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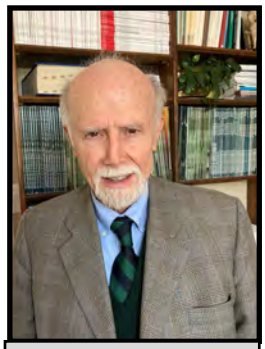
Heidi Bunes—A Fond Farewell

By Thomas E. Allen, MD



Thomas E Allen MD

Some History: I was elected to the MPS Council in 1983. At that time, the MPS "staff" consisted of two part-time, retired secretaries on Medicare who had previously worked in the private office of a past MPS president. They used manual typewriters, had lunch in their office at Med Chi on China plates and paper doilies. Their small office was tucked away in a remote corner of the Medical Society's buildings in downtown Baltimore, and they kept to themselves. Their main task was to send out notices of meetings, collect dues, and type up minutes of the MPS Council.

The MPS Council met in a space at an inpatient psychiatric unit at Sinai Hospital. Scientific meetings were held at Sheppard Pratt. There were generous inpatient and outpatient mental health insurance benefits available (although not parity with general medical care). But there were some ominous clouds on the horizon. Medical liability insurance rates were significantly on the rise, quite severely for OBGYN and Neurosurgery, but also for other specialties including psychiatry. Med Chi fought in the legislature to establish some caps on huge awards.

In the following years it became quite clear that medicine was under attack, rightly or wrongly, from a number of different directions: the plaintiff bar lobbied to expand liability challenges, non-physician professionals lobbied to expand scope of practice roles, the insurance industry fought expanding mental health benefits, and the state, while supporting deinstitutionalizing the mentally ill, did not want to fund the community and patient support needed make that work.

In 1987 I was elected to the MPS Executive Committee as Secretary/Treasurer and it became clear that the MPS needed to transform itself from being a professional organization that mainly put on meetings and social events for psychiatrists, to an organization that could effectively represent the profession in the legislature and to the public. That meant, among other things, hiring staff that could support that effort. We initially hired a young woman who was the daughter of a doctor. She gave us a better idea of what we needed, but after a year she left to get married and moved to another city.

Enter Heidi: The MPS again needed to hire an Executive Director. We put an ad in the newspapers and encouraged members to suggest possible candidates. We received 26 resumes, eliminated 14 as either over qualified (supervising 15 employees, salary requirements beyond what we were able to pay) or under qualified (recent college graduates without work experience) which left us with 12 applicants who merited serious consideration. We rank ordered our top 5 and interviewed all of them.

Heidi Bunes was the unanimous choice. She had B.S. and M.B.A. degrees, a background in accounting and finance (She left a large accounting firm in Washington). She had communication skills and familiarity with a computer (In 1989 still new technology). She was hired March 10, 1989. To quote from my report in the April 1989 **MPS *News***: "(She) is interested in working with a membership organization and as she put it in her letter: 'Perhaps my greatest strength is the ability to take an idea from concept to practice'". It was *exactly* what the MPS needed. Our concern was that she would not take the job or, if she did, she would not stay long-term. But 35 years later she put those fears to rest. We are sorry to see her leave.

Here is some sense of what the MPS has achieved with Heidi's able executive leadership, and the quality people she has hired to assist her.

Heidi took over a monthly ***News*** bulletin begun in 1988 that keeps MPS membership informed about topical issues related to the organization and their practice (now under the editorship of Meagan Floyd). The ***Annual Membership Directory*** made its appearance in 1989. Staff also oversees the publication of ***The Maryland Psychiatrist***. The MPS developed closer ties with the **APA, MedChi** and the **Suburban Maryland Psychiatric Society**. We joined a parity coalition, a Medicaid mental health coalition and a provider coalition the Maryland Joint Commission for Inter-professional Affairs.

We are a relatively small association in the APA but have played a big role over the years, thanks to our staff. We are a small organization affiliated with Med Chi, but again

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have played a big role there, thanks to Heidi's support. She is well known and respected in both the APA and Med Chi.
Many specialty societies at Med Chi, and DBs in the APA, wish they had someone with Heidi's talents.

Federations (APA, AMA, Med Chi) have strengths due to their size, but encounter weaknesses due to that circumstance as well. Under the US Constitution, health care is organized at the state level. Preauthorization and managed care came earlier to MD than other states so that other states could not understand the problem we were having at first. Similarly, specialties organize practices differently so the MPS voice is very important at Med Chi.

We were the first state in the country to pass parity in our state legislature, although managed care has limited its potential. The MPS struggled with many managed care injustices impacting psychiatry over the years. We have reached a "consensus on high-priority issues such as patient confidentiality" as reported in the *MD Psychiatrist in 1999.* The MPS has created a website with capacity to allow members to communicate online and to help people find a psychiatrist. By 1999 we had 2.6 full time employees and had allocated $17,000 to modernize our information processing systems.

Heidi and the MPS staff work mostly for the MPS, but also support two related entities that the MPS had an important role in creating, All three get timely and useful financial statement that have kept them in the black. She has found excellent staff to assist her. The MMPAC helps connect psychiatrists with legislators on an individual level by paying for members to attend legislator's fundraisers where they can talk about issues in psychiatry with elected officials. The Maryland Foundation for Psychiatry that has provided information and advocacy in the community.

In the 35 years that Heid has worked for us she has married, has 2 lovely daughters that are college graduates and we are very happy for her. The MPS has celebrated her marriage and her pregnancies with her. She lives in Baltimore County in a lovely area and has a wonderful garden planted by a world class landscape garden designer. She has reduced her involvement from time to time as personal demands necessitated, but has been willing to help us out when she could

We wish her the best and thank her for the incredible things that she has done for the MPS and all of us. We have been indeed fortunate to have had her work with us.

Robin Weiss, MD

Heidi Retires

By Robin Weiss, MD

When you first meet Heidi Bunes, perhaps you are struck, as I was, by her bearing. Graceful, almost royal. Yet then, maybe unlike one's preconception of a royal, you discover that Heidi is warm, helpful, and patient. She answers the most naïve—or the most sophisticated—question with equal thoroughness and no trace of judgment.

Patience, I thought to myself in the late 1990's, hanging around the MPS suite on St. Paul Street, is truly a requirement for the job of Executive Director. The Executive Council changes every year, and they may or may not know much, at first, about what the MPS actually does. I was often baffled the first year that I attended Executive Committee meetings with Jeff Janofsky, Harry Brandt, and Lisa Beasley. I remember Heidi translating many short-hand, seemingly English, sentences into lay English for me after those meetings ended. And to think that she did that year after year, with other new officers, never seeming ruffled or condescending, always appearing to be engaged. I believe that she must possess an astonishingly rare set of characteristics to pull off this feat. And what's more— it's all entirely authentic.

Heidi's loyalty to the MPS runs deep. In 2000, I was turning 50, and my husband Tim had planned a surprise party for me to take place at a Federal Hill restaurant on Light Street. Several psychiatrists would be in attendance, including my dear, now deceased, friend Lisa Beasley, who was then President of the MPS. The only hitch: the party was scheduled to take place on a night that conflicted with an MPS council meeting. So, he and Lisa concocted a cockamamie scheme to tell me that the meeting's venue would be changed to the restaurant because a pipe had burst at the MPS office; they wanted Heidi to deliver that message. Heidi resisted involvement in the caper—she was uncomfortable with even this temporary deception, I was later told. I always thought this said something about her character; even a little white lie that involved our MPS office made her squirm, and she stood firm. (PS: Somehow Lisa got me to the restaurant, and I was, indeed, surprised.)

Heidi has been our quiet north star all the years she's been at MPS, since 1989, helping the organization stay the course with her deep institutional memory.

Whether a member asks about a piece of legislation, a CMS regulation, or about the history of MPS's involvement in a state-wide issue, she chimes in with essential information, helpful direction, or the definitive answer. I hope it isn't too late to elicit a recorded Heidi Bunes oral history!

How extraordinarily lucky that Heidi has enriched the MPS with her steady guidance for 35 years. I know everyone whose professional life she has touched is as thankful as I am. I will miss her friendship, her kind smile, and her warm greeting at meetings, but boy, if anyone deserves a leisurely retirement after a meaningful career, Heidi does! She's made an impact on mental health in Maryland, and on the mental health of our MPS members!

Thank you, Heidi—we are filled with gratitude.

Heidi Bunes
MPS Executive Director
1989-2024

MPS Holds Annual Meeting in Baltimore

by: Bruce Hershfield, MD

Neil Warres, MD

On April 18th, the MPS hosted about 120 people at its annual meeting, at *Fogo do Chao* in Baltimore. After a welcome by Dr. Carol Vidal, Dr. Neil Warres announced the presentation of the MD Foundation for Psychiatry Anti-Stigma Award to Lt. Gov. Aruna Miller and Dr. Robert Herman told us about the work of the MD Psychiatric Political Action Committee.

Dr. Vidal then presented the Presidential Award of Excellence to Dr. Cynthia Lewis, who has been Director of Psychiatric Emergency Services at Johns Hopkins since 2019. Dr. Lewis is joining the Council and will be Co-Chair of the Legislative Committee. She talked about the successful efforts the MPS made to get an assisted outpatient law passed this session in Annapolis.

Next on the agenda was the presentation of awards for the Best Paper and the Poster Competition. These were given by our Academic Committee Co-Chair, Dr. Traci Speed. Drs. Deepak Salm, Andrew van der Vaart, and Aditya Pawar accepted awards for Best Papers. Dr. Barry Bryant was recognized as the Resident-Fellow Poster Contest winner and Dr. James Aluri was a finalist.

