THE
MARYLAND PSYCHIATRIST
APRIL 2025 VOLUME: 48 NO: 1

Ronald Means, MD: New MPS President

by: Michael Young, MD

Michael Young, MD

Ronald Means, MD, DFAPA, has been practicing in Maryland for nearly 20 years. After receiving his MD from Case Western Reserve, he completed his adult psychiatry residency training at the University of Maryland/Sheppard Pratt, did child-adolescent psychiatry fellowship training at Johns Hopkins, and followed up with forensic psychiatry fellowship training at University. He is board certified in psychiatry, child and adolescent psychiatry, and forensic psychiatry.

With extensive experience in outpatient and community mental health, he is particularly interested in working with underserved populations and improving the quality of mental health services on a population level. He recently moved from being the chief medical officer at Catholic Charies of Baltimore to his current role as chief of the medical staff at Sheppard Pratt. He is also an Instructor at the Johns Hopkins School of Medicine and a Clinical Assistant Professor at the University of Maryland.

Ronald Means, MD

Additionally, he is very active in several professional organizations, including the APA (where he is a Distinguished Fellow), the American Academy of Child and Adolescent Psychiatry, and the American Academy of Psychiatry and the Law, where he serves on the editorial board of its Journal.

We recently met for an interview to provide insights into his background, interests, and vision, and to see what advice he has for trainees and early career members.

Q: "What drew you into the field of Medicine and, ultimately, Psychiatry?"

Dr. Means: "From an early age,--high school, even--I wanted to be a child-adolescent psychiatrist. I also knew I wanted to work with underserved populations. At Case-Western medical school, Phil Resnick was influential in me going into forensic psychiatry. Ultimately, I did fellowships in forensic and child-adolescent psychiatry with a particular focus on community psychiatry."

Q: "How did you first get interested in organized Medicine and the MPS?"

Dr. M: "I started off as a Resident and was co-chair of the Residents' Committee. I saw people with direct relationships working collaboratively to solve problems. I love MPS so much because you get to see the outcomes in a very direct way and collaborate with leaders in the field."

Q: ": Can you talk about your journey from general member to president?"

Dr. M: "I've for years been involved with the legislative committee, which I think represents one of the most significant aspects of the MPS. This is a committee where you're going to learn all aspects of psychiatry. It enhanced my understanding of payer systems and community psychiatry, and gave me the chance to learn from my colleagues and their areas of expertise."

Q: ": What is a good way for members-in-training and early career to get involved?"

Dr. M: "Dipping your toe in the pool is key...seeing what you might want to get engaged in. Sometimes you just need to pop in and out, rather than making an initial time-

In This Issue

Ronald Means, MD
Continued

consuming commitment. I've had great knowledge offered from unofficial mentors who have taught me things along the way. I recommend to all members to pick a committee, give it a try, and, hopefully, that will help you see the value."

Q: "What are the priorities you see for Psychiatry and organized Medicine over the next few years?"

Dr. M: "The need to protect access to care for those who need it most. I see this as our key priority. I plan on working collaboratively to advocate for ongoing funding in that area."

Q: ": What do you like to do outside of your professional career?"

Dr M: "I've been married for 21 years, have two wonderful kids, and I enjoy being active in their lives and 'trying to do a good job raising them". I enjoy running, reading, the gym, and being by myself working in my yard. I've done a couple of marathons and try to do at least one 5K a year. I'm very dedicated to the Baltimore City Turkey Trot."

Q: ": Anything else you would like to share with the membership?"

Dr. M: "I continue to look forward to finding ways to engage more junior members. I want to make sure that people maintain connectivity to the MPS as they start their careers so we can have a diverse voice as we continue to advocate for Psychiatry in Maryland. "

Maintaining Professional Discourse on the MPS Listserv

by: Theodora Balis, M.D.
MPS President, 2024-25

Theodora Balis, MD

Editor's Note: This is a version of a message sent on the MPS listserv in early March

As Meagan Floyd has pointed out, we must keep our discussions focused on professional matters. Politics, while impacting all of our lives, should not dominate the conversation here.

Federal changes are significantly affecting Psychiatry, and many of our colleagues and patients are concerned about job security, benefits, the anti-science movement, and other uncertainties. These are valid concerns that we can and should discuss, and the recent e-mails describing the crises that some of our patients and colleagues face are consistent with our missions and values. Discussing how the MPS and APA can advocate also aligns with the purpose of our listserv, as we work to have a collective voice.

However, as an organization, we must not create a space where those with differing opinions feel intimidated or silenced. These are just the first months of this administration. There may be many changes ahead that we should be prepared to respond to. But we have to be careful to prioritize having a robust discussion of important issues in Medicine without disparaging and alienating others. Discussing how our patients are impacted *is* completely appropriate, but it is *not* appropriate to target specific groups, such as "Trump voters", or use pejorative language to attribute to groups of people with whom we don't agree. Critiquing government actions is appropriate and sometimes necessary, but we must stay within our professional scope and avoid disparaging any side. As psychiatrists, we also are well aware that this is not the way to encourage others to agree with us.

I also appreciate Laura Gaffney's post highlighting how straying from the listserv's engagement policy can negatively affect the MPS. As a 501(c) (6), we must be careful not to engage in anything that could be misconstrued as lobbying. Also, while some may wish to vent to colleagues, disparaging voters on either side of the political spectrum would be better off outside of MPS sponsorship.

I want to express concern that MPS could be seen as attempting to censor members' opinions. I fully understand that it can be difficult to separate the social aspects of our lives from our work, and that much of social discourse can be political. We do not advocate for silence, nor do I wish to discourage the expression of thoughtful perspectives. I actually encourage you to be active in advocacy efforts. I want us to fight for things we care about. Ruth Bader Ginzburg was right when she repeated to us that, "when injustice becomes law, resistance becomes duty".

Opportunities to work within the organization have helped combat the apathy and defeatism we may feel. It's wonderful if members feel energized to advocate, and channels are available through organizations like the APA and MPS. Additionally, sharing information with the MPS resources page is another proactive step to help our patients, colleagues, and our community.

Let's ensure we maintain a space for open, respectful discussion in line with our shared mission.

Join the MPS Listserv

MPS members are encouraged to join the listserv to easily share information with colleagues. An email message sent to the listserv goes to all members who have joined. Posts can be questions, information, thought-provoking articles and more. To join the listserv, please go to: http://groups.google.com/group/mpslist or email mps@mdpsych.org. The listserv is open to members only so you will have to wait for membership approval and will be notified by email. If you have any trouble, please call or text the MPS office at 410-625-0232.

