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Voices for Change
A Profile of the MPS Legislative Committee

by: Elizabeth Ryznar, M.D., M.Sc.

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The 2024 legislative session concluded with many wins for mental health treatment in Maryland, thanks in part to the efforts of the MPS Legislative Committee. As it prepares for the 2025 Legislative Session, I want to highlight its motivations and victories.

Motivations

Many psychiatrists joined in order to effect change after encountering hurdles in getting effective care for their patients. For example, Dr. Michael Young (Medical Director of The Retreat at Sheppard Pratt and Associate Residency Training Director of the University/Sheppard Pratt Psychiatry Residency Program) commented: "Often people who are willing to seek help for their mental health issues have difficulty finding it, affording it, or both." As Director of Adult Psychiatric Emergency Services at Johns Hopkins, Dr. Cynthia Major Lewis saw many patients with severe mental illness who frequented the ER, but who never improved. She realized "that being on the front lines of treating patients was not going to be enough…I learned that in order to effect much needed change, laws would need to be changed, and this could only be done via the Maryland legislature." She joined the Committee specifically to advocate for Assisted Outpatient Treatment (AOT).

Other psychiatrists were already performing advocacy work individually and wanted to coordinate their actions. Dr. Paul Nestadt (Associate Professor at Johns Hopkins) frequented Annapolis because of his research in suicide prevention. There, he noticed that groups with formal lobbyists were more effective. He was also impressed with MPS's work after witnessing a bill modification that Dr. Annette Hanson (former forensic psychiatry fellowship director) pushed through. Similarly, I decided to join the Committee because of my interest in climate change and plastic pollution.

Committee members also described a sense of duty. For example, Dr. Robert Herman believes, "It is our responsibility as psychiatrists to speak out on issues that affect our work. Especially since there is often a limited understanding of mental health and the role of Psychiatry among the general public and legislators." And as Dr. Ronald Means (Chief of the Medical Staff at Sheppard Pratt) wrote, "Sometimes there is a disconnect between administrators and practicing clinicians."

Finally, members highlight the collegiality of the group, noting the opportunity to work closely with good friends and with mentors.

Victories

The work often spans multiple years and requires lots of cooperation and compromise. Dr. Lewis reports that upon joining, "I observed the process in 2022 when one county was trying to get an AOT bill passed. I provided oral and written testimony in 2023 and saw the statewide bill pass the House for the first time in nearly two decades. I provided oral and written testimony and sat on the Governor's panel in 2024. The bill passed and Governor Wes Moore recently signed it into legislation…This was a huge win for the many patients I see who are failing outpatient treatment and who deserve humane and dignified care, when they might not be able to appreciate the need for that care."

Dr. Nestadt has also experienced many wins since joining the committee: "Closing the long-gun loophole, expanding child access protection laws, most recently passing the ERPO data and gun violence center bills." However, for him, the most satisfying accomplishment was the establishment of the Suicide Fatality Review Committee: "MPS helped to heavily amend the proposed legislation to make it safer for physicians to participate (share data), pre-empting a potential objection we may have had from MedChi. The bill passed on the second go, and now the Suicide Fatality Review Committee in Maryland has been touted as a model for other states."

Unfortunately, other bills may get watered-down, due to competing corporate interests. Dr. Herman led a multi-year effort to prevent pharmacy benefit managers (PBM's) from denying clinically appropriate

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medications. The most poignant case was a nurse who survived cancer, but developed debilitating cognitive problems after chemotherapy. Modafinil was the only medication that treated her symptoms well-enough to allow her to continue working. However, it was a branded medication at the time, so her PBM denied it, ultimately leading her to stop working and seek disability. Three years ago, he drafted a bill with other members, but it did not make it past the senate committee. The next year, MedChi sponsored an expanded bill. Dr. Herman wrote: "Despite enormous support for this bill from nearly every health care organization in the state, it was again killed in secret. But the vice chair of the senate committee promised to have meetings after the legislative session was over to try to reach a compromise." Those meetings resulted in a slimmed-down bill, which requires PBM's to integrate electronically with health records so that prescribers know in real time whether a drug is covered and, if not, what alternatives *are*. It also streamlines prior authorization requests and informs patients about out-of-pocket costs and alternative medications. These requirements will go into effect July 1, 2026.

The Future

Members of the committee are keen to influence policies that can significantly improve the quality of treatment. As they gear up for the 2025 session, there are many issues of concern, including scope of practice, collaborative care models, climate change, assisted suicide, and ongoing accessibility problems. They also hope to recruit more psychiatrists to advocate for policy. As Dr. Lewis remarks, "There is too much at stake to leave all of the decision-making to those who don't have first-hand knowledge of how we assess and treat patients." Prior advocacy experience is not needed. According to Dr. Hanson, part of the Committee's legacy is mentorship and "encouraging a new generation of young residents and early career psychiatrists to carry on the work."

Dr. Herman shares advice he once received about being politically active: "If you hesitate to speak your opinion to decision-makers about important issues of the day, you should realize that the people who have exactly the opposite view to yours are not hesitating to speak out."

Democracy requires participation, so let's make sure our voices are heard for the good of our patients.

Navigating the Abyss:

My Observations as a Second Year Psychiatry Resident

By Shyam H. Bhatt, M.D., MPH

Shyam H. Bhatt, M.D., MPH

Psychiatry is an unknown abyss to most third-year medical students, with vague definitions of diseases and often poorly understood pharmacokinetics. For most aspiring doctors, hard-wired for scientific precision and concrete definitions, it represents an uncomfortable unknown. But the select few who gravitate toward it are drawn into it, seeking answers in the darkness. My decision to walk this path came late in medical school and initially felt unnatural, but the vast unknown called to me, and I relished the chance to impact the lives of those who often exist invisible to the rest of society.

In residency, we begin learning to navigate this abyss, attempting to map the human mind. Over time, with the grace of the patients we care for, patterns begin to emerge, and we build trust. The weight of that trust is both humbling and awe-inspiring. In the first year of residency, the goal is not to get lost in the "cave". It's a year of gaining perspective on how psychiatry fits within the medical field and learning to identify its disorders in their many forms.

If the first year of residency teaches us how psychiatry fits within medicine, the second year begins to pull it apart. A psychiatrist's judgment formed in an interview becomes a large part of the objective data, a concept foreign to most other fields of medicine. Slowly, I am learning to use my interview as a hospitalist would use an MRI or a pathologist a microscope slide. Each encounter—in inpatient units, emergency rooms, and clinics—builds a database that helps guide care for the patient. The more patients we meet, the more this inner compass grows, helping us navigate future complexities.

This is when psychiatry starts to morph from a series of procedural steps into a dance, where subtle cues from patients dictate the rhythm of care. Patient interactions take on new dimensions. Working with patients in their most vulnerable moments, knowing that you are responsible for their recovery, is both terrifying and beautiful. We learn to understand their presentations as part of a chronic process, rather than just one acute episode after another. Each decision feels more informed, more connected to the broader arc of what is happening to them.

The transition into residency is often fraught with mistakes, and it's not without reason that physicians say they "practice medicine"—a reminder that we are always learning. My experience as a psychiatry resident has been no exception. While medication errors are a common concern among physicians, it's procedural errors that can sometimes prove more harmful. During my first month on an inpatient unit, I found myself in a five-hour hearing regarding the retention of a patient, all due to a documentation error that had previously gone unnoticed. The patient was eventually released, only to return to the hospital within a week, still gripped by a persistent paranoid delusion that led to an unfortunate outcome. Though many factors contributed to this, the experience underscored the stark difference between the psychiatry of textbooks and the realities of clinical practice. Mistakes, while inevitable, offer invaluable lessons, shaping us not just as *scholars* of psychiatry but as true *practitioners* of the field.

This year is also when we learn how to lead the medical team. Working alongside attending physicians, I've realized that the multidisciplinary approach of an inpatient team is essential. Medication titrations and lab values are just parts of the equation; observing a patient's progress in group therapy gives a more rounded view of how they are functioning. Collaborating with social workers to address socioeconomic stressors and where to refer someone often plays a more significant role in a patient's recovery than the nuances of psychopharmacology. Supervising medical students has added another layer of challenge, forcing me to reflect on my own journey and figure out how to best guide them. Learning to work with team members and, at times, leading them toward the shared goal of patient care, is an important role of the attending psychiatrist. Residency is when these skills must be honed.

The journey is challenging, but there is little that is more rewarding. Psychiatry is a deep dive into the messiness of the human experience, a test of the power of compassion and understanding. I am learning to accept the privilege of caring for our patients and how to use the skills we cultivate to help guide them out of the cave.

Letter to the Editor

By Heidi Bunes

Heidi Bunes

All the expressions of appreciation and good wishes in the last issue were heartwarming. Thank you! It has truly been a pleasure working at MPS.