Ann Hackman, MD then was given the 2024 Lifetime of Service Award by Drs. Carol Vidal and Theodora Balis. Dr. Hackman served on Council from 2010-17 and was Chair of the Public Psychiatry Committee for 10 years until it merged with the Cultural Psychiatry Committee to become the Community Psychiatry & Diversity Coalition in 2020. She has been Co-Chair of that, with Dr. Balis, since its inception. Comments made about her at the presentation referred to her as a passionate advocate for people living with serious mental illness, mentioned her success in teaching (where she has won departmental and school-wide awards) and praised her courage—"she does not hesitate to speak truth to power".

Drs. Balis and Hackman then described the founding of the Dr. Wonodi Award; this was followed by comments from Adora Okogbule-Wonodi, M.D,.

Next, Dr. Thomas Allen read his tribute to Heidi Bunes on the occasion of her retirement after 35 years as Executive Director.

Dr. Vidal then "passed the torch" to our incoming President, Theodora Balis, MD, after speaking about what a challenging year it has been and praising the staff—Heidi Bunes, Meagan Floyd, and Jora Hritz. Dr. Balis commented about what a wonderful role model Dr. Vidal has been, and thanked the staff. She urged us to demonstrate we are the leaders in diagnosing and treating psychiatric disorders and told us we need to continue trying to ally ourselves with others in the helping professions.

It was a fine occasion—a chance to see each other again and to appreciate what we have been able to accomplish and to hear what still remains for us to do.

(L-R)
Traci J. Speed, MD, PhD
and Deepak Salem, DO

Maryland Psychiatric Society President's Vision 2024-2025

By Theodora Balis, MD

Theodora Balis, MD

I am very grateful to Carol Vidal, who has been a wonderful role model as MPS president. She has been a tremendous leader and advocate for the people we treat and for our psychiatrist colleagues in Maryland. I hope I can accomplish even a fraction of what she has contributed. MPS staff have been invaluable. MPS staff is really responsible for the majority of the work and the longevity of MPS. Welcome to Jora Hritz, who has been a wonderful addition and is mostly responsible for organizing the highly successful Annual Meeting and dinner at Fogo de Chao that was fully sold out. Meagan Floyd has been amazing in her new role as executive director and brings her wonderful energy to the work. A personal thank you to Heidi Bunes, who has kept me on track through all my roles at MPS. I most certainly couldn't have done anything without her support.

I am deeply honored to serve as MPS president and I am committed to doing what I can to increase our community presence and have more impact on changes that affect psychiatrists in Maryland.

I was a resident at the University of Maryland and then became faculty there for 15 years, working in community psychiatry and education. I then went to Bon Secours, now Grace Medical Center/Lifebridgehealth, for 10 years and did similar work as medical director of the ACT team and director of education, focusing on training off-shore medical students. Since 2023, I have been at MedStar Health as Regional Vice-Chair for Education in the Baltimore region, working to establish a new residency program in psychiatry, and as a psychiatrist in the mobile collaborative care HEART team.

I have had various roles within the MPS for many years and more recently as Co-Chair of the Community Psychiatry/Diversity Coalition, Council member, Secretary-Treasurer, and President-Elect. I am truly honored and delighted to serve as President for the 2024-2025 year.

One of my goals is to increase our relevancy to those making policy decisions about how psychiatric care is provided. To do this, I recognize the importance of leadership and collaboration beyond our society. By engaging with and partnering with other psychiatric societies and organizations, such as MedChi, district branches, and other psychiatric groups like Black Psychiatrists of America, we can amplify our collective voice, advocate for our profession, and drive positive change in mental health care delivery in Maryland. When it comes to increasing our community presence, we must not only forge partnerships, but also actively engage with community leaders, organizations, and grassroots initiatives. By being visible and accessible in our communities, we can foster trust, promote dialogue, and demonstrate that we are leaders in addressing the mental health needs of Maryland's diverse populations.

And we should not seek just to partner with organizations that agree with us, but also with those who could benefit from our expertise in treating people who live with mental illness. This may include collaboration with law enforcement and emergency medical services to ensure the best possible outcomes for individuals experiencing psychiatric emergencies.

In line with the goal of increasing visibility and engagement, I propose pursuing a suggestion from some of our more youthful colleagues for the creation of a VLOG series that highlights the invaluable contributions of our members and showcases the impactful work of the MPS. By sharing our stories and experiences, we can inspire others, foster connections, and attract new members to our society.

Recruitment of new members has long been a goal of MPS and I would like to move forward with ideas to make this a priority. Recruiting recent graduates of residency programs will be a top goal. The idea of personally visiting residency programs, perhaps accompanied by key committee chairs, would be a way to promote participation. Offering informative sessions and maybe even lunch will provide opportunities for networking and showcasing the diverse opportunities available within our society.

Moreover, I am keen on showcasing the relevancy and importance of our committees to our membership and prospective members. Each committee plays a vital role in advancing our goals, whether it's through advocacy efforts, continuing medical education, or promoting diversity and equity. It is imperative that we highlight committee achievements and encourage members to get involved in what I consider to be the heart of the organization.

Our values as a society must be reflected in our actions. Therefore, I am committed to establishing meaningful awards and events that recognize and celebrate excellence, innovation, and dedication within our profession. Initiatives such as the establishment of the Ikwunga Wonodi Award to recognize members dedicated to equity and social justice exemplify our commitment to these values. The new MPS ECP fellowship award is another excellent example.

In conclusion, I am truly excited about this opportunity and look forward to hearing more from you about how we can succeed in these efforts.

Theodora Balis, M.D.
Our New President of MPS

by: Sue E. Kim, MD

Sue E. Kim, MD

Congratulations to Dr. Balis on becoming the new president of MPS. All of us will be fortunate to have her as our president. The depth and scope of her experiences and unrelenting passionate engagements will motivate us to make positive changes.

She is the Regional Vice-Chair for Education, Psychiatry, Medstar, and is Associate Professor of Psychiatry at Georgetown

Dr. Balis states: "I have been an active member of MPS for 26 years. I have focused my career on public sector psychiatric work and cultural issues that affect treatment, as well as in the education of various trainees in Psychiatry from Social Work students to Medical students and Psychiatry Residents. I am passionate about the importance of destigmatizing mental illness as a means to contribute to better somatic care, fair treatment by law enforcement, and the legal system, and equitable high quality mental health services for people of color and other underrepresented people of our community. This has been a focus of mine in my clinical work, training future physicians and psychiatrists, and in my work at MPS".

Retiring Executive Director Heidi Bunes writes: "I started working closely with Dr. Balis in 2017, when I began staffing the MPS Diversity Committee, which she chaired. Soon thereafter, it was combined with the Public Psychiatry Committee and renamed the Community Psychiatry and Diversity Coalition (CPD). This change in the MPS structure illustrates the creativity and vision she brings to the organization. She saw an opportunity to collaborate and realize synergies by merging two groups that met separately, yet were closely aligned. Since then, she and Co-Chair Ann Hackman, M.D. have led the group to be one of the most active and influential in the MPS. CPD has been behind most of the recent MPS positions. It initiated the ongoing MPS efforts toward diversity and inclusion, and reaches out regularly to other groups to create linkages and share information with members. In addition to many other activities, the most recent CPD initiative is the new Wonodi Social Justice and Health Equity in Psychiatry Award. Dr. Balis has a very collaborative, yet tenacious, approach. Even among psychiatrists she is an excellent listener and can bring together people and ideas to facilitate action toward a desired outcome. She is passionate about Psychiatry and even more so about serving patients. One of the very few misgivings I have about retiring now is not being able to continue working with her (and other EC members) during her presidency."

Our new executive director, Meagan Floyd writes: "Dr. Balis has played an instrumental role at the MPS for many years. She has served on the Program & CME Committee, Disaster Psychiatry Committee, Maryland Foundation for Psychiatry Board, MPS Council, and Executive Committee, and she is currently Co-Chair of the Community Psychiatry and Diversity Coalition. Her unwavering dedication to the field of Psychiatry and her enthusiasm towards new endeavors and ideas is inspiring."

The MPS has been grappling with painful issues, and we have been speaking out! I am grateful that MPS provides positions on difficult issues.

In one of the CPD meetings I sat in, I was talking about my frustration and disappointment. I was complaining that other people did not solve the problems. Dr. Balis calmly said something to the effect that you make changes one step at a time. Yes! She is about solving problems—providing steady and sensible leadership as we try to make things better.

Enhance Your MPS Membership!

Join the MPS Listserv

Join the online MPS community to quickly and easily share information with other MPS psychiatrists who participate. To join, click here. You will need to wait for membership approval and will be notified by email. If you have any problems, please email mps@mdpsych.org.

Member Spotlight Opportunity

Have you recently worked on an exciting research project? Reached a milestone in your career and want to share it with other MPS members? Have some good advice for younger psychiatrists who are just starting their careers? Submit a short article and photo through this Google Form to showcase your experiences with the MPS community.

Lifetime of Service Award
Ann Hackman, MD

By: Theodora Balis, MD

(L-R)
Ann Hackman, M.D., Theodora Balis, M.D., Carol Vidal, M.D., Ph.D.

Dr. Hackman's dedication, passion, and tireless efforts have significantly impacted the fields of Psychiatry and mental health care, as well as the MPS. She has stood as a beacon of dedication and excellence for over three decades. She has consistently contributed to the advancement of psychiatric care, leaving an indelible mark on the field. She has devoted her career to understanding and addressing the complex challenges faced by individuals with severe mental illness and homelessness, and other marginalized populations. Through her extensive teaching of psychiatry trainees, broad research, innovative programs, and insightful presentations, she has been a mentor for psychiatrists in Maryland and beyond.