A Career of Passion, Purpose & Psychiatry:

Annette Hanson, M.D., Winner of the 2025 MPS Lifetime of Service Award

By Dinah Miller, M.D. & ChatGPT

Dinah Miller, MD

I met Anne when we were PGY-2 residents at Johns Hopkins. At the time, she had two cats, nicknamed Eli and Zac -- short for Elavil and Prozac,-- whom she fondly referred to as "my antidepressants." In addition to cats, Anne liked running and baseball, and she introduced us to the expression "uff da," an exasperated sigh imported from Minnesota. It was clear, even then, that Anne brought a unique combination of warmth and wit to everything she did, and I was a bit surprised that this unassuming and rule-following Midwesterner chose to pursue a career in forensic psychiatry.

Anne's 2025 *Lifetime of Service* Award is a fitting tribute to a career spent advocating for the vulnerable, mentoring the next generation of psychiatrists, and contributing tirelessly to the profession and the MPS.

Annette Hanson, MD

Originally from Worthington, MN, Anne worked as a hematology technician before attending medical school at the University of Minnesota. After completing residency, she pursued a fellowship in forensic psychiatry at the University of Maryland. It was the beginning of a storied and deeply impactful career that spanned over three decades.

From 2008 until she retired in June, 2024, Anne served as the Director of Fellowship Training in Forensic Psychiatry at the University of Maryland. In that role, she mentored dozens of young psychiatrists and helped shape the field's future. She also served as a staff psychiatrist at the Maryland Diagnostic and Classification Center from 1993 to 2023, and as a staff psychiatrist at Clifton T. Perkins from 2008 to 2024. For 30 years she worked, first as a medical officer and then as Assistant Chief Medical Officer, at the Baltimore City Circuit Court Medical Service.

Anne's career has been defined by a tireless commitment to justice, ethics, and education. Her professional affiliations reflect that commitment. She has served on numerous committees and councils for the American Academy of Psychiatry and the Law (AAPL). She also brought her trademark passion to leadership roles within both the MPS and the APA. At the MPS, Anne chaired the Forensic Committee and co-chaired the Legislative Committee—where her advocacy was both strategic and heartfelt—and served on Council and as an Assembly Representative to the APA.

She was named Instructor of the Year at the University of Maryland in 2000 and received the MPS Presidential Award of Excellence in 2021. Other honors include the APA's Carol Davis Ethics Award, the Red Apple Award, and the Seymour Pollack Distinguished Achievement Award from AAPL.

It is Anne's zest for life that has always stood out to me. Over the years, I've watched her take on one passion after another -- cats and running were just the beginning. There were Kung Fu, tai chi, and computer coding. She learned to swim after the age of 50 so she could go scuba diving while attending the APA annual meeting in Hawaii. Around the same time, she was rappelling down cliffs like Spiderman. There was also the unforgettable "soap era," during which Anne made handmade bars of individually wrapped and labeled soap—each one a little fragrant masterpiece—tucked into brown paper lunch bags and given generously to friends and colleagues.

From bird-watching to tending a plot at the community garden, Anne has always been curious, joyful, and unafraid to try something new. That same spirit carried over into her professional life, where she remains engaged and dedicated even after her formal retirement.

Whether teaching Residents and Fellows, testifying in support of legislation to help our patients and profession, or working with incarcerated individuals, Anne is always enthusiastic. Her dedication is rooted in a deep empathy for those society often overlooks and an unwavering belief in the power of Psychiatry to promote justice and healing.

Anne's contributions go far beyond what any plaque or speech can capture. She has left an indelible mark on the MPS, and on the hearts of the many people fortunate enough to work alongside her.

Congratulations, Anne—and "uff da", what a legacy!

NIH Funding is a Matter of Life or Death

By Paul Nestadt, M.D.

Editor's Note: first published in Hopkins Hub

Paul Nestadt, MD

Johns Hopkins psychiatrist Paul Nestadt says cutting NIH funding for suicide prevention research is 'not just a fiscal decision—it's a threat to human lives'

As I listen to a mother describe her child's suicide, the missed clues posted online, the locked door that prevented rescue, I know that the next words from her mouth will start with "if only..."

Those "if only"s are the reason I'm here. They will inform the prevention measures developed from my interviews, from this research that I am grateful has been made possible by the National Institutes of Health.

As a physician-scientist working to understand and interrupt pathways to suicide and overdose, I was deeply dismayed by the Trump administration's decision to slash indirect funds granted by NIH. My work relies on machine learning techniques and psychological autopsies—detailed conversations with grieving families—to pinpoint where interventions might have prevented these untimely deaths. In a time when opioid overdose and suicide rates are soaring, reducing the support that keeps our research operational is not just a fiscal decision—it's a threat to human lives.

Indirect costs, derogatively referred to as "overhead" in the recent announcements, form the backbone of our research infrastructure. These funds cover essential expenses like maintaining state-of-the-art laboratories, ensuring our computer systems remain secure, and supporting the administrative staff who keep the wheels turning. After World War II, the U.S. government realized that rather than build its own facilities, it would be cheaper and more efficient to fund our world-class universities to house the cutting-edge research that makes America a leader in drug development, public health, and scientific discovery. This meant providing an additional 50% to 70% in grant funding whenever money was given to fuel direct research costs. By unilaterally capping this support at 15%, the administration isn't just trimming expenses—it is grounding the very platforms from which scientific breakthroughs take off.

Consider an airline as an analogy. The direct costs in this scenario—the planes and the pilots—are like the core research funds that pay for salaries and essential supplies. But a safe, efficient flight depends equally on indirect costs: air traffic control, runway maintenance, ground crew support, and the technology that monitors flight paths. Even the most skilled pilots and the best aircraft cannot ensure a successful journey if the supporting infrastructure is compromised. Similarly, our research endeavors, no matter how promising, cannot soar without the foundational support of indirect funding.

My own research is a case in point. By blending machine learning with in-depth interviews from families who have experienced the loss of a loved one, we strive to identify the missed opportunities where intervention could have altered a tragic outcome. Direct funds pay for the computers that analyze my data, but "indirects" pay for that computer's electricity, the office it is in, and the IT support to encrypt sensitive subject files. They cover a review board to guarantee that my team is acting ethically and a grants office to ensure I am spending responsibly. Without these funds, high-quality science is impossible. The impact isn't confined to budget sheets—it could delay or derail lifesaving discoveries that have the potential to reverse the tide of the overdose epidemic and rising suicide rates.

