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Tyler Hightower, MD: MPS President 2026-27

by: Katherine Cinnamon, D.O.

When I was asked to write an article about Dr. Tyler Hightower, I was both excited and honored. I looked forward to letting everyone know about the person I have come to value as a colleague, educator, and friend.

Her interests are mainly focused on social determinants and the needs and mental health treatment of minority populations who encounter the criminal justice system.

I first met Dr. Hightower when we started our general residency at the combined University of Maryland/Sheppard Pratt program in June of 2003 (Wow! Yes, it has been that many years.) She was originally from Georgia and I wondered, "How did she end up in Maryland?" I soon discovered that she had a previous connection to Maryland. It turns out she had gone to Johns Hopkins for her undergraduate degree and then attended its School of Public Health for her master's. She later earned her MD from the Morehouse School of Medicine in Atlanta. While there, she began to get involved with professional organizations at the state and national level.

Tyler Hightower, M.D., MPH

During our PGY-II year, we were on the same rotation track. When we were assigned to 11 West at the University of Maryland Medical Center (which was one of the adult psychiatric units), I quickly learned that Dr. Hightower was not only both efficient and diligent in her clinical work, but she also always wanted what was best for her patients. She was wonderful to work with and also had a great sense of humor. I got to know her more as we transitioned from taking overnight call from Q4 days to taking call only Q6 days. We were moving up in the world!
It turned out that during her undergraduate studies she had done a work-study job with the Mood Disorders Center at Johns Hopkins. She shared that she then went on to work as a clinical research assistant, looking at the genetics of mood disorders under J. Raymond DePaulo, MD. She shared, "I always knew I wanted to be a physician, but the idea of becoming a psychiatrist developed as an option when I worked with Dr. DePaulo and his group." As our psychiatry residency ended in June of 2007, she went to New York to complete a fellowship--in forensic psychiatry and the law--at the Columbia/Cornell program. Her experiences at the Walter P. Carter Center during our PGY-I year of working with individuals with illness who were entangled in the criminal justice system had piqued her interest in forensic psychiatry. She also remembers, "I do not think I realized it then. I now know that my decision to practice forensic psychiatry was influenced by the ability to contribute to justice for persons suffering with a severe and persistent mental illness. My work today contributes to the fairness of the legal proceedings and the humane mental health treatment of offenders. An overwhelming majority of the individuals I see are dealing not only with the stigma associated with a mental illness, but also with the additional brand or mark of being a 'criminal.' Equally concerning to me is the overrepresentation of persons of color and other underrepresented groups with psychiatric disorders, whose entanglement in the criminal justice system is prolonged."

We reconnected in 2008, when she decided to return to Maryland, to practice at the state psychiatric facilities. Most of her time has been spent at Springfield Hospital Center. She has held various roles such as an Attending Psychiatrist, a Forensic Evaluator, a supervisor to PGY-IVs completing their forensic rotation, and. for much of her time, as the Director of Forensic Services.

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She has also been active in the MPS's Community Psychiatry and Diversity Coalition Committee for the last 10 years and the Ethics Committee for the last five. While a member of the CPD Committee, Dr. Hightower helped coordinate a presentation of the Sequential Intercept Model (SIM) for MPS members. "I truly enjoyed this experience as it was an opportunity to share how we could use this framework to address disparities in access to healthcare that result in arrests and incarceration. The more we can get stakeholders involved and increase awareness of SIM, the more likely we are to address some of the key social determinants of mental health."

She recalls that her desires to increase her involvement in the MPS, and also to draw upon her health policy education gained from her Master of Public Health degree, were sparked by a suggestion from a fellow advocate. In 2021, Dr. Ann Hackman told her to consider running for the MPS Council and she took on an additional challenge by joining the Executive Committee in 2024.

She also recalls that since she began working with the state hospitals, she has been very fortunate to have Gayle Jordan-Randolph, MD as a kind of unofficial mentor. "Gayle (fondly referred to as JR) has offered valuable life and career advice, which has directedly contributed to my growth, my empowerment, and now my involvement in the MPS."

This year we will have the pleasure of having Dr. Hightower serve as our President.

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.

MPS Annual Dinner 2026

by: Bruce Hershfield, M.D.

Bruce Hershfield, M.D.

On April 30th the MPS held its Annual Dinner at the Mt Washington Tavern in Baltimore, with 94 registrants. Dr. Ronald Means, our outgoing President, began with a summary of the successes of this past year. We are continuing to do well financially and in reaching out to our legislative representatives. We have had a good year in allying ourselves with the Washington Psychiatric Society and our legislative committee has been very active in reviewing and advocating for bills in Annapolis. We need to continue trying to hear all of our members, he emphasized.

The Maryland Foundation for Psychiatry then presented the Anti-Stigma Advocacy Award to Dr. Robin Weiss, who gave a very moving description of her struggle with addiction. (See her article on p.6)

The Lifetime of Service Award was then presented to Dr. Anita Everett, who has held several important positions, including as President of the MPS and then the APA, and as Director of the Substance Abuse and Mental Health Services Administration for the federal government. She is now Director of the State Psychiatric Hospital System. She told us the MPS has been a source of strength and inspiration to her and thanked everyone for their support.

Drs. Ann Hackman and Theodora Balis then presented the Ikwunga Wonodi Social Justice and Health Equity Award to Dr. Deborah Rose. (Please see the article about her on p.5)

Dr. Means recognized the Council Members and Committee Chairs and new Fellows, then handed the gavel to our new President, Dr. Tyler Hightower. She urged us to stop the spread of "scope of practice"—including attempts to give prescribing privileges to psychologists—and to get better gun control, then she addressed the increased demands on young psychiatrists, who are being asked to treat patients who suffer from more and more complex problems. In the future, she said, we have to look to the challenges that will be coming from Artificial Intelligence. She also emphasized that without good outpatient services, providing inpatient beds accomplishes very little.

We are fortunate to have leaders like we do.

Southern Psychiatric Association Resident/Fellow Research Award

The Southern Psychiatric Association (SPA) offers an annual award for an original manuscript concerning basic or clinical research on a topic pertinent to psychiatry.

ELIGIBILTY

- Psychiatric Residents or Fellows that are currently in training at an approved and accredited graduated medical education program at the time of the Annual Meeting.
- The applicant must attend and present their research at the September 2026 Annual Meeting in Baltimore in order to receive the award.
- All submissions must be original and not previously published.
- One manuscript per applicant.
- PowerPoint not accepted.
- Literature reviews are excluded from acceptable manuscripts.

AWARD WINNER RECEIVES

- Travel expenses up to $1,000 to SPA's Annual Meeting, September 16 – 19 in Baltimore, MD.
- Presentation of research at the Annual Meeting
- $500 honorarium for presenting.
- Meeting Registration Fee Waived
- Recognition of the winner's training program

DEADLINE

- June 15, 2026
- Applicants are encouraged to submit manuscripts as early as possible for consideration.

WHAT TO SUBMIT

Email Submissions to: Janet Bryan at janet.bryan@sheppardpratt.org.
All submissions will receive an email confirmation of receipt, and must include:

- Cover sheet with contact information of applicant (name, residency program, email, phone, mailing address) and all other authors
- Abstract: 2-page limit
- Completed manuscript:
  - — Typed, 12pt font, double spaced, 15-page limit
  - — Enough information for a 30-minute presentation, if selected as winner
  - — Formatted as follows: Introduction, Purpose, Methods, Results, Discussion/ Conclusion, and at least 3 references

Strong consideration will be given to the timeliness of the topic, applicability to a general psychiatric audience, and originality of the paper.

A Conversation with Anita Everett, M.D.

By Rachna Raisinghani, M.D.

Rachna Raisinghani, M.D.

I had the opportunity to talk with Anita Everett, MD, Former President of the APA and this year's recipient of the MPS Lifetime Achievement Award. Dr. Everett reflected on her career, her enduring commitment to public psychiatry, and the lessons she has learned as a clinician, advocate, and leader.

"This award feels like an acknowledgment of the patients we serve-- individuals with serious mental illness whose needs are often overlooked."

She described the lifetime achievement award not as a personal accolade, but as a recognition of the broader field of public and community psychiatry. Her early career in a rural community mental health center in Virginia's Shenandoah Valley grounded her in the realities of community-based care and the importance of tailoring services to local needs.

"You really get to know the population - you're not practicing in the abstract. That shapes how you think about Psychiatry."

A formative childhood illness-- spinal meningitis at age 12 -- sparked her interest in Medicine. By observing care in a teaching hospital she got an early glimpse into the collaborative nature of medical practice. Throughout her career, she has advocated for improved access to care, including efforts to expand access to medications like clozapine. This work broadened her understanding that decisions about medications are not just clinical, but are influenced by policy and systems and advocacy.

During her presidency of the APA, which coincided with a particularly challenging period, she focused on addressing physician burnout -- when the topic was not widely discussed. She also developed key leadership skills in communication, consensus-building, and organizational governance. She navigated complex ethical challenges, including debates around the Goldwater Rule, emphasizing the importance of maintaining the profession's integrity and public trust.

