THE
MARYLAND PSYCHIATRIST
SUMMER 2017 VOLUME: 42 NO: 1

The Changing Of The Guard

By: Jennifer Palmer, MD

It is the end of an era. Kery Hummel served as the MPS Executive Director in glorious technicolor for over 10 years. During his tenure, which overlapped to a great extent with my own, we streamlined our legislative process, overhauled our website and converted our budget to a calendar year, putting us in sync with APA and most other district branches. One benefit of this last change was to allow the APA to take over most our dues billing and free our staff for other endeavors. (Centralized billing kinks are still being smoothed out.)

Plus ça change, plus c'est la même chose — Jean-Baptiste Alphonse Karr

Kery's extensive experience in health policy and unique talent for fostering relationships helped make the MPS a model district branch. Our relationship with other Maryland stakeholders, including DHMH, MHAMD and MedChi flourished under his stewardship. He was also instrumental in the evolution of my personal involvement in the MPS, from Legislative to Executive Committee. I am thrilled that we will still be able to cross paths with Kery intermittently, as he will be working with APA District Branches on behalf of APA, Inc.

I am also very excited about the new era we are entering. Pending input from Council, the Executive Director's role will be resumed by Heidi Bunes, a long-time staff member and former MPS Executive Director. Meagan Floyd, who has overseen our CME activities and the overhaul of our website, will be taking over as the Associate Director. I am delighted that Heidi and Meagan are here and, with their experience and professionalism, in the unique position to make our transition seamless.

The Executive Committee and I look forward to working through these exciting changes with you in the coming year.

In this Issue...

MARYLAND PSYCHIATRIC SOCIETY

A District Branch of the American Psychiatric Association

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.

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Letter from the Editors

As Time Goes By

With this issue, Drs. Bruce Hershfield and Jessica Merkel – Keller will be your new Editors, taking over from Nancy Wahls, MD.

First, and most importantly, we want to thank Nancy for what she has done as Editor. She has put out a string of valuable issues. Most of the work for the current one was done under her leadership.

Of the two of us, one has a history of having been on the Editorial Advisory Board since 1979 and having served as Editor from 1983 to 1991. The other has had a shorter career, but one that has been full of interesting experiences that have given her opportunities to write, which she has done in several recent issues. It should be a good combination. It's a good sign that we have been friends for years.

Psychiatry has changed dramatically since 1991, but it's "still the same old story" and some "fundamental things" do still apply. The MPS remains one of the strongest district branches in the APA, with a long string of effective Presidents and competent -- more than competent --Executive Directors. We are currently choosing a "new" one, since Kery Hummel retired, and there is reason to be confident that the MPS is again making the right choice. We owe a lot to the success of Kery's efforts in the last 10 years. He was helped by our very able Associate Director, Heidi Bunes and Assistant Director, Meagan Floyd, as well as by our elected officers and the general membership. Ms. Bunes is once again becoming our Executive Director and Ms. Floyd is advancing to Associate Director.

The current issue shows that the psychiatric community is thriving, despite the obstacles we've come to expect in a rapidly changing environment. It is sad to note the obituaries and memorial articles, but all of those who have passed had long and useful careers, helping their patients and our community. New leadership is coming, with new directors at University and Sheppard Pratt and Hopkins. The next few years should give us plenty of opportunities to discuss new developments, as we publish your articles about changes in our community and about how best to handle them.

Potash New Director at Johns Hopkins

By: *Bruch Hershfield, MD*

On July 1, James Potash, MD is came back to Johns Hopkins, as the new Henry Phipps Professor. and Director. of the Department of Psychiatry and Behavioral Sciences. He has been the Head of the Department of Psychiatry at the University of Iowa College of Medicine since 2011.

Originally from the Baltimore area, where his father had a long-standing private practice in Psychiatry, he graduated from Yale College in 1984 . (By then he had already spent a summer as an intern at Sports Illustrated, covering the Los Angeles Dodgers.) He served as a volunteer in the Peace Corps in Senegal, and it was during that time that he decided to become a physician. He earned a post – baccalaureate degree in premed from Goucher in 1988, a Master's degree in public health at Johns Hopkins, and then an MD from Hopkins in 1993. After finishing his psychiatric training at Hopkins, he served on the faculty there for 13 years, eventually becoming the Director of the Mood Disorders Center and of Psychiatric Emergency Services before moving to Iowa.

He is known for his research on the genetics of mood disorders-- in particular, for efforts to identify the genes that determine the epigenetics of stress and depression. He has written more than 100 publications and has collaborated on revising the well – known textbook by Goodwin and Jamison, "Manic Depressive Illness. He has won the Robbins/Guze Award for research excellence in the American Psychopathological Association and the NARSAD Independent Investigator Award.

He commented in an 2015 interview for the newsletter of the National Network of Depression Centers, "I got started with a wonderful mentor and role model, Ray DePaulo at Johns Hopkins, who began looking for bipolar disorder genes in the 1980s. From my Chair when I was a trainee, Paul McHugh, I learned a systematic way to think about the nature of psychiatric disturbances."

Many of us are pleased to see him return to Hopkins and to Baltimore, where we expect him to continue the pattern of excellence that he has shown throughout his career.

Death With Dignity: Examining Both Sides Of The Physician Assisted Suicide Debate

Jointly Provided by the Maryland Psychiatric Society and MedChi, The Maryland State Medical Society

Saturday September 16, 2017
9:30 am-1:15pm

Background: The topic of physician assisted suicide (PAS) is being debated throughout the country. Six states have established physician-assisted suicide via legislation, while 44 states consider PAS illegal. In 2017, legislation was filed (for the third year) in the Maryland General Assembly that would allow doctors to legally prescribe a lethal dose of medicine at the request of a patient who has been deemed mentally competent and who has received a terminal diagnosis. These bills — HB 370 and SB 354 — were both ultimately withdrawn from consideration. However, legislation will be filed again during the 2018 Maryland General Assembly.