The broader implications are equally concerning. Across institutions nationwide, including renowned centers like Johns Hopkins, hundreds of clinical trials and innovative research projects depend on the robust infrastructure provided by indirect funding. This isn't a minor adjustment—it's a tragic decision that risks dimming America's leading role in medical innovation, from breakthrough cancer therapies to interventions for chronic diseases.

We stand at a crossroads. The current proposal threatens to dismantle not only groundbreaking projects in overdose and suicide prevention but also the entire ecosystem that enables transformative scientific discoveries. For the sake of public health and the future of American innovation, it is imperative that we resist these cuts and safeguard the indirect funds that are integral to our research infrastructure.

Let's ensure that every dollar of federal support is invested in a way that allows our research to truly take off—and ensures that other parents don't have to have these conversations. Because when our support system fails, it's not just labs that go dark, but human lives.

What is the APA Doing About…?

By Annette Hanson, M.D.
MPS Rep to the APA Assembly

Annette Hanson, MD

During the first week of the new presidential administration, President Trump issued dozens of executive orders related to immigration, federal employees, energy production, diversity and inclusion, climate change and the environment, foreign aid and foreign policy, the death penalty, transgender policies, medical research, classified documents, emergency management, and reproductive rights. The wide range and quantity of these orders made me feel like they were confetti spewing out from a cannon. This strategy, sometimes referred to as "flooding the zone," is derived from football--a team sends so many receivers to one side of the field that the defense must overcommit itself to that side and leave an opening uncovered.

Meanwhile, MPS members are left struggling to interpret these orders and to anticipate their effects. I have heard from colleagues employed by the VA as well as researchers at the NIH that some work has been frozen and even temporarily cancelled. Our patients still risk serious fallout in ways that remain to be seen. All of this was also taking place while Congress debated whether to confirm a nominee for Secretary of Health and Human Services who was vocally opposed to the use of psychotropics. It's difficult to imagine how the government will Make America Healthy Again by firing healthcare workers, cutting funds for medical research, removing public health information from government web sites, and undermining psychiatric care for children.

I applaud our e-mail list members who have issued calls to action and suggested ways to mobilize through informal health care coalitions.

Eventually, it comes down to: what is the APA doing about all this?

In fairness, it would have been impossible to predict the breadth of actions taken by the new administration. It is also important to remember that the APA is a national organization, drawing members from both blue and red states. This was particularly driven home to me several years ago during one Assembly meeting, with a vigorous floor debate over an action paper related to gun safety.

In order to be an effective federal advocate, the APA must create alliances with both parties, so as to maintain the cohesiveness of the organization even in the face of controversial issues. Advocacy is also guided by action papers and position statements and these are constrained to topics directly or primarily related to professional practice.

The APA posts periodic policy updates on its web site. The latest hour-long advocacy presentation summarized actions taken in 2024 as well as plans for 2025. It can be viewed on this web page: https://www.psychiatry.org/psychiatrists/advocacy/advocacy-update-webinars

Press releases and advocacy resources are also available on a variety of topics and can be found here: https://www.psychiatry.org/psychiatrists/advocacy/federal-affairs/diversity-health-equity. Any questions about APA actions on a topic that is not on this list can be directed to advocacy@psych.org.

Members may also want to sign up for the APA Action Alert system in order to hear late-breaking news and federal actions related to the new orders. Donating to the Maryland Psychiatric and APA political action committees can also help a lot.

The Maryland Psychiatric Society's legislative affairs committee will continue to stand in the vanguard of our members' interests.

MPS Advocacy Alerts

The MPS Executive Committee has asked MPS Staff to compile a list of current Advocacy Alerts to share with members and help our organization stay up to date on pertinent issues. Keep an eye out for monthly emails containing alerts on SAMHSA Updates, General Advocacy, Medicare Reform, and Maryland Advocacy.

In Memoriam: Robert Robinson, MD

by Jimmy Potash, MD

from "Cheers from the Chair", January, 2025

This is the tenth poem
and it is the last. It is right
at the last, that one
and zero walk off together,
walk off the end of these pages together,
one creature
walking away side by side with the emptiness.
Lastness
is *brightness. It is the brightness*
gathered up of all that went before. It lasts.

--Galway Kinnell, The Book of Nightmares (a ten-part poem)

As Dr. Bob Robinson walked off the end of his career, he wrote an article he called "a personal scientific autobiography" and it shone with the brightness of all that went before in the 50 years of his medical career. Bob was one of the great clinician-scientists in the history of our department and he passed away last month, on Christmas Day, at the age of 79. He came of age professionally in the 1970s when the battle for psychiatric supremacy raged between the psychoanalysts and the psycho-scientists. Bob was squarely in the latter camp. He wrote "The discovery of a new finding or a new idea after analyzing the data ultimately gave me the greatest sense of awe and motivation for science…There was a tremendous thrill about finding something no one had ever discovered that gave me exhilaration like nothing else in my career." Dr. Robinson made seminal discoveries published in *Nature* and *Science*, about how a model of stroke in the brains of rats led to changes in key neurotransmitters and in the animals' behavior. Additional studies demonstrated particular brain regions where damage from stroke increased risk of depression in patients. Much of Bob's important work was done during his 15 years on our faculty, during which time he mentored people who would go on to distinguished careers, like Tim Moran, John Lipsey, Godfrey Pearlson (now at Yale a leader in psychiatric brain imaging), and then-fellow Helen Mayberg (now at Mt. Sinai and the world leader in deep brain stimulation for depression).

Bob went on to a highly successful 20-year tenure as Chair of Psychiatry at the University of Iowa. I was most appreciative of how warmly he welcomed me and showed me the ropes as I followed him in that role. Our former department chair, Paul McHugh, had this to say: "Bob was one of my first students at Cornell – one who took quickly to the themes and methods of empirical psychiatry and the importance of experiment in advancing the subject…and was happy to adventure out with me in his residency to [Cornell's] Westchester division…After [time he spent at] NIH he joined me again as resident (and eventually Chief Resident) at Hopkins, joining our faculty promptly on finishing the residency. He was an excellent clinician and cheerful colleague as we gradually won round the Hopkins community to our modes of reasoning and practice in psychiatry…He'll be remembered with honor and gratitude by me and many others." The thrill Bob felt is gone, but his memory will last.

Robert Robinson, M.D.

Lots of Stories Out There

By John Buckley, MD

John Buckley, MD

In this time of isolation and personal distance, the Editorial Advisory Board of The Maryland Psychiatrist would particularly like to know what's going on out there. We invite you to share a story with your peers. Have an opinion? Had an experience, good or bad, that altered your career? Have a suggestion for a clinical tip that has helped your work?