"Leadership often means guiding difficult conversations while staying grounded in what serves patients and the integrity of the field."

Reflecting on changes in Psychiatry, she noted both progress and areas of concern. While stigma has decreased and tools have improved, she worries about a diminished emphasis on psychiatrists' roles in team leadership and systems-based care. Her international work in Iraq and Afghanistan further highlighted the importance of adaptable, culturally sensitive approaches, including rebuilding training systems and integrating Psychiatry into primary care.

She credits her resilience to a commitment to doing what is right for patients and strong family support. She encourages early-career psychiatrists to seek mentorship, develop leadership skills, and remain open to choosing among many different paths. She also emphasized the importance of authenticity in leadership, noting that open, candid dialogue is essential for meaningful collaboration.

Anita Everett, M.D. receiving the 2026 Lifetime of Service Award at the MPS Annual Meeting

Dr. Deborah Rose Wins Wonodi Award

By Ann L. Hackman, M.D.

Deborah Rose, M.D. 2026 Ikwunga Wonodi Award Winner

The winner of this year's Ikwunga Wonodi Social Justice and Health Equity in Psychiatry Award is Dr. Deborah Rose

Currently a Neuropsychiatry fellow at Johns Hopkins, she completed her undergraduate work at Cornell, her MD at Loyola University Chicago and her residency at Duke. Her clinical and research work is focused on advancing equity in psychiatric care for individuals with serious mental illness, especially those from historically marginalized and underserved communities. She is especially passionate about reducing structural barriers to care by incorporating social risk screening into psychiatric visits, fostering clearer prognostic conversations in dementia-related psychiatric illness, and helping families plan for safety, behavioral symptoms, and care needs. Clinically, she cares for populations with high rates of serious mental illness—particularly, patients with post-traumatic brain injury symptoms, dementia with behavioral disturbance, major depression, psychosis, and complex comorbid medical illness. She frequently encounters patients whose psychiatric outcomes are impacted as much by social challenges (e.g., housing instability, food insecurity, transportation barriers, financial strain) as by diagnosis. She believes that it is important to assess these social circumstances as core components of psychiatric care rather than background context, and works to incorporate social context into the assessment and treatment.

Dr. Rose was selected for the Physicians Foundation fellowship, a national leadership program for physicians who are passionate about addressing social drivers of health in clinical practice. During this program and the first year of her Neuropsychiatry fellowship she designed a project to identify social drivers of health during psychiatric clinical visits and to respond to those needs in real time. This consisted of a screening tool that asks patients about basic social needs (e.g., food security, housing instability), and is paired with locally relevant resources during the same visit (e.g., local shelters, food pantries). She aims to make identification of unmet social needs routine, and to reduce reliance on patients navigating fragmented systems on their own.
She is also actively engaged in community-based advocacy through the Alzheimer's Association in Baltimore. She collaborates with community members, care partners, and local organizations to provide education, reduce stigma, and improve access to dementia-related psychiatric care, including in neighborhoods that have been historically excluded from specialty services. Her work there has reinforced the importance of trust, cultural humility, and sustained presence in these communities.

She aspires to develop a novel screening tool to assess childhood trauma-informed psychosocial dementia risk, namely depressive symptoms, loneliness, negative affect, and low sense of purpose. Early life adversity is rarely assessed or incorporated into psychiatric prognostication related to dementia. This work is central to her long-term goal of improving how risk is identified, communicated, and acted upon for historically underserved populations.

Dr. Rose's values and work deeply resonate with Dr Wonodi's legacy of compassion, advocacy, and commitment to uplifting others. Her dedication to advancing equity in psychiatric care makes her a worthy recipient of the Ikwunga Wonodi Social Justice and Health Equity in Psychiatry Award.

I'm Grateful to Receive the Maryland Foundation for Psychiatry's Anti-Stigma Award

Here's My Story

They Tried To Make Me Go To Rehab but I Said No, No, No—Amy Winehouse

By: Robin Weiss, M.D.

Robin Weiss, M.D.

When Elias Shaya called me in February, I was laboring at my computer, trying to write a chapter of a book I've been working on for years, about my addiction. I saw his name pop up on my phone, and I answered right away; it's always a pleasure to talk to Elias. But then I thought, *uh oh*, have I forgotten to make my contribution to the foundation this year? He must be calling to hit me up for money. We chatted pleasantly for a few minutes, with no mention of money, and then he told me that the foundation had decided to present me with the Anti-Stigma Award for 2026.

I was flabbergasted. I said, "That's lovely Elias, but why?" I even had the fleeting, paranoid thought, can they be hacking into my computer and reading my book? Then he told me that members of the foundation board had attended a MedChi conference where I had spoken on a panel about my long-ago experience with the Physicians' Health Program.

I've never kept it a secret that I became addicted to Demerol (meperidine) in my thirties. I've spoken openly about it to my family and friends. When Ernestine Cosby retired as Vice President for Nursing at Sheppard Pratt several years ago, I took the open mic and thanked her for saving my life when she was the head nurse on unit B2 in 1985. She, along with the other staff, and of course my fellow patients, were instrumental in my recovery.

When I was nineteen, a freshman in college, I was in a devastating car accident: broken bones in both legs, smashed ankle, broken ribs and clavicle, cuts all over my body, and head trauma. Over many months and throughout multiple surgeries, I was treated for pain with Demerol. It not only diminished my pain, but it also allayed my fear and lifted my depression. I believe its effects were imprinted on my biologically susceptible brain. I've learned over the years that some people—like my husband—hate opioids. Those people don't respond well to narcotics for pain, and all they remember are the side effects: the nausea and the constipation. For others, like me, Demerol both reduced the pain and induced a welcome euphoria. I was treated with the drug intravenously, never tapered, and discharged from the hospital, over and over again.

One important theme of my story is that I was something of a goody-goody. I didn't drink in high school. I didn't do drugs. I was a good student, and when I recovered from the car accident I went on to a Phi Beta Kappa college career, to medical school (AOA), to an enduring marriage to Tim, a wonderful man—a man who was forced to resuscitate me twice, all by himself, after I accidently overdosed in a row house in Baltimore—and to become the person many of you know today, a former president of our organization. But for sixteen years, between the ages of nineteen and thirty-five, another story was slowly unfolding behind the scenes, a story that is all too common. For example, suicide remains the most common cause of death in residents and fellows. And women physicians have a higher suicide rate than women in the general population. In my mind the murderer is shame: shame that we can't keep working through depression, through fatigue, through a feeling of brokenness. Efforts have been made to rectify this, for example, through the work of The Lorna Breen Heroes Foundation, but the situation remains dire.

I want to emphasize, by telling my story, that if it can happen to me, it can happen to anyone.

I've suffered from severe migraines since I was twelve years old. When I was a pediatric resident living in New York with Tim in the 70's, an aunt of mine who also was a migraineur told me that her doctor would come to her home and administer intramuscular Demerol to treat her migraines. When I heard that, my dormant dopamine receptors must have stood up and cheered. Believe it or not, in that era, it was easy to prescribe controlled substances for your family members, so I was able to start using it for my migraines.

Then, after our pediatric residencies, we spent two years on the island of St. Vincent, a developing nation in the West Indies, running the pediatric ward. In most ways, taking charge of a unit, working with Vincentian nurses, and doctoring malnourished children back to health was a fantastic experience. However, one afternoon, I was raped in our home.

The rape reactivated the simmering PTSD that had never left me after my car accident. Between migraines, PTSD symptoms, and a miserably depressed mood, I found reasons enough to use Demerol, which was readily available from the pharmacy across the street from the St. Vincent hospital. But I didn't use it regularly, and I was able to stop as soon as I became pregnant with my first child, Gabriel.

(Continued on next page)

MFP Anti-Stigma Award Winner

Continued

We moved back to New York from St. Vincent in 1983 to give birth to Gabe. Six weeks later, another move took us to Baltimore where we both started Robert Wood Johnson fellowships at Johns Hopkins. That was the start of my downfall. Looking back, it's easy to see how adrift and alone we were. Tim's mother—his remaining living parent— died soon after Gabe was born; my parents lived in another city and rarely visited; we had no social circle and just one close new friend, Archie Golden, a pediatrician and mentor at Francis Scott Key Hospital.

Although we were both doctors, we failed to see that I was suffering from postpartum depression. I desperately wanted to stay home with my new baby. I was breastfeeding and felt very close to him: it was a love affair! I had no idea that motherhood would be so wonderful. And yet, I didn't believe that quitting the fellowship was an option.

I hated my fellowship's clinical placement. The director was paternalistic and condescending, and I dreaded being around him and his acolytes. The academic portion of the fellowship was a different story: it took place at the Hopkins School of Public Health, and I clicked with the folks there. Despite that, my mood continued to plummet, and I persisted in using Demerol in secret: I was a solitary user. Tim started to go to Nar-Anon meetings while I went to Narcotics Anonymous meetings. I saw a psychiatrist trained in addiction. I tried to stop using; I did not want to die.

Eventually, as the Amy Winehouse Song says:
They Tried to Make Me Go to Rehab and I Said No, No, No

I was angry, I was resentful, I was ashamed, I was afraid.