Fees are non-refundable.
Please send check or money order to:
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Interview: Harsh K. Trivedi, MD MBA

President & CEO Sheppard Pratt Health System

By: Bruce Hershfield, MD

Towson, MD June 28, 2017

Q.: "It's been one year since you came to Sheppard Pratt Health System. What has it been like for you?"

Dr. T.:" It's been a wonderful transition—getting to meet everyone in the community, getting to see the wide variety of everything we do. I've been really impressed by the longevity of many of the people on our staff—people have worked at Sheppard Pratt for more than 40 years—and by the incredible quality of the programs. To be in Maryland, where, regardless of what you have going on, you can get help for it, is something that you cannot say in most states. There is an incredible richness of resources. Compared to the national landscape, I think we're doing pretty well."

Harsh K. Trivedi, MD MBA

Q.:" What's it been like for you to come to Maryland?"

Dr. T.:" It's interesting, because when my wife and I moved down to Nashville, it was a truly southern culture, everyone was warm and friendly, and we thought it couldn't get better than that. But our reception in Baltimore and the Maryland area has been even better. People invite us with open arms and have been more than happy to help educate me about local things. A lot of those little touch points make all the difference in life and whether you settle in or not."

Q.:" What surprised you about the transition?"

Dr. T.:" I transitioned in for Steve Sharfstein. Across our system and probably for most of psychiatry, we're coming to the time when many people are going to retire in the next five to seven years. It's caused me to spend a lot of time thinking about succession planning for a whole host of programs. I've always been about collaboration and developing a stronger sense of community. For me, *which* organization you're with is not as strong as us all doing what we are passionate about. I'm hoping, with Bankole Johnson being new at the University of Maryland and Jimmy Potash coming to be the new Chair at Hopkins, that we can find ways that we can all work together."

Q.:" What about your background helped prepare you for this job?"

Dr. T.:" I'm someone who has always been a systems thinker. I generally don't like to complain about what's not working. I'd rather spend all of my energy trying to figure out how to fix it. I went to a seven-year college/medical school program in New York, at City College. One of the wonderful things about that program is that, long before anyone thought about population health and all these healthcare reform ideas, they taught the ideas of community health and social medicine. How do you look beyond the one patient whom you're treating? How do you really impact the health of that community?

Between my general psychiatry and child psychiatry training, I spent time as an APA Spurlock Fellow and worked on Capitol Hill. I was fortunate to work for Sen. Jack Reed's office, from Rhode Island. I actually got to work on the bill that later became the Garrett Smith Memorial act. That has already provided over $180 million of funding for suicide prevention programs for kids and the building of more college mental health service programs. The money has gone to all 50 states and nine tribal territories. I also want to figure out how to have a larger impact. That way, people can do more to actually help others than I can do over an entire career of seeing one patient after another.

After that, I went to Children's Hospital Boston and did my child psychiatry training. We had three incredible training sites—we had Mass General, we had Cambridge, and we had Boston Children's for our child programs. All of the Child Fellows met together for didactics, so we had a sense of community. I think that we could be doing a lot better job for

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Richard Kogan, MD On Stage

By: John Buckley, MD

Did you know that Beethoven could perform only simple arithmetic and couldn't even multiply? Even if you did, you couldn't know as much about the great composer as does Richard Kogan M.D.

On the stormy evening of 11/19/16, Dr. Kogan, the concert pianist-academic psychiatrist returned to Goucher College so that he might once again enthrall a rapt audience in a concert sponsored by MPS and Med Chi.

Richard Kogan, MD

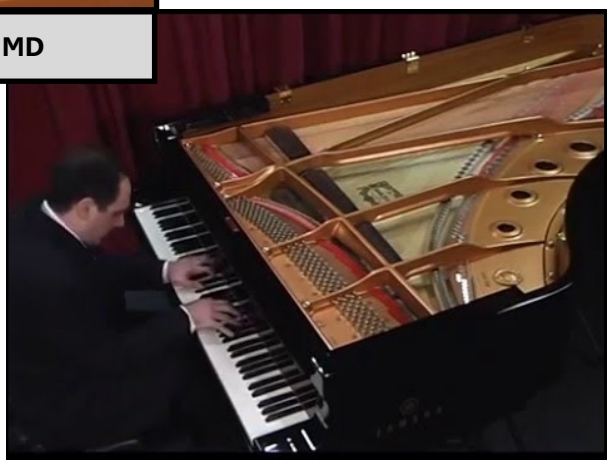
Merle McCann opened with a warm welcome to Dr Kogan. The only presence on the wide stage was a very large piano. Dr Kogan appeared: dark suit, dark tie, black shoes-no jewelry, no sequins, no pony tail, no affectations. He joined the piano at center stage and with the manner of a friendly but no-nonsense cleric, began the story of Beethoven in the latest chapter of "Music and Medicine".

The large respectful audience continued to breathe but made not a sound as Dr. Kogan introduced them to perhaps the greatest composer of classical music: Ludwig Von Beethoven. His deafness, his arrogance, his isolation, his delusions, his illnesses and his genius were all woven into a story of a larger than life character. Dr Kogan illustrated Beethoven's early, middle and late musical phases with virtuoso performances of representative piano works.

Before reaching the scene of Beethoven's deathbed (during a thunderstorm...at age 56....in 1827) the listeners realized they were witness to an exceptional talent...Kogan, that is. Here was a man who with just his fingers and his voice brought those present into Beethoven's time and brought his work and his personality to life with rich detail. After 90 minutes, the spellbound audience stood to applaud. Then Dr Kogan fielded some insightful questions before ending his performance.

Neil Warres, M.D. (another pianist-psychiatrist) then awarded a $500.00 anti-stigma prize on behalf of the Maryland Foundation for Psychiatry to Amy Marlow for her 2/9/16 piece in the Washington Post. He closed the meeting with an invitation to enjoy some dessert and to hob nob in the lobby with friends and with Dr Kogan.