How about an account of a night on call in a psych ER, or what it's like working in a prison? Or how one might manage a school request for evaluation of a behavioral problem, or deal successfully with third party payers? Or a clinical vignette with an unexpected outcome? Or how about a personal history of the emotional aspects of illness (when doctors are patients)?

Lots of stories out there…we hope you will share them with us.

A nice length would be about 500 words. If you would like advice, call the MPS and one of us will contact you with help.

Submit a Story to The Maryland Psychiatrist

If you are interested in joining the Editorial Advisory Board, or would just like to submit an article for publication in an upcoming issue, please email jhritz@mdpsych.org.

An MPS Presentation

The Physician Health Program and Dual Agency Conundrums

By: Jesse Hellman, MD

Jesse Hellman, MD

On February 27, 2025 the MPS's Ethics Committee hosted a Zoom seminar, "Introduction to the Maryland Physician Health Program." Participants were psychiatrists Joanna Brandt, Arthur Hildreth, and Ronald Means, neurologist Martin Rusinowitz, and Margaret Ann Kroen, LCSW-C, Director of the program. Psychiatrist Jeffrey Janofsky MD spoke on "Dual Agency Conundrums in Psychiatric Practice" as part of the evening's activity. Support came from the MindWork Group and the Maryland Foundation for Psychiatry.

The complexity of dual agency conundrums is faced in many parts of life, in many professions, and by many businesses. Loyalty to one group, for example, may create unacceptable consequences for another. This is seen in Medicine, for example, when the wishes of an insurer or hospital to maximize profit lead to denying treatment that is both needed and desired.

Margaret Kroen said in her presentation that MPHP helps physicians with issues, such as addiction, that disrupt their ability to practice. While MPHP advocates for the physicians, it does not provide medical or therapeutic interventions, but it does collect pertinent information and find ways to be of assistance. MPHP has three programs, 1) Rehabilitation; 2) Maryland Physician Health Care; and 3) Health Care Professionals Program (e.g. for chiropractors and veterinarians). It tries to provide care in the most confidential way possible. But if participants are sent by a Board, then information may be sent to it, which is one example of the conundrums that are faced. Another is that a threat of harm to self or others may need to be reported.

Three issues are faced regularly: 1)Alcohol/substance abuse is perhaps most common (requiring abstinence, daily check-in, lab testing for abstinence, and referring participants to self-help groups such as AA.); 2) Disruptive behavior and boundary issues; and 3) Cognitive impairment. The program refers patients to programs both in and out of state, and also can set up forensic evaluations.

Ms. Kroen stressed that in the past they never saw physicians who were found to have cognitive problems, but they now are. She said that "in 2024 we worked with 61 individuals... alcohol and drugs used to be major reason for enrollment, now other issues are more common such as cognitive ones." How is the program doing? Recovery rate from substance issues is very high. In 2024 there were 29 discharges from the program. The last time someone was discharged from substance use, but did not return to practice, was in 2023. Ms. Kroen suggested watching the YouTube channel *Center for a Healthy Maryland.*

In the second part of the program, past-president of the MPS Jeffrey Janofsky, an expert in forensic psychiatry, talked about Dual Agency. He pointed out that *pure* beneficent interaction is to the benefit *exclusively* of the patient. The duty of the psychiatrist is to protect the patient, but, if the patient is being investigated legally or by an employer, this is not absolute. He noted that as "important preventing sepsis is to surgery, confidentiality is to psychiatry." In investigations, he reminded us, a psychiatrist may ethically disclose only information that is truly relevant.

He noted that the continuing duty of the psychiatrist to protect the patient includes fully apprising him/her of the connotations of waiving the privilege of privacy. Psychiatric records, including even the identification of a person as a patient, must be protected with extreme care. This may become an issue when the patient is being investigated by a government agency, is applying for a position, or is involved in legal action.

Regarding a situation where no doctor/patient relationship exists: the APA published a commentary, "Ethics in Practice", in 2015. It noted that a psychiatrist should inform the person being examined as to the purpose of the evaluation. Because limits on confidentiality exist, such evaluations/examinations may have a most serious effect on the person being examined; they bring up the problem of Dual Agency and the overlapping roles of the physician. He stressed that, while circumstances may compel the practitioner to be both treater and evaluator, this conflict should be avoided whenever possible.

He noted the importance of avoiding offering speculation as fact. Sensitive information such as an individual's sexual orientation or fantasy material is usually unnecessary to reveal. The psychiatrist should reserve the right to raise the question of adequate need for disclosure. In the event that the necessity for legal disclosure is demonstrated by the court, the psychiatrist may request the right to disclosure of only *that*

(Continued on next page)

An MPS Presentation

Continued

information that is relevant to the legal question at hand.

An empathic relationship is very important in practice, and public questioning of such empathy in a forensic evaluation may lead to serious problems for both patient and physician. There are differences between "truth" and "causation": in therapy the therapist tries to see world through patient's eyes, but in forensic evaluations objectivity--rather than empathy--is most important.

Dr. Janofsky stressed that to say, "I am reasonably certain that this person ls presenting with posttraumatic stress disorder," is not to say, "It ls my opinion, to a reasonable degree of medical certainty, that the trauma was caused by the sexual abuse she says she suffered at her father's hands," and that equating these two statements is a damaging mistake that clinicians unfamiliar with the courts often make when they move into the legal arena.

Dr. Mark Komrad asked what could be the consequences of not complying with a subpoena to release records. Dr. Janofsky replied that this issue might be best referred to the doctor's own attorney, which might lead to applying for a protective order to protect those records.

Dr. Arthur Hildreth commented on dual record keeping: when should psychotherapy notes be kept separate from medication records, and might they then remain completely confidential?

Dr. Ronald Means commented that if a patient brings in a form--perhaps for disability--it is may be best to fill it out rather than not doing so, but in such situations filling it out needs to be done carefully, so it does not interfere with treatment. *The point is to be careful about what you document*. Keeping process notes in a separate folder may be wise. It may indeed be possible to avoid releasing all records, but in such situations a really good attorney may be helpful.

Dr. Janofsky stressed that we should never fill out a driving ability form, as we have no expertise with the pertinent issues. He noted that guardianship issues are also complex and may need special assessment, for example by an attorney.

This was a most thoughtful presentation and discussion of important issues. Members of MPS are encouraged to call the Maryland Physician Health Program if they have specific questions.

Interview: Cynthia Major Lewis, MD

By Bruce Hershfield, MD

Bruce Hershfield, M.D.

Baltimore March 24, 2025

Q: "Please tell us about your work."

