many services it provides.

Catholic Charities of Baltimore was established in 1923, with the goal of meeting the needs of the community. Today, it consists of 80 programs, spanning three divisions – Community, Family and Senior Services. Programs exist to mitigate the effects of poverty, to help those in crisis, to provide low-income seniors with affordable housing, and to help provide supportive housing options to individuals with developmental disabilities. Every year, it provides care to at least 160,000 people in 9 counties.

Many are familiar with some of its programs. Housing and food programs such as Our Daily Bread and the Weinberg Housing and Resource Center are a couple of the more commonly known. Innovative programs such as the Esperanza Center and Safe Streets might be less known, and many have no idea that it also manages some Headstart and various senior housing/care programs.

The division in which I work - the Family Services Division - provides mental health care services via a variety of programs. Services include outpatient behavioral health, substance use disorder, youth crisis, residential treatment and special education school programs. In addition, it provides supportive housing for developmentally-disabled adults. Outpatient behavioral health and substance use disorder services are delivered primarily through the Villa Maria Community Resources clinics. We have 8 outpatient mental health centers across the state, including over 100 school mental health partnerships.

The agency strives to provide high quality services to the most challenged and disenfranchised. That type of service was what inspired me to be a community psychiatrist in the first place. I am fortunate to have found an organization that is dedicated to pursuing that goal.

Poster Contest for Residents & Fellows

The MPS poster competition for our Resident-Fellow Members will be held again this year, with all entries displayed at our annual meeting in April 2022! Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the meeting. Two finalists will also be selected and will receive **$100 each** in addition to complimentary tickets.

The winners in past years are listed here. Please click here for complete details about the process and requirements. **The deadline to enter is January 31.** Electronic copies of posters are due **February 10**. For more information, or to apply please click here.

LETTER FROM THE EDITOR
Pharmacy Benefit Managers: Keystone Kops

by: *Bruce Hershfield, MD*

Bruce Hershfield, MD

This is what happened when I had to get annual re- certification for Adderall for a patient from Pennsylvania who has been on it for at least 10 years.

I suspected the number the pharmacy faxed me was incorrect, which it was. Her insurance plan clerks insisted I had to talk with the company it uses as its Pharmacy Benefits Manager, though they could not connect me. I eventually did hear from that company, which sent me a form, which I filled out and faxed.

Three days later, I received a copy of the rejection form it had sent my patient, explaining that she did not meet clinical criteria for continued use and suggesting she consider talking with me about an alternative. It suggested she or I could appeal the decision and it gave the number of the insurance company, who of course said it was not their doing. I insisted on talking with a pharmacy supervisor, who told me it was likely because I had used the name "Adderall" instead of amphetamine/ dexamphetamine salts. I pointed out that pharmacists always have to fill prescriptions with generics when they are available, and I had not specified "brand name necessary". She told me it did not apply to PBM's, and that if I referred to "Prozac" on one of the forms instead of "fluoxetine" it would happen the same way. (All of this turned out not to be true.) She told me none of her supervisors was available, but I insisted on talking with a physician, even if he was not a psychiatrist. His secretary arranged a phone appointment two days from then, but called back to tell me he had intervened and all was settled. (This also turned out not to be true.)

The next day, I checked with the pharmacist, who told me the prescription would not go through. I finally reached someone at the PBM company, who told me they had tried unsuccessfully to reach me by phone the morning before (while my phone was being repaired). They rejected my application, by FAX, because they did not have answers to two questions: whether the patient had had ADHD as a child and whether it interfered with her academic or occupational life. (Neither question was on the form.) They hadn't tried to send me these questions by FAX—just the rejection. I answered the questions on the phone and she determined the amphetamine/ dexamphetamine salts combination could be "pre-authorized".

Who ARE these clerks and pharmacists who are questioning our judgment? When I mentioned Adderall to one of them, I was told she had "heard of it".

I haven't mentioned the times I was cut off, referred to the wrong person (in nephrology!), asked my birthdate and first name because the person on the physician's line still thought I was the patient, or been told someone would call me back on another line and no-one did. I had a lot of trouble getting to supervisors because they were "in meetings".

The MPS, along with Med-Chi, and the APA, along with the AMA, must help the government reform this "system".

First, permitting a patient to remain on a medication after so many years is not "PRE-certification". It's intruding on practice, it's dangerous, and it's likely to harm the patient's perception of the treatment. Secondly, we need to hear a clerk's complete name so we can call back and get the same person after we are cut off or referred to answering machines. (It would be helpful when we complain, too.) Third, any questions that are not asked on these forms cannot be used as excuses for rejecting them. And, if consultation with a physician is indicated, it should be with a psychiatrist.

This process of requiring continuing certification does not really save anybody any money—particularly with generic medications. At least temporarily, it deprives patients of the medications they need (or makes them pay out-of-pocket). It sows mistrust on all levels. I still can't get used to people lying to me.

Here are some elements of Med-Chi's Resolution 30-21 concerning legislation in the 2022 General Assembly (and which the MPS is helping to back):

1. Support continuity of care for patients on appropriate, chronic, stable therapy through minimizing repetitive prior authorization requirements
2. Require carriers to issue a "gold card" to certain physicians that waives prior authorization requirements if that physician is continuously approved for a specific procedure/service over a certain time frame
3. Examine whether appropriate staff from carriers is available ...24 hours a day, 365 days per year
4. Prohibit prior authorization requirements for FDA-approved medications for which a patient needs ongoing treatment and which a patient has previously received.

It is time for some changes. I am pleased that our organizations are working on it.