Over the years I have partnered with so many great leaders to respond to challenges and member needs. The lists of MPS presidents, Lifetime of Service winners, and Presidential Award of Excellence winners include talented, highly respected psychiatrists from a wide range of practice settings. The MPS represents all of Maryland psychiatry and I have been happy to see more diversity among top positions.

After 35 years, there are far too many volunteers to thank but I remember all the passion and commitment they brought to their roles. It's almost magical how MPS members have come together to advance psychiatry in the state. In response to their concerns, we have reined in the Maryland Medical Care Data Base to better protect patient privacy, enacted one of the earliest state mental health parity laws, created the Maryland Foundation for Psychiatry, and pursued litigation all the way to the Supreme Court to fully reimburse psychiatric services for Qualified Medicare Beneficiaries. Quality, access, and third-party intrusions to care are other recurring areas of focus. Again, there are too many issues to list, but MPS is always open to considering ones that members raise and working to effectively address them.

It doesn't seem possible that I've been at MPS for so long, but being part time for half of those years explains some of that. I want to acknowledge the wonderful staff that I worked alongside, including Robert Dillard, Jennifer Gajewski and Kery Hummel. I'll truly miss Meagan Floyd who has been a great team player. I'm very optimistic for the future with her and Jora Hritz, the newest staff member.

I'm grateful for the opportunity to do such interesting work with so many dedicated people and wish all of you the very best!

A Two Hour Education
An Evening with Glenn Treisman

by: John Buckley, MD

John Buckley, MD

The evening of 9/23 was dark and rainy with heavy mist and poor visibility. No pedestrians ventured outside in central Towson: the perfect scene for a London crime drama. But inside the Sheppard Pratt conference center, the MPS faithful were mingling; snacking on hors d'oeuvres and desserts before the performance.

At 7:00 the audience settled and the program began.

Bruce Hershfield, the unofficial MPS historian, was the emcee. He steered the interview with a few open-ended questions to Glenn Treisman, the unofficial Hopkins raconteur. With just the two on stage, what followed was a fascinating discourse about the state of psychiatric practice today. With timed breaks for questions from a sophisticated audience, the next two hours contained a lot of engaging stories of Dr. Treisman's adventures as a professor of both Medicine and Psychiatry. His knowledge of humans and our behavior were impressive.

Some of the topics, with frequent clinical vignettes, were:
-The benefit of graduate education in basic science and research before medical school
-Work in the AIDS clinic with a long list of med/psych conditions
-Work in the chronic Pain clinic with some team successes
-Research into autonomic dysfunction
-Providing comfort to dying patients
-Caution with the current reliance on algorithms, checklist diagnoses and "evidence based" Medicine
-Attempts by insurers to lump diagnoses/ medications as the same for all patients
-Scope of practice for non-MDs and the current limits of A-I for psychiatrists
-The dramatic increase in salary for medical administrators—who are often not physicians--and the ongoing balance of medical costs/budget vs. what is best for the patient
-The gut biome, Vagal Nerve Stimulation, and future research

Dr. Treisman described some personal experiences, like letting go when the doctor becomes the patient. He told us that the worst aspect of medical practice is EMR and that the best vacation consists of three weeks at the Outer Banks.

The evening ended with his encouragement to keep searching for the best treatment for YOUR patient. His outlook was positive for the specialty, predicting dramatic advances in the next decade.

The audience left with a lot to think about after an entertaining education.

Vagal Nerve Stimulation
A Useful Tool in a Century of Progress

By Robert Herman, MD

Robert Herman, M.D.

As physicians who treat disorders of the brain, we face challenges that do not exist in other specialties. The organ that we treat is extremely complex, and it is largely encased in bone, and resistant to manipulation.

Psychotherapeutic treatment was pioneered in the early 1900s by Sigmund Freud, who had trained as a neurologist. He went to France, where he saw a demonstration of hypnosis by Charcot. He returned to Vienna, where he tried to do hypnosis, but he did not have a booming voice and had trouble getting his patients in a trance. He tried laying them on a couch, sitting behind them, asking them to say whatever came to mind. He listened intently, and then told them what he thought they were repressing. Many of them got better. I think some form of psychotherapy, helping patients to understand themselves, should likely be a part of the treatment of every patient.

In 1906 Golgi and Cajal won the Nobel Prize in Medicine for demonstrating the basic architecture of the nervous system. Previously, all neurons were believed to touch each other directly, with no space in-between. Their work showed that there were small spaces in- between neurons, called synapses, and chemical messengers released by one neuron travelled to the next one. This fundamental discovery became the basis of psychopharmacologic treatment of psychiatric illnesses.

An important demonstration of the equivalence of electrical and chemical manipulation of the nervous system was made by Otto Loewi, which won him the 1936 Nobel Prize in. Medicine. He dissected two still-beating frog hearts, each connected to their respective vagus nerves. He applied electrical stimulation to the vagus nerve of one frog, which was known to reduce the heart rate. After several minutes, he poured the liquid surrounding the slowed heart onto the other heart. It then slowed down as well. It was a demonstration that nerve cell communication can be chemical or electrical.

In the 1940s and '50s direct surgery on the brain, the prefrontal lobotomy, was popularized. The Portuguese neurologist Egaz Moniz was awarded the Nobel Prize in Medicine for it in 1949. This was a huge mistake and harmed countless patients and their families. It also sullied the Psychiatry in the eyes of public. The 1975 film "One Flew Over the Cuckoo's Nest", based on the popular novel by Ken Kesey, portrayed a patient who had a frontal lobotomy.

In 1949 John Cade, an Australian Psychiatrist, published a paper in the Medical Journal of Australia : "Lithium Salts in the Treatment of Psychotic Excitement". It was a case series of 10 patients hospitalized for psychotic mania who responded dramatically to lithium. It ultimately led to the widespread use of this agent in Psychiatry. Its use had earlier been advocated by William Alexander Hammond, former Surgeon General during the Civil War, in his 1873 textbook on treatment of diseases of the nervous system.

In 1952, Henri Laborit, a French surgeon searching for new anesthetic agents, happened on chlorpromazine, and then it was quickly recognized as a useful agent in the treatment of psychosis. Several structurally related compounds were synthesized, and one of them, imipramine, was found to have antidepressant effects. Most antipsychotic and antidepressant drugs work in a similar manner to these compounds.

Electrical stimulation of the brain is made very difficult by a major barrier--the skull. Yet a magnetic field *can* induce an electrical current nearby, Transcranial magnetic stimulation was found to be effective for the treatment of depression. It was approved for this by the Food and Drug Administration in 2008. Repetitive magnetic pulses on the skull in the prefrontal cortex region produce repetitive electrical stimulation of this region of the brain, which can improve depression.

When Loewi did his experiments, he relied on the *efferent* fibers of the vagus nerve-- the fibers that transmit impulses from the brain to the peripheral organs. But it turns out that most vagus nerve fibers are *afferent*--they transmit signals from the gut, liver, heart and lungs *to* the brain. They travel to several brain regions that are important to psychiatrists, particularly in what we call the limbic lobe, which seems to. regulate emotions. So, a "gut feeling" is a signal. that is. being transmitted by the vagus nerve to our brains.

This nerve travels through the neck and is therefore much more accessible to electrical stimulation than the brain. Neurologists found that electrical stimulation of the vagus nerve aborted seizures. A vagus nerve stimulator consists of a wire connected to

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Vagal Nerve Stimulation

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the vagus nerve that is connected to a current source implanted in the chest and delivers current at programmed intervals to the nerve. Vagus nerve stimulation for treatment-resistant epilepsy was approved by the FDA in 1997. Patients who used this device for epilepsy and who also suffered from clinical depression started reporting that it improved their mood. The device was approved for treatment-resistant depression in 2005.

In September of 2021 I saw a 52-year-old woman with a history of recurrent depressive episodes beginning at age 13. They were getting longer and more severe, despite multiple trials of medication and psychotherapy. She had atypical features including hypersomnia, hyperphagia, leaden paralysis, and profound anhedonia. She had asked the person treating her to prescribe an MAOI; then contacted an international expert in MAO inhibitors in Australia, who connected her to me. I treated her with tranylcypromine in doses up to 80 mg with no response. I added nortriptyline. She failed to respond. I then treated her with multiple other treatments for depression alone and in combination, including atypical antipsychotics for bipolar depression, lithium and thyroid augmentation, novel antidepressants including dextromethorphan/bupropion, Transcranial Magnetic Stimulation, and ECT. All produced no improvement. She was concurrently receiving psychotherapy from a seasoned clinical psychologist. Her depression continued to worsen to the point where she had difficulty getting out of bed.

She had a VNS device implanted in November 2023, and came to my office shortly afterwards for me to activate it. I have been gradually increasing the intensity of the stimulation. It has now been about 5 months, and she, her psychotherapist and I all note her mood is brighter at times and she expresses an enhanced sense of well-being, but she remains depressed.