Did you know that Beethoven's ninth symphony is played in public the world over, often as a hymn to the new year? Did you know that a more entertaining method of earning CME has yet to be devised?



Becoming an Ironman for Myself and My Patients

By: Thomas Franklin, MD

The sliver of light coming under the door of the windowless office seemed unbearably bright and offensive. I turned away from it and closed my eyes. There is a flat spot on the back of my head that, if angled just right, would lie on the textbook I was using as a pillow. In a few moments, I would be asleep again. I was supposed to be out seeing patients, but it was all I could do to show up at work and hide in my office. My supervisor was a gentle woman who would come check on me a couple of times a day. She would crack the door and ask, "Dr. Franklin, why don't you come out and see one of the new patients?"

"I can't. I just can't... I'm no good to anyone." Drifting in and out of consciousness in that dark room seemed far superior to being up and about, feeling the pain that seemed to emanate from my chest and flow throughout my body. It was as if my blood had been replaced by some impossibly dense material that could barely flow, making every step I took an effort. If I didn't lie on that floor and feel my body supported all the way from that flat part of my skull to the small of my back, to the backs of my ankles, it felt like I might fall through to the center of the earth, through the dirt, rock, and then to the molten core where I would be incinerated. I wondered if that might be better than living like this.

Fearing Stigma but Seeking Help

I was a psychiatric intern at the time, and I was depressed. But I couldn't bring myself to seek treatment. I suffered like that for months until I saw a colleague in consultation, where I described suffering the symptoms of attention deficit disorder, but suggested that a third-line medication for that diagnosis, also used for depression, might help me. I needed so much more than that medication, but my depression, my own inhibitions, and stigma kept me from getting the help I needed. Difficulty concentrating seemed a safer problem to admit to than depression. I was worried that I wouldn't be taken seriously as a psychiatrist if it became known that I, too, was a patient. Until now, I have kept quiet about my experience. A continued fear of stigma has kept me quiet. I felt that if I was known as a psychiatric patient, even a so-called "cured" one, I would be labeled or disgraced or stereotyped. I thought it might hold back my career.

But the only way to combat stigma is to speak out. This is not easy, but I am inspired by those that have travelled before me on this road and by my current patients. I can't go on urging them to be courageous, to face down the stigma they were feeling, without doing all I can to fight stigma myself. Only by shining the light of truth on people's lived experience of mental illness will stigma finally become a thing of the past.

Why a Triathlon?

After my psychoanalysis was over, I took up triathlons. Exercise has not only helped my mood, but I found that endurance sports are a powerful metaphor for what living with a mental illness can be like. In some ways, training for and finishing races makes me feel that I have mastery over that part of me that suffered so much.

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Psychopharmacology Forum:
More on SSRI's

By Neil Sandson, MD

I'd like to once again address recurring psychopharmacological issues and concerns that arise in routine clinical work.

SSRI-Induced Sexual Dysfunction

Since so many of our patients develop sexual side effects with antidepressants, we should understand how to correct them. The three main varieties of SSRI--induced sexual dysfunction are impairment in libido, erectile dysfunction, and anorgasmia or delayed orgasm. There are several possible approaches that target different aspects of these problems.

Phosphodiesterase inhibitors: These are fairly effective for addressing SSRI-induced erectile dysfunction. Be careful when the patient is also taking nitrate – containing compounds.

An ounce of prevention: As antidepressant monotherapies, bupropion, mirtazapine, and nefazodone ("Serzone") tend not to cause sexual dysfunctions. Vilazodone (Viibryd) is supposed to be an SSRI that does not cause this problem, but, since it is relying on a buspirone-like effect, it has not generally impressed clinicians as effective. Aripiprazole, brexpiprazole, and cariprizine can actually suppress serum prolactin levels, which can help avoid sexual dysfunction.

Augmentors: The antidepressants I just mentioned could helping alleviate SSR induced sexual dysfunction. Bupropion could do this by contributing noradrenergic reuptake inhibition, and mirtazapine and nefazodone by contributing 5-HT2a antagonism, which increases presynaptic dopamine release. But this is far from reliable. Buspirone seldom works. Stimulants are sometimes helpful for orgasmic issues. Cyproheptadine is said to be helpful for libido, but it could put you to sleep first. Yohimbine is also said to be helpful for libido, but it can cause panic attacks. Flibanserin, which is supposed to enhance female libido, cannot be used when the patient is drinking alcohol, and the effect size is only modest.

Drug holidays: Patients taking an SSRI that has a short half-life, such as paroxetine or venlafaxine, should be able to discontinue the drug for 2 to 3 days before planned sexual activity and probably not suffer breakthrough depressive symptoms. In other words, they would have a drug level "trough" that would allow them to function sexually, and then they could resume the medication. I'm not a big fan of this strategy. First, the patient may experience an unanticipated decompensation because of this rapid change in drug use. Also, the effect that the patient is counting on-- rapid decrease in serotonin reuptake blockade-- is precisely what is implicated in producing uncomfortable "serotonin withdrawal" symptoms. It requires good luck to experience a remission of sexual dysfunction without being afflicted with anxiety, insomnia, headache, dizziness, fatigue, irritability, flu – like symptoms, and nausea. Not a good gamble!

SSRI's and Drug Interactions

Here are a few of the major ones:

TCA's: Combining these with fluoxetine, paroxetine, or more than 150 mg of sertraline per day can be especially dangerous, due to inhibiting CYP2D6, which could lead to T CA toxicity. Using TCAs with other SSRI's is not as likely to produce this problem.

Digoxin: All SSRI's except for citalopram and s-citalopram are inhibitors of the Pglycoprotein transporter and can raise the levels of digoxin to a dangerous extent.

Warfarin: Co-administration with fluoxetine or fluvoxamine, both of which are potent inhibitors ofCYP2C9, can raise S-warfarin levels significantly, producing excessive INR levels and potentially dangerous declines in coagulating ability. All SSRI's decrease platelet adhesion and therefore act synergistically with warfarin to inhibit coagulation. This can be difficult to quantify unless you also have measured bleeding times. The best advice I have is to be aware of this and use your best judgment. If the patient is getting frequent bruising despite having INR's between 2 and 3, consider changing from an SSRI to a non-serotonegic antidepressant like bupropion.