However, I acquiesced— under protest. I didn't want to leave my child, but I knew it had to be. First, I was admitted to a rehab called The Meadows for thirty days, over Christmas and New Years during the final year of the fellowship. In some ways, I rediscovered my true self there: I laughed as I hadn't for years. I did well, and in July of 1985, I started a new job at the Institute of Medicine, National Academy of Sciences in Washington D.C., with two superb bosses. Unfortunately, my recovery faltered, and I relapsed.

I was taken to Sheppard Pratt for sixty days of inpatient treatment, again, unwillingly. I wish that everyone could have the privilege to benefit from that level of intensive inpatient care. I emerged from those two months, finally, in recovery, and I continued to go to meetings for years. My psychiatrist helped sustain my recovery for many years after that.

After six years at the Institute of Medicine, where I had been the director of the HIV/AIDS program, I decided to become a psychiatrist myself. When I interviewed at Sheppard Pratt, I asked Don Ross, the director of the residency program, "I was once a patient here, is that a problem?" Don answered, "No, all the better! Glad to have you!" As Steve Sharfstein said to me recently, when we were standing together at the most recent No Kings Day Protest, "That's because we psychiatrists are human beings."

I am proud to be a psychiatrist. And tremendously grateful to receive the Foundation's Anti-Stigma Award for 2026.

Robin Weiss, M.D. receiving the MFP Anti-Stigma Advocacy Award at the MPS Annual Meeting

Cheers from the Chair

by: Jimmy Potash, M.D.
Printed in *Cheers from the Chair March 20, 2026*

Jimmy Potash, MD

(Ed's Note: This is an excerpt from Dr. Potash's message to the department)

In January, Dr. John Campo relinquished his leadership of our Child and Adolescent Psychiatry Division, as a result of serious illness. Recently John penned a moving personal reflection called "Epiphany for a Doubting Physician," about his return to the divine after many years of drifting from the religious landscape of his youth, which had filled him with a deep sense of wonder.

Here's an excerpt: "[A year or so ago] I awakened in the middle of the night…I took a moment in the silence to pray, albeit with little expectation of 'connection'…What surprised me then was an overwhelming sense that I write down a message that felt like it came from outside me in words that did not seem like my own: 'Someday your body will fail you, and all you will have is me. It will be enough.' To be clear, I did not 'hear' a voice, but I felt compelled to pull a piece of paper from my nightstand and write it down…I had just completed an aggressive course of treatment for prostate cancer, so my own physical vulnerability and mortality seemed clear enough to me…The remainder [of the message] was both enigmatic and reassuring.

Several months later, after a long walk on the beach during a family vacation, I experienced symptoms [leading to a diagnosis of] a glioblastoma. While my story isn't complete, it seems likely that the initial words that came to me in the quiet of the night are true enough: someday my body will fail. Indeed, that process has already begun…While there is some mystery in the remaining words of the message and my future, I am confident that I will be covered and upheld by God and the connections and love surrounding me, and that 'it will be enough.'"

We will host a celebration of John's decades of dedication and accomplishment in child psychiatry on Friday April 24, from 12-1:30 on Zoom. We trust it will be enough, to honor this wonderful man.

In Memoriam: Douglas Logue, M.D.

by: Gary A. Klein, M.D.

Douglas Logue, M.D.

Doug Logue passed away on March 14 of complications of ALS at the age of 87.

I was very fortunate to know him during the 6 years I worked with him at the Sinai community mental health clinic. He was a mentor and a friend. He was a gifted psychoanalyst, and I learned a great deal from him. During those years, the Sinai clinic was staffed mostly by psychoanalysts, and Doug enjoyed teaching psychodynamic principles to those who worked there.

Doug had other roles, too. He was an accomplished aviator who owned his own plane, getting his pilot's license at the age of 23. He became a forensic psychiatrist. He loved the water and swam for his Princeton team. He was a brilliant student at Hopkins and became part of the surgical team that developed the blue baby operation.

After leaving Baltimore, he lived in Princeton with his wife, Judy, before eventually moving to Florida. He joined an aviator community and had his own plane by his house. In later years, his passion was flying, and he lived to fly.

When I gaze in the sky, I hope to see Doug in the clouds, flying his beloved plane.

Legislative Update

by: Michael Young, M.D..

Michael Young, M.D.

The MPS Legislative Committee had a very busy start to 2026, reviewing many pieces of legislation in the Maryland General Assembly. It assessed 55 pieces of legislation and actively advocated on 32 of them.

One very positive sign is that our members were frequently called on to participate in discussions with legislators in addition to giving written and oral testimony.

Below are selected highlights:

This session saw a significant boost for the Collaborative Care Model in Maryland with the passage of **SB 428/HB 746**. This prohibits imposing a copayment, coinsurance, or a deductible for services provided in accordance with the Collaborative Care Model in primary care settings, and requires certain insurers, nonprofit health service plans, and HMO's to provide coverage for services provided in accordance with the Collaborative Care Model. It takes effect January 1, 2027.

SB 326/HB377 is a scope of practice bill to include Physician Assistants among practitioners who may take certain actions, including those related to the guardianship of disabled persons and admission of individuals to mental health facilities. MPS advocacy was important for getting the involuntary commitment components amended out of the bill that eventually passed.

HB 1012 relates to local suicide fatality review teams. It's passage authorizes local jurisdictions to establish a suicide fatality review team, similar to child fatality review and overdose fatality review teams--to review suicide deaths, identify systems-level risk factors, coordinate responses, and recommend interventions. It outlines the makeup of a Local Suicide Fatality Review team, establishes data-sharing requirements, outlines operations, and authorizes the Department of Health to adopt certain regulations.

HB 1118 also passed and authorizes insurers, nonprofit health service plans, and health HMO's to provide coverage for screenings for perinatal mental health conditions at specified intervals, including during prenatal visits, within 6 weeks postpartum, and during well-child visits within the first year.

SB 490/HB 808, relating to utilization review for drugs to treat serious mental illness, sought to prohibit Medicaid from applying prior authorization, step therapy, or fail-first protocols to prescription drugs used to treat specified serious mental health conditions. It did not pass; but represents continuing efforts to increase access to care for our most vulnerable patients.

SB 568/HB 1021, which was not passed, would have authorized licensed psychologists to gain prescriptive authority in Maryland. Advocating against this legislation was among our committee's top priorities this session. In the proposed legislation, a psychologist would have to (1) successfully complete an educational program recognized by the State Board of Examiners of Psychologists and a postdoctoral prescribing psychology fellowship; (2) pass a specified examination; and (3) submit a form and evidence of compliance with said requirements.

In 2024, the Assisted Outpatient Treatment (AOT) law addressed the needs of individuals with serious mental illnesses who are unable to seek treatment voluntarily. This law provides for court-ordered, community-based treatment to prevent hospitalization, incarceration, or harm to self or others. Unfortunately, it missed an important component--to prevent individuals from having firearm access while in court- ordered AOT programs. **SB 942/HB 1306** would have required a court to (1) order the respondent to surrender firearms to law enforcement authorities and (2) prohibit them from purchasing or possessing any for the duration of the court-ordered AOT. Unfortunately, it failed due to lack of action by the House Health Committee and the Senate Finance and Judicial Proceedings Committees. This will certainly remain a priority for our committee for the 2027 legislative session.

Significantly, the definition of dangerousness was revised during this session. **SB 707/HB 1014** redefined "danger to the life or safety of the individual or of others" as it relates to the emergency evaluation of an individual with a mental disorder and the involuntary admission of an individual who has one. Under the *Senate* bill, as amended, "danger to the life or safety of the individual or of others" means: "there is, as a result of a mental disorder, a substantial risk, based on conduct that is recent and relevant to the danger that the

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Legislative Update

Continued

individual may present and in consideration of the individual's current condition and, if available, recent personal, medical, and psychiatric history, that the individual will: (1) cause serious bodily harm to the individual or another individual; or (2) be unable, except for reasons of indigence, to provide for the individual's basic needs, including food, clothing, shelter, medical care, self–protection, or safety, to such a degree as to create a substantial risk of serious bodily harm, serious illness, or death in the near future". While the *House* bill failed, the *Senate* Bill passed and goes into effect October 1, 2026. The change in defining dangerousness is likely to play a role in future commitment hearings.

Finally, I want to express gratitude to the members of the MPS legislative committee, as well as other MPS colleagues, for participating in our discussions and advocating for our mission. Together we are doing the hard work to assure that Maryland is a role model for other states to follow regarding access to affordable, quality care.

Call for Volunteers!

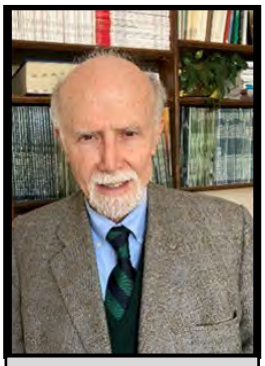
ALL members are invited to step up with MPS and make a difference in how psychiatry is practiced in Maryland

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 Tyler Hightower, M.D., MPH., will appoint FY27 committees this 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**.