Response to this treatment is slow, with about 50% of patients responding one year after it being implanted, compared with 25% of control subjects. I have now assumed care for another patient who has been implanted, and I am appealing an insurance denial for another, whom I feel is an appropriate candidate.

The brain is capable of doing amazing things. But, when it malfunctions, determining what is wrong--and being able to successfully treat it--is an enormous challenge. But painstaking progress has been made over the past 100 or so years, and we are all justified in believing that progress will continue to be made.

Some Thoughts About Restraining Patients

By Sue Kim, M.D

Sue Kim, M.D.

How can we understand why and how we use restraints in a psychiatric treatment setting? How should we handle violent behaviors in *any* treatment setting? Once the violence subsides, we need to explore its underlying causes and to institute ways to cultivate an environment where it is less likely to occur.

There may be some reasons why doctors don't want to order restraints, including possible legal risks and the risk of patients dying while in them or getting hurt while being put in them.

Dr. Annette Hanson, a forensic psychiatrist, with years of experience working in the prison setting, writes "The pendulum has swung too far in the direction of being 'hands off'. Some of my forensic colleagues now have trouble convincing security to provide backup when physical restraint is absolutely necessary. Even in the prison setting, I've had extreme difficulty convincing custody staff to do what they are hired to do. This has resulted in injuries to both staff and other patients. Very psychotic people don't always respond well. And antisocial people merely disregard this when they hear the word "no" or when limits are set. Violence can be learned behavior, and behavioral interventions do work. On the average, one mental health worker per year is murdered by a patient and some of those murders happen within the facility.'

Dr. Dinah Miller, a former president of MPS, responded to a *New York Times* article about use of restraints, "I don't think there is a great answer to this problem."

These are age-old dilemmas: How do we balance safety vs violence, can we maintain safety without restraints, what is the appropriate use of restraints?

Regulatory bodies mean well when they instruct when to use and when not to use restraints. They are trying to protect vulnerable and powerless patients, even in their violent episodes. Psychiatrists do not have a magic wand to subdue wild behaviors, though we do know how to help patients to become peaceful. We want to strive to reach such expectations—so that we and other employees, as well as patients, are not attacked, injured, slapped and spit on.

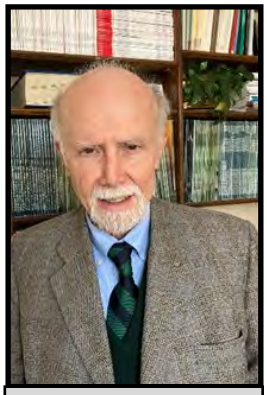
Dr. Miller's recommendations regarding future directions of psychiatric care were summarized in her interview titled "Cultivating Thoughtfulness in Involuntary Care: A Q& A with Dr. Dinah Miller" in a recent issue of *Psychiatric Times*. They include providing single rooms to patients, allowing them sufficient food and amenities (including access to the internet), and ensuring there is a valid process to report any mistreatment.

We want to treat them as though they are family. But, at times, we have to take what appears to be drastic measures. We have to accept that applying restraints may be the only way to control a dangerous situation in order to allow us to safely deliver the care these patients need.

Medical Records Destruction—Notice and Retrieval

Boxes of Old Records to Be Found in Attics

by: Thomas E. Allen, MD



Thomas E. Allen, M.D.

House Bill 149, adopted by the MD Legislature and signed by Governor Moore on 05/16/2024, is entitled: *Medical Records – Destruction – Notice and Retrieval*. Introduced by Delegate Jesse Pippy, a Republican from Frederick County. It is, in effect, an unfunded mandate on all health care providers including specifically: "a physician, a nurse, a professional counselor, a psychologist, a social worker … etc."

The provisions of concern in the final adopted legislation include: "a health care provider may not destroy a medical record or laboratory or X-ray report about a patient for 7 years after the record or report is made unless …the notice …be made by (I) First Class mail to the last known address of the patient And (II) E-mail to the last known E-mail address of: 1. The patient; or 2. If the patient is a minor, the medical care documented in the record be provided to the parent or guardian" And it must "Include the date on which the record shall be destroyed and include a statement that the record or synopsis of the record, if wanted, must be retrieved at a designated location within 30 days of the proposed date of destruction. (60 days in the case of a minor)". "A health care provider or any other person who knowingly violates any provision of this subtitle is liable for actual damages". In addition, regarding minors, "it may not be destroyed until the patient attains the age of majority plus 7 years".

"After the death, retirement, surrender of the license, or discontinuance of the practice or business of a health care provider, the heath care provider, the administrator of the estate, or a designee who agrees to provide for the maintenance of the medical records of the practice of business, and who states in writing to the appropriate health occupation board within a reasonable time, that the records will be maintained in compliance with this section, shall forward the notice required in this section before the destruction or transfer of medical record to (1) the patient (2) for a minor patient, the parent of guardian of the minor patient".

Prior to this legislation, physicians were required to post notices of their retirement and their proposed disposal of records in the newspaper. A patient who wanted a summary could then contact the doctor.

At this time there is no repository that can safely hold medical records of physicians after they retire, unless they work in a large corporate entity like a hospital or large group practice or clinic. Solo private practice physicians after HB 149 must now retain those records for 7 years after the last contact, even if they move out of state or retire, and their heirs are responsible after they die. This will entail additional expense for storage and retrieval. Over time, it will result in higher prices for medical care and/or fewer solo physician practices that are so necessary in less- populated areas. Obligating the heirs of physicians to be responsible for record preservation and retrieval is unfair and unwise, as they cannot be expected to have the sensitivity to confidentiality that a physician has.

Inevitably there will be boxes of old records found in attics long after the physician is gone. If discovered by the new owner of the property, who being naturally curious, they may look through the box and find the record of someone they know. If that person is a public figure and they have a reporter friend, it might make a reporter's day.

Contacting former patients can be extremely problematic. I have had some who did not want their spouses to know they were in psychiatric treatment and parents who did not want their children to know. Because I do not communicate with patients via e-mail, since it can be easily hacked, I do not routinely ask for those addresses. Who knows who will actually receive letters or messages sent to people at the places where they lived 7 years ago? Legislation could mandate returning to asking physicians to put a notice about practice closure and retrieval of records in the newspaper, which newspapers would support.

I am stunned that professional organizations did not realize the implications of this legislation and oppose the original bill. What can be done now?

If the legislature is really interested in preserving and being able to retrieve medical records, they should set up, at public expense, a repository for medical records of physicians and other professionals. We could send our records there when we close our practices. A model for this already exists in insurance company files, where they routinely, before paying any healthcare claims, require the Date of the visit, the Diagnosis and the CPT code.

I would like to see the MPS and Med-Chi work to reverse the new law and allow us to preserve records safely and sensibly, without burdening our heirs and endangering the confidentiality of people who trust us to preserve it.

Planetary Health and Psychiatry

By: Elizabeth Ryznar, M.D., M.Sc.

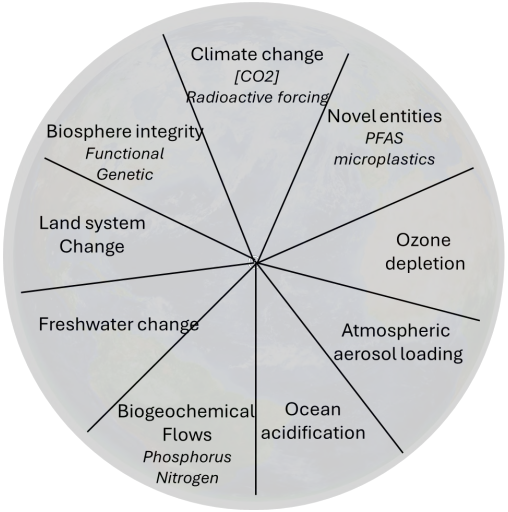
Elizabeth Ryznar, M.D., M.Sc.

Most psychiatrists are familiar with climate change and its deleterious health effects. But climate change is not the only planetary system that is perturbed by human activity and threatens human health. Planetary health refers to the study of all of these systems and their impacts.

Planetary Boundaries

Scientists have identified a safe operating zone for humans based on 9 planetary boundaries (Figure 1A). I will highlight several here. Climate change refers to an increase in global temperature beyond what is expected from natural shifts in climate. This is caused by the release of greenhouse gases through human activities such as burning of fossil fuels for energy, industrial methane emission, and fluorocarbon use. When these gases enter the atmosphere, they prevent solar energy from leaving the planet as infrared radiation, thus warming the planet. Increasing temperatures trigger additional feedback loops. For example, as temperatures rise, ice melts. Because ice reflects solar energy--whereas water absorbs it--its melting leads to increased entrapment of solar energy on the planet and to further temperature increase. Climate change is also associated with more frequent and intense weather events such as heat waves, droughts, and hurricanes. In the last few months, we witnessed the fall-out from Hurricane Helene (which killed over 230 Americans across 6 states and led to a shortage of IV fluids from factory shut-down) and the record-breaking Hurricane Milton.