She has an extensive educational background, including a B.A. in Psychobiology from Western Maryland College, an M.A. in Clinical Psychology from Loyola College (Baltimore), an M.D. from the University of Maryland, and an M.L.A. from Johns Hopkins. She is also triple-boarded in General, Addictions, and Forensic Psychiatry.

Throughout her career, she has held various academic appointments and administrative leadership roles,-- notably, during her tenure as an Associate Professor of Clinical Psychiatry at the University of Maryland. In addition to her academic achievements, she has made significant contributions to clinical practice, particularly in areas such as Community Psychiatry, Assertive Community Treatment, and the treatment of individuals with first-episode psychosis, as well as in addictions and forensics. She has worked tirelessly towards eliminating stigma and social disparities, especially for people from underserved minority groups.

In addition to her research and presentations, she has also been a passionate advocate for social justice and equity in mental health care—from addressing systemic racism to advocating for the needs of individuals living with schizophrenia and other serious mental illnesses.

Her long list of awards includes the Brody Award for excellence in psychotherapy for people with SMI in residency, the APA's Nancy Roeske Award for teaching psychiatry residents, and the Virginia Huffer Award for medical student teaching. She was awarded three times by the residents themselves (the ultimate honor) with the Jose Arana Award as a role model, the Walter Weintraub Award for excellence in teaching, and the Rose Award for faculty dedication to the underserved and for excellence in cultural psychiatry from the University of Maryland/SEPH Psychiatry Residents. NAMI Baltimore honored her with the Heroes in the Fight Award. The Medical School has awarded her multiple times with the School of Medicine Student Council Faculty Preclinical Teacher Award, the Medicine Student Council Student Marshal for graduation, the Medicine Student Council "hooder" for graduation, and the School of Medicine Teaching Commendation for Pathophysiology and Therapeutics.

Her involvement in initiatives such as the Diversity, Equity, and Inclusion Curriculum Committee underscores the school's commitment to promoting diversity and inclusion within our institution. Her contributions to the MPS include Co-Chair of the Community Psychiatry & Diversity Coalition, Public Psychiatry Chair, Nominations & Elections Chair, and membership on the Psychiatric PAC and on the Council. As well, she has been a leader in the American Association of Community Psychiatrists and the Group for the Advancement of Psychiatry, and ha been a consultant and lecturer for Crisis Intervention Training for Baltimore City Police Officers. She has worked for the Mental Health Policy Institute for Leadership and Training, been a Consultant to Baltimore Mental Health Systems Dual Diagnosis Training Program, and has served the APA Corresponding Committee on Poverty and Homelessness.

Most importantly, she has been a source of inspiration and mentorship for countless individuals. Through her leadership, guidance, and unwavering support, she has nurtured the next generation of clinicians, researchers, and advocates.

Ann has been a most dear friend and mentor since my internship year, when she presented at grand rounds at the University of MD. One of her PACT patients was a man living with schizophrenia who was very symptomatic and difficult to engage with, who lived in an abandoned office trailer in a junkyard, would not accept medications, and had no support at all. But the person she described was a man who was highly creative, very intelligent, and tenacious, and who loved to use humor in their day-to-day interactions. She saw this--not the figure of "a homeless schizophrenic" that others might see. She leads by example to show respect, compassion, and tenacity. Since then, Ann has been my mentor and role model (and to many others as well). She is constantly challenging herself to learn more and to share that with others, encouraging so many to contribute to "the body of knowledge". Fiercely supportive of trainees and peers, she is responsible for getting me to take positive risks in my career. She does not hesitate to "speak truth to power". Having had the privilege of working closely with Ann for several years, I have witnessed first-hand her exceptional compassion, dedication, and expertise (and her delicious brownies).

This year, we express our deepest gratitude and admiration for all that Ann has accomplished by giving her this award.

In Memoriam: Ikwunga Wonodi, M.D.

By: Theodora Balis, MD and Ann Hackman, MD

Ikwunga Wonodi, MD

Ikwunga Wonodi, M.D., DFAPA passed away on January 7, 2024 at the age of 57. He had an admirable, extensive career in Psychiatry that led to his promotion to Professor in the Department of Psychiatry, University of Maryland, as well as to many awards throughout his years in the field. These included the H. McKee Jarboe Award for Mental Health Research, Department of Psychiatry, University of Maryland, the APA/CMHS Minority Fellowship Award, the 2017 African Community Service Award, the Jeanne Spurlock Minority Fellowship Achievement Award, and the UM/ SEPH Rose Award. He was a highly respected clinician, educator, and researcher in Psychiatry and an exemplary anti-stigma activist, philanthropist, poet, and musician.

Dr. Wonodi grew up in Port-Harcourt, Nigeria, the son of a tribal chief who was also a renowned poet. He completed his medical degree at the College of Health Sciences, University of Port Harcourt, Nigeria in 1989. He then completed a year of service in Lagos, with the National Youth Service Corps. During that year, he established a mobile clinic that provided medical services and basic supplies to foster homes throughout the city. This innovative clinic was one of a few programs nominated for Nigeria's National Youth Service Award. He continued his education at the University of Maryland/Sheppard Pratt Residency Training Program; which he completed in 2001. He then went on to acquire two research fellowships at the University of Maryland Medical Center, Maryland Psychiatric Research Center--one as part of a PGY-5 Research Track and the second a Post- Doctoral Fellowship in clinical schizophrenia. He later earned an MBA in health care management from Johns Hopkins, which allowed him to combine knowledge of hospital management with his finely honed clinical skills to create both efficient and effective programs.

After training, he joined the faculty at the University of Maryland, Maryland Psychiatric Research Center, where he was highly successful in expanding the New Episode Clinic for Schizophrenia and the Motor Disorders Clinic and also published extensively in the areas of the genetics of schizophrenia, medication-induced motor disorders, psychiatric genomics, and ethnopsychopharmacology. In 2017, he joined the Sheppard Pratt Health System as Service Chief of the General Adult Unit and Thought Disorders Day Hospital, at Sheppard's Baltimore Washington Campus (BWC); and as its ad hoc Medical Director. He also gave his extensive expertise to the MedStar Health Systems, where he established highly needed clozapine clinics as the Medical Director of Behavioral Health Service, MedStar Southern Maryland Hospital Center. His clinical expertise spanned the areas of first-episode psychosis, schizophrenia-related disorders, motor disorders, antipsychotic-induced side effects, clozapine treatment and long-acting injectable medications. He took his time when working with patients, understanding the need for different methods of care and communication for individuals from diverse backgrounds.

Dr. Wonodi published extensively, contributing over 30 peer-reviewed articles, several of which he first-authored, and writing numerous chapters in leading textbooks. He presented his innovative research and educated peers at prestigious conferences and programs, including the National Medical Association National Conference and the Federal Neuropsychiatric Hospital in Lagos. He successfully won repetitive grant funding for his research from the NIMH, NARSAD and the Passano Foundation.

However, Dr. Wonodi's contributions to the field extended far beyond his research contributions. He was a very generous master-educator. Amongst his peers and admirers, he was respected as a compassionate mentor to young psychiatrists. While working at the Maryland Psychiatric Research Center, Dr. Wonodi formed a clinical elective for University of Maryland medical students. He also mentored several post-doctoral fellows and graduate students.

His enthusiasm for education was exemplified in his willingness to present lectures to students upon their request and to encourage undergraduates to pursue careers in Medicine, including in Psychiatry. He volunteered much of his time to programs focused on cultural diversity, educating others on the importance of cultural inclusion within Psychiatry and providing mentorship to Minority Fellows and Residents within the APA Minority Fellowship Program. Annelle Primm, M.D. once described him to Psychiatric News as an "outstanding clinician and researcher." "The beauty of being a mentor to Dr. Wonodi is that the information exchange is bidirectional," she continued. "While I may have helped him in some ways, he

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In Memoriam: Ikwunga Wonodi, M.D.

Continued

has helped me as well." She also called upon him early in 2005 to help launch APA's "Office of Minority and National Affairs (OMNA) on Tour" at the American Association of Community Psychiatrists winter conference at Howard University.

His activism and philanthropy were truly remarkable and much of his work centered around advocating for under-represented individuals who are historically overlooked. His advocacy for human rights began in his youth. As a medical student, he formed a band called "What?" and began to combine his poetry with music. He was the originator of "Afrobeat poetry", where he blended spoken-word poetry with the music and rhythms of his native Nigeria. He performed for audiences throughout the Washington-Baltimore region, London and New York. His poetry, which accompanies the music, provides an impetus for change. His lyrics address societal problems and political strife and many of the songs contain sociocultural messages. He used his love of poetry and music to work towards positive social change around the world--including Nigeria, Sudan, and the US. In 2004 he traveled to London to record "Calabash -Afrobeat Poems by Ikwunga Volume 1", describing his work as "a labor of love". One of the tracks, "Di Bombs," a song about the mislaid goals of certain African leaders, raised more than $115,000 to provide relief to thousands of refugees of the genocide in Darfur, Sudan. Around this time, he established an organization called The African Alliance on Mental Illness (TAAMI) to identify and eliminate barriers to mental health for Africans over the continent and for African immigrants in the US. In describing his goals for the organization he said, "My first goal with TAAMI is to reduce the stigma surrounding mental illnesses. That is the most difficult thing—to change how people think."