Dr. L: "I am in charge of psychiatric emergency services for adults here at Johns Hopkins. I was a community psychiatrist for the majority of my career. I had a private practice, but I did about 16 years in community Psychiatry. In 2010 I was asked to work in the emergency department, but it was mostly supervising the Residents. I left Hopkins in 2015 to do private practice alone, but then the hospital asked me if I would come back to be embedded in the emergency department. This was 100% clinical, all in the ER, which really was my dream job. "

Q: "What exactly do you do in that role?"

Dr. L:" We changed the structure of our work force. Initially, we had all Residents, but now we have Nurse Practitioners, so I have been charged with training them to be able to evaluate patients in crisis—patients who come from all over to be seen at Hopkins We're tasked with admitting people if we feel admission is indicated, either voluntarily or involuntarily. We have the ability to send people to crisis facilities, or to substance abuse facilities in the community for treatment of the dually-diagnosed. Or we can decide someone is safe-enough to be discharged; in that case we can arrange for social workers to work with families and providers to make sure they can be safely discharged.

Q: "Is this a 24-hour system?"

Dr. L: "During the daytime we will sometimes have Residents who are doing sub-internships for the month. We do have Residents who are in the ER from 7PM-7AM, but our daytime shift is really handled by the NP's. On Fridays, I am not in the hospital, so our Residents are there then, 24/7, as well as the weekends.

Recently, we hired an assistant, Dr. Caroline Frank, who is wonderful. She covers for me on Fridays and when I am on vacation or ill, but I am pretty much on -call 24/7. Even if I am on vacation, if I see the ER is calling I have no problem answering the phone and

(Continued on next page)

Interview: Cynthia Major Lewis

Continued

trying to give some guidance."

Q:" What has surprised you about working there?"

Dr. L: " It was eye-opening! Being a community psychiatrist for 16 years, I took for granted what it was like for us to have a fully-functioning wraparound team. We had nurses, social workers, therapists, psychiatrists. I saw a lot of chronically ill patients. Some were going to day programs. Most of them were functioning pretty well. But some of them required us to have a team that could go *to* them. So we had a mobile treatment team we could refer them to. It wasn't till I was embedded in the ER that I realized there is another population--the ones who are not following up with an ACT team and are using emergency departments and acute services for their treatment. It was eye-opening to realize that this population is not being served well. We didn't have a mechanism in Maryland to do right by them. That is what set me on my journey. I look back to my experience in community psychiatry and think that we do very well with probably 90% of our patients with severe mental illness who want treatment. It was that population who didn't appreciate they were ill who were not getting the care they needed. We weren't doing a good job making sure that that population stayed safe and got the treatment they need."

Cynthia Major Lewis, MD

Q: "I understand you played an important role in getting recent legislation passed concerning assisted outpatient treatment."

Dr. L: "When I realized this population existed, I started questioning why I was seeing them several times per week or several times per month. I knew I was admitting them, but then I would see them back within a week. I started inquiring if the insurance companies were concerned if I would see someone like 15 times in a month. To my surprise, I realized hundreds of thousands were being spent on people who were being seen in the ER's with no improvement. That sparked me to wonder what I could do from the front lines. I reached out to Jeff Janofsky and Annelle Primm and they encouraged me. They told me nothing is going to change unless you start impacting laws. I had been an MPS member for many years without having been much involved. They encouraged me to join the legislative committee and to figure out what bills are out there. I joined the committee and learned that an assisted outpatient bill had been coming up for like 18 years. I had given a Grand Rounds in 2020, speaking to what we needed to do with this population. I took this back to state hospitals and de-institutionalization, the communities that were supposed to capture these patients. I didn't even know what assisted outpatient treatment *was*. Realizing that Maryland was one of only 3 states that didn't have this opened my eyes to addressing how to get that here."

Q: "Why were you successful this time?"

Dr. L: "I think the crucial step was understanding that we had not been having a psychiatrist "at the table". It was mainly the family advocates who were working hard at trying to get this done. The organizations who were opposing this had a megaphone that was much louder. Patient advocacy, disability rights, public defenders. Even organizations that work hand in hand with this population, like on outpatient civil commitment, were opposed, which I found shocking. Behavioral Health Systems Baltimore, which is a core service agency, understood this problem and had a pilot project, but it didn't have a lot of teeth. An order would be placed for outpatient civil commitment, but it was still voluntary. The patients I was seeing were the ones who would not do this voluntarily. They would have to have some sort of treatment that was mandated. The MPS was opposing the bills, not because they didn't appreciate the concept, but there were problems with the structure or concern that maybe rights would be impacted. When I came on to the committee, I voiced my concern that part of my reason for joining the committee was that my patients were not doing well. Fortunately, that year we decided to "support with amendments". After two years the momentum changed in our favor. Governor Moore was elected and AOT was part of his platform. I testified in favor of it; that was the year it did get out of the House. The next time, I was able to bring along some other psychiatrists who were involved with delivering emergency services."

Q: "What did you learn by going through the process?"

Dr. L: "This was during COVID. The mask mandate debate was very similar to what I was seeing. There was a lot of misinformation that was not being challenged. The people who were making the decisions were not getting the information they needed. There was a lot of

(Continued on next page)

Interview: Cynthia Major Lewis

Continued

concern about autonomy-- patients could make the decision not to get treatment. I had to respect that and I do, but I also felt like these people were not appreciating they needed treatment. They were advocating for their "right" to die early deaths.

After the first year I watched this, on-line, I noticed the legislators picked up their bags and went home. It was *done*, so far as they were concerned, but I was going back to the ER the next day, seeing individuals who were not getting the treatment they deserved. I was disappointed. Once we got the psychiatrists who were able to challenge what was being said on the other side, the legislators got a better picture of the need. "

Q: "Congratulations! I understand you will be getting the APA's Solomon Fuller Carter Award this year because of your success with this."

Dr. L:" Thank you. After it passed, I was given the Achievement Award by the MPS and I think that was because of it. I also got a NAMI award-- the Marcia Pines Award. It was heartwarming to me that all this hard work was getting recognized."

Q: "When does the law go into effect?"

Dr. L: "In July. Now we will see an advisory council that will be responsible for developing the program. Unfortunately, the law is due to sunset in 5 years, so I assume the people who opposed it will be back about it then. So it is our job to see that it succeeds."

Q: "What else do you do?"

Dr. L.: "I am the mother of daughters who are 16 and 14. They are involved with a very competitive sport that involves much of my time when I am not working. I am also involved with a service sorority--Delta Sigma Theta—I have a great group of friends. It's a busy life!"