Figure 1A:
The 9 Planetary Boundaries identified by scientists



Biogeochemical flows are altered by industrial agriculture's excessive use of fertilizers. A good principle to keep in mind is that anything applied to the soil during agriculture will make its way into the water system. Thus, excess phosphorus or synthetic nitrogen ends up in lakes or oceans, causing large algae blooms to form. These blooms deplete oxygen and also block sunlight from penetrating deeper into the water, leading to "dead zones" where other marine plants and animals die off. This impacts not only the marine environment, but also human health. Across the world, approximately 10% of people depend on fishing as their source of income and nearly 50% rely on seafood as a major source of protein.

Another example is land system change, which refers primarily to the destruction of forests and wild ecosystems for human settlements and, more significantly, for agriculture and cattle ranching. Beef, in particular, has the highest environmental cost, because of the land necessary for ranching and because of the methane released by cattle. A historical example of land system change is the Dust Bowl, which resulted from over-plowing of the fields and loss of deep-rooted grasses. Imagine the whole planet as a Dust Bowl!

A third example is microplastics and their associated chemicals. Plastic production has grown exponentially since its commercial introduction in the 1950s, and half of all plastics ever produced were produced in the past 20 years. Once produced, plastics and their chemicals persist in the environment. Now, for every three pounds of fish in the ocean, there is one pound of plastic in the ocean. These novel entities disrupt the marine environment and also contribute to biodiversity loss for aquatic birds (which eat the plastics). Microplastics travel through the air in massive quantities as well, where they may impact precipitation and temperature and contribute to air pollution.

Unfortunately, we have been surpassing several vital boundaries. In 2015, we had exceeded 3 boundaries, and as of 2023 we have exceeded 6, including the four described above (Figure 1B). To keep the planet from experiencing unpredictable and cataclysmic climate events, we need to keep average global temperatures to no more than a 1.5°C increase above pre-industrial global temperatures. (A more lenient boundary of 2°C above pre-industrial global temperatures would allow humanity to stay in

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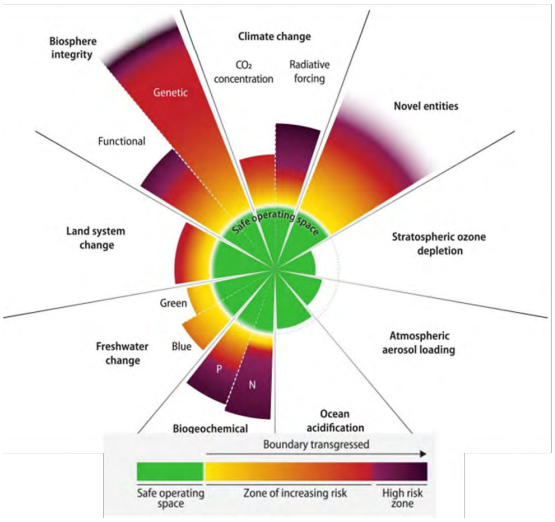
Planetary Health and Psychiatry
Continued

some parts of the world.) We are very close to breaching the 1.5°C boundaries—in the past 12 months, global temperatures have been on average 1.5°C above pre-industrial levels.

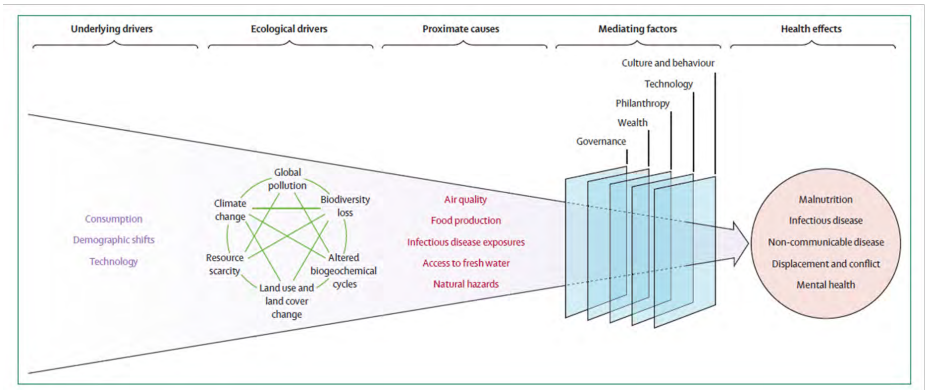
Figure 1B:
Level of transgression of each boundary. Copied from Richardson et al. *Science Advances* 2023: 9(37).



Psychiatric Impacts

What do all of these planetary boundaries have in common? They are affected by human activity. That is why scientists have named a new geological era: The Anthropocene, which recognizes that now human activity is the main driver of planetary changes. And these planetary changes are already impacting human health negatively (See Figure 2)

Figure 2: Schematic describing how human degradation of the planet leads to negative health outcomes. Copied from Myers *Lance* 2017; 390:2860-68.



Climate change causes extreme heat events, which can increase the risk of heat stroke. Many psychiatric conditions and medications themselves increase the risk of heat stroke and death (conditions such as schizophrenia and dementia; medications such as antidepressants, beta-blockers, antipsychotics, and stimulants). Extreme heat events are associated with increased rates of psychiatric hospitalizations, suicide, and violence. They can increase the risk of PTSD and disrupt essential services (access to schools, clinics, hospitals, psychiatric programs, grocery stores).

Air pollution (which relates to the atmospheric aerosol loading boundary) impairs cognition in everyone, but is especially concerning for children and also increases risk of incident dementia in older adults.
Under the "novel entities" category, chemicals from pesticides (like organophosphates and glyphosate) and plastics are often neurotoxic. All have been found in human tissues and fluids, including in pregnant women, and they cross the placenta as well. Glyphosate has been suspected of causing unexplained diverse neurological problems in certain counties. Endocrine-disrupting chemicals like phthalates and bisphenol A have been linked to decreased IQ and increased rates of autism spectrum disorder over time. Separate from the chemicals they contain, the actual plastics particles themselves may be risk factors for dementia through inflammation and abnormal protein folding.

Finally, these environmental problems disproportionately affect structurally marginalized communities (including people with lower socioeconomic status, communities of color, and the Global South). They are experiencing higher levels of health impacts from climate change, air pollution, and plastics pollution. Therefore, we cannot achieve health equity without addressing planetary health.

Reactions

Some of this information may be new to you and it may make you feel demoralized, hopeless, or powerless. However, please do not despair or disengage. Humans are capable of societal change and

(Continued on next page)

Planetary Health and Psychiatry
Continued

technological innovation. Moreover, we have succeeded before. National and global efforts stopped further depletion of the ozone layer and eliminated lead from gasoline, pipes, and paint.

If you do need a motivating emotion, consider anger. The fossil fuel and petrochemical companies knew the harms decades ago and still pursed profits over people. Internal documents from Shell and ExxonMobile from the 1970's described the greenhouse gas effect, accurately predicted what our global temperatures would be in 2020, and warned that unmitigated activity could lead to civilizational collapse. Nevertheless, they publicly denied climate change until the 2010's. Similarly, 3M knew about the persistence and toxicity of PFAS (dubbed "forever chemicals", another novel entity), but hid their data from the government and from the public. Finally, petrochemical companies knew that plastics recycling was not effective, but nonetheless promoted it as a solution in order to encourage increased consumption. In 1988, the president of the Society of the Plastics Industry (now the Plastics Industry Association) stated: "If the public thinks that recycling is working, then they're not going to be as concerned about the environment." This practice of deception continues today, leading the groundwork for California's lawsuit against ExxonMobil in September.

Solutions

There are three spheres of influence in which you can act. In your personal life, to decrease greenhouse gas emissions, you can switch to renewable sources of energy, purchase solar panels, use heat pumps for heating, or reduce your overall electricity use (by switching to energy-efficient appliances and lightbulbs, lowering your thermostat, washing clothes in cold or warm water, or line-drying your clothes). Many of these home changes qualify for tax incentives in Maryland. You can reduce your own plastics use or exposure to endocrine-disrupting chemicals. You can learn about regenerative or sustainable agriculture. Finally, you can talk to friends and family, galvanize your religious and neighborhood communities, and get involved with a sustainability organization.

On a professional level, you can counsel patients about risks. Climate Psychiatry Alliance and Americares have resources. You can become a climate -aware therapist. You can join a professional organization such as the APA's Caucus on Climate Change and Mental Health, Climate Psychiatry Alliance, Maryland Health Professionals for Healthy Climate, the Medical Societies Consortium for Climate and Health, and the Planetary Health Alliance. The MPS is also supportive of efforts to mitigate climate change. You can advocate for change at your institution. You can become a climate- resilient clinic, contact your organization's sustainability committee, pursue a certificate from the Joint Committee in sustainability, or partner with an organization specializing in improving health care sustainability (like My Green Doctor, Practice Green Health, or HealthCare Without Harm). You can pick a small project (such as reducing glove use, eliminating plastic medication cups, installing solar panels, or buying IV fluid bags that are safer).