Ikwunga Wonodi's impact on physicians, students, and patients in Maryland, the USA, and across the world is long-lasting. Mourning his passing and cherishing many fond memories of his life are his wife, Dr. Adora Okogbule-Wonodi, three daughters, Dr. Omasirichi Okogbule-Wonodi, Orukanma Okogbule-Wonodi, and Anaykwe Okogbule-Wonodi, a son, Ezeboula Wonodi, his mother, Mrs. Eunice Wonodi, brothers, sisters, in-laws and members of the Rumu-Wori Royal Family of Egwuma-Abali, Rebisi, Port Harcourt--and many grateful colleagues and students.

Donate to the Dr. Wonodi Award Fund!

To donate to the award fund, please pay online or send a check to *The Maryland Psychiatric Society 1211 Cathedral Street, Baltimore, MD 21201* and designate that the funds be reserved for the *Dr. Wonodi Award*. Donations are not tax deductible as a charitable contribution.

Cynthia Lewis, MD Receives Presidential Award of Excellence

by: Bruce Hershfield, MD

Cynthia Major Lewis, MD
Presidential Award of Excellence Recipient

This year, the Executive Committee honored Cynthia Lewis, MD for her extraordinary work surrounding the Assisted Outpatient Treatment legislation, by giving her the Presidential Award of Excellence at the Annual Meeting.

Dr. Lewis has been an MPS member for over 20 years, has been on the Legislative Committee since 2022 (and is becoming the Co-Chair), and has been active within the Community Psychiatry & Diversity committee. She also is joining the Council this year.

As Dr. Jimmy Potash, Chair at Johns Hopkins, remarked in a recent "Cheers from the Chair": "Among those testifying on the assisted outpatient bill was Assistant Professor Cynthia Lewis, our Director of Psychiatric Emergency Services. In her remarks, she said: *'It is 1% of patients with severe mental illness who are falling through the cracks of our mental health system and have become our revolving door of patients circulating in and out of our emergency departments, inpatient units and jails. It is this group that would benefit from Assisted Outpatient Treatment…Continuing to allow Maryland's mental health system to function in its current form is unacceptable. Our patients deserve better.'"*

Congratulations to Dr. Lewis and a "thank you" for all she has been doing to improve the lives of the people who need our attention the most!

Cheers from the Chair: Jeff Janofsky Retires

by Jimmy Potash, MD
Chair, Johns Hopkins Dept. of Psychiatry & Behavioral Sciences
Previously Printed in *Cheers from the Chair December 1, 2023*


Jimmy Potash, MD

Last evening, in the Phipps Lobby, we celebrated Associate Professor Jeff Janofsky, who has been a part of our department since the year we moved out of the Phipps Clinic and into the Meyer building—1982. Jeff began his internship at Bayview that year, before it was called Bayview. It was Baltimore City Hospitals back then. Jeff had just graduated from Hopkins Medical School, and before that he had graduated from the Hopkins undergraduate program in 1979, having transferred from Emory two years earlier. He has been a part of Hopkins for close to half a century!

Like me, Jeff grew up in the northwest suburbs of Baltimore in a Jewish family. His grandfather, who was raised three blocks from Hopkins Hospital, had a pharmacy (as did my grandfather!) across the street from the Dome, and Jeff worked there on weekends. During medical school, he rotated at City Hospital, and he attended an ongoing seminar led by Dr. Ray DePaulo, then an Assistant Professor based at City, during which he became fascinated with psychiatry. "Ray is the reason I went into psychiatry," he told us last night.

After residency, Jeff did a forensic psychiatry fellowship at the University of Maryland with Jonas Rappeport, the founding father of the American Academy of Psychiatry and the Law. Jeff went on to establish the Hopkins Psychiatry and Law program and has directed it as our forensics expert ever since. In that role, has been involved in training every resident who has come through our program for decades. I remember well how valuable he was in my own residency education in the '90s. He was always available, always ready to provide advice and help. He had a well-informed, pragmatic, and clear view of how to respond to any issue brought before him. And he could explain his thinking and his weighing of the relevant principles in a way that always made complete sense. The overriding principle he taught that has stuck with me over the years was, "Think clinically first, then think legally." Jeff joked last night that that will be the epitaph on his tombstone. I suggested "forensics virtuoso."

Jeff's clinical sensibility was well-honed over years of co-leading the Meyer 3 short stay service—later, the acute psychiatry service--with Dr. Geetha Jayaram, who spoke movingly last night, as did Drs. Ray DePaulo, Karen Swartz, Bernadette Cullen, and Paul McHugh. She recalled the wonderful camaraderie she and Jeff had over a quarter century of working closely together, and the enormous support he provided her during a couple of the most difficult stretches of her life.

Jeff's teaching of so many of us included his supervision of trainees at the Circuit Court Medical Office teaching site. He supervised all involuntary civil commitment hearings. The excellence of his work with residents resulted in his winning the Paul McHugh Teaching Award. He also published more than 55 papers and book chapters. His influence extended far beyond our four walls, including both across the state, and across the country. He is Past President of the MPS, and also a Past President of the American Academy of Psychiatry and the Law. He was that organization's representative to the APA Assembly for 10 years.

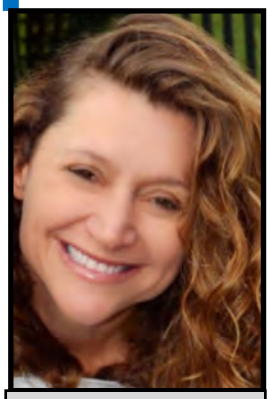
It, no doubt, helped his forensics career to be married to a lawyer. He and Julie have been married more than 40 years. Julie was in attendance last night, and quite pleased that the two of them will have the chance to embark on a four-month, around-the-world cruise when Jeff's retirement starts at the first of the year. His daughters were there too--one a lawyer, and one an administrator at our Bloomberg School of Public Health.

I want to express my profound gratitude for his tremendous contributions to the work and to the culture of our department. We will miss him greatly, but I am comforted by his guarantee that, once back from his travels, he will be available for legal advice at any time.

I will leave you with a song from The Crickets, post-Buddy Holly, that came out when Jeff was just a toddler, *I Fought The Law and the Law Won*: https://bit.ly/46DXVz2

Keeping Up with Psychotherapy

by: Gillian Schweitzer, MD



Gillian Schweitzer, MD

Growing up in my family, psychotherapy was something you just *did*. It was like going to the gym. So, I started in high school. After only a few sessions I knew I wanted to become a therapist myself. And, since my therapist was a psychiatrist, those were the footsteps I followed.

In medical school (in the 1990s) I was the anomaly -- the rare student studying to become a psychiatrist who had hopes to later provide psychotherapy. My residency at NYU was a program that heavily emphasized psychotherapy training. Many of the therapeutic modalities practiced today were still in their infancy back then. As part of my residency, I was encouraged to enter analysis with a training analyst. This meant, as an intern, I got excused from the Medicine wards for two hours daily (which included travel time) to see my analyst. It was a "therapeutic" (pun intended) way to move through those demanding years and the Medicine residents whom I worked with were envious. But, it also extended the length of my work day, and often I was stuck working later than the other residents on my team. On balance, it was well worth it.

One year after my residency ended I left New York and treatment with my analyst ended. As there was no remote therapy at that time, my pause in treatment became a 15-year break. Once computers were starting to be used for video calls, I was so thrilled by the prospect of returning to therapy that I literally sat next to my therapist and showed him how to open a Skype account on his computer. What would Freud think of that?

Today, my private practice is 70% psychotherapy and 30% medication management. I love just about every aspect of therapy. I like being the patient. I like being the therapist. I like reading about therapy and thinking about it. In my early years as a psychiatrist, it was what I'd learned from being in the patient's chair and on the couch that helped me feel most prepared to practice psychotherapy. Back then, the array of trainings that are now available to us did not yet exist.

All of us work hard to remain current regarding new advances in medication. I would argue that continuing to be current with advances in psychotherapy is equally important.

Psychiatrists go through training and become proficient in several key areas of mental health treatment. We work with inpatients and outpatients, we learn medication management and psychotherapy. We go through the most rigorous medical training available to anyone in the mental health field. In my residency program it was often said, proudly, that after residency we would be prepared for "anything that came our way".

As each of us moves through our careers, our focus narrows to what we do day to day. Those of us who work in the outpatient setting may start to feel our inpatient skills getting rusty, and vice versa. We all try to keep ourselves current, but typically this means keeping abreast of advances with psychiatric medication. As psychiatrists, we are not encouraged to focus on learning the new psychotherapy modalities that emerge, nor on how the existing ones continue to evolve.

There are many ways to stay current, from bite-sized psychotherapy skills that can be learned in a weekend, to year-long courses that walk you through a model step by step. In recent years I have discovered a whole new world of psychotherapy trainings. What makes them even more appealing for me is that most are accessible on-line. These trainings have been instrumental in helping me to expand my psychotherapeutic clinical repertoire. Even when seeing medication management patients, I find greater fluency with these newer modalities to be useful. I believe that using therapeutic techniques in the last 5 to 10 minutes of a med management appointment - when time allows - deepens my connection with patients and enhances my impact. I also believe that knowledge of these newer modalities enables me to provide finessed referrals when outside therapy is indicated.

Types of psychotherapies that currently exist can seem a lot like alphabet soup. There are CBT, CPT, EMDR, DBT, AEDP, IFS, EFT and on. Trainings are available throughout the year for almost all of these therapies, with varying levels of certification.