External Appeal

By Thomas E. Allen, M.D.



Thomas E. Allen, M.D.

This spring the *AMA Morning Rounds* (a sort of AMA "clipping service" about "news" that may affect physicians and their patients) posted this:

"Many denied health insurance claims are overturned if the case reaches independent review experts"

MedPage Today (4/13, Clark) reports, "Persistence in appealing denied health insurance claims resulted in overturned decisions between 30% and 78% percent of the time, when the case reached independent review organizations (IROs), an analysis of completed external appeals showed." The analysis indicated that "among 51,394 closed cases in New York state from May 31, 2019 to Dec. 10, 2025, almost half (46.7%) of external appeals were overturned at this third level of appeal, which often involves independent physicians and other specialists." The findings were published in a research letter in JAMA Internal Medicine."

I became very aware of the importance of an independent external appeals process when I became President of Med Chi (1997-1998). Med Chi and the MPS worked closely to pass a *Grievance and Appeal* Bill which stipulated that patients who were denied access to health care (including mental health care) by their managed health insurance company, had the right to have that denial reviewed by an outside party, i.e. the office of the Maryland Insurance Commissioner and the denial revoked. Prior to that, there was only the company's own internal appeal process, and denials of care were rarely overturned through the company's internal process. There was an inherent conflict of interest, even if the parties tried to close their eyes to it, because the company saved (made) money by not spending it on health care. An example of such an abuse from that period was brought to the MPS Council while I was still serving on it after my term as MPS President. A well-respected child psychiatrist in the community, working with a suicidal adolescent patient, felt the patient needed to be hospitalized, but the patient was turned down for hospitalization care by the insurer's managed care company. The company at the time (before the *Grievance and Appeal* Bill passed) refused to cover the care. The family (and the psychiatrist), desperate for help for the patient, requested a second opinion and the company's 2nd reviewer reluctantly granted "18 hours" of inpatient care. Both reviewers were company reviewers. Such was the control managed care was allowed before an external appeal process was mandated. When the *Grievance and Appeal* Bill was passed, over the opposition of many managed care companies, the number of overturned denials of care increased.

Managed care learned better what was unacceptable to the public, what the public would not stand for. That was to everyone's benefit, including theirs.

Turning 80 and Still Showing Up

Happy Birthday Dr. Hershfield!

by Dinah Miller, MD

Dinah Miller, MD

"Every old person knows what it is to be young, but no young person can know what it is to be old." -- Eddie Cohen, character on The Pitt.

In Dr. Hershfield's *Letter from the Editor* for this issue of The Maryland Psychiatrist, he announces his upcoming 80th birthday. How can that be? It was just a few years ago that I was a post-call resident in the Hopkins Emergency Room presenting cases to him on morning rounds. And it was not so long ago that we noted his 60th birthday at a dinner in Toronto during the APA's annual meeting. Where did the decades go? Then, as now, Dr. Hershfield was tall and slim with a head full of distinguished white hair. He is the only psychiatrist I have ever watched bottle-feed a newborn calf, because when he isn't working, reading, or traveling, he is also a farmer. He has had opinions and directives that he has always been quick to share, and I have been lucky to have Dr. Hershfield in my life, first as a teacher, then as a colleague and friend. He has provided decades of support, kindness, and wisdom. Happy Birthday, Bruce. You haven't changed a bit, and that's a good thing.

Psychiatry lends itself to long careers with low physical demands and options for working part-time. In fact, one survey revealed that 61% of psychiatrists are 55 or older, compared to 43% of all physicians. It seems that increasing workplace demands are inspiring physicians in many specialties to retire younger, while private practice psychiatrists who don't participate with insurance plans may be shielded from at least some of this stress.

Working serves many purposes for people -- it provides a sense of purpose and identity, adds structure to the day, and provides an income. But it also comes with a sense of obligation and responsibility, often to people who can be very ill, often distressed, and sometimes demanding of our time and emotions. What we don't say is that there is a great privilege to having relationships with our patients that are often intimate, and there is something wonderful about growing old alongside people we have come to know and care for over decades.

I often think that, from a purely logistical standpoint, planning for finances and retirement would be easier if we all started out knowing when we would die. Can you imagine what it would be like to know just how long you have to get in that Alaskan cruise or to see Machu Picchu? To live large and not bother with saving for retirement if you knew you wouldn't live that long? Why delay the purchase of that Maserati? Or perhaps you'd live even more frugally, with the knowledge that you had to provide for 98 years of room, board, and entertainment? Or that your earning years would be cut short, so you'd need to squirrel away college tuition for your children early? Yet it would be like walking around with a guillotine overhead, knowing the moment when the blade would drop, so perhaps it's just as well we live with the uncertainty of how long we will remain here. You don't need to practice psychiatry very long to know that issues of health, aging, and vitality are prime topics for exploration in psychotherapy.

Regardless of how people age, medicine divides us all neatly into categories based on age: pediatrics, people, and geriatrics. Maybe you're a senior at 60 or 62 (it comes with a discount for your cinema ticket), but medicine agrees that at 65, you're geriatric. You now have different medical needs than your younger counterparts, and welcome to Medicare.

Obviously, for those who are lucky enough to make it to their geriatric years, age impacts people differently, influenced by lifestyle, healthcare availability, genetics, and perhaps most of all, luck. Dr. Hershfield is quick to tell us that while he is 80 and still going strong, so is his friend and colleague, Dr. Thomas Allen, who, at 90, continues to see patients five days a week.

I like to hope that for the octogenarians (and older) among us, the issue of retirement and bucket lists is one that has been addressed, and that practicing psychiatry is what they love and want to do most.

You may not know this, but Bruce Hershfield was one of the very first MPS members to win The Lifetime of Service Award 23 years ago in 2003. For years, I have suggested that he received that award at too young an age, and that it's time he won a second lifetime of service award as he continues going strong with his service to our organization! The next time you're at a professional meeting, whether it's for the MPS, the APA this May in San Francisco, or the Southern Psychiatric Association Annual Meeting in Baltimore this September, be sure to say hi to Dr. Hershfield and wish him a happy 80th, because he's sure to be there.

Interview: Thomas E. Allen, M.D.

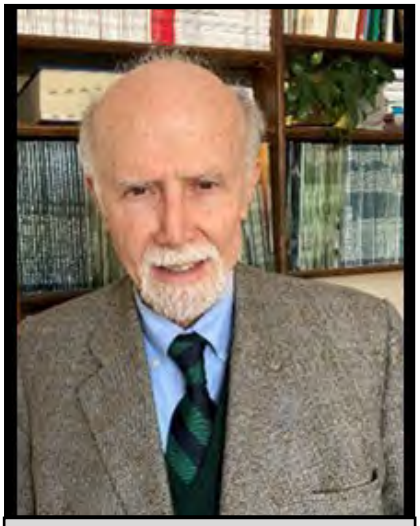
By Bruce Hershfield, M.D.

Q: Congratulations on turning 90 while still practicing. How have you been able to keep so active?"

Dr. A: "It was probably due to the luck of good genes, exercise (walking), and learning in medical school to be careful about diet. I also never smoked and used alcohol moderately."

Q: "Please tell us about your practice."

Dr. A: "I no longer take new patients for psychoanalysis because of my age. I do see chronically ill patients through a federal program. Many have had physical problems or a history of conflicts in the workplace, particularly in social security or the US post office. I also do some work virtually with patients in China, which I have been doing for the last 15 years. The patients there are people who speak English and usually they are in training for a psychodynamic psychotherapy practice. It was only really in the 1990s that China began to look to help some people with psychodynamic issues. Before that, Psychiatry had been mostly hospitalization and medication. They could easily duplicate the medications of the West and manufacture them in China. But after the Cultural Revolution ended and China became more prosperous, they began to accept counseling and even psychodynamic treatment to help people who were otherwise more high functioning but suffering at home, in school, or in workplaces.



Thomas E. Allen, M.D.

Q: "Have there been problems with getting permission to do that?"

Dr. A: "Not in China. I work through psychoanalytic institutes in this country. It was started by a program in the American Psychoanalytic Association created by a member who recently died and others equally farsighted. A number of psychoanalytic institutes in the USA have taken on Chinese patients for full analytic training, and I have provided supervision and have treated patients through those programs."

Q: "How many days per week are you working?"

Dr. A: "I'm working 5 days per week, but that doesn't mean they are full days. There is about a 12-hour time difference between China and the US. I currently have an analytic patient I have seen for a number of years and I see her at 8:30 in the morning, which is 8:30 PM in China. Over the years I have been doing this work I have heard from people who lived through important events in Chinese history (the Cultural Revolution, the death of Mao, COVID, etc.) and have heard about them from the Chinese perspective.

Q: "Tell us about your work in organized Medicine, including Psychiatry."

Dr. A: "At this point, my only continuing activities include participation in the Med Chi Legislative committee. I retired from my position as Secretary of the Maryland Foundation for Psychiatry in 06/2025 and from the Med Chi Foundation in 12/2024 where I had been Chair of the Oversight Committee for the Physicians Health Programs. I served in these roles for many years after serving in MPS and Med Chi leadership. I feel some committed younger people should be taking them over."