Most importantly, you can act at the civic level. These are large problems that need societal solutions. If you would like to safeguard our planet and our public health from environmental threats like pollution and climate change, pay attention to candidates' policies when you vote and contact your legislators via telephone or email to let them know you are concerned about this.

Figure 3: Your personalized climate action plan (courtesy of www.ayanaelizabeth.com/climatevenn)

While this list of solutions may seem overwhelming, find one action that speaks to you (see Figure 3). This is what I did when I decided I wanted to make a larger-scale difference about plastics by using my expertise as a psychiatric and medical educator to publicize the harm they cause. I have made progress in large part due to the support of the Maryland Psychiatric Society. So take some action! I am happy to support you in your journey. If we all take a step towards preserving our health and our planet's health, we can make a large difference.

In Memoriam: Chester Schmidt, M.D.

by Jimmy Potash, MD

Previously Printed in *Cheers from the Chair May 16, 2024*

Jimmy Potash, M.D.

It is with both sadness and fondness that I write to let you all know of the loss of one of the long-time pillars of our department's success, Dr. Chester "Chet" Schmidt, who passed away yesterday following a brief illness, at the age of 89. I last heard from Chet just two weeks ago when he responded to my email about the retirement of Associate Administrator Mary Keyser after 47 years in the department and 50 at Hopkins. He sang her praises and said how much she would be missed. The two of them had plenty of opportunity to get to know each other, as Chet was likely the longest serving person in the history of Phipps psychiatry, with a remarkable 61 years in the department, and 70 as a part of Johns Hopkins!

Chet was best known to many as the Director of Psychiatry at Johns Hopkins Bayview, a post he took on in 1972 when it was Baltimore City Hospital, six years after completing his Phipps residency, and continued in until 2006. At Bayview, he helped create the faculty practice association, which became a national model for such plans in academic medical centers, and he served as its president for 23 years. He brought this experience to the American Psychiatric Association (APA), where he was a longtime chair of the committee focused on reimbursement for care, and authored several APA books on the subject. His expertise in the business of healthcare led Chet to take on a role as Medical Director of Johns Hopkins Health Care, the health insurance arm of Hopkins, which became his full-time occupation once he stepped down from his Bayview leadership role.

The year before Chet took on his Bayview role, he had co-founded the Sexual Behaviors Consultation Unit (SBCU) to manage patients who had sexual dysfunctions, gender identity issues or psychosexual disorders. He would continue his involvement in the assessment and treatment of these patients for over 50 years, right up to the present, and author or co-author about 50 papers and book chapters in this area.

A career as long as Chet's has many layers to it. Before the SBCU, from 1967-1970, he co-led the department's Suicidology Fellowship Training Program, and he entered into a program of research related to it, publishing a number of significant papers, including a pair examining suicide by car crash, in our leading journals, the *American Journal of Psychiatry* and *Archives of General Psychiatry* (now *JAMA Psychiatry*).

Chet had a ready smile and a genial manner. He was always well-dressed, typically with bow-tie in place, and he had a hearty, youthful look that somehow persisted into his 80s. Someone remarked they had recently been to a Hopkins lacrosse game where a Blue Jays national championship team from the mid-1950s was called to come out onto the field. They said that everyone looked very old and hunched over and slow moving, except for one guy in the middle of the bunch, who stood straight and tall and appeared to be in his 40s. It was Chet, class of 1956.

Dr. Schmidt will be very much missed by the many people whose lives he touched: patients, colleagues at Bayview and JHH, friends, and of course family, including his daughters, Eliza Dunn (11536 Falls Rd, Lutherville MD, 21093) and Maggie Sollers (PO Box 71, Gibson Island MD, 21056).

Chester Schmidt, M.D.

Are Professional Meetings Worth It?

By Michael Young, M.D.

Michael Young, M.D.

It could appear to be a tough call for a psychiatrist to take time away to attend professional conferences. This is time taken away from seeing patients and attending staff meetings and seeing to other important responsibilities. It can also be expensive, due to lost productivity and "professional days", besides travel costs and conference fees. It takes a lot of planning just to organize the time away from work – and it may mean losing vacation time meant for enjoying life and making memories with loved ones.

Furthermore, the academic value of professional conferences can appear limited, with many sessions providing recaps of information already well-known to a practicing psychiatrist or showcasing research with minimal clinical application. So why would one even consider attending a professional meeting?

For me, it's the intangibles. Some of these are obvious, such as the opportunity to reconnect and catch up with former colleagues, make new professional connections, and feel engaged as part of a professional community. But there are others. One of them is the energy of students, trainees, and early-career clinicians forging ahead with their passions. I am always able to learn something when interacting with or taking in one of their poster presentations. Interacting with students and trainees provides a view into the future of our field. Another of these intangibles is the awe and knowledge gained by observing the steadfast commitment of later-career clinicians and researchers continuing to share their experiences and learn from the younger generation. No matter how many journal articles I read, learning from and discussing challenges in Psychiatry with experienced clinicians presenting at the major national conferences is invaluable. The value of attending professional conferences also includes getting out of my comfort zone and into the greater world. Navigating travel and unfamiliar cities, meeting new people, and engaging different perspectives consistently supercharges my professional and personal growth. During them, and in the weeks following them, I consistently feel more invigorated, more creative, and more inspired. It leads me to be more engaged both in my professional field and in my life outside of work--the antidote for professional burnout. After a conference I read more, write more, and imagine more.

In the first half of 2024, I enjoyed engaging in the annual meetings of the American Psychoanalytic Association and the APA, which enabled me to better view Psychiatry's past, present, and future. These meetings also afforded me the opportunity to take in the sites of NYC, connect with colleagues, hear from inspired speakers, and feel invigorated. For 2025 and onward, I'm setting a goal to attend at least 3 national conferences per year, to include diverse meeting agendas and perspectives on the future of psychiatry.

I hope to see all of you at a conference sometime soon!

Some Remarks About Chet

by: Kostas Lyketsos, MD

Kostas Lyketsos, M.D.

A Version of the Remarks Made about Chester Schmidt, MD at His Celebration of Life

October 9, 2024

I direct the Department of Psychiatry and Behavioral Sciences at Johns Hopkins Bayview, having succeeded Chet in this position on 1 July 2006.

Chet's impact is much bigger than his psychiatry leadership role, as he was a central figure in the incorporation of City hospitals--now Bayview-- into the core of Johns Hopkins, and also as Medical Director of Johns Hopkins Healthcare for over a decade.

I first met him in July, 1988 when I came to what was known then as Francis Scott Medical Center as an intern. I remained under his tutelage through June, 1989, when I moved over to the Broadway campus, to complete my residency. Chet and I stayed in touch on a regular basis. He was one of the first people who invited me to apply for the directorship that I now hold.

Chet lay the critical foundation for Bayview Psychiatry, which--thanks to his legacy-- is now ranked #13 among psychiatry departments in the country (with Johns Hopkins ranked #4). Harvard is the only other institution that has two of its hospitals highly ranked in this way. Bayview Psychiatry now has scores of full-time faculty, one of the largest outpatient psychiatric care programs in the country, sought-after educational programs, and an impressive research portfolio. These features would rank it in the top 30 departments in the nation if it was on its own. Those of us who serve Bayview Psychiatry at this time are deeply thankful to Chester's vision; it made our successes possible.

I would not be true to my Greek heritage if I did not have a quote from a Greek luminary (in this case, Thucydides): "**What you leave behind is not what is engraved in stone monuments, but what is woven into the lives of others**." I think this clearly describes the wide-reaching impact of Chet's life.

Dr. Chester W. "Chet" Schmidt Jr

What Glenn Treisman Said

A Version of His Remarks on September 23, 2024

by: Bruce Hershfield, MD.

Bruce Hershfield, M.D.

A few months ago, I wrote a Letter from the Editor in *The Maryland Psychiatrist,* saying we ought to get together again. When I look through the directory, I notice I don't know a lot of the members, even though I've been in the MPS for almost 50 years. I don't think that's good for the future of our organization, which depends on people associating with each other and working together. So I suggested I interview a leader in our community in front of a live audience. If this works, we can look into other ways of getting together again and, getting to know each other and working together better.

Glenn is the Eugene Meyer III Professor of Psychiatry & Medicine at Johns Hopkins, where he's an expert on HIV, affective disorders, and pain.

Q: "What part of your work do you like the best, and what part of it do you like the least?

Glenn J Treisman, M.D.