The trainings I have recently done are on modalities that range from highly structured programs to extremely fluid techniques. CPT (cognitive processing therapy) is a structured therapy that addresses negative beliefs held after trauma, and is typically completed in 12 sessions. Much like anything else, doing CPT with finesse takes time, skill and practice --yet the basics can be learned in

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one day by watching a series of videos. With a minimal investment of time, it's possible to learn enough to begin working through the steps with a patient.

Currently, I am studying more fluid techniques based on concepts and psychotherapeutic frameworks that require a deeper time commitment. The two modalities I have studied most recently are AEDP (Accelerated Experiential Dynamic Psychotherapy) and IFS (Internal Family Systems). Their trainings consist of live interactive learning, lectures to watch, and hours of observation of videotaped sessions demonstrating techniques in action. Question and answer sessions that unpack the therapists' choices and technique follow taped sessions. And, many hours of didactic teachings precede and accompany video footage of patient sessions. I find the "experiential exercise" component of these trainings particularly helpful. Three or four therapist trainees take turns role-playing therapist, patient, and observer. This is when practice and integration happen. The exercises are observed by a moderator who is available for moment-to-moment supervision as we play the role of therapist with peers. I read widely on these topics, but have found that the experiential exercises prepare me for the integration of modalities in a way that books never do.

We are not granted CME for psychotherapy trainings and, in my small sample size, I have not seen many other psychiatrists seeking them out. The trainings give continuing education credits to social workers, psychologists, and therapists of all sorts, but not to psychiatrists. This continually surprises me, because I believe that continued psychotherapy training makes me a more effective psychiatrist.

I suspect that, if psychotherapy trainings granted CME credit, more physicians would be encouraged to participate. Perhaps the more psychiatrists who attend psychotherapy trainings and ask for CME credit, the more likely it will become available to us in the future. Regardless, I will continue to pursue future trainings and deepen my knowledge of the array of modalities.

Expand your MPS Engagement in 2024!

With the start of FY25, MPS members may be looking to get more from their membership in the Maryland Psychiatric Society. Consider trying the following offerings, all of which are easy to get started.

MPS Interest Groups
Interest Groups are a way to connect with other psychiatrists around areas of mutual interest. Most communication occurs over email, but other options are possible. MPS members can opt in indefinitely to receive information and the opportunity to share news, ideas and concerns with participating members. Be sure to check out our new Collaborative Care Model interest group!

Curbside Conversations Resource
Over 20 topic areas with limited participation are available! 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.

Enhance your Credentials
Apply for Fellow or Distinguished Fellow status later this year. Visit the APA website for details and a link to apply.

Engage with Digital Options
To stay informed, visit the MPS website regularly and follow us on Facebook, Instagram, X, formerly Twitter, and LinkedIn.

Other possibilities coming next month include voting in the MPS election or serving on a committee. Watch your email for details.

Interview: Alden Littlewood, M.D.
Maryland Board of Physicians

by: Bruce Hershfield, MD

Alden Littlewood, MD

Q. "Please tell us about the work you do."

Dr. L "I wear a few different hats. I'm trained in child and adolescent Psychiatry, as well as in Adult. That's what brought me to Maryland. I did my child fellowship at Maryland, after having trained in New Orleans. I came in 2019, after I finished, I came straight to Midtown. I do about 70% adult work, 30% child work. The majority of the adult work is inpatient. A lot of inpatient work, but we also rotate, so we do a lot of consults and take care of the ER. I'm the Medical Director for our adult psychiatric day program, as well as for emergency consultation services. I do some teaching. We have a teaching service. We do change our assignments every month. I love the teaching part. Working with Residents keeps you on your toes—keeps you sharp—forces you to make your thoughts as clear as possible and to articulate your position, "

Q: "Do you also do research?"

Dr. L" I don't do a lot. I did some research in medical school and found I was much happier in the clinical realm. So that has been my focus—that and the teaching."

Q: How did you become a psychiatrist?"

Dr. L.:" That's a good question! I did not intend to be a psychiatrist when I went to medical school. I thought I would be probably be an OB-GYN—with a focus on the intersection between women's physical and emotional health. I grew up in a family of doctors and other medical providers. Three of my four parents/step-parents are doctors and the other is a retired ICU nurse! My mother has been a psychiatrist in New Orleans for years and years. I came to Medicine a little bit circuitously—first, I was considering doing something in the humanities—art -related. Ultimately I made the transition and was much happier in med school, I knew I loved Psychiatry when I was rotating through those blocs—particularly the acute care ones. I found I could relate to the patients. I found those interviews to be very meaningful. The interventions were some of the most dramatic and meaningful things I did. But because I had a parent who is a psychiatrist, I wondered if it was just because it was familiar. So I did a year of Internal Medicine training. I found I missed Psychiatry!

Q: "Who influenced you along the way, in addition to your family?"

Dr. L: "I found some of the most incredible mentors here. Sara Edwards, who is the head of Child Psychiatry, is a role model. She manages to be both an incredible educator and an incredible clinician. She is also a really impressive administrator. Dr. Stephanie Knight, who is our Division Chair at Midtown, shows a balance of a thoughtful clinical approach and interpersonal leadership skills. Having female role models in the profession has been very, very helpful. They have provided models of how to interact in a personal style and clinical style, with regard to a career trajectory."

Q: "We have been fortunate to have had so much female leadership here in Psychiatry in recent years."

Dr. L: "We have. It wasn't quite as true when I was in my training in New Orleans. Since I have been at Midtown, our core psychiatric staff has fluctuated in number. Usually, we have members, but we haven't had any more than two *men* at a time."

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

Dr. L:" I will always have at least a foot in acute care. It's the part that fascinates me the most and where I can make the most impact. I like the way it overlaps with Medicine. I feel it's important to be part of this academic network, where I can keep up-to-date and have access to these brilliant minds"

Q: "How did you get involved with the Medical Board?"

Dr. L: "I think that since I've been at Midtown I've made it known that policy and public service are interests of mine. Also, the intersection of the Law and Health—particularly Mental Health—has always been particularly interesting to me., That may come out of the kinds of work my mother was doing when I was a kid, but I have always been interested. I think the Board wanted to have a psychiatrist as one of the nominees and the word went out from the Department, asking who would be interested. I threw my hat in the ring and I started in December."

Q: "Do you have any advice for how people can keep from having to interact with the Board?"

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Interview with Alden Littlewood

Continued

Dr. L:" I can't give any specific advice. The Board is comprised of an incredibly thoughtful panel of people who take their job very seriously. The primary intent is to protect the people of Maryland and to ensure those who are providing services to them are of the highest quality and are thoughtful and are keeping up to date. I have been impressed by how empathic they are—the comprehensive nature of how they think through individual cases. It's very reassuring. I can't say I'm surprised!

Q: "It's supposed to be a lot of work."

Dr. L: "There is quite a bit of material to review. Luckily, a lot of that has been compiled by others, for us to review. It's significant enough in its importance that it feels compelling and necessary to read through it. I appreciate how thoughtfully the cases are presented to us as clinicians. There are others on the panels who are equipped to explain the legal underpinnings to us. They clarify which aspects should be taken under consideration by us as clinicians. The organization as a whole and the support they have given me has been very impressive. It allowed me to hit the ground running, as a new member."

Q: "How can we help you in your work?"

Dr. L: "Continue to be thoughtful. Keep up to date. Keep abreast of what is happening tin the world at large. Continue to be a community that supports each other and our patients. Continue to be a network."

MPS ADVOCACY FUND

Psychiatry faces legislative and regulatory opportunities and threats in our state. The MPS works for you by advocating with lawmakers and the executive branch. To sustain government affairs activities and legal counsel for our role as the voice of psychiatry, we need financial support from all Maryland psychiatrists. **Every contributor, every member strengthens our collective position!**

To support the MPS over and above your membership:

1. **Visit: https://mdpsych.org/contact-us/**
2. Click on the yellow "Pay Now" button
3. Enter your credit card information

In Memoriam: Diane Gutterman, MD

by: Bruce Hershfield, MD

Diane Gutterman, MD

Diane Gutterman, MD died on March 30th.

After graduating from Cornell, Dr. Gutterman earned a PhD and then did post-graduate work in Princeton and in Sao Paulo. She attended medical school at the University of Miami, then trained in Psychiatry at Johns Hopkins. She went on to have a 45-year career caring for patients in the Baltimore area, most notably at MedStar Health.

Elias Shaya, MD commented, "Dr. Gutterman worked at MedStar Union Memorial Hospital for many years and she is fondly remembered by staff and colleagues. Over the years, she worked in various capacities and directed the Inpatient Unit. She is remembered for her extraordinary patience and compassion as she cared for very challenging and challenged patients and provided them with long-term follow-up. She was known for her keen ability to galvanize the team and come up with "creative administrative solutions" when needed. 'She was collegial and greatly responsive'…"always ready to help and cover colleagues".

Dr. Ray DePaulo added, "When she was a 4th year Resident she did an elective, then she did a year of fellowship with me working on lithium and the kidney. But she preferred the complexity of real patients she could help. After the fellowship, she took care of some of the sickest patients we had then in our Mood Disorders Clinic. (Most of them had Bipolar I disorder.) I continued to hear back from patients and families what a kind and highly competent clinician she was."

I supervised her when she was a Resident and would later see her at meetings. She was interested in many subjects and it was very enjoyable to talk with her. It was clear she cared about being an excellent psychiatrist and in providing the best treatment for her patients.