Q: "You were president of Med-Chi and the MPS and were in the APA Assembly for 9 years."

Dr. A: "I served as President of Med Chi (1997-98) and the MPS (1989-1990) and was also President of the Baltimore-Washington Analytic Society 1993-94) and The Baltimore County Medical Association (1985-86). I also served as APA Assembly Rep 1992-2001) and AMA Delegate (1997-2015). I don't know if I was blessed or cursed with living in 'interesting times'". As President of the BCMA in 1985, I was faced with an increasing "malpractice crisis" where physicians were being faced with significant increases in malpractice premiums. It became clear that Maryland would have to cap malpractice claims or there would no physicians left working in high-risk specialties such as OB or Neurosurgery, but it was also a significant threat to psychiatry. As President of one of the four largest Med Chi components, I was part of the effort (led by Med Chi) to bring that legislation about. When I became President of the MPS in 1989, psychiatry was, without warning, assaulted by managed care and we had to find ways to deal with some of the abuses being faced by patients. Later, when I was Med Chi President, we were able to change the managed care "appeal process". Before it was changed, if a managed care program denied care and the patient appealed, it went to an in-house review and the in-house review usually sustained the company's decision. There could be a higher-level review but it also was in-house and, not surprisingly, usually sustained the lower reviewer's decision. Med Chi spear-headed legislation that required the higher-level appeal to go to the State Insurance Commissioner for decision and that

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Interview: Thomas E. Allen, M.D.

Continued

resulted in many more denials being overturned. In the APA, the MPS Reps brought many issues on managed care to the Assembly for consideration as well as issues on confidentiality, etc. In the AMA I worked with Med Chi and the MPS (2010) to develop ethical principles for the development of *medical practice guidelines* to ensure scientific and professional credibility; including rules to govern financial relationships between guideline members and industry. Also, I worked (2006) with the APA and Med Chi requesting (the AMA Council on Science and Public Health to study the possibility of video games becoming addictive that has led to incorporation in ICD-10 of a possible *Internet Gaming Disorder*. Also, I have been involved on many issues to support patient confidentiality and to provide help for impaired physician while in the AMA House of Delegates.

Q: "How did you get so involved with all that?"

Dr. A: "I went to medical school at Columbia and one of my colleagues there, Dr. Bill Reichel, came to Maryland and he got me involved with the general medical community. He was Chair of the Department of Family Medicine at Franklin Square Hospital and was beloved as a teacher and as author of a textbook on Geriatric Medicine, a standard in the field. He is much better known than I am. I have enjoyed my participation with colleagues in psychiatry and in other specialties as well.."

Q: "How did you get involved in Psychiatry and how did you come to Maryland?"

Dr. A: "I had gotten a 3-year deferment through the USPHS from military service to complete a psychiatric residency at Columbia in NYC. The USPHS was considered a uniformed service and satisfied the selective service requirements at the time. At the end of my residency, I had to serve on active duty for 2 years with the USPHS (all physicians needed to serve in a Uniformed Service until the draft was ended). I wanted to go into an NIMH branch of course, but got assigned to the Bureau of Prisons. At that point I was married and had a wife and infant daughter so I wanted to go with my wife and to look at what might be the best location for a family. We planned a trip in the spring of my second year of residency to several sites, one in DC and another in VA. A colleague at Columbia at the time was doing a follow up study on treatment failures, one of whom had ended up at Sheppard Pratt and he asked me if I could stop in Baltimore and interview her about her experience at Columbia. I agreed. My wife and I arrived in Baltimore at the peak of the azalea season, and I had never seen anything so beautiful. So, when I finished my training, I wanted to come to Sheppard Pratt as junior staff and live in this beautiful city.

I stayed at Sheppard for about 4 years and worked with both adults and children. I became interested in analytic training and got involved with the Analytic Institute and left Sheppard because it was impossible to do everything."

Q: "What else do you do?"

Dr. A: "I have also written some clinical papers. At first, I considered publishing some cases and did follow-up's and shared papers with the patients involved and got their approval to publish them. But then I decided not to publish the papers because no matter how carefully you try to conceal the patient's identity, in the age of the internet it is not possible to completely prevent discovery unless you do so in a way that takes away from the substance of the report. So, I decided instead to write about great authors whose writings are in the public domain and where there is already a lot of publicly available biographical information that can be used to freely examine motives and conflict. So, I have published papers on Melville and Salinger and have an unpublished paper on Kafka.

Q: "What has been the best part of your life?"

Dr. A: "I've loved seeing my children grow up and my grandchildren come along."

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

Dr. A: "I intend to continue with my limited practice. I like seeing people. "

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Interview with Mark Komrad

Assisted Suicide Cannot Be an Option, Expert Says

By Charles Collins

Ed's Note: This is an excerpt of an interview Mark Komrad, MD had with Charles Collins of Crux magazine on March 12, 2026. It is reprinted with all due approval; you can read the entire interview here).

***Crux Now*: Why is the current debate on assisted suicide so important to the psychiatric field? How is psychiatry different than what people think of as "therapy?"**

Komrad: The state of the art in psychiatry uses a large toolbox of interventions to help people who have distress and problems functioning in the domain of mental life, meaning thoughts, feelings, and behaviors.

Inside that box are a variety of tools including medications, various methods of helping people change using "talk therapies," and the emerging use of neuromodulation technologies, such as magnetic and electric stimulation of the brain and central nervous system. A psychiatrist who has completed 4 years of medical school after college and at least 4 years of residency uses all those tools. Many go on to a 1–2-year fellowship in a subspecialty like child psychiatry, geriatric psychiatry, addiction medicine, et cetera.

Mark Komrad, M.D.

RELATED: Ethicist says psychiatrists should prevent suicide, not prescribe it

One of the most serious symptoms psychiatrists encounter is suicidal thinking and behavior. This arises in a number of psychiatric conditions and is not diagnostic of any one; just like fever is not a diagnosis of any somatic condition.

Psychiatrists encounter this potentially life-threatening symptom in outpatient offices, emergency rooms, hospitals, group homes, nursing facilities—anywhere a psychiatrist's help is sought. Of all physicians, we have particular expertise in dealing with suicidality—independent of what is the underlying diagnosis. Indeed, we have the capacity to help people see beyond the choice of death and find a better path to the future, even if they have no clear "psychiatric diagnosis" at all. We specialize in ministering to helplessness, hopelessness, and demoralization, whatever the reason. This is our core skill set, the "bread and butter" of what psychiatrists encounter and work to ameliorate.

The emerging practices of legal "assisted suicide" (prescribing an oral medication to produce death) and "euthanasia" (starting an IV to push a lethal medication) unfortunately establish two categories of suicide — the suicides that should be *prevented* (as is the status quo of psychiatric practice), and the suicides that should be *provided* — by doctors. Not only is there no clear way to distinguish for which patients should be prevented, and which provided, suicide, it inverts a fundamental ethos of psychiatry — especially when these procedures are made available to people with mental illness.

Besides colluding with patients' hopelessness, demoralization, and death wishes, medicalizing the provision of suicide puts psychiatrists in a paradoxical, indeed a subversive and rogue position of enabling suicide.

To consider suicide a potential treatment option is anathema to psychiatry. Besides creating an impossible position for psychiatrists to parse these two kinds of suicide for an individual patient, it interferes with psychiatry's public health agenda to reduce suicide rates in the population. It makes a form of suicide desirable, acceptable, even honorable, as a means of relieving others of a sick patient's burden (a very common motivation for the suicidal thinking we see in psychiatry).

We actually see emerging data now that natural suicide rates have accelerated in jurisdictions that have legalized these procedures, suggesting that "suicide contagion" (a known phenomenon) may be occurring, likely thanks to reducing the suicide taboo.

What does "futility" mean in the medical field – especially in hospitals?

The word "futility" has not been a standard terminology in *any* field of clinical medicine until the advent of legalized physician administered death.

It is a term of art that emerged as a key designed to open the legal and clinical gates to these procedures in jurisdictions like the Benelux countries, or Canada, that moved beyond "terminal illness" as an eligibility criteria, to include the chronically ill and disabled.

If you look up "futility" in Webster's, it is defined as "uselessness," which is certainly an emotionally loaded definition.

RELATED: Assisted suicide increases rates of non-medical suicide, statistics show

What can look "futile" to one clinician can look different to another, particularly a dedicated specialist in a particular condition.

However, not everyone has access to state-of-the-art

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Interview with Mark Komrad, M.D.

Continued

specialists who might have additional approaches that local clinicians may either not have available, or sometimes even know about. Or they can't afford a more effective treatment. In Ontario, for example, the wait for one of their few eating disorders subspecialty programs is over 400 days! In my own practice, high-end psychiatric residential treatment has completely turned around many "futile"-looking cases.

How does "futility" work in the psychiatric field?

It doesn't.

Psychiatric conditions are among the most *human* forms of suffering, as they afflict higher consciousness. They can be some of the most difficult to bear, both for patients and for their treating clinicians. Absorbing a patient's hopelessness, struggling to bear the burden of a challenging patient, and wrestling with one's own values about what is a life worth living, are vulnerabilities for all specialists, but especially in the intensity of long term encounters with psychiatric conditions. Professional terms of art for these challenges are "counter-transference" and "projective identification."