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REMEMBRANCE:
Gordon Livingston, MD

By: Bruce Hershfield, MD

Gordon Livingston, MD

Dr. Gordon Livingston, who practiced in Columbia for many years and who was the author of well-received books that taught others what he had learned about life, died on March 16, 2016 of heart failure at age 77.

Originally from Tennessee, he was raised in Troy, NY and attended West Point. He graduated from the Johns Hopkins School of Medicine, interned at Walter Reed, then volunteered for Vietnam, where he received a Bronze Star. He participated in a protest the war and left the military, then did his training in Psychiatry and Child Psychiatry at Hopkins before joining the Columbia Medical Plan, where he became Chief of Psychiatry.

After he lost two of his children in a 13 – month period, he wrote "Only Spring", which was about his six -year-old son, who died in 1992. He established a fund that pays for hotel rooms and local transportation for families whose children are inpatients at the Johns Hopkins Hospital.

His book, "Too Soon Old, Too Late Smart" consisted of 30 essays about truths he had discovered. It was translated into 22 languages and was followed by a sequel, "And Never Stop Dancing" and then by "How to Love" and "The Thing You Think You Cannot Do". He also wrote essays in the *Baltimore Sun* and the *San Francisco Chronicle.*

He was an exceptionally active man, taking up hang gliding and scuba diving and sailboat racing. He liked taking down his own trees so much that he established the Columbia Tree Service, for which he was licensed and bonded.

I asked to interview him 10 years ago because I had read an article in *Reader's Digest* about how he had discovered he was adopted and how he had found his birth mother and then I had read "Too Soon Old…"

Let me repeat what he said in that interview: "Since I'm fond of aphorisms I started writing things down that I thought were true but not so obvious as to be clichés. They included things like, 'We are what we do,' and "Every relationship is under the control of the person who cares the least.' I ended up with 30 of them. So that the book would be longer than three pages I wrote an essay about each one."

He told me that writing "has also allowed me to make use of my life experience as someone who has had some unusual things happen to him. I think it is also increasingly important as we grow older to have a sense of being listened to. To be ignored is the ultimate rebuke to our humanity and it is a sad fact that the elderly has a devalued status in this society."

He also shared with me that "Patients, of course, are an endless source of inspiration and stories… We're changed by these stories just as our patients are, and the truths they lead us to are worth preserving. Writing down what we have learned also constitutes a kind of 'ethical will', something to convey to succeeding generations in the same way that we distribute our property. I think that we have some obligation before we die to enunciate whatever we think we've learned about life."

He was an extraordinary man who helped a lot of people—patients and also many others who read his books and essays—to benefit from the tragedies he endured and the courage he displayed.

REMEMBRANCE:
Clarence Schulz, MD

By: Miles Quaytman, MD

Clarence Schulz, MD

After attending the memorial service for Dr. Clarence Schulz on May 13th and listening to his friends, colleagues, and students share their memories of him, I can only conclude that he was one of the best psychiatric clinicians and teachers in the *multiverse*. Yes, the *multiverse*! How do I know this? The summer before I began my residency at Sheppard Pratt more than 40 years ago, I attended the annual Scientific Day. One of the presenters said that almost everything useful that he had learned in psychiatry he had learned from Clarence Schulz. I was understandably skeptical, but, after I began my residency at Sheppard Pratt, I asked Clarence to chair a reevaluation conference that reviewed the treatment course of a patient over a three month period. Again and again, the patient and I seemed to be hitting a stone wall in terms of making any progress. Clarence listened to my presentation and then interviewed the patient. It was not what I expected. They seemed to chat amiably and then, after the patient left the room. Clarence agreed with what I was trying to accomplish with the patient, and was particularly taken with a number of his art therapy productions. The patient looked at me when I next met with him and said that, although we had worked together for six months, it was only after the interview with Clarence that he had finally understood what we were trying to do together. The patient wondered why I had not explained this to him in the first place! Three months later, he was discharged in much better shape. It is difficult to try and explain this kind of magic. Thereafter, I asked Clarence to chair as many of my reevaluation conferences as possible-- often with similar outcomes.

Clarence was, at his core, a psychoanalyst with a profound understanding of Freud's ideas who also had been taught by such giants as Frieda Fromm-Reichman and Otto Will, and who was greatly influenced by Harry Stack Sullivan. Clarence created a circles diagram that he used to teach object relations theory to many generations of residents. He felt that the Baltimore-Washington area had a unique tradition of using psychoanalytic principles to treat patients with severe disorders. Patients who suffered from schizophrenia needed to be treated as fellow human beings whose words and symptoms had meaning. Clarence taught, and lived by, Harry Stack Sullivan's dictum that, " We are all much more simply human than otherwise." Clarence was in a unique position to understand this tradition, having worked at Saint Elizabeth's Hospital and at Chestnut Lodge. He received his analytic training at the Washington Psychoanalytic Institute, where he became a training and supervising analyst. He spent the greater part of his career in various positions at Sheppard Pratt, including as Director of Inpatient Services, Assistant Medical Director and Director of Residency Training.

He told me that although he used psychoanalytic and object relations ideas in particular as a road map of the terrain, one always needs to respect different points of view. He taught that patients need a therapeutic milieu as well as a psychotherapeutic understanding of their conflicts. Two of his works stand out--"An Individualized Psychotherapeutic Approach to the Schizophrenic Patient", published in the Schizophrenia Bulletin, and his book, "Case Studies in Schizophrenia". He had a knack for distilling the most complicated psychiatric and psychoanalytic ideas into concepts that could be easily understood. For example, he described as an "all or none phenomenon" the complexities of the object relations view of splitting. Harold Searles in his forward to "Case Studies", described Clarence as a "man greatly admired by that most critical of audiences, his own workaday comrades in arms". Dr. Charles Peters commented at the Memorial Service that, once he read this book, he knew what he wanted to do with his life.