MD Psychiatrists Oppose Medical-Aid-in-Dying Bill for Good Reason

By: Carol Vidal

Carol Vidal, MD, PhD

Ed's Note: This is a version of Dr. Vidal's Op-Ed piece in the 2/23/24 Baltimore Sun

This year, the Legislative Action Committee of the MPS voted to oppose the End-of-Life Option Act (Senate Bill 443/ House Bill 403), which has been discussed in the Senate and House this month. This bill would allow physicians to prescribe lethal drugs to terminally ill and mentally capable adults who request to die. The practice has alternately been known as "physician-assisted suicide," "medical aid in dying" or "death with dignity." However, its essence remains: It involves medical professionals as active agents in the death of patients. The bill, as written, supports a practice that is contrary to the professional philosophy of psychiatrists, our training and the reasons why we choose this occupation.

In 2020, the MPS conducted a survey of our members about the topic of medical assistance in dying. While there was support for a right of terminally ill patients to choose to die in principle, there was considerably less support for any physician role. Most of our members opposed the idea of physicians administering medications with that goal. While there is not unanimity, the highest agreement existed for a question stating "a physician who prescribes or administers lethal medication should be trained to recognize signs and symptoms of mental illness," followed closely by "a patient who requests lethal medication should be evaluated by a psychiatrist." In other words, the members who responded to the survey mostly supported ensuring that those patients who requested to die were not suffering from depression, a treatable disorder.

The only way to ensure that a patient is not depressed is by conducting a comprehensive psychiatric evaluation. These evaluations are to depression what a blood pressure reading is to hypertension. We cannot diagnose without them. The evaluation would also allow a physician to determine if the person is competent to make the decision to die. Competency evaluations are the core of a consultant psychiatrist's work. For physicians to prescribe, we first need to diagnose. In order to diagnose, and to rule out depression and lack of competency, a psychiatric evaluation is warranted.

Supporters of the bill often mention a Medscape 2020 poll completed by 5,000 American physicians that asked if physician-assisted dying should "be made legal for terminally ill patients", to which 55% responded positively. It is important to point out that something can be legal and still require safeguards and that this survey indicated that roughly one out of two physicians disagreed with it being legal.

As physicians and psychiatrists, our goal is always to minimize physical and emotional suffering in our patients. Hospice care provides comfort to those suffering from pain in the later stages of a terminal disease. However, providing a lethal drug to a patient without a proper psychiatric evaluation to rule out depression is simply malpractice.

Our MPS colleagues have suggested many amendments to the bill over the years which its supporters have refused to adopt. The guardrails are essential in a bill that deals with life and death.

Call for Volunteers!

ALL members are invited to step up with MPS and make a difference in how psychiatry is practiced in Maryland

The MPS offers multiple ways for members to be involved, including volunteering for committees, joining an email interest group and other ways that members request. MPS President Theodora Balis, M.D., will appoint FY25 committees next month so please sign up NOW!

Engage with us to represent psychiatry. This is your chance to have a say! Your energy and ideas can help the MPS effectively focus on issues that are important to you! Participation from members is essential to accomplishing our goals. To review the options and sign up, **please click here**.

In Memoriam: John A. Talbott, M.D.

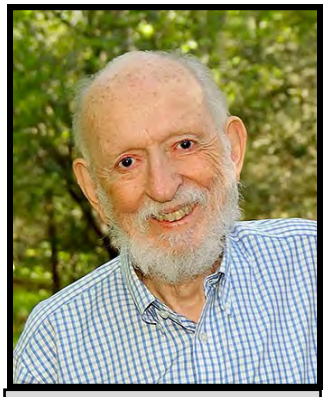
By: Jill RachBeisel, MD & David Mallot, MD

Psychiatry suffered a major loss on November 29, 2023, when John A. Talbott, MD passed away at the age of 88. A pioneer in the field of Community Psychiatry, he relentlessly advocated for some of the most disadvantaged people in our collective communities—individuals with severe and persistent mental illness—a population that remains stigmatized and forgotten. His career was both defined and fueled by his rage against the neglect and indifference to these sickest members of our society. His advocacy included obtaining the necessary resources and access to care, as well as the need for empathy and understanding for the "person" trapped in the throes of severe mental illness.

An otherwise reserved and contemplative man, John Talbott influenced the world of psychiatry and mental health through his words, both spoken and written. While he could easily command a room of listeners with a style conjuring up Old Testament wrath, he didn't demand attention, and was a powerful advocate through his writing about the plight of the severely mentally ill and editing of important journals devoted to Community Psychiatry--including the biologic, psychologic, and social factors of mental illness.

He was an undergraduate English major at Harvard, where one of his favorite activities was the *Harvard Lampoon*. This combination of seriousness of purpose and an ability to laugh at the absurdity of the world would be part of him for the rest of his life. He received his MD at Columbia, followed by a residency at the New York Psychiatric Institute and Presbyterian Hospital. Following his residency he served as an Army physician in Vietnam, a major factor in shaping his views of psychiatry and the severely mentally ill. In Vietnam, he encountered the ravages of war as he treated both psychiatric trauma and severe substance abuse. He was on duty during the Tet offensive as the North Vietnamese army swept through the hospital. Following his discharge, he participated in the Vietnam Vets Against the War and served as a press spokesman at the 1968 Democratic National Convention.

As he returned to academia, first in New York and then in Maryland, he blazed a trail of leadership and advocacy for the severely mentally ill. His 1978 book, "The Death of the Asylum: A Critical Study of the State Hospital" encapsulated the horrors of closing thousands of State Hospital beds and assigning the severely mentally ill to a life on the streets. In the words of his friend and colleague, Allen Frances, MD, "Dr. Talbott became the most powerful voice of the voiceless." He is correctly seen as one of the founders and champions of Community Psychiatry.



John A Talbott, MD

John's leadership abilities were clearly recognized and sought in the number of psychiatric organizations that he led. President of the APA, Vice President of the American Board of Psychiatry and Neurology, and President of the American Association of Chairmen of Departments of Psychiatry were only a few of his leadership positions.

He was Chair of Psychiatry at the University of Maryland from 1985 to 2000. His commitment to the severely mentally ill dovetailed perfectly with the research on schizophrenia at the Maryland Psychiatric Research Center, led by Will Carpenter, MD, and a residency, led by Walter Weintraub, MD, that partnered with the State of Maryland to treat individuals with severe mental illness. His connections to seemingly everyone in the world of Psychiatry enhanced the department and allowed it to thrive. After stepping down from the Chair, he was involved in the creation and maintenance of ethical standards in the University of Maryland Medical Center and within the medical student education program.

If you asked John what he liked most about his work, he would often mention his editorial work. He was the editor of *Psychiatric Services[Hospital and Community Psychiatry*] —during much of his time as editor, Psychiatric [Quarterly], and the *Journal of Nervous and Mental Disorders*. He was continuing to edit the latter until just a few days before his death. His CV is weighted to books and book chapters, as well as invited lectures, as these were his preferred ways of espousing his views.

John Talbott also liked to eat. In his semi-retirement he spent much of his time in his beloved Paris, where he had a blog describing his gastronomic adventures. He was also a proud husband and father and was able to gather his family for one last Thanksgiving shortly before his death.

Dr. Allen Frances summed up the essence of John Talbott in a piece he wrote for the *British Medical Journal*. "John Talbott was one of the pioneers of community psychiatry, one of its most prominent and enduring advocates, and a man who never lost his optimism that societal decency would eventually triumph over societal indifference and neglect. He believed and embodied Edmund Burke's dictum: 'Nobody made a greater mistake than he who did nothing because he could do only a little'."

Who will follow in his footsteps? Who will take up the cause as our country and communities waver in their understanding and support of those with serious mental illness? There is only one answer. It is *our* responsibility to carry on the work that Dr. Talbott lived and died for.

Has Medical Aid in Dying Been Extended to Patients with Anorexia?

by: Douglas W. Heinrichs, MD.

Douglas Heinrichs, MD

Opponents of medical aid in dying (MAiD) legislation for the terminally ill face a problem--most American citizens, physicians, and psychiatrists actually support it. So, its opponents tend to maintain that, while MAiD may be acceptable for the terminally ill, it would inevitably lead to a slippery slope where all sorts of folks would be eligible for it --including those with psychiatric illness. A similar version of the slippery slope argument is frequently made with respect to the disability community. While logically flawed, the rhetorical strategy of these arguments is to try to force proponents of legislation that has the support of most of the population to either defend imagined future legislative proposals, or to provide ironclad assurances that such legislation will never be proposed – -an impossible task.

But promoters of the slippery slope argument have to face that, in the USA, where MAiD has been legal in 11 jurisdictions for periods ranging up to 26 years, nowhere has the patient criteria for eligibility been broadened beyond the terminally ill.

While broader applications of MAiD do exist in several European countries and in Canada, it is important to note that there are fundamental cultural and societal differences. The European countries involved have much more liberal populations than the USA, and even Canada has fundamental differences in how it views the obligations of society and government to its population. Just consider its approach to healthcare versus ours. Furthermore, in Canada the extension of MAiD to psychiatric illness was not based on legislative action, but on court order. In our country, a Supreme Court that overturned *Roe v Wade* would not mandate such an extension. Also, Canada has put the extension on hold for an extended period to allow time for thoughtful and adequate safeguards to be put in place. The inference that what has happened there is likely to happen here is not valid.