Q: "Tell us about your background and about how you got into Psychiatry."

Dr. L.: "I am from Nashville. I have a twin sister. When we were young--about 6--people would comment about what made us tick. We heard about a case in London where one child lured another into the woods and that child was harmed. I remember wondering why a 10 year old would do this while my sister said he should be thrown in a cell and they should throw away the key. So she was very black-and- white about it and it was a little bit gray for me. People would tease us that she will be an attorney and *she* will be a doctor. Sure enough, she is an attorney and I'm a psychiatrist. I always wanted to figure out why people do the things they do. I thought you had to go to med school to get there. I'm very glad I didn't know any better because I love the interaction between the brain and Psychology and I love solving things. The ER is a place where you don't know exactly why they are coming in, so you have to do a little bit of detective work."

Q: "Where did you do your training?"

Dr. L.: "I went to Howard University, then to Meharry for medical school. Both are HBBC's—Meharry is only one of 4 HBBC's med school in the country. When I was finishing at Meharry I knew I wanted to come back to this part of the country, so I interviewed at Hopkins and Maryland and Georgetown. I felt that if I was accepted at Hopkins I would come here. I felt very comfortable at these HBCU's, but I knew I had to take the opportunity to come to Hopkins and I've never regretted it."

Q: "Who influenced you the most here?"

Dr. L.: "I would say Annelle Primm. When I came here she was one of the people who interviewed me. Sometimes it's good to have people see folks who look like them and to get their perspective. She made it very clear that if I came here she would *be* here for me. She was a great mentor. She was Director of Community Psychiatry. I had a national health service corps obligation that I had to pay back after residency, and that obligation forced me to do community work. So I did outpatient work on the eastern shore. That changed the whole trajectory because I then started working one day a week in community psychiatry here, along with fulfilling my obligation. Then I came to work full-time in community psychiatry here. Being in the ER has solidified my love for working with the most vulnerable patients. In my private practice I got to see a lot of depression and anxiety. I did a lot of injured workers' work. But my passion was for the patients with severe illness."

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

Dr. L.: "I think that if I could continue directing emergency services, I would love nothing more than to also run an assisted outpatient clinic. Perhaps we could do something like that at Hopkins. Kind of like they do at Bellevue in New York. If I could be a part of running that clinic—making sure this population gets the care they deserve—then I would love to do some sort of hybrid of both kinds of work."

Update on Clozapine

by Robert Herman, MD

Robert Herman, MD

On February 24th the FDA eliminated the requirement for reporting absolute neutrophil counts to the REMS (Risk Evaluation and Mitigation Strategy) program for clozapine.

This medication was first synthesized in 1958. After the synthesis and discovery of chlorpromazine--the first effective antipsychotic-- and imipramine--the first effective tricyclic antidepressant-- investigators were synthesizing related compounds and testing them. Clozapine was patented in the USA in 1970. In 1975 its development was suspended when a cluster of elderly and infirm patients in Finland developed agranulocytosis, leading to 8 deaths. The ensuing investigation rejected the conclusion that clozapine was the cause of the deaths; nevertheless, this led to its withdrawal from general use. Some of the patients who were involved in the clinical trials in the USA were doing remarkably well, and when they were forced to stop the drug many relapsed quickly into psychosis

When the Hatch-Waxman Act was signed into law in 1984, allowing pharmaceutical manufacturers to extend their patent for an additional 5 years, Sandoz pushed for FDA approval of clozapine. Instead of requiring that it perform better than placebo, the FDA required that it respond better than other antipsychotics. The clinical trials showed this to be true and clozapine was approved by the FDA in 1989. Because of the risks of agranulocytosis, the FDA required all Clozapine prescribers and pharmacies be enrolled in a REMS program. If lab results were not promptly reported, pharmacists were instructed to refuse to dispense the drug.

Over the years patients and providers complained about the rigidity and burden of this program. When patients were denied the drug because of the stringent rules, many relapsed into psychosis. The complaints of patients and providers finally led the FDA to eliminate the REMS for Clozapine program.

During my residency at Bellevue, I treated a great many patients with psychotic disorders and a fair number had treatment- resistant psychosis. As clozapine was not available at the time, I never had the opportunity to use it. When clozapine was approved I was building an outpatient psychoanalytically-oriented practice and working in a drug and alcohol treatment program. I had virtually no patients with treatment-resistant psychosis, so I did not pay much attention when clozapine was approved. I attended psychopharmacology conferences on a regular basis and heard again and again that clozapine was recommended if a patient with psychosis failed two or more antipsychotics.

After moving to Maryland in 1996, I resumed having an outpatient psychiatry practice in 2000. I began to focus exclusively on psycho-pharmacotherapy. From time to time, I did encounter patients with psychotic illnesses. I recall one patient with psychosis who did not respond to conventional antipsychotics. When she heard borborygmi emanating from her abdomen she believed that creatures inside of her were making these noises. She was so preoccupied with this that she was unable to function. With clozapine treatment she still believed that these sounds were from creatures inside of her but they became much less prominent, and she got a job as a waitress.

I gradually increased the number of patients I was treating with clozapine. I inherited several patients who were stable on clozapine whose previous psychiatrists were retiring. I learned that very few of our colleagues were willing to prescribe it and the patients that I saw had called many psychiatrists before they had found me. Many are doing exceedingly well

In 2020 I was part of a study at the University of Maryland Psychiatric

(Continued on next page)

Update on Clozapine

Continued

Research Center about how to increase clozapine prescribing, called "Champion Echo". Participants were divided into those who participated in an educational activity about clozapine and those who did not. I was randomized to *not* receive the intervention, but I was given something called the Athelas One point of care device. This looks like an Amazon "Alexa" device and allows one to measure Absolute Neutrophil Count via a finger stick. I tried it in on myself and was impressed. I have one patient on clozapine who is bed bound-for medical reasons; I am attempting to obtain it for her so she does not have to travel to the lab or have a mobile phlebotomist come to her home.

Now that the REMS program is abolished, professional bodies will be issuing revised recommendations regarding the frequency of blood monitoring. I hope that these requirements will be less onerous and it will be it easier for clinicians and patients to use Clozapine. In most developed countries, it is regularly used in patients with schizophrenia—20% in Germany, 30 in China, 35 in Australia. This is probably the percentage of patients with treatment- resistant psychosis in these countries. But only 5% or fewer of patients with schizophrenia in the USA are being treated with it. This almost certainly means that many patients who can benefit from it are being denied it.

As psychiatrists, we all should be willing to prescribe this drug so our patients with treatment- resistant psychosis may benefit from it.