Dr. .T: "I can easily tell you what I like the least--Epic. Electronic medical records are the bane of my existence. They are a billing platform that's supposed to keep our records and I think they are a curse. They take up a huge amount of administrative time. The other thing that I don't like doing is fighting with people in administrative positions about patient care.

I still run the HIV clinic, which I've run since 1988. In that clinic, we learned that-- I know this is going to be shocking--viruses affect your brain. Inflammation affects your brain. Being sick affects your brain. Having an immune-deficiency syndrome affects your brain, and your brain goes steadily downhill as your immune system goes downhill because they're intricately linked. The other thing we learned is psychiatric illnesses affect behavior. It turns out that one of the ways you get HIV is by doing a list of behaviors that were well publicized by the time I was in the HIV clinic. And the people who were doing those things, despite having seen everybody else they know die from those things, were troubled, making them vulnerable to HIV infection. OCD was *not* one of them. People with germ phobias tended to *not* get HIV.

The things that *do* cause people to be at risk for HIV are substance abuse disorders, personality disorders, bad mood disorders, schizophrenia, and life story disorders.

It turns out everything in Psychiatry, with the possible exception of OCD, is well- represented in the HIV clinic. You're a substance abuse specialist. You're a mood disorder specialist. You're a dementia specialist. You're working with people with personality disorders. About 25 % of *our* patients have personality disorders.

People in Medicine are uncomfortable with Psych patients. One of the fears was our psychiatric patients in the HIV clinic wouldn't take the medicine right and would get resistant. Some of them never got HIV medicines and they died, and that's *very* resistant. So we started treating people who had HIV for their other medical problems as well as their psychiatric problems, only because getting them medical treatment was often very difficult. We wrote a lot of prescriptions for HIV medications for patients, and we treated a lot of their minor medical problems, which we still do."

Partly because of my work in the HIV clinic, I started to see a lot of patients with chronic pain. Neuropathy can be exquisitely painful. Many of *you* have chronic pain, but you're not disordered by it. What's the difference? Chronic pain causes disorder when there is a comorbid mood disorder or personality disorder or horrendous life circumstances or an addiction to your pain medicine or all of the above. So, that's the second thing I do. I continue to run the pain service. Is treating chronic part of Psychiatry? The reason it's part of Psychiatry is that the comorbidities that make these people disordered from their chronic pain are mostly psychiatric."

Q: "What did you do before you became a psychiatrist, and what else could you have done that might have been as satisfying in your life?"

Dr. T: "I was an evolutionary biologist, and then I got involved in pharmacology research and basic science and neurobiology. I did my PhD in Neuroscience and Pharmacology at Michigan. I taught pharmacology classes and learned all about anticancer drugs, anti-infective drugs. When I was going to medical school and into residency, the big

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What Glenn Treisman Said

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idea was one drug--push that drug till you couldn't use anymore and then go to another drug. In HIV, what we learned is that 3 drugs at a lower dose are much better than one drug. You'll see that people are gradually realizing that polypharmacy, far from being the worst thing, may produce much better results with less toxicity. I had a negative experience during my Psych rotation at Michigan. At the last minute, I did a Psych rotation at Stanford. I had a great experience, changed back to Psychiatry. I did a year of Medicine at Bayview, then I finished my psych residency. Turns out, if you're a psychiatrist, you're also a doctor.

And the third thing I'm doing now is looking at patients with autonomic dysregulation. Your autonomic nervous system can get dysregulated. Usually, it's post-COVID, post- Lyme, post-mononucleosis, post-viral gastroenteritis. People get POTS, they faint when they stand up. People get temperature dysregulation, can't tolerate hot temperatures. People get GI dysmotility disorders. Briquet's syndrome, when I was going to school, was thought to be hysteria. If you look at the list of things in the Briquet syndrome description, they're all autonomic functions.

People just said, 'Well, these people have a review of systems that's positive.' No. They don't have blood in their urine. They don't have thick white mucus or green mucus. But the autonomic nervous system regulates a huge amount of what we do. So these patients have been construed as being hysterical or psychosomatic for years. And we're just starting to discover that a lot of them have sodium channel mutations, which probably makes people vulnerable to this, and then you get a secondary hit of an immune activation, and you get immune dysregulation. They get better if you manipulate their autonomic networks."

Q:" What advice did you get that you found most useful, and what advice did you find least useful?"

Dr. T: "The least useful advice was, 'You've got to focus.' By being a generalist, in an academic center, I've created a unique career path. The best advice I got was, 'Don't let anybody tell you how to practice Medicine'. I got that advice from several mentors, including you, because I was struggling with time constraints in 20 minutes. I wasn't good at it. And, several people whom I admired said to me, 'Just don't do it. See the patients as long as you need, and let the administrators yell at you a lot.'

Four years ago, we had a patient who was on GI, and her gut had shut down. Couldn't stand up, couldn't walk, and had been in the hospital about 6 months out of each year since she was 13. She was 17, and they didn't know what to do with her on GI. The assumption was this was all psychosomatic, so she was on Psychiatry for 162 days. Each week, somebody would yell at me about her being there. After about 140 days, I gave her IVIG. She's out of the hospital 3 weeks later, walking a mile a day and eating and pooping every day. About a month after she was discharged, I was invited to a hearing to discuss my use of resources. This was like one of these things where people are going to yell at you because they said we could've treated a lot of patients in that time. I said those patients could have been treated anywhere. And they said, 'You can't give IVIG on Psychiatry.' And I said, 'I did give her IVIG on Psychiatry, and she got better'.

Q: "If you wonder why I asked you to be the first in what I hope to be a series of interviews, you just figured it out!"

Dr. T: "Everybody wants to tell you how to practice Medicine. But it turns out, if the patient dies, those people who told you that you have to see people in 20 minutes, don't say, 'We told them to see the person in 20 minutes.' They say, 'He's the doctor. He discharged the patient.' If I had discharged the patient and she had died, those people wouldn't have come and said, 'We told you to discharge the patient.' The thing I've learned most is, since ultimately we are the doctors responsible for the patient's outcome, we should probably make the decisions.

I have a high tolerance for being yelled at. I think most people in Medicine don't. I learned to have a high tolerance for being yelled at because I was taking care of HIV patients."

Q: "What about working with HIV patients has helped you the most in terms of your own development as a doctor, as a person? What surprised you about working with this population?"

Dr. T: "That they can get better, which I did not believe. The bleakest case I ever saw, it was the first case in my book on HIV psychiatry, and I published it in *JAMA*. Her "expiration date" was 35 years ago, and she's still alive. If you met her now, you wouldn't believe she has an antisocial personality, because it turns out if people stay in treatment with a personality disorder, eventually, they get better."

Q: "I heard you talk about that at a Southern meeting, and I think that's a very important point."

Dr. T: "A person is disposed to live in the now or to think about the future and past--to look for rewards or to avoid punishments. Most of the personality disorder patients I have been asked to see are people who are unstable extroverts or very unstable introverts. Combine that

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What Glenn Treisman Said

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temperament with a family that doesn't teach you how to manage your feelings and you have a personality disorder. It's a combination of learning and temperament. Some people are much more sensitive to rewards, some people are much more sensitive to consequences.

One of my "miracles" was a teenager who was considered untreatable. I said, 'We're going to have a behavior plan. What do you want that you can't get? He gave me a list of about 20 things he wanted that he couldn't get. And I said, 'If I asked you to do things and you could then get these things you want, would you do them? If I told you that you could get an iPad Mini, you'd be willing to be sober for a month?' He said, 'Oh, absolutely. I'd stop smoking pot tomorrow. I said, 'Great!' Using rewards, we got his behavior shaped; he graduated from college, lived independently, didn't use drugs anymore. After about 5 years, his mother said, 'How much longer do I have to keep doing this till he's normal?'

It turns out half the country is paid on commission. They do what you want them to do because you pay them to do it. These people respond to rewards better than consequences. So if you help people by shaping their behavior by using rewards, eventually, the world takes over and starts to reward those same behaviors. And the world rewards them and maintains your therapy, which has been all about giving them rewards. One of the rewards they like is attention. They get lots of attention from me if they're doing what I want."

Q: "I'd like to invite questions from the audience. Dr. Annette Hanson:" I came here directly from a 3-hour Zoom session about medical aid in dying sponsored by the APA. You work with HIV patients who either have exhausted all their options and nothing works anymore, or they have a personality disorder and they refuse treatment, and they come to the very end stage of the disease. In this APA session, psychiatrists were saying, 'These are the people who really should have a right to have lethal medication prescribed for them, and it's cruel of you not to do this.' What would you do in these situations? How do you care for patients at the end of life?"

Dr. T: "I'm extremely familiar with the end of life for patients with HIV. For the first 8 years of my career, a lot of our patients died. And, when they got to the place where I couldn't improve function, quality of life, or longevity, then I would focus on comfort. But as long as I was able to improve function, quality of life, or longevity, that's what I focused on. Sometimes you have to trade off. Sometimes to make people more functional, you have to make them uncomfortable. Sometimes to make people more comfortable, you have to decrease the quality of their life some.