It is in this context that opponents have leapt upon an article, whose lead author is an eating disorder specialist in Colorado, involving three patients with what she termed "terminal anorexia." (Gaudiani et al. Terminal anorexia nervosa: three cases and proposed clinical characteristics. *Journal of Eating Disorders* (2022) 10:23 https://doi.org/10.1186/s40337-022-00548-3) As MAiD was ultimately involved in two of these cases, it has been put forward as an instance of it being extended to the mentally ill. Those who have been looking for an alleged instance of the slippery slope have seriously mischaracterized the point of the article and what actually happened in those cases

I strongly urge anyone interested to read this article. Its fundamental focus is to argue that there is such a clinical entity as "terminal anorexia" and to suggest criteria for it. The implication is that, for the very small group of patients who meet such criteria, there comes a point when it is reasonable for the treating clinician to support the patient's decision to reject further aggressive treatment and to assume a more palliative role. This is likely to eventually result in death from starvation--they eventually would become terminally ill. At such a point, they would be eligible for the full range of end-of-life services – palliative care programs, hospice and, where available, MAiD. Both the concept and proposed criteria are controversial and deserve serious scrutiny by the community of eating disorder specialists. But this is not in any direct way about MAiD.

At the core of the article are three detailed case studies that the author believed qualified as "terminal anorexia." All three suffered from severe anorexia nervosa for many years and had attempted a wide range of treatments, including specialized inpatient and residential programs. None had achieved anything beyond brief temporary improvement. All three found living with the disease increasingly painful and intolerable. All three were again approaching a state where the medical complications of their food restriction put their health in imminent danger. All refused further residential treatment

It is important to remember that in all jurisdictions in this country, whether or not MAiD is in place, any competent adult with intact decision-making capacity may refuse potentially life-saving treatment. The decisive question in each of these cases was whether the distortions intrinsic to anorexia interfered with their decision-making capacity such that they were not competent to make the decision. Each of these patients was carefully assessed by appropriate mental health professionals and judged to be competent. This decision has nothing whatsoever to do with MAiD.

After this crucial decision was made, these patients reduced their nutritional

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intake further and eventually became so medically compromised that they were judged to be terminally ill from starvation and likely to die within 6 months. All three were admitted to hospice or palliative care programs. The first never requested MAiD. He was eventually given doses of morphine as he approached death and he died from the medical complications of starvation. The second, wishing to avoid a slow and painful death, did request MAiD and was given a prescription for lethal medication. She did not take it for some time and was admitted to a hospice program. Eventually, after consulting with her family, she took it and died peacefully in the company of her family. The third also entered a home hospice care program as her condition deteriorated. She also requested MAiD and received a prescription for lethal medication over a month after entering hospice. She found it very comforting to have the option of controlling the timing and manner of her own death, but she never took it and died from starvation.

So, what does MAiD have to do with these cases? Actually, very little. The first patient chose to stop eating and ultimately succumbed to starvation. He never applied for nor received lethal medication. The crucial controversy was over his right to refuse more intensive treatment. Was he competent to do so, with unimpaired decisional capacity? I want to stress that this issue is the crucial one, but it has nothing to do with MAiD. He was deemed competent to refuse treatment, so he was in the same position as a cancer patient who refuses further rounds of chemotherapy. This is every competent patient's right. Once that right is exercised and the patient has fewer than 6 months to live, the question of end-of-life care arises. He entered home hospice and did indeed succumb to starvation.

In the second case, as well, we are faced with an anorexic patient's decision to refuse aggressive treatment. Fighting the illness had become too distressing and intolerable. Avoiding this distress was her motivation, rather than an active desire to die. She was judged to be competent. Once she is allowed to make that decision, she is in the same situation as the cancer patient. Following that decision, her medical condition deteriorated as her anorexia progressed. She was sometime later judged to be within 6 months of death, and palliative care options were discussed. Only at this point did she apply for MAiD, was assessed to be competent to do so, and received a prescription for lethal medication. She did not use it for several months, then ultimately took it and died quickly and peacefully.

The third patient's situation is in many ways parallel. She was judged competent to refuse treatment. Once that decision was made, it was virtually certain that she would ultimately die from starvation. Sometime later, she was judged to be likely to die within 6 months, was admitted to a home hospice program, and requested MAiD. She was judged competent to make that request and received a prescription. She described great comfort in having it and the feeling of control that it gave her. She never took it and died from the medical complications of starvation.

So how should we assess the claim that these cases show that the slippery slope is here and that MAiD is being applied on the basis of having a psychiatric illness? It is clear that it is utterly false:

1. Only two of the three ever requested MAiD, and only one actually ingested the lethal medication. The other two died naturally as a result of starvation.
2. In the two cases in which MAiD was requested, this occurred a considerable time after the crucial decision to refuse treatment was made. Judging them to be competent and thereby permitting this decision was what crucially determined their fates. This is clearly true in the two patients who never actually ingested lethal medication. The circumstances of the third case make it hard to doubt that this patient also would have died shortly from starvation even if she had not taken it. It is reasonable to assert that all three of these patients would have died in roughly the same timeframe, whether MAiD was available to them or not.
3. In no instance was MAiD authorized because the patient suffered from anorexia. No psychiatric illness, in fact no illness of any kind, is itself a legitimate qualifier for MAiD anywhere. The essential qualifying criterion is that the patient has a medical disorder likely to cause death within 6 months. These two patients eventually qualified only because they were judged to be within 6 months of death secondary to a medical condition - starvation.
4. The primary goal of this article, as articulated by the authors, was to propose a set of criteria for "terminal anorexia." Both the term itself and the proposed criteria are controversial and open to debate. When is it reasonable for patients with anorexia to refuse further aggressive treatment? Once they are allowed to do so and their condition deteriorates to where it is likely they will die from starvation within 6 months, like any other dying patients they become eligible for any of the available end-of-life care options. The issue is not specifically about MAiD.

These issues are exceedingly complicated, and deserve serious discussion and debate by the psychiatric community. It is a service to no one to muddy the waters further by conflating this issue with "medical aid in dying".

Taking the History:

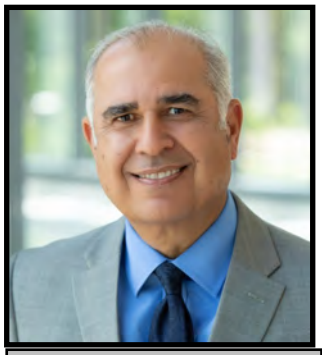
A Profile of Baltimore's "Top Doctor," Khizar Khan

by: Elizabeth Ryznar, MD.

Elizabeth Ryznar, MD

Baltimore Magazine recently profiled Dr. Khizar Khan in their annual "Top Doctors" issue. Dr. Khan serves as the Medical Director of Sheppard Pratt's Baltimore-Washington Campus, as well as Chief of the Harbor Unit, one of the five specialized inpatient units on that campus. Clinically, he sees inpatients and outpatients; he also provides ECT one morning a week. He has worked on the adult psychosis and mood disorders unit since he started at Sheppard Pratt in 2012, appreciating the "art and challenge of treating patients at the height of their mental health difficulties…if you connect with them, you can meaningfully change their outcomes."

I recently spent a day with him to learn more about his work and his perspectives on psychiatry. I noticed three elements of Dr. Khan's practice that make him so effective as a psychiatrist. Firstly, he *listens* while taking a comprehensive history. He believes that the psychiatrist's primary role on inpatient teams is to make an appropriate diagnosis and formulation, and "you can't do that without taking a full history." He regularly sees people with a missed diagnosis of bipolar disorder because their outpatient providers had narrowly focused on the acute depressive episode, without assessing their longitudinal course of symptoms or their family history. Similarly, he finds that substance use, general medical causes, and trauma can also be overlooked as causes or contributors. He screens all of his inpatients for emotional, physical, and sexual abuse, and the majority who answer affirmatively report that their outpatient providers (including psychiatrists) do not know about it because they never asked. Amazingly, he obtains all of this information efficiently from his patients without compromising his attention to the patient's perspective. Indeed, after rounds, one of his new inpatients, who has been hospitalized multiple times and in group programs for many years, exclaimed: "that doctor—he's fast but at least he listens to me!"



Khizar Khan, MD

Secondly, he advocates for all aspects of a patient's health: "Yes, treating the psychosis is important and necessary. But ensuring that comorbid medical issues are addressed, that housing is addressed, that the disposition meets their needs—all of that is important, too." As we all know, tackling these psychosocial factors often prolongs hospitalization. When asked for advice to those psychiatrists who might face administrative or industry pressure to minimize the length of stay, Dr. Khan warns: "never compromise your clinical decision-making." He adds that he appreciates working for an organization that supports his goal of providing the best overall patient care.

Thirdly, he recognizes that inpatient psychiatry is a team endeavor: "as an inpatient psychiatrist, my role is just one piece of the pie. The rest of the inpatient staff is on the unit with the patient 24/7… the nurses and mental health workers are constantly supporting and encouraging patients, helping them with medications, attending to their physical needs, and de-escalating agitation." He laments that there is a "whole group of people integral to the patient's success on the inpatient unit that do not get highlighted," which is why he regularly gives positive feedback to team members and shares positive anecdotes during administrative meetings. He describes a recent situation in which a nurse noticed that an older patient was slightly more confused than usual; she alerted the nurse practitioner who sent the patient to a nearby ER The patient had had a transient ischemic attack, which otherwise would have been missed. Dr. Khan's team spirit might stem from his athletic background: while growing up in Lahore, Pakistan, he played cricket at the club level until he started his medical studies (in fact, one teammate was Wasim Akram, who went on to become Pakistan's most iconic cricket player).