During the memorial service we fondly remembered "disorientation" sessions that Clarence held for residents and other staff at his home. This was on the official schedule of Sheppard's residency program for many years. "Disorientation" provided an opportunity for residents to bond, ask questions that they might be afraid to ask in other settings, and perhaps get to know

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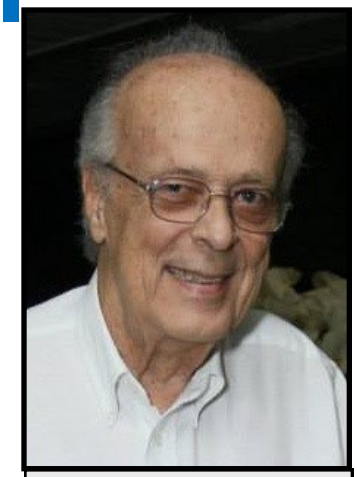
REMEMBRANCE:
Marcio V. Pinheiro, MD

By: Bruce Hershfield, MD



Marcia Pinheiro, MD

It's been one year since Dr. Marcio Pinheiro died of heart and kidney failure in his home town of Belo Horizonte, Brazil on August 15, 2015. People still ask me about him, even though he left Maryland in 2001. It's clear that a lot of us were very fond of him

I first met him, briefly, just after I came to Sheppard Pratt in 1974. He had announced he was returning to Brazil, after several years on the hospital staff. I can still picture him, laughing as he entertained a group of people. I was sorry to hear that he was leaving. Afterwards, I heard of him from time to time, but I did not see him again until after he called me in 1987 to ask how he could apply for a job at Springfield, where I was working. He had decided to return to the USA. I showed him around the hospital and enjoyed his company once again. I was very pleased when he decided to work with us. He did his job so well that he got a special commendation for Outstanding Service from Governor Schaefer, who singled him out at the Statehouse when he gave a speech about Marylanders who were making a difference. Marcio worked for the state for 14 years-- in addition to working in a clinic and having a part-time private practice -- before he went back again to Brazil in 2001. I met with him several times afterwards, at an APA meeting and in Baltimore and then in Los Angeles, where all three of his children eventually settled. I visited him twice in Belo Horizonte—the first time in 1993 so that we could give a joint presentation at a psychiatric meeting -- and got to know his family and friends, both here and there. We were the subjects of a cover article in the Baltimore Sun magazine in 1990, which highlighted differences in our approaches to Psychiatry, while making it clear that we considered each other good friends. When the reporter asked me about him, I remembered something I had read in an obituary of a psychiatrist from Philadelphia—"You could warm your hands on that man."

He was very well-respected -- even admired--both during the time he practiced in Maryland and when he practiced in Belo Horizonte. One of his colleagues in Brazil, Dr. Fernando Portela Camara (whom Marcio asked to look after me when I attended the Brazilian Psychiatric Congress meeting in Rio four years ago) wrote recently that he "will be remembered for his gentleness and tolerance. His patience was unshakable. He treated everyone cordially and never imposed his points of view. He has left us with his example and the tender memory of a good companion."

In 1957, he decided to move to Baltimore to do his residency at Mercy Hospital, after he graduated with an M.D. degree from the Federal University of Minas Gerais. He completed his psychiatric training at the University of Maryland, then worked at the North Charles General Hospital and at Sheppard Pratt, while training in psychoanalysis. He became an American citizen. After he returned to Brazil in 1974 he had a significant influence on how psychiatrists practiced in his hometown, edging them towards a more psychodynamic approach. He helped found two psychotherapy clinics, a psychiatric day hospital and a school of mental health. According to the "Sun" magazine article in 1990, "He developed a reputation as a kind of guru, known widely for his belief that a patient must be understood from a dynamic and social point of view." When I visited him in Belo Horizonte on my way to Rio in 2011, I got to know his friend, Dr. Karla Miranda. She said, after Marcio died, that she had given up on having a career in Psychiatry until after he had returned to Brazil. For her, the approach he taught served to counteract what she felt was the coldness of the biological orientation in the local hospital. He was generous in sharing his knowledge with others –-so much so that the Psychiatric Association of Minas Gerais gave him an award in recognition of his teaching.

He was one of the first people I knew who had a computer in his house, which went along with his interest in combining traditional and innovative approaches to helping patients. We had many discussions about where Psychi- *(Continued on p. 16)*

REMEMBRANCE:
Lois Love, MD

By: Bruce Hershfield, MD

Lois Love, MD

Dr. Lois Love, a Life Member of the MPS, died on July 22, 2016 of lung disease at age 94.

Born and raised in Ocean City, NJ, she graduated from Swarthmore in 1943 and went on to get a PhD from the University of Pennsylvania. She then taught at the Women's Medical College of Pennsylvania (now, the Medical College of Pennsylvania) before "retiring" in 1951 to raise a family. She and her husband moved to Baltimore in 1957 when he became an Assistant Professor of Biophysics at Johns Hopkins. She applied for admission to the Johns Hopkins School of Medicine in 1958, but she and another woman who was applying were rejected. However, they were both then admitted to the medical school at the University of Maryland, where they graduated "magna cum laude" in 1962, when Dr. Love was 36. They were the only two women in the graduating class of 97 students. She then interned at South Baltimore General Hospital (now Harbor Hospital) and did her psychiatric residency at Sheppard Pratt.

She maintained a private practice in Baltimore, and was a member of the Baltimore – Washington Center for psychotherapy and psychoanalysis. She retired in 2003.