But, overall, if you keep those three things on the table--function, quality of life, and longevity--you get people better. The time to assist people in being more comfortable with death is when those are no longer attainable goals. The only way you can contribute to someone's function then is by improving the quality of their life as they're suffering. When they get close to the end, I make them comfortable. But I don't make people comfortable if I can get them better. It turns out that getting better is often very uncomfortable.

When people tell me that they know better than me what's good for some person, I just think that it's clear that they have an agenda *other than* what's best for that person. It's best for people to thrive, and killing people does not make them thrive. I have not had any patients who died in my service who then thrived.

I treated an 80 year old guy from California who couldn't walk because of horrible spinal stenosis. We got him off narcotics. We got him on neuromodulator drugs. His pain got better. He left us when he was walking two miles a day and he still does, two years later. When I first met him, he was talking about, 'I'm going to die soon anyway. Why don't they just kill me?' I said, 'You're depressed. And when we get your depression better, you'll want to thrive.' My job is to get people better. If somebody else wants to kill people, that's not my job."

Q from the audience: "Especially in our field, "match" is an extremely important medically active ingredient. You have an extremely compelling, convincing, strong, self-assured personality. I think that's what has allowed you to survive institutions that yell at you and browbeat you and it's what's responsible for a lot of your success. So what can you export to our profession? What should we be studying in ourselves that you think would make us more effective psychiatrists?"

Dr. T: "We did a study in my clinic. We compared Jeff Hsu and me by looking at matching patients. And if there is an anti-Treisman, style wise, it's Jeff Hsu. My outcomes are exactly the same as his. He uses the same method I do, but he uses a different instrument. Each of you has an instrument that you use to interact with patients. Mine is not better. The method behind mine is the same as the method behind Dr. Hanson's-- to try to figure out what the problem is and then offer a remedy that you think will get the person where they're supposed to be. Believe me. I know that in that curve of normal distribution, I'm way out here in my style interacting with patients, but the method is what does it, not my style. I use my style, and Jeff Hsu uses his. You have to figure out how to use your style to the patient's

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What Glenn Treisman Said

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advantage. Behind the style, there is a method that we use that is learnable, teachable, and effective."

Q. from Dr. Steven Sharfstein: "I want to say something on behalf of administrators. Administrators have a tough job. They're there to try to manage resources in a way that allows somebody like you to thrive. In fact, you have thrived where you are. So I think the frustrations you've had with administrators need a little bit of leavening. "

Dr. T: " Absolutely! They allow you to do your thing. Some of the administrators at Hopkins whom I clash with have the utmost respect for what I do, and I have the utmost respect for what they do. But I also recognize that the cost of physician time has gone up like *this*, and the cost of Administration Medicine has gone up like *this. T*hat vast increase in administration is not helping patients, and it's partly because the administrators have a very tough job. They have to satisfy more than the doctors.

I didn't become a Chairman of a department, because what most departments that I talked to wanted was somebody who would worry about the bottom line--financial issues--and squeeze clinicians to provide more care for less money. I wanted to run the department where the goal was to make the best department of Psychiatry in the whole world."

Q: "Tell me about your research."

Dr. T: "I've been involved for a long time looking at a cohort of African-American, intravenous drug-using HIV-infected patients. Most of them use cocaine. We paid them to *not* use cocaine--eventually up to $200. If you fail your drug screen, you're not kicked out .By doing that, we got 35% of the patients to be completely abstinent from cocaine, and everybody who completed the study reduced their usage markedly. Their cardiac C-T scans predicted a dramatic reduction in heart disease.

Second research I'm doing is on dysautonomia. We're trying to understand what the factors are that lead to these patients having dysmotility in POTS and all these other things, and the connection between infection, immune activation, psychiatry, depression, and autonomic dysfunction.

The third area of research is in the gut-brain thing. We made mice depressed by manipulating their gut and by having other mice bully them. We're trying to see if there's differences in their gut microbiomes and changes in their brain. The next experiment in that line is if you take mice and you irritate their colon, they get very depressed. If you cut their vagus nerve and you irritate their colon, they get irritable bowel syndrome, but they don't get depressed. They get the same GI stuff, but they don't get the depression part. So it's clearly going from the gut to the brain.

We tend to think about depression causing the gut problems. But, in this experimental design, it's clearly the gut causing the brain problems. I want to treat those mice with antidepressants that seem to work better in my patients and antidepressants that don't work as well. Because in people with GI dysmotility, we do much better with SNRIs and tricyclic antidepressants than we do with SSRIs."

Q: "Would you like to comment about other aspects of psychiatric research that appeal to you, that other people are doing?"

Dr. T.: "I'll tell you what I think we struggle with. We struggle with the phenotypes. I think the more you try to create operationalized criteria to make a diagnosis rather than really looking at the individual patient, trying to understand the condition, the bigger your placebo response.

When I was in graduate school at Michigan, we were doing one of these studies, and 10-12% of our patients had a placebo response and almost 85% had a response to nortriptyline. If you look at the last 5 to 10 years of studies, the placebo response at all the clinical trials is 40%, and the drug response is 60%. It's telling you that a lot of people in this study don't have the condition--that's why they're responding to placebo.

So the push to making operationalized criteria means some people say, 'Oh, I took the test online. I have depression. I took the test online. I have ADHD.' You do not have ADHD! I wonder who sponsored putting that test online. It's a company that makes drugs for ADHD. Isn't that shocking? I am interested now in trying to understand Individualized Medicine--the pathology of an individual person. Major depression is a disease just like diabetes. It's a medical problem, and it needs a medical approach.

Q: "Do you want to say something about evidence-based Medicine?

"The problem is the push to say you shouldn't do anything without evidence. Evidence-based Medicine is great if we understand the problem. But, a lot of the time, we're trying to lump a lot of people together with quite different conditions and come up with a guideline. So for instance, 60% of people get better on SSRI's and 60% of people get better on *SNRI's*. But, if you look at the group of people who get better on SSRI's, a lot of them don't get better on SSNRI's. So it makes a difference. Drug and insurance companies will tell

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What Glenn Treisman Said

Continued

you that those drugs are equivalent. They're not. These studies are done to try to develop algorithmic approaches to treating patients, instead of thoughtful ideas about how you move forward with a patient who's refractory.

I think that evidence-based Medicine has real flaws. One of the flaws is that a clinical trial lumps together a group of patients and then demonstrates a treatment most effective for the average patient in the group. Many patients don't improve, and we do not know what to do to get them better. When we don't have evidence we should not just abandon the patient".

Q: "You've had experiences as a medical or surgical patient yourself?"

Dr. T: "I learned that that when you go into the operating room, you're a patient. Shut up! At some point, you have to say, 'You're my doctor. And so I said to my surgeon, 'Look, can you try to spare the nerves as much as possible when you do my prostatectomy?' And he said, 'I know we've been friends since we were interns, but I want to tell you something. You have cancer. When we put you to sleep, we are going to try to get rid of the cancer. You may wake up with no legs, but you'll wake up with the cancer removed, if at all possible. And if you don't want it treated as aggressively as we can so that we give you the best chance of survival, you should not have surgery.' You learn that we're all going to be patients."

Q: "What's changed in students since you started teaching, and what do you look for as signs that they're going to be exceptional?"

Dr. T.:" On the inpatient ward, if the Resident thinks those are *his* patients and that I'm a consultant, they do great. If the resident thinks they're *my* patients, I can't wait for the month to be over. I like to teach. I teach as much as I can and I also give lectures in a lot of places that aren't Hopkins. But, at the medical school right now, you might say something we don't agree with. One of the students, the last year I was lecturing, came up afterwards and said, you said "mental retardation" instead of "intellectually disabled". I said, 'Yes. I like mine better. You don't get to tell me what words to use.' And then she went and complained to the Dean that I was mean to her."

Q: "George Will said years ago, that there are more people on disability in the USA than in the manufacturing part of our economy. And I've seen that once they're considered permanently disabled, they almost never go back to work full-time."

Dr. T: "Being engaged at an occupational thing stimulates us. It engages us with people. We talk about politics. We talk about what's on TV. Our patients who are disabled are sidelined from life.

And everybody's a victim right now. I'm a victim. I'm a cancer survivor. We all have cancers. Your immune system usually mops them up. It's not surprising our cells, in replicating, sometimes make mistakes.
We tend to use language that's politically correct rather than thinking critically. In the world of HIV, I can just tell you how it went. We said "noncompliant", and we were told you should not say that. You should switch from "compliance", which comes from the Latin "to fulfill", and use the term "adherence", which means "sticky". And then we said, 'Nope'. Now, "Adherence" is out. Everything that you say that could make somebody have a bad feeling is eventually going to be out."