Although inpatient psychiatry is his main clinical passion, he has always maintained an outpatient practice. He emphasized the complementary benefits of doing both: "If I'm confined to a specific aspect of clinical care, I only see those narrow challenges. For example, as an inpatient psychiatrist I may have a patient with severe and difficult-to-treat psychosis, so I choose olanzapine. But as an outpatient psychiatrist, I see the ramifications of that choice – someone only got stabilized on

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Khizar Khan Profile

Continued

olanzapine, but now 6 months later may have weight gain." He also appreciates that he has time to work with patients on how to improve their lives. He notices that in our current culture, many patients focus solely on medications, thinking they are the only solution to their problems. He encourages them to also address their diet, sleep, nutrition, and social connections as well.

His emphasis on quality holistic and longitudinal care also informs his administrative decisions. Shortly after coming to Sheppard Pratt, he became Associate Medical Director of the former Ellicott City campus. In that role, he was intimately involved in the planning of the new Baltimore-Washington Campus, which opened in June, 2021, when his title changed to Medical Director. He and other Sheppard Pratt staff worked with the architects to intentionally create a safe and healing environment for patients and a welcoming and efficient environment for staff. That includes centrally-located nursing stations overseeing the entire unit, single rooms to better manage the census in case of agitation or infection control (which was prescient in light of the COVID-19 pandemic), easy transit between inpatient units and outpatient offices for staff, and independent access to sunlight and outdoor spaces. That included an enclosed outdoor basketball court and a beautiful central courtyard. The new campus created an opportunity to expand clinical offerings across the whole spectrum of care in Howard County: creating a psychiatric urgent care center, adding a dedicated young adult unit, starting an ECT program, and expanding outpatient services. Now, there are dedicated mood/anxiety partial hospitalization programs for children/adolescents and adults. He is currently recruiting staff to open a day program for patients who are psychotic.

After 25 years of practice, Dr. Khan continues to work energetically and enthusiastically. He continues to be motivated by the ability to make "a meaningful difference in the trajectory of patients' lives." Indeed, he has impacted thousands of patients through his inpatient care, and many multiples of that as Medical Director.

He truly is a "top doctor".

Ketamine-Assisted Group Psychotherapy

By Dinah Miller, MD

Dinah Miller, MD

Editor's Note: Dr. Miller agreed to answer a series of questions.

How did you get interested in ketamine-assisted psychotherapy (KAP)?
I've always considered myself to be a mainstream psychiatrist--a bit of a dinosaur in that I see patients for both psychotherapy and medications. There are some people who have tried many, many medications over the years, and nothing really eases their psychic discomfort. They get very stuck in negative cycles of thinking that fuel their depression.

Ketamine, has been around for a while in the form of intravenous infusions or, more recently, as nasal esketamine (Spravato), which is the only FDA-approved form. With these forms of ketamine, a dissociative experience is considered an unwanted side effect. With KAP, the idea is to *cause* the patient to have such a dissociative experience-- or to use the psychedelic lingo, a *journey*. To help them along, you ask patients to set an *intention* for the journey.

KAP helps patients on a number of levels. First, ketamine, in any form, has antidepressant properties for many patients. The antidepressant effect may be transient (hours, days), or more long-lasting. On a second level, the material that comes out in the journey is regarded as meaningful, and sometimes these experiences give patients an opportunity to revisit traumatic experiences. Finally, what really piqued my interest is that ketamine may give people a period of neuroplasticity afterwards.

There is a crucial 24-to-72 hour period where things can be unlearned and relearned. I like to make that my focus with people-- that here is a time when you can rewire your thinking, or you can possibly change unwanted behaviors. I've hoped it would help loosen the self-critical thinking that I see in people with treatment--refractory depression, who seem to get so trapped. I just love the idea that we might have something to offer people that would work quickly and be radically different

Why are you doing KAP in groups?
People write about the experience with words like "transpersonal" and talk about feeling connected to the universe. KAP trainings are often experiential --

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Ketamine-Assisted Group Psychotherapy

Continued

people take ketamine as part of the training, and many feel it is important in a way that trying a traditional medication is not. I was impressed that everyone I spoke to who had been to one of these trainings talked about how close and connected they felt to the other participants. Psychiatric disorders are so isolating and I hope that, even if ketamine does not "cure" the depression, there might be something transformative and healing. And, finally, there are the logistical issues--it takes about 3 hours to do this safely, using sublingual ketamine. I figured I would try doing it for a while and if it helped people, I would continue. If it doesn't help, I will stop.

How did you get the initial group together?
I started with my own patients who were struggling. These were all people who had tried many medications, some for many years. I did KAP with one patient to start -- this patient wanted to try Spravato, but couldn't take the time off work, and lived alone, so transportation was an issue. Next, I had two patients come together -- I called this the 'mini-group' but the patients called themselves 'the guinea pigs' since they were aware that I was new at this.
I also have an assistant in the room with me for groups. My assistant has a PhD in psychology and recently retired from working in Human Resources at Hopkins. She has a lot of experience running groups and has had wonderful ideas and insights. After the mini-group, I started to accept patients just for the groups. They come for the 5 sessions (three with ketamine administration) but continue with their own treatment teams.

How has it been going?
Really well. I love doing the groups and I have seen some people make remarkable progress. I think everyone has gotten something out of them. And it is really interesting to hear what happens for people during the psychedelic experience.

What has surprised you so far?
A lot. There is more coordination with other psychiatrists, therapists, and sub-specialists than I had envisioned. What has surprised me most is how safe and easy this is. People are very quick to point out the perceived dangers of ketamine, but we have few qualms about the side effects that come with the medications we are already comfortable using. Ketamine is not for everyone, and it needs to be dosed carefully with monitoring, but in many ways it is a cleaner drug.

What criteria did you find useful?
There are criteria about who should *not* get ketamine. It can cause a rise in blood pressure and heart rate, and people with a history of psychosis should not have it. There are no specific criteria for who are good candidates for KAP I offer it to people who have not had a sufficient response to at least 4 antidepressants. People don't need to come off their medications, and they don't need to be severely depressed. I am happy to try KAP with people who have only had a partial response, or people who have been tried many other treatments, including other forms of ketamine
There are no protocols for KAP, and, especially *group* KAP. The ketamine may be given by many different routes. For the sublingual route, it's unclear what the dosing should be, how long the patient should hold the lozenge in the mouth, and whether it is better to spit it out or swallow it. For IM administration, some people give the whole dose at once, while others give one injection and then a second one later. Some people prescribe for on-going home use. Because ketamine can be addictive, I have been providing patients with enough for a few sessions to be taken in my office with supervision. If there is leftover ketamine, we melt it.

Has it changed your view of psychotherapy?
I don't know that it has. Groups are powerful, even without ketamine. And with most of my patients, I'm still doing traditional psychiatric work. Everyone is a bit anxious about trying ketamine, and for people who are having trouble taking action to make changes in their lives, the idea of trying ketamine can be particularly difficult.

Would you encourage other psychiatrists to do this?
I would certainly like other psychiatrists to know about it and share my enthusiasm. Ketamine infusions are often done by people with anesthesia and emergency medicine backgrounds. Sublingual ketamine is generally done by non-medical psychotherapists where a doctor (sometimes by video from another state) prescribes the ketamine. And many people do it with remote, online companies where the ketamine is mailed to the patient and they take it at home.

What obstacles have you encountered?)
It took more time than I initially anticipated to get it up and running. I read, I talked to everyone I could find who had done KAP, I watched instructional videos and listened to ketamine podcasts, and then I went to Colorado to take a course. Then there were things I needed for the office--for example, camping mattresses, eye masks, and a sound system, because the music is an important part of the experience. I'm adding as I go -- I've gotten better pulse oximeters that beep if someone goes out of a certain range, and a one-piece blood pressure cuff that is less bulky. I bought a new book of poetry to read. People have to fast before ketamine to prevent nausea and vomiting, so I'm thinking maybe it's time to up my game on the post-treatment snacks.

Adult, Child & Addiction Psychiatry

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LETTER FROM THE EDITOR
Heidi Bunes Retires

by: *Bruce Hershfield, MD*

Bruce Hershfield, MD

Someday far in the future—when you and I are long-gone—people may wonder why the MPS has been so good at guiding us in how we treat our patients and each other. Heidi Bunes' name will come up and someone will ask who she was.

A clue may come in the derivation of the name "Heidi". It's a diminutive of the Old German Adelheide (Adelaide, in English)—"of a noble kind".

Make sure to read what Robin Weiss and Tom Allen have written about her in this issue. Just look at what people wrote on the message board for her retirement:

"*You navigate with grace and tact. Your warmth and personal style have enriched the MPS.*" (Jessica Merkel-Keller).

"In my world of Psychiatry the MPS has always been Heidi! I was a Resident and there was Heidi. And then I was on the Women's Committee and there was Heidi. And then as Editor of TMP, then year after year of Council. The soul and ability of the organization have always been Heidi." (Dinah Miller)

"*Your time as the MPS Executive Director has had such a tremendous impact on us and what we have been able to accomplish as a professional society. Your attention to detail, exceptional writing skills, and knowledgeable financial guidance have been crucial to our success.*" (Theodora Balis)

"You have a quality that can be rare: you spend your time quietly caring for other people and for a job well done, without asking for credit and recognition, but we all see you and appreciate you." (Carol Vidal)

"Since my early days in Maryland and over the years, for me and for many of us, Heidi has been the MPS!" (Elias Shaya)

"Your kindness, decency, intelligence and patience have been inspirational. I feel very lucky to have known you." (Neil Warres)

It is difficult to add to what these fine people have so eloquently said about her. We need to be sure we leave this record of our appreciation in the MPS archives, so psychiatrists in the future will know how Heidi Bunes, for 35 years, has shown us how our society—and each of us--should be.

She has been *of a noble kind*, indeed.