So, the lure of concluding that a patient's condition is "futile" can be a path to relief *for the doctor* in euthanasia jurisdictions, meaning there is a highly subjective component to this. Christopher de Bellaigue wrote of allowing one or two consulting doctors to open the gate of euthanasia for a patient: "As the most solemn and consequential intervention a physician can be asked to make . . . the decision to kill is oddly contingent on a single, mercurial human conscience."

You have said that futility is very proximate to the notion of "terminality." Can you tell me what this means in layperson's terms and how this affects your field?

An ambiguity of "futility" in this context is that it's often unclear whether it refers to the "uselessness" of *all possible treatments* for a condition (FDA approved, evidence based, anecdotally effective) or only the treatments that a patient will *accept*.

Very few statutes permitting medical administered death require patients to undergo any and all eligible, appropriate treatments for their condition. By refusing a treatment, a patient can *produce* a terminal situation by choice, in a condition that is not theoretically terminal.

In the U.S., we have physician assisted suicide in 12 states and DC (oral lethal pills, at the time of one's own choosing), not euthanasia (IV, scheduled, with the doctor at the bedside).

Also, the criterion for eligibility is having a "terminal" condition, a predicted 6 months life span — (whether with or without treatment is usually not statutorily specified). So, in the U.S., to enter the gate of assisted suicide, one must be "terminally" ill. What about psychiatric conditions? We have NO established notion of a terminally ill psychiatric patient, since nobody can come close to predicting that any one patient is nearly certain to die within 6 months from their psychiatric illness.

So, "futile" if it's Canada, but in the U.S. that notion has to be rhetorically wrestled into "terminal" to open the assisted suicide option. That is how these notions are proximate.

Why do you think the push for assisted suicide is growing in many countries, and how does this affect the medical field?

There are multiple forces at play. In psychiatry we say that the causes are "overdetermined." There is the "old world" ethos, which thrived in Judeo-Christian-Islamic soil, in which "sanctity of life" was a key moral fulcrum.

Then there is the "new world" ethos emerging from the Enlightenment and subsequent values that have ascended to high primacy in the post-modern world, such as fairness, autonomy, and justice. So, the old-world matrix is increasingly effete. In some countries, such as Canada and Belgium, the cultural urge to differentiate themselves from their heavy Catholic moral parentage is a real force. In Belgium, churches have very few attendees for services, and many have been turned into architectural and historical museums. Similarly in Canada. Self-determination, individualism, and entitlement are important dominant themes.

Also, life extension due to medical advances and lifestyle improvements doesn't always mean more quality of life. The drive for euthanasia and assisted suicide is a counterpoint to the impetus to "pull out all the stops" medically, often excessively deployed beyond measure. Effective palliative care, if available, is of course the appropriate response to that—getting out of the way of death, with comfort care and accompaniment—not medically killing the sufferer, nor aiding and abetting their suicide.

What can ordinary people opposed to assisted suicide do to help stop this from growing?

I am a founder of the international organization Doctors Say No, in which doctors from all over the world have signed a manifesto stating that these are not "medical procedures." They should not be dressed in the white coat. These worldwide physicians advocate for more robustly available training and utilization of state-of-the-art palliative care for those who suffer chronically or terminally, rather than making the sufferer dead. Many leading professional medical organizations agree, notably the American Medical Association, and the World Medical Association.

Many are explicitly opposed to euthanasia for those with

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Interview with Mark Komrad, M.D.
Continued

mental disorders, such as the American Psychiatric Association and the International Association for Suicide Prevention.

But doctors alone can't check the metastasizing spread of this meme. All citizens who can influence the crafting of laws must participate. It is the effect of ordinary individuals' anecdotes to legislators, telling of their or their loved-ones' sufferings, which helped pass these laws in the first place. Legislators need to hear other kinds of stories — wrong diagnoses, prognostic errors, unavailable treatments due to finances, manpower, or insurance refusal.

There is a growing coalition of organizations dedicated to preventing legalization of these procedures, or rolling them back. Anyone can donate to them, participate, or attend their numerous online seminars, which provide education and inspire advocacy.

Examples are:

- The Euthansia Prevention Coalition and Collectif Des Medicins Contre L'Euthanasie in Canada in Canada
- Patients Rights Action Fund and Aging with Dignity in the U.S.
- Caring Not Killing and Our Duty of Care the UK
- The Society of Supportive and Palliative Care in France

Many of my own presentations to these organizations are available at their websites. Don't think that, once passed, these laws are a done deal. Slovakia is a recent example of where a general referendum was able to retract a previously passed euthanasia law.

The forces promoting euthanasia and assisted suicide are coherent, strong, well organized, and well-funded. But, like David against Goliath, strategy, determination, and hope can redress an imbalance of strength against values.

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How I Became a Writer

By Dina Sokal, M.D.

Dina Sokal, M.D.

Dr. Dina Sokal, a child, adolescent, and adult psychiatrist, received her M.A. in Creative Writing and Publishing from the University of Baltimore and self-published her first book of short stories, After the Rain, *for her thesis. Since then, she's published two stories based on the characters in* After the Rain*: "A Symphony of Sorts" and "Henry's Dilemma." A third story, "The Hug," was published on April 5. Her stories derive from years of experience working as a psychiatrist with people of all ages and promote themes of hope and renewal.*

I've always loved to read and write. In second grade, I wrote fairy tales and won a contest for reading the most books. Whenever I visited the library, my favorite librarian, Miss Coughlin, found 10 books for me to read. I'd carry the stack home and sit in the middle of the living room surrounded by the chaos of four brothers and read despite the noise. At night, I'd sit in the hallway and read until my parents yelled at me to turn off the light. I read all the fairy tale books, the red book, the blue book, the chartreuse book (just kidding) and then read Nancy Drew, *The Little Women*, *The Little Men*, and then, as I matured, I read the classics, including *D.H. Lawrence's Lady Chatterley's Lover*--the romantic scenes head spinning for me when I was in high school. Reading books inspired me to want to be a writer. My other dream was to be a waitress. When I was fired twice as a waitress, I decided it wasn't for me.

In college, I majored in English and took the courses I needed for medical school, a profession suggested by my father, whose mother had trained as a dentist in Austria. After escaping the Nazis, she came to America and became a psychiatrist. She trained at Crownsville, where she was the only woman doctor, and then in New Jersey. In the meantime, my father read all of Freud's books and talked about the Oedipal complex at the dinner table. Despite how awkward these conversations were, he did inspire me to choose psychiatry like my grandmother and two of my brothers; it became the family profession.

I had put aside my dream to be a writer to go to medical school, a more practical choice. But in choosing psychiatry, I found the profession closest to storytelling--the one training me to be a good listener and challenging me to find hope for myself and others despite life's challenges.

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How I Became a Writer

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I eventually took courses on-line in creative writing, first at the Community College of Baltimore County and later at the University of Baltimore for an MFA in Creative Writing and Publishing. I took one course in creative writing at Goucher, where the teacher asked us to write stories. However, she did not teach us how to use point of view, setting, character development, or plot to enrich them. Only after completing my MFA in May 2023 and writing a book of short stories, did I begin to know how to write fiction. I loved the program. It started with a course in creativity where we used a variety of prompts and exercises to access our imagination. In that course, I started to watercolor and I used my paintings in my thesis book, *After the Rain*.

We took courses in literary, experimental, and fabulist (magical realism) writing, wrote stories and workshopped them with our teachers and fellow writers. I tried memoir, but preferred fiction. I learned how to survive feedback and not take it personally and how to use what seemed helpful. I hated revising my stories at first. I wanted them to be finished after writing them, but learned how revision is key to improving a story. So, I learned to revise and am still learning. I have stories I've revised over 14 times.

The funny thing is, my fellow students often said I analyzed too much, or my stories were too psychological, so I had to unlearn some of my ways of doing things as a psychiatrist. In writing psychiatric evaluations or essays, I was trained to make sure the reader would understand what I wrote. In fiction, the writer expects the reader to get the gist without explaining too much. I'm still working on being more subtle, but I do continue to focus on deeper characters and psychological issues, no surprise, considering my profession and my father's obsession with Freud.

Since graduation, I've forced myself to continue to write and revise and have had three stories published online. I've taken courses at an organization in NYC called One Story. These included "Revise" with Hannah Tinti and "Hit, Submit" with Lena Valencia. I've met people through these courses and joined two writing groups. Now that I'm semi-retired, I'm devoting more time to writing and, when I'm on a roll, I enjoy being in the heads of the characters I've created and writing their stories. I've written 10 more stories using the same characters as the ones in *After the Rain* and I'm trying to write a novel--which is like riding a roller coaster, an up and down experience, my first roller coaster ride as a child having put me in tears.