Erik Roskes, MD said of Dr. Love, "During my fourth year of residency, I had an interest in emergency and crisis psychiatry, and I created an elective with Baltimore Crisis Response, Inc. (BCRI), which had just begun operating. I recall Dr. Love's great interest in the work we were doing, and her unique insights into the dynamics of situations in which we were responding very quickly to urgent situations. I came away with a new appreciation for the insights of psychodynamic thinking, even in situations where the issues presented were so unlike those she was working with every day. Her nimbleness of mind is what I remember most. This was so far from what I expected, and it is what made her such a wonderful supervisor."

Christiane Tellefsen, MD said after she learned of the death of Dr. Love, "She was one of my favorite supervisors.....She had a way of packing enormous amounts of wisdom into brief statements....many of which I can still hear her saying to me...." Jay Phillips, MD added, "Lois was a sophisticated clinician, often turned to for consultation or a second opinion on difficult cases in long term intensive treatment. She was highly appreciated as a teacher and supervisor of psychoanalytic work. She always offered her thoughts in plain language, and was skeptical of overvaluation of theory. She wore her high intelligence lightly, but it shone through in any discussion of a case. She was a great resource for the professional community."

REMEMBRANCE:
Thomas Cimonetti, MD

By: Bruce Hershfield, MD

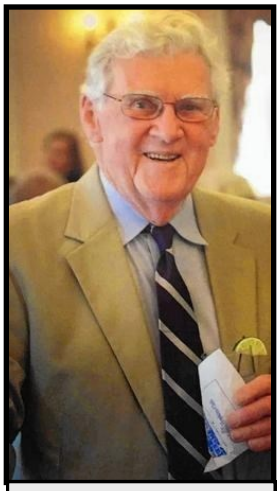
Dr. Thomas C. Cimonetti died in October 17, 2016 at age 87. Born in Vermont, he attended Fordham University and then the University of Maryland School of Medicine, where he graduated in 1965. In addition to teaching at seven colleges, he saw patients for more than 50 years in private practice and in hospitals in Maryland, Oklahoma, and Nassau, Bahamas.

An indication of how those who knew him felt about him was on his memorial page after he died: "To know Dr. Cimonetti was to love and admire him. We will forever miss his brilliance, warmth, and compassion. He had profound influence on people's lives... We love you, Tom." ("Marilyn C." of Columbia).

He was always very pleasant and I enjoyed seeing him in meetings. Dr. Philip Dvoskin commented that he was, "gentle, kind, always had a smile." I agree, and, like "Marilyn C.", I'll certainly miss him.

REMEMBRANCE:
Thomas Lynch, MD

By: Bruce Hershfield, MD



Thomas Lynch, MD

Thomas Lynch, MD, an important member of our psychiatric community for many years and a Past President of the MPS, died at age 94 in October 2016.

Originally from Ireland, he trained in psychotherapy in England and then came to the United States, where he worked at the Haven Sanitarium in Rochester, Michigan with Dr. Leo Bartemeier. He came to the Seton Institute in Baltimore in 1954 as its Assistant Clinical Director. He remained there until it closed in 1973; by then he was its Acting Director. He had a private practice for many years and worked at Sinai Hospital, where he was responsible for developing its inpatient psychiatric services.

In appreciation of all he did for the psychiatric community and our patients, the MPS recently gave him its Lifetime of Service award.

Many of us have benefited from knowing him. Dr. Thomas Allen pointed out that Dr.
Lynch was the first President of the Maryland Foundation for Psychiatry. Dr. Laurie Orgel described him as "gracious". Dr. Neil Warres noted he was "a real gentleman" and cited his interest in helping people.

It was a pleasure to see him at MPS functions–he always had a ready smile and a cheerful way that made everyone who knew him glad that he was there. We'll miss him.

MPS Annual Dinner

By: Bruce Hershfield, MD

About 90 people attended this year's Annual Dinner at the Hopkins Club in Baltimore.

Dr. Neil Warres began the proceedings by giving the Maryland Foundation for Psychiatry's Anti-Stigma Advocacy Award to John Lion, MD. Dr. Lion explained how he came to write the "op-ed" piece that led to the award, and he spoke about what he called the "tyranny of evidence-based Medicine".

Dr. Robert Roca then announced the winners of this year's "Best Paper"–Drs. Jennifer Coughlin and Traci Speed. It was then time for Dr. Roca to receive his award– for a lifetime of service to the MPS. This was followed by the MPS Ethics Committee Recognition Award -–given to Paul McClelland for his 28 years of service on that committee.

Dr. Merle McCann, the outgoing President, then reviewed the past year's events. He expressed his concerns about public health and recognized the contributions that the officers and staff of our organization have been making. "We need to unite and pursue our professional interests," he told us, before he recognized all that Kery Hummel, who is retiring as Executive Director, has done for us. Mr. Hummel then commented about how fortunate he is to have "an ocean of friends".

Dr. Jennifer Palmer, our incoming President, then addressed us and introduced Drs. Saul Levin and Anita Everett–-the Medical Director and President-elect of the APA. Both are MPS members. Dr. Everett talked about issues of physician burnout and also about our aspirations. She talked about the innovation within the APA and about how the organization –- with more than 37,000 members now-- is doing. The APA is looking forward to moving its administration to a new building next January 1st. Dr. Levin told us that a psychiatrist, Dr. Katz, is due to be Assistant Secretary of Health and Dr. Everett will be the Chief Medical Officer at SAMSHA.

Both the MPS and the APA are fortunate to have such able leadership. The awards and the talks could only touch on the many contributions our members make. They do it all the time; we just take the opportunity once a year to make sure that they know how much we appreciate them.

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our residents and our fellows here in that sense. Forget the organizational affiliations; they're all at an incredible time in their careers. You learn a lot more by having exposure to people across the street, as opposed to forming small tribes. It can be done through the MPS, or in places like the APA, or ACAP, or other formal meetings. Even receptions, where we can all get together, are opportunities to build community. There are also folks who are not with any of those three organizations, who are very much a part of the fabric of mental health services. They are very much our colleagues and friends and should be at the table as well."

Q.:" I understand that you're still head of one of the components of the APA."