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: Wendy Spencer, MD

by: Bruce Hershfield, M.D.

Dr. Wendy Spencer died on January 15th at the age of 71 from the effects of Parkinson's disease, about two weeks after she stopped practicing.

Originally from the Baltimore area, she attended college at Michigan State and medical school at the University of Maryland. Her internship was completed as Case Western Reserve hospital in Cleveland before she transferred to Johns Hopkins hospital to complete her residency in psychiatry. Afterwards, she worked at Springfield Hospital Center and then went into private practice, with offices in Laurel and Columbia.

I attended her memorial service on April 12th (as I had attended her wedding in 1988). Many people at the service spoke about her generosity, warmth, and approachability. It is clear she was very devoted to her patients; it was like her to work to help them until so shortly before she died.

I supervised her at Hopkins and then worked with her at Springfield. She really *was* warm and generous and sincere about helping people. She was a fine psychiatrist and a lovely person and those of us who got to know her were fortunate indeed.

Wendy Spender, MD

Back to Baltimore: Interview with Jacob Taylor, MD, MPH

by: Elizabeth Wise, MD.

Elizabeth Wise, MD

Last summer, Dr. Jacob Taylor returned to Baltimore to become Program Director for the Hopkins Psychiatry Residency, joining Associate Training Director Dr. Anne Ruble, and replacing Dr. Graham Redgrave, who had served 13 years in residency leadership. Dr. Taylor received his MD and MPH from Hopkins and completed his residency at Hopkins (serving as chief resident his fourth year) before moving to Cambridge, MA in 2016 to pursue a research fellowship in psychiatric genetics at the Broad Institute of Harvard and MIT. He then became Associate Program Director for the Brigham and Women's Hospital Psychiatry Residency. Now he is back in Baltimore and just celebrated a successful Match Day with the rest of Hopkins leadership.

Jacob Taylor, MD, MPH

EW: What motivated you to return to Hopkins in the role of residency director?

JT: A few years ago I became an associate program director for the residency at Brigham and Women's Hospital and found that I loved being involved in graduate medical education. I think very highly of the program at Brigham but as I learned more about the world of graduate medical education, I became increasingly convinced that the training I got at Hopkins is truly special and rather unique. When the opportunity arose to lead the residency program it felt like too good an opportunity to pass up.

EW: How did this residency recruitment season go?

JT: Great! We have an extremely talented class of interns coming in July. We also recruited two PGY2 residents who will join the excellent interns the program recruited last year.

EW: What do you think attracts trainees to come to Hopkins? Or Baltimore, in general?

JT: I think medical students interested in psychiatry are aware of our program's reputation as training fantastic clinical psychiatrists. Our program also has a well-deserved reputation for helping prepare future psychiatrists for positions of leaderships – including as researchers, teachers, government officials, clinical leaders, and administrators. So it is the combination of a serious commitment to clinical excellence (much more, in my opinion, than at many similarly prestigious programs) with the opportunities for careers that include academic and other forms of leadership, that is especially attractive to many applicants.
In terms of Baltimore – I really do believe that there is a case for Baltimore as "the greatest city in America" (as the park benches used to say). I think that the unique cultural and historical niche that Baltimore fills is attractive to many creative, ambitious and talented people. I think that this is especially true for any of our applicants who are lucky enough to have spent time here.

EW: Are there aspects of Brigham's psychiatry residency that you think should be incorporated into Hopkins residency (or changes you have already incorporated since being back at Hopkins)?

JT: The Brigham program does a really great job of making sure that each resident is aware of the opportunities for mentorship that exist in whatever areas they are most excited about. Hopkins implemented a "track" system a few years ago to facilitate identifying mentors for residents in areas that they are passionate about, as well as giving them time and resources to fulfill scholarly and other projects in those areas. At a place like Hopkins with so many opportunities for mentorship in so many different areas (and even across institutions such as the School of Public Health, the Lieber Institute, other departments within the school of medicine, etc.) it is a perpetual challenge to figure out how to make sure busy residents discover potential mentors and feel empowered to connect with them. I've enjoyed working with the track leaders to figure out how to continue to improve in our ability to help every resident connect with mentors who help them feel inspired to pursue their highest ambitions within psychiatry.

EW: Psychiatry has become a much more competitive and sought-after residency in past few years; why do

(Continued on next page)

Back to Baltimore

Continued

you think this is?

JT: It's just so much fun being a psychiatrist. Though I think that has probably always been true, maybe it doesn't explain why it is becoming increasingly competitive and sought-after. I do think that mental illness is becoming somewhat less stigmatized and that it is increasingly recognized how important addressing mental health problems is to the lives of individuals and to our flourishing as a society. In addition, there is a real sense of scientific progress in unlocking potentially new and exciting approaches to diagnosis and treatment within psychiatry. So for bright medical students looking for a field where one feels like they are serving a critically important mission as well as those looking for a field with a lot of opportunity to be at the cutting edge both clinically and scientifically, psychiatry has become increasingly attractive.

EW: Any ideas to increase mingling/engaging between Hopkins and UMD residents?

JT: That would be great. I think there could be a lot of opportunities to perhaps combine didactic teaching opportunities (especially given the ubiquity of Zoom). As I go into my 2nd year on this job I'll try to connect more with educational leaders at Maryland and brainstorm with them about this question!

EW: Any data on resident plans after graduation, i.e., clinical, academic, research positions? Do you observe new trends in post-residency plans?

JT: I don't know if there are new trends. This year, some of our graduates are pursuing entirely clinical jobs and some are pursuing research and/or clinical fellowships. Folks seem like they have been very successful at landing positions that serve their long-term career goals and that are located in the places they want. This includes several graduates who will be staying at Hopkins and an unusually large number who will be heading up to my former stomping grounds in Boston for exciting academic opportunities.

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**.

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.

2025 MPS Member Survey

The annual MPS member check in on a variety of topics will be sent via email and USPS. Please respond to help guide how MPS committees, Council and staff will work for you in the coming year.

INCENTIVE: Three respondents who complete the entire survey and provide their names will be chosen at random for a **$100 credit** that can be applied toward MPS dues or an MPS event.

This should take less than 5 minutes!

MPS Hosts Psychopharmacology Seminar

A Virtual Presentation on November 14

by: Bruce Hershfield, MD

Bruce Hershfield, MD

Fifty people attended a three-part virtual seminar on psychopharmacology sponsored by the MPS on November 14th.