Initially, my goal for writing was to write and enjoy it. I didn't care if I published. But after the excitement of seeing my thesis book in the mail and sharing it with others, I changed my mind. I wanted to share my stories and get them published. And I had to decide that making money through writing was not my goal. Lucky for me, I have had my career in psychiatry for that purpose and can now spend time on writing. However, I am spending money on submission fees, courses, conferences, and--if you get help with publicity--fees for your publicists. At least, I can write off my losses when I do my taxes.

So, writing is not for the faint-hearted. It takes motivation and the will to keep writing even if you're not inspired all the time. I let my subconscious take over for my first draft and don't know where I'm headed until I get there. Sometimes, I pause when I have no idea of where the plot is going and take a break. One time, I was getting an MRI, and in a meditative state, I came up with a plot twist. I think I'm a combination of a "pantser"--someone who writes by the seat of their pants--and a "plotter" someone who plots out their story. The combination is called a "plantser".

I'm pleased I took the time towards the end of my career to pursue my dream and highly recommend others do the same.

Dream Team Discussion on January 28th

By John Buckley, M.D.

John Buckley, M.D.

In the week before the Winter Olympics, the MPS assembled its own Dream Team. It met January 28 (7-9 pm) before an attentive audience to discuss the current state of Psychiatry in Maryland.

Here were: Drs. Rishi Gautam (Lifebridge Health), Jimmy Potash (Hopkins), Jill RachBeisel (Maryland), Elias Shaya (MedStar), and Harsh Trivedi (Sheppard Pratt). The plan was for them to discuss in-person a few topics proposed by MPS President Dr. Ronald Means, then field questions from the audience at Sheppard's conference center. Icy weather caused a late switch to Zoom. It took a while to get going, but eventually the panelists weighed in on topics of much interest to all.

Regulatory changes.
Multiple rules from government agencies have resulted in frozen grants, reduced health insurance, funding limits for clinical care, and halting of ongoing research projects. All panelists agreed that the level

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Dream Team Discussion

Cont.

of uncertainty made it difficult to plan for the allocation of resources. Aside from the chaos in D.C., Maryland state agencies need to coordinate existing programs better.

Telehealth.
Benefits and drawbacks continue to cause debate among clinicians, patients, institutions, and third- party purse holders. While in-person contact may have the advantage of human connection/interaction, electronic visits have improved outpatient attendance rates. Electronic appointments may offer glimpses of home environment and family interaction. There was no consensus, but it was noted that the conference attendance gathered 20 more attendees after it was announced that it would be held by Zoom instead of in-person.

Scope of practice.
Who should prescribe? Common sense has dictated that those with the most education, experience, and history of supervision are best-qualified to prescribe. Some groups with a few credentials and little else are now seeking the authorization to prescribe. The panelists supported the MPS attempt to caution legislative advancement of less qualified prescribers. It was noted that outcome studies are missing. It was also noted that some nurses and pharmacists with years of experience, but few credentials, may not be seeking prescribing rights. Yet they can give valuable advice to prescribers.

The panelists were well- informed, and well-spoken, and provided lots of food for thought. All the panelists were given time to present their sponsoring institution's current programs--including research, special treatments, care of special populations, and plans for the future. The financial climate in Maryland was mentioned. Low reimbursement rates and high costs of living have affected job satisfaction, physician wellness, and recruitment of residents.

The MPS managed to provide MPS membership with a first-rate educational program. Alas, there was little time for questions. A panel consensus was that any debate deserved scientific study with outcomes to guide clinical (and legislative) decisions.

I would like to propose that the MPS sponsor a recurring quarterly lunch meeting for the same 5 with a deli menu and a short agenda. Sitting around a large table with an MPS president, and/or committee Chair and/or an invited guest, this group of physicians with a wealth of knowledge could continue what they started in the January 28th meeting. As colleagues in a less structured setting, they could share personal experiences, clinical vignettes and dollar amounts. Even though they represent programs that sometimes compete with each other, they could advise one another about new projects and how to avoid pitfalls.

The edited minutes of meetings like that would help us all.

Maryland's Quiet Push for More Physicians

By Shayam Bhatt, M.D.

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While Maryland has three well-respected institutions of medical education, it is quietly adding two new ones to tackle the state's growing physician shortage. The Morgan State University School of Medicine is in Northern Baltimore, at one of the nation's most recognized Historically Black College and University (HBCU). And the Meritus School of Osteopathic Medicine in Hagerstown aims to address the need for more physicians in Western Maryland.

Morgan State University School of Medicine, Baltimore
Morgan State University is the third largest HBCU in the nation, and its development of a medical school carries enormous historical significance. When complete, it would be the first publicly funded HBCU medical school, since all four others are privately funded. It is designed for affordability for students in the hope of expanding physician access in underserved communities. The university recently received a $1.75 million grant from the Robert Wood Johnson Foundation that specifies a focus on equity-driven medical education. The campus is likely to be located at the former Lake Clifton High School site acquired in 2022, with hopes to eventually enroll up to 120 students annually--though likely not before 2028 or 2030.

Meritus School of Osteopathic Medicine, Hagerstown
The Meritus School of Osteopathic Medicine (MSOM) enrolled its inaugural class in 2025. In doing so, the school became the first civilian medical school to open in Maryland in over 100 years, joining the ranks of the University of Maryland and Johns Hopkins, as well as the Uniformed Services University, a military-only institution. The inaugural class has about 90 students, with plans to double that, aiming for a full capacity of 720 students at a time. Located about 70 miles from both Washington D.C., and Baltimore, the school has built a partnership with Meritus Health, a long-standing teaching hospital with existing residency programs, giving students immediate access to hands-on clinical training. The choice of location was intentional, as there is a dearth of physicians in rural communities like Hagerstown, and most physicians tend to practice within 100 miles of where they trained. Hagerstown is strategic, since it can serve not only western Maryland, but also southern Pennsylvania and eastern West Virginia. It recently received a $400,000 grant from CareFirst BlueCross BlueShield to fund partial scholarships for the upcoming academic year.

Together, these two schools represent a meaningful shift in Maryland's medical landscape-- expanding access, diversifying the physician pipeline, and bringing training closer to communities that need it most.

Should Psychotherapy Be a Crime?

by: Anne Hanson, M.D.

Anne Hanson, M.D.

As a rule, professional organizations do not support legislation that criminalizes their members or puts them at risk of civil litigation. One notable exception to this practice is legislation related to the use of conversion therapy-- counseling designed to alter gender identity or sexual orientation.

In 2018 the MPS supported a bill to prohibit conversion therapy with minors, making it subject to the licensing board as unprofessional conduct. Now codified under Maryland Health Occupations §1–212.1, a licensed mental health clinician may still provide counseling designed to provide "acceptance, support, and understanding" to the individual or to prevent unsafe sexual practices. At least 20 states now have these laws, although restrictions and challenges are ongoing.

The MPS position was consistent with the positions of several other professional organizations. The APA opposes conversion therapy, due to lack of established efficacy and known risk of harm. Similarly, the American Academy of Child and Adolescent Psychiatry acknowledges that therapy can ethically address "open exploration of all identity issues, including sexual orientation, gender identity, and/or gender expression according to recognized practice guidelines." The National Alliance on Mental Illness opposes this treatment because it stigmatizes LGBTQ individuals and can contribute to harmful procedures that raise the risk of suicide. There is general recognition that gender identity and sexual orientation are not mental illnesses to be cured, but that some people may seek treatment due to personal distress related to this.

After the ban was passed, a professional counselor sued then-Governor Hogan and the attorney general in federal court, alleging that the law infringed on his rights of free speech and free exercise of religion under both the Maryland Declaration of Rights and the U.S. Constitution. This challenge was rejected since clinicians were still free to speak generally about conversion therapy as long as they didn't practice it. The counselor appealed to the Fourth Circuit Court of Appeals, but the appeal was unanimously rejected.

The main organization promoting conversion therapy laws is the Trevor Project, a non-profit organization focused upon suicide prevention and crisis intervention for LGBTQ+ young people. On the opposition side are religious organizations concerned about parental rights and an organization speaking on behalf of "de-transitioners"-- former patients who allege they had been subject to coercive gender-affirming care practices.

The debate came to the forefront this year during a hearing on SB950/HB1209, a bill that would make provision of conversion therapy not only a basis for a civil suit against the practitioner, but would also impose liability upon the clinician's employer or supervisor. The bill would allow monetary awards for both economic and non-economic damages with no cap on the amount that could be recovered. A claim could be filed as late as 20 years after the last session. It would also make provision of conversion therapy a felony punishable by up to 5 years of incarceration.

The MPS legislative committee ultimately decided to support it with amendments to remove criminal liability and to create a cap on damages. Clinicians could still be held civilly liable for several years after treatment. The bill has not moved out of committee and is unlikely to pass this year.

There is no need to pass the bill this year because the U.S. Supreme Court has announced its opinion in the *Chiles v. Salazar* case, a challenge to the Colorado conversion therapy ban. A licensed professional counselor in that state challenged the ban on both free speech and religious freedom claims, but lost the suit in both the district and Court of Appeals. A Supreme Court opinion favoring the counselor overturns the conversion therapy ban in Maryland and several other states. In a surprising 8-1 opinion, they ruled that the lower courts failed to apply a "strict scrutiny" test to the laws and that professional speech is also protected by the First Amendment.