Dr. T.:" I am Chair of the Council on Healthcare Systems and Financing. We work on a very broad set of things. From anything that has to do with healthcare reform to new models of practice, such as collaborative care, getting new collaborative care codes through the AMA-RUC process, to commenting on each new regulation that comes out for MIPS or MACRA and all the other acronyms. Things that don't necessarily have a neat home within the APA end up coming to our council so that they can get more attention. For example, how to best help patients who are suffering with severe and persistent mental illness. The APA, a while back, had a committee that basically thought about that, but since the council structure was reorganized about a decade ago, there really hasn't been a component that thinks about that all the time. We focus on those issues as well. As telemedicine became more common, so we took that on as well. There is no shortage of different things for us to work on."

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

Dr. T.:" I was one of those people who, when I went to medical school, was sincerely fascinated by every single rotation. For me, it came down to where could I work where my skill set would have the most impact. I was also asking what could I do that just not everyone else could do. What really attracted me to the field was the possibly of becoming a child psychiatrist. There was a large shortage of physicians who could provide that care. If you had someone with diabetes, you would know how to treat it, but when it got to depression, particularly for kids, no intervention would be successful unless you also knew how to deal with the parents and the system and everything else involved."

Q.:" How did you become involved with administration?"

Dr. T.:" It happens for all of us at different times. Events come up. Are you going to raise your hand and volunteer? Or are you going to just go on seeing patients and going about your regular day? What happened to me is, right after my child psychiatry training, I was recruited to work at Bradley Hospital, which is part of Brown, in Rhode Island. I started working on the adolescent inpatient unit. Within three months, the child psychiatry training director got seriously ill and needed to step down from her role. The person who was my supervisor in my first role out of training became the next training director, so he could no longer run the adolescent services. So, within nine months of me getting out of training, I found myself the Director for Adolescent Services. At the same time, I got involved with building a 60–bed addition to the hospital. What should a new psychiatric hospital look like? It ended up being about a 40,000 foot expansion and I ended up running two of the units—about half the square footage. It also meant hiring staff, designing processes, and building up the clinical programming."

Q.:" Did you learn administration on your own or did you take some formal training?"

Dr. T.:" At that time, I didn't, I ended up working there for a while and then getting recruited down to Vanderbilt, where I did my MBA. I studied for it with a cohort of about 60 physicians from all different fields, specifically focused on the business of health care. That's what set me up for becoming the CEO for Vanderbilt's psychiatric hospital and running the entire behavioral health science line down there"

Q.:" How did you enjoy your time in Tennessee?

Dre. T.:" I loved it. I was there for about 7 years—professionally, as well as personally, some of the best ones. We moved there when our older son was only three months old, so essentially all of the infancy and the toddler years of our two sons were spent there. Professionally, I got to take part in an incredible turnaround of the psychiatric hospital, where it went from almost being sold to a for–profit hospital management company to recruiting a brand-new medical staff, developing really great programs, and turning the hospital around clinically and financially.

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My wife and I could have seen me having a long career there, but things pop up. Opportunities come. We invited Steve Sharfstein to be our guest speaker at our faculty retreat. He said, 'I'm going to be retiring, you should really look at my role and see if that's of interest to you.' I got to Vanderbilt in a similar way. The relatively new Chair of Psychiatry there, who had previously been at McLean, asked me to look at the Vanderbilt job. Never in my life had I thought I would move to Tennessee. I had grown up in New York and pretty much have always been in the Northeast. But Nashville felt like a lot of other places that I had been, particularly on the Vanderbilt campus, which looks a lot like other medical centers. Amazingly, we ended up going down there and it turned out to be a great decision."

Q.:" Did you know that the Southern Psychiatric Association decided to meet in Nashville next year?"

Dr. T.:" Perfect! That should be a lot of fun!"

Q.:" How did you get involved with the SPA?"

Dr. T.:" When it met in Tennessee a couple years ago, we exhibited there, and I know that our chairman, Dr. Heckers, spoke. With the transition to Sheppard, and all of Steve's years as being part of the SPA, and now having Janet Bryan involved, it's kind of a no-brainer that we would be more actively involved. We want to make sure that that continues."

Q.:" How do you see the SPA and the APA helping psychiatrists in the future?"

Dr. T.:" In all times of transition, the difficulty that comes up is that each physician is looking at what it means for him or her--for the practice, for their patients, and how they are going to deal with all the changes around them. I think that fundamentally, for organizations, it's really important to keep the focus on why each one exists – How does each organization do its best to make the most impact at the ground level? On the Council for Healthcare Systems and Financing, every conversation is singularly around the idea, 'How does this impact the psychiatrist who is working in the field?' (As well as, 'How does it impact the care that our patients receive?')

Electronic medical records are a source of frustration for many. I've long been an advocate of thinking that there's so many psychiatrists are in private practice, in smaller situations, where it's not economically feasible to have an EMR. If there really was an EMR for psychiatrists – – something that could really work well and something that could be discounted financially for members of an organization--it could make a world of difference. The mental health registry that's being rolled out, it's fundamentally what we need to do to get more data in. The benefit of the mental health registry is that it allows any participating psychiatrist to get qualified to earn incentive dollars for MIPS and MACRA. It also can become, depending on how the whole world of MOC goes, useful for meeting the quality assurance part. More importantly, it could actually help to advance the field, with data coming from people who are actually doing the work all over the country, practicing what is routine care. How can we improve that to make sure that people get better care everywhere?"

Q.: Would you like to make some predictions about how Psychiatry is likely to develop?"

Dr. T.:" The hardest part for Psychiatry is that within the next 10 years about half of all its practitioners will reach retirement age. Fundamentally, the challenge is going to be, 'How do we make sure that we have an impact?' How do we multiply our effect? How do we have physician–led teams? How do we think about how we may oversee the work of multiple social workers, or nurse practitioners, or P.A.'s? Unless we can do it in a thoughtful way, just because of the sheer shortage of providers we may not even be at the table."

Q.:" How can we help you?"