First up was Dr. David Neubauer, who lectured on "New Horizons in Sleep Medicine Pharmacotherapy". He suggested that key elements in selecting the right medication include shared decision-making, a review of the expectations, and checking for drug-drug interactions. Choices include FDA-indicated meds, off-label prescription meds, OTC-regulated ones, and dietary supplements. Melatonin may help with sleep onset if taken 1-2 hours before bedtime, antihistamines are relatively long-acting and therefore may cause morning grogginess, and trazodone is the most commonly prescribed sleep medication. The "z-drugs" like zolpidem have relatively shorter ½-lives. Ramelteon, a melatonin-receptor agonist, has a relatively short ½ life, but should never be prescribed when someone is also taking Luvox. Very low-dose doxepin is indicated for sleep maintenance. He went on to talk about sleep disorders other than insomnia. These include narcolepsy (for which Provigil and Ritalin can be helpful) and the parasomnias like REM-sleep behavioral disorders. He talked about Prazosin for nightmare disorders and Mirapex and Requip for restless legs syndrome, then went on to describe the sleep-wake disorders (advanced onset and delayed onset). Finally, he talked about shift-work disorder, jet lag, and obstructive sleep apnea.

Christopher Welsh, MD then spoke about "Gambling Disorder: A Hidden Addiction". He told us that about 85% of Americans gamble--about $100 billion each year. Maryland has the 10th highest figure, with over $4.5 billion per year. Problem-gambling and pathological gambling affect more than 150,000 people in our state. There are no good objective tests—but some good screening tests-- to determine if gambling is a problem. There is a high correlation with a risk of mood and anxiety disorders—including suicide--and a very high correlation with alcohol and nicotine use disorders. There appears to be a genetic component for the risk of having it.

There are some treatment options. Naltrexone, which appears to lower the pleasure associated with it, may help. SSRI's don't seem to help (though of course they may affect the co-morbidities). Using Mirapex, Requip, or Abilify may increase the risk. Gamblers Anonymous, started by Jim W. in 1957, along with a Voluntary Exclusion Program that allows gamblers to volunteer to be kept out of casinos, lotteries, etc., and 1-800-GAMBLER are all options. A good resource can be the Maryland Center of Excellence on Problem Gambling.

Finally, we heard from Dr. Mary Elizabeth ("Bit") Yaden about Psilocybin. She said that psychedelics bind to the 5-HT2A receptor, inducing a non-ordinary state of consciousness. This can include a sense of expansiveness and connection and awe—and also fear. Dosing sessions at the Johns Hopkins Center for Psychedelic & Consciousness Research, lasting for 8 hours, include 25 mg of psilocybin. She told us that healthy volunteers have rated the experience as among the most meaningful in their lives and that the treatment has helped some patients who have cancer and depression/anxiety. It is helpful to those with nicotine and alcohol-use disorders and appears to be as useful as SSRI's in treating depression. However, bipolar I disorder and schizophrenia may be exacerbated. Although Buspar and trazodone can decrease the subjective experience, there appear to be no significant drug-drug interactions. Increases in blood pressure, and also headaches, can occur. Of course, there are ethical considerations to be addressed before it can be widely used.

We are fortunate to have three such experts in our community—and who are willing to take the time to describe their work.

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 show-case your experiences with the MPS community.

LETTER FROM THE EDITOR
In No Pack

by: *Bruce Hershfield, MD*

Bruce Hershfield, M.D.

Robinson Jeffers wrote in "Be Angry at the Sun" in 1941 that "The cold passion for truth hunts in no pack."

These are very strange times. The strangeness of it all has seeped into my practice. Patients insist on talking about politics. Some who used to ask me to help *them* distinguish what was real from what they were imagining now lecture *me* about things that aren't true. If I tell them a fact, they simply dispute the accuracy of my source. Theories that I thought were abandoned years ago are brought up again. I am hearing about people refusing vaccinations; it is as though our communal memory of how much polio was feared has simply disappeared. Patients tell me they are scared and I find it hard to try to help them change their perceptions because I am as scared as they are.

I know that others have been asking our leaders to meet the challenges we are facing. Dr. Jill RachBeisel wrote in her column to the University staff on April 2nd, "We find ourselves in volatile times. Daily, it seems, there is news of another agency being reduced through layoffs, funding being cut… Education is also under fire, threatening training programs and even the basic right to education …The vital contribution to science that supports discovery of effective treatments is being undermined…" She recommends we remember our professional ethics. She reminds us to speak up (even when it feels strange to do or to say something different) and to believe in truth. "To abandon facts is to abandon freedom."

Dr. Robin Weiss, a former MPS president, wrote to our Executive Committee about the threats we are facing, including the list of "banned words", "which is real, is Orwellian." She commented, "I have found the MPS listserv to be useful…in the past, to discuss issues that concern us as a community of psychiatrists. It bewilders me that discussion of the current political situation, which our own APA considers urgent, has triggered a 'cease and desist' order…" Dr. Weiss proposed that the MPS actively monitor the APA Advocacy page and "can then decide whether the membership needs to be kept aware…Perhaps at this crucial juncture, there should be a monthly update, keeping members abreast of the APA's efforts to sustain the care of our patients."

Drs. RachBeisel and Weiss—and so many others—are trying hard. They deserve our admiration. However, we cannot be sure that the collective efforts of our institutions are enough to get us through the current situation. Organizations tend to compromise and to try what has worked in the past. But these times are different than any others we have ever seen. In the meantime, we *must individually* insist on telling the truth to patients and to each other—*particularly* when we are scared.

Jeffers told us 84 years ago:
That public men publish falsehoods
Is nothing new…
Let boys want pleasure, and men
Struggle for power, and women perhaps for fame,
And the servile to serve a Leader, and the dupes to be duped.
Yours is not theirs."

THE MARYLAND PSYCHIATRIST IS PUBLISHED BY THE MARYLAND PSYCHIATRIC SOCIETY. MATERIALS FOR PUBLICATION SHOULD BE FORWARDED TO THE EDITOR. THE VIEWS EXPRESSED IN ***THE MARYLAND PSYCHIATRIST*** REFLECT THOSE OF THE AUTHOR AND NOT THOSE OF THE MPS, APA OR EDITORIAL BOARD.

SUBSCRIPTION RATES: $25 PER YEAR PAYABLE TO THE MARYLAND PSYCHIATRIC SOCIETY.

SEND ALL CORRESPONDENCE TO:
MARYLAND PSYCHIATRIC SOCIETY, INC.
1211 CATHEDRAL STREET
BALTIMORE, MD 21201
PHONE: (410) 625-0232; FAX: (410) 625-0277
EMAIL: MPS@MDPSYCH.ORG
WEB: WWW.MDPSYCH.ORG