Q: "How can Psychiatry be better?

Dr. T: "I think that we should all be doctors, and we should not use algorithms for diagnosis or checklists.
We should examine every patient, think about every case critically, and develop a formulation that encompasses the elements of the case. We should constantly be learning about Medicine, and convincing our colleagues that psychiatric disorders are part of Medicine. It turns out you can teach doctors eventually to respect the idea that psychiatric disorders are a part of Medicine. But, as long as we keep separating it out, it's a problem."

Q: from the audience: "So many of my young Residents are quite concerned about those who are moving into the house of Psychiatry, who are non-psychiatric, mid-level practitioners. And, in 28 states now, they can practice without any physician supervision and have all of the privileges of practice of a psychiatrist, and many of them are getting the jobs."

Dr. T: "I'll tell you what I think we should do. The nurses in the HIV clinic who work with me love working with me, and they take a $50,000 pay cut from other nurse practitioners' jobs to work in my clinic. They don't claim to be doctors, and we shouldn't treat them as though they were, but the pressures economically are to give those people more and more autonomy because then they can displace physicians.

We have to point out the difference between doctors and nurses. I have a very succinct definition of what a doctor is --somebody who has a specific expertise in diagnostic formulation, workup, history taking, and differential diagnosis. They are the custodians of a body of knowledge and they are advocates for their patients.

I heard a claim once that just

(Continued on next page)

What Glenn Treisman Said

Continued

because SSRIs seem to reduce OCD symptoms doesn't actually tell us anything about OCD and whether it has much to do with serotonin--any more than a steroid cream would tell us that psoriasis is a lack of steroids. It's been several decades since we had any significant advances in medication for OCD. High-dose SSRI's seem to work about half the time, but come with a lot of side effects. What do you think it is about that condition that seems to elude pharmacology? Well, not enough people have it, and, therefore, there's not enough money in it to make everybody work on it.

Q from Dr. Robert Herman: I've been in Maryland since 1996, but I don't think I've met you before. And I feel a connection with you, so that's really nice. Basically, you're right about vagal nerve stimulation. The afferent fibers that go from the vagus--from the gut to the brain--go to the emotional part of the brain, and stimulating it to give an extra boost seems to be helpful.

Though I moved to Maryland in '96, I still feel a little bit like a foreigner. Do you have any observations about the culture of your department?"

Dr. T: ". When I interviewed at Columbia, I went to the Brain Institute, then I went down to the psychoanalytic institute. And the woman who was at the psychoanalytic institute said, 'All the Residents go downtown twice a week for psychoanalysis.' And I said, 'Are they sick?' She said, 'Oh, no.' I said, 'Then,why do they go downtown for psychoanalysis? Doesn't it change their brains?' She said, 'Oh, it doesn't change your brain'. I said, 'Then how could it work if it doesn't change your brain? To change anything in the mind, you have to change the brain. If they're not sick, what do they get out of it?' She said, 'Having psychoanalysis really makes you a much better psychiatrist.' I said, 'Do the neurosurgeons need to get neurosurgery to be better neurosurgeons? And each group there hated the other groups.

Everybody at Hopkins didn't always like each other, but they all talked to each other in the same language. That's what compelled me to come here--everybody talked to each other and you could learn from everybody. That culture persists of trying to think about how to put it all together, and I think that's, something that's had an influence on Baltimore.

So I think vagal nerve stimulation is a really cool modality. It's good for migraine headaches too, and there's a relationship between depression and migraine that's really exciting.

You should know every drug effective against pancreatic cancer if you're treating pancreatic cancer, and you need to think similarly about this one person who is your psychiatric patient. Is this person sleeping or not sleeping? Is a manic episode going to get them put in jail? So many questions about an individual case shape my choice of medication for every patient.

People are not thinking critically about this guy or this woman. They're not thinking critically about what would be better. The algorithms help with speed but they hinder because they make you not think. And I've had many people say, 'That's outside the guidelines.' The guidelines are nonsense. They're a lazy way of getting by without thinking enough. And you should know every nuance of a medicine you give to somebody because it might kill them. I tell people all the time—'This drug could kill you.'

Q from the audience: How would you advise that AI be used?

Dr. T: "When I've talked to people about AI, I've talked to them about the problem of the phenotype that I already mentioned. We have these phenotypes that are limited and very inadequate to describe our patients. I think that one of the problems for AI is that it has to help you sift through a lot of data to pick out what's important. I don't mind trying it, but the people I've talked to, their ideas are to take that information that is in that algorithm and plug it into AI. When you complain about a patient being difficult, through says, 'You didn't try this yet.' I want something way more sophisticated than that, and I don't think it's there yet.

The Gold Lab Symposium in Boulder, Colorado is run by Larry Gold, who just goes around and finds everybody who's doing something he finds really interesting and invites them to give a lecture. There was a guy there this year talking about AI and he said, right now, it takes information out of the ether, out of the Internet, out of everything. And the more it's talked about, the more it weighs it, because that's all it can do--to weigh it. So, if there's a conspiracy theory out there, it gives it as much credence if it's about the Middle East as if it's about Sasquatch.

And, he showed us he had asked chat GPT or one of those things about the Gold Lab Symposium. And the first answer it gave him was the Gold Lab Symposium is held in Boulder, Colorado every year, and it's a conglomeration of scientific talks about blah, blah, blah. And then it said the Gold Lab Symposium doesn't exist--it's a mythical meeting that people cite all the time as a source of information, but it's never actually happened. This came straight out of the same AI thing.

Q:"I think that's a great note to end on."

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On February 4tj from 8:30AM—1PM, we invite all MPS members to join us in Annapolis to meet with House and Senate leadership to discuss current and future legislation affecting psychiatry and mental health in Maryland. The day will begin with breakfast and a meeting with MPS lobbyists to review talking points and protocol.

Contact Meagan Floyd (text 410-625-0232) or email.

Are You Interested in Becoming Chair of the MPPAC?

The Maryland Psychiatric Political Action Committee (MPPAC) is looking for new members and a new Chair in 2025! If you're interested in attending political fundraisers, working to solicit contributions from Maryland psychiatrists and help advocate for the practice of psychiatry within our state, we want to hear from you! Please email mppac@mdpsych.org for more information.

MPS Best Paper Contest

The MPS established annual "best paper" awards to recognize outstanding scholarship by young psychiatrists in Maryland. Previous winners are listed here. The Academic Psychiatry Committee is currently soliciting nominations for the 2023 Paper of the Year Award in three categories:

Best Paper by an Early Career Psychiatrist Member (ECP):

Eligible psychiatrists are ECP members who are first authors of papers published or in press in 2023. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2024.

Best Paper by a Resident-Fellow Member (RFM):

Eligible psychiatrists are Resident-Fellow members who are first authors of papers that were written, in press, and/or published in 2023. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2024.

Best Paper by a Medical Student Member (MSM):

Eligible students are Medical Student Members who are first authors of papers that were written, in press, and/or published in 2023. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2024.

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

Matthew Peters, M.D. mpeter42@jhmi.edu
Traci Speed, M.D., Ph.D. speed@jhmi.edu
Academic Psychiatry Committee Co-Chairs

LETTER FROM THE EDITOR
Taking a Treasure for a Walk

by: *Bruce Hershfield, MD*

Bruce Hershfield, M.D.

Interviewing Glenn Treisman, as I did for the MPS at Sheppard Pratt on September 23rd, reminds me of the instructions about taking a tiger for a walk: put on a leash and follow him wherever he wants to go. Glenn, of course is not a tiger, but a *treasure*.

As I said at the end of the meeting, I remembered when President Kennedy remarked to the American Nobel prizewinners he was hosting at the White House: It was the best assemblage of intelligence there since Thomas Jefferson had dined alone.

Topics ranged from his work with HIV patients to psychotherapy, the gut-brain connection, and how some medications actually work. I found it most encouraging when he talked about how he could help patients with personality disorders—given enough time—and most inspiring when he talked about his unusual tolerance for being yelled at when he was insisting on helping them.

About 25 people showed up. I believe they enjoyed it. Why so few for such a valuable opportunity? As one of the psychiatrists in the audience said, he has been in Maryland since 1996 and had never met Glenn before that evening. Only one Resident showed up. What would it take to get others to attend?

I understand some reasons why people avoid in-person meetings. They are traveling or are seeing patients or have family responsibilities. Some want to only attend meetings remotely. But I still believe that the MPS must get people together if we are to succeed. I could see from the conversations in the reception that preceded the interview that people were establishing—or renewing—relationships. Without working together or otherwise getting to know each other, members tend to drift away from organizations--or remain without contributing anything but their dues.

I find it much more stimulating to discuss issues with colleagues—particularly with leaders like Glenn—than to attend lectures. I think we should set up another in-person get-together.

What would it take to get us to see--and know--each other again?

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