Dr. T.:" For me, it's all about community. I will fully acknowledge that I'm only one year into my role. I have a ton more to learn about Psychiatry in this area. I'm all about collaboration, and learning, and seeing what great ideas we can export, as opposed to having to reinvent the wheel. I think that when I have the opportunity to build stronger relationships and to figure out how we can all work together, I'm all for it."

Becoming an Ironman

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In triathlons, like in depression, you have to go on putting one foot in front of another for as long as it takes. It w ill be painful. Your best-laid plans w ill go awry. Small mistakes early in the race can turn into big problems before the end of the day. The finish line will seem an impossibly long way away. There are moments of despair, but also moments of triumph. There is beauty around the next corner that can give you hope, if you only look up long enough to take it in. But preparing for and finishing the race is much more about your mind than your body.

Dr. Thomas Franklin is the medical director of The Retreat at Sheppard Pratt. He is a clinical assistant professor of psychiatry at the University of Maryland School of Medicine and a candidate at the Washington Center for Psychoanalysis. Dr. Franklin previously served as medical director of Ruxton House, The Retreat's transitional living program, before assuming the role of medical director of The Retreat in 2014.

Psychopharmacology Forum

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Phenytoin: Combining fluoxetine or fluvoxamine with this anticonvulsant can produce toxic levels of it.

Risperidone: Fluoxetine will raise levels of the "risperidone active moiety" (risperidone plus paliperdione) by about 75% and paroxetine will raise them by about 45%. Tamoxifen: This is really a "pro -drug" that relies on intact functioning of CYP2D6 to undergo conversion into 4-hydroxy tamoxifen or endoxifen. That is 100 times more potent an anti-estrogenic compound than the parent drug. So, the same medications that are more dangerous when combined with a TCA, like fluoxetine, paroxetine, or high – dose sertraline, are more likely to deprive tamoxifen of its effectiveness in fighting cancer.

Codeine and hydrocodone: Both are also "prodrugs" at CYP2D6, which converts codeine into morphine and hydrocodone into hydromorphone (Dilaudid). So, when this enzyme is inhibited by potent 2D6 inhibitors, these analgesics might lose their effectiveness.

Next time, I'll continue with antipsychotic crossover titrations, clozapine issues, lithium issues, and a few other bits and pieces.

Dr. Sandson is Clinical Associate Professor for the University of Maryland Medical System and Medical Director of the Baltimore VA Hospital's Acute Inpatient Psychiatric Unit. He is also author of two books: Drug Interactions' Casebook: The Cytochrome P450 System and Beyond (APPI - 2003) and Drug-Drug Interaction Primer: A Compendium of Case Vignettes for the Practicing Clinician (APPI - 2006).

REMEMBRANCE: Clarence Schulz, MD

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Clarence better. The disorientation meeting helped put what we were doing with patients in the context of Sheppard Pratt's rich history of moral treatment.

At the memorial service, Clarence's children spoke about his love of gardening. Their glowing descriptions of their father echoed the nurturing that he provided to his patients. He and his wife, Connie, were inseparable, and her warmth in social situations teamed up well with his somewhat reserved demeanor. It was not surprising and somewhat touching that she passed away shortly after he did.

He helped us become comfortable with our own feelings and ultimately how to use them to help patients. In his later years, Clarence would visit hospitals to do consultations, looking for a narrative of the patient's history that would shed light on the present difficulties. He would look for an example of how a patient interacted in the milieu that was a reflection of his interactions with his family. He would shake his head when what he found was primarily checklists and regulatory obligations. Clarence would be incapable of doing a "med check". He always felt that psychiatrists should adapt to change, but also should maintain their commitment to understanding how people struggle to cope with the ravages of mental illness. He was adamant about the need to have the time to *talk* with patients. He firmly believed that the practice of psychotherapy should be an integral part of what psychiatrists have to offer patients. He felt that psychiatric hospitals need to provide a psychotherapeutic program that prepares the patient for transitioning to outpatient treatment. We would be well advised to advocate for the implementation of these ideas.

I have come to agree with what that clinician described 40 years ago at Scientific Day. I often find myself sitting with a patient and quoting some practical, yet profound, comment of Clarence's. His spirit is still encouraging me to also find the time to listen carefully to what staff members say about the patient. Sometimes, despite my best efforts, I feel entirely hopeless as my countertransference seeps in and obscures the patient's efforts to get well. Yet, in the midst of all this, what he taught me inspires me to continue with the work. Almost everything useful that I have learned in Psychiatry I have learned from Clarence Schulz.

REMEMBRANCE: Marcio V. Pinheiro, MD

(Continued from page 10)

atry was going and what could be done to push it in the right direction. Even in his last years, he enjoyed communicating with people all over the world. He liked to fly and to sail and to learn. He was still seeing patients in his private office two months before he died.

He was very devoted to his family and was justifiably proud of all of them. His elder daughter, Vanessa, commented that they learned a lot from each other because she "was the oldest of the three and he and I faced uncharted territories together. But he taught me most of all respect for human beings. What a wonderful person, with such a big heart, big smile and kind words." His son, Marcos, remembered that he encouraged him to try new things and was always supportive. Alessandra, the youngest, mentioned how patient and caring he was. She pointed out something I first noticed in 1974--people always gravitated towards him at a party or family reunion. Alessandra pointed out that he was such an easy person to talk to, and could comfort her during difficult times in person, over the phone or even through an e-mail. His wife of 43 years, Erika, remarked, "He was a special companion, very warm, present every day in my life, always with extreme dignity. His patience and tolerance were endless."

There are usually only a few colleagues who really change us. They can illustrate the best features of what it means to be a physician and a psychiatrist—what Sir William Osler meant when he said that "the secret of caring for the patient is caring for the patient". Marcio really cared about other people. He knew how to appeal to their inner goodness and how to build up their strengths. Folks just did better when he was around. Those of us who knew him will just have to get along without him, and to try to pass on to others what he so generously shared with us.