From Lantern Slides to A.I.

Rereading the 1911 Maryland Psychiatric Quarterly

by: Steven R. Daviss, M.D.

Steven R. Daviss, M.D.

In preparation for an invited nomination to be the 2026 President of the Baltimore City Medical Society -- one of the oldest medical societies in the U.S -- I spent some time last summer in the MedChi Library, reading up on the history. While exploring the stacks, I came across the inaugural volume of *The Maryland Psychiatric Quarterly (1911)*, the first publication of the **Maryland Psychiatric Society**, formed on November 6, 1908. (Readers can access this July 1911 issue at this Dropbox link: MCL191107.MPS MPQ Md Psych Quarterly 2025-06-06 14-50.pdf

As I reviewed a copy of this 115-year-old "Salutatory" issue, I expected to find a relic of a bygone era. Instead, I found a mirror. The challenges addressed by our predecessors – administrative burnout, the "revolving door" of hospitalization, and the struggle to communicate scientific truth to a skeptical public – read like a transcript from a modern-day board meeting.

In May 1911, a group of Maryland physicians boarded a special car on the 1:25 p.m. train from Camden Station, heading toward Springfield State Hospital in Sykesville. They were traveling for the 11th meeting of the Maryland Psychiatric Society, an organization then only three years old. It was there that they planned for the inaugural issue of *The Maryland Psychiatric Quarterly*, a publication born from a need for a "direct and official means of communication" among physicians, hospital boards, and the public. The origins of today's MPS publications – *MPS News* and *The Maryland Psychiatrist* – are discernable amongst the minutes, articles, and news updates found in the MPQ.

The Burden of Documentation

One of the most striking parallels appears in Dr. Henry Hurd's article on The Medical Organization of Hospitals for the Insane. He warned against a superintendent being consumed by the details of administration, such as time spent writing letters by hand, clinical notes, and signing requisitions. Dr. Hurd argued that these laborious details forced physicians to postpone the regular systematic visitation of wards, keeping assistant physicians waiting while the head of the institution measured windows for curtains.

For the modern Maryland psychiatrist, the hand-written letters and clinical notes have been traded for the electronic health record (EHR) and prior authorization requests. Just as Dr. Hurd lamented the loss of clinical time to clerical tasks, we are similarly tethered to keyboards and devices, our "systematic visitations" interrupted by digital notifications.

Today, we find ourselves increasingly using ambient AI and agentic agents to address these ongoing administrative tasks. High-tech answers to century-old demands. Dr. Hurd's clinical leadership framework remains: that a physician must be the hospital leader, and should find capable "medical men and women" to tend to all branches of hospital work so that they can focus on new patients and other medical details. Today, we continue to fight for physicians being in leadership positions.

After-Care and Social Determinants of Health

In his section on After-Care, Dr. Adolf Meyer issued a challenge that sounds remarkably like a modern manifesto on the Social Determinants of Health. He argued that "the discharge of patients to an uncorrected environment is as unpardonable as to allow a diabetic patient to return to a common diet." He considered this a form of "mal-practice."

Dr. Meyer advocated for "field work in psychiatry," which he believed should occur before, during, and after hospitalization. He envisioned social service workers who could address misunderstandings and correct an attitude of suspicion in the family home. "If you wish to help a nervous patient, you often must reach him through an improvement of the methods of living of the whole family and the immediate environment."

Today, we struggle with the same economic issue Dr. Meyer identified: that prompt action in the community can make involuntary commitment unnecessary. As Maryland psychiatrists navigate the complexities of Medicaid waivers and community-based crisis teams, we are essentially iterating on Dr. Meyer's 1911 proposition to collect enough facts to support funding from the state. Funding for behavioral health in FY2027 would have been much worse if MPS, MedChi, and others had not impressed upon the legislators the value of these services.

Timing, Stigma, and Technology

The very existence of the *Quarterly* was a response to the isolation of the psychiatric

(Continued on next page)

From Lantern Slides to A.I.

Continued

physician. The Society was formed in 1908 because hospital physicians found it difficult to attend evening meetings of MedChi's Neurological Section due to the travel required from distant institutions. In fact, it was for this simple, practical reason why the neurologists and the psychiatrists – who had previously been accustomed to meeting together to discuss overlapping clinical topics – ceased their mutual meetings, presaging the ever-widening gulf between how the two specialties addressed problems of the brain.

But MPS also had an outward mission. The inaugural editorial committee, including Drs. Arthur Herring and William Rush Dunton Jr., stressed that the *MPQ* was needed to harmonize efforts and improve clinical services. They were practicing public health communications before the term was popularized, seeking to unify boards of managers (who were often political appointees) and the public through a permanent record of transactions.

This matches our current fights against misinformation. Whether it was the 1911 debate over the diagnostic value of examinations of cerebrospinal fluid or today's discussions on the efficacy of psychedelic-assisted care, the psychiatrist has always served as a bridge between the science and the community. The publication even records Dr. Harvey Cushing giving a lantern-slide talk on intracranial growths to the Society. It was a moment of then-current high technology—the "lantern slide"—being used to educate clinicians on the newest diagnostic frontiers.

The Therapeutic Value of Agency

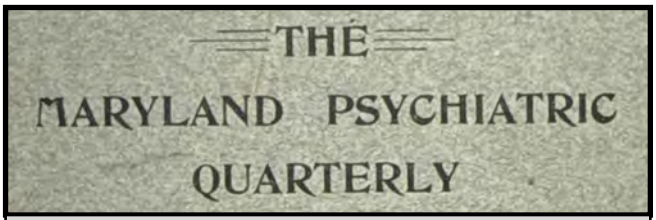
Finally, the 1911 issue contains a debate on "Occupation," what we might now call psychiatric rehabilitation or behavioral activation. Dr. J Percy Wade argued that the therapeutic value of work must always outweigh pecuniary return. He noted that while it was easy to find work for men, finding suitable employment for women was a significant challenge.

Dr. William Rushmer White shared a success story of two patients—one with melancholia and one with alcoholism—who were given an egg incubator. They became so invested in hatching chickens that the patient with melancholia requested an alarm clock to check on the eggs every two hours. This "personal element," as Dr. Dunton called it, remains at the heart of our work. We are not just managing symptoms; we are restoring the therapeutic value of a life lived with purpose.

The More Things Change...

As we look toward the future of psychiatry and the MPS, it is worth remembering that special car on the train to Sykesville. Our predecessors were not just treating the sick; they were building a system of care and of prevention. They were advocating for changes in the legislature, addressing social determinants of health, and using the latest technology to understand the brain. The inaugural *Maryland Psychiatric Quarterly* serves as a reminder that while our tools have changed -- from hand-written letters to EHRs, from chicken incubators to digital therapeutics, from lantern slides to AI -- our core mission is unchanged. We are still a group of physicians seeking to harmonize our efforts, support the public, and strive to ensure that no patient is ever discharged to an uncorrected environment.

The MPS founders from 1908



The title page of the first MPS publication

LETTER FROM THE EDITOR
Grow Old Along with Me

by: *Bruce Hershfield, MD*

Bruce Hershfield, M.D.

Grow old along with me!
The best is yet to be
The last of life, for which the first was made.
Robert Browning, *Rabbi ben Ezra*

I remember my grandfather's 80th in 1954 and my father's in 1993. Now it is my turn.

As you can see in the interview with Tom Allen on page 12, I am still far from the eldest among us since he is 90 and is working 5 days per week. It's an advantage of being a psychiatrist instead of a surgeon.

I have heard about several attempts to make it mandatory for aging physicians to take cognitive tests. This could be relevant for us because a large percentage of psychiatrists are over 70. The drive to mandate this for physicians does not seem to inspire similar efforts concerning lawyers or political office-holders. Discrimination by age is illegal. There are already many feedback procedures to protect the public from incompetence on the part of all physicians, and new technologies are making it easier to keep up with advances in Medicine and to monitor how well we are practicing.

I do feel a strong desire to pass on what I have learned to today's trainees. I can see the mistakes they tend to make. It is clear to me that experienced psychiatrists don't make the same mistakes younger ones do. (The cliché is that good judgment comes from experience and experience comes from bad judgment.) Maintenance of Certification is predicated on the idea that the longer one practices the worse one does it, but If this were true then people would be clamoring to see inexperienced physicians—which they never do.

Cicero comments in "D*e Senectute*," "No one is so old that he does not expect to live a year older. But the same persons bestow great pains in labor from which they know that they shall never derive any benefits". Then he quotes a playwright named Caecilius Statius, "He plants trees to bear fruit when he shall be no more".

Browning may be right about it being the best part of life. I am enjoying being free of many of the worries I had when I was younger. I value my relationships with colleagues more—including the ones I have in the MPS and in the Southern and in the Senior Psychiatrists. My 60s and 70s—the "go-go years" and the "slow-go years"-- have been happier than my adolescence and 20s.

I've heard the 80s are the "no-go years". But I plan on continuing to see my patients--as I plan to continue being your Editor—and I hope to get better at doing both.