



THE
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A Personal Remembrance: Dr. Carol Elizabeth Beasley, MD

By: Robin Weiss, MD



Lisa Beasley, MD

How often do you remember exactly where you were standing the first moment you met someone new?

Rarely. Yet I remember my first encounter with Lisa Beasley. It was 1991, when she found me idling near the residents' office at Shep-

pard Pratt Hospital. Lisa was a fresh attending and I—older than she—was a new resident. We had both taken circuitous paths to arrive there, and she sought me out because she had heard I was a fellow Case-Western Reserve School of Medicine alum.

There she was in the hallway: tall and angular—her blond hair just slightly out of control. Lisa regarded me directly, with her sparkling eyes and warm smile, as if she already knew me. She seemed to emanate light; she had presence.

And that was it. We became friends.

Carol Elizabeth Beasley was born in Little Rock, Arkansas, which endowed her with a certain mid-western solidity and common sense. (You may think of Arkansas as a Southern state; however, it abuts Oklahoma, and Lisa saw it as a hybrid: part mid-western.) Her family moved to Maryland when she was 11. Lisa attended Towson High School where, as a senior, she met Rob Kearney, who later became her husband of 41 years. She referred to him as her rock and the love of her life.

After graduating from college at the University of Maryland, Lisa sauntered into the Phipps Outpatient Clinic at Johns Hopkins and scored a job as an intake worker. In a conversation at Gilchrist Hospice, not long before her death, she marveled that those were the days when such a thing was possible—without submitting a resume or

using LinkedIn. She proved herself invaluable, and her success in the role motivated her to seek further training by attending social work school. However, soon after she embarked on that path, Lisa surveilled the landscape and realized that—at least at Hopkins—doctors, not other professionals, were in charge. So, she decided to change course and go to medical school.

Lisa took pre-med courses at Goucher

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MARYLAND PSYCHIATRIC SOCIETY, INC.
1101 ST. PAUL STREET, SUITE 305
BALTIMORE, MD 21202
PHONE: (410) 625-0232; FAX: (410) 625-0277
EMAIL: MPS@MDPSYCH.ORG
WEB: [HTTP://WWW.MDPSYCH.ORG](http://WWW.MDPSYCH.ORG)

A PERSONAL REMEMBRANCE (Continued from front page)

College and then attended Case-Western Reserve School of Medicine. She completed a residency at Sheppard Pratt Hospital and became a staff psychiatrist there for two years, from 1990 to 1992. After that she opened a private practice, and later joined forces with her best friend and colleague Dr. Virginia (Ginger) Ashley. Lisa and Ginger shared an office for over ten years, until her death.

At the Celebration of Life, held in February at The Church of the Redeemer in Baltimore, Ginger offered a eulogy. She said "Lisa's patients loved her direct, caring, reassuring manner. She was able to put her patients at ease no matter the situation. She was extremely conscientious as a physician. She has had a distinguished career, including past MPS president, but her patients were always first."

For much of her career Lisa worked one day a week at the Johns Hospital Outpatient Clinic, where she lunched regularly with a circle of friends. One of those, Dr. Dinah Miller, remembers, "Lisa always just seemed to delight in everything about her life, whether it was what her girls were doing, her marriage to Rob, going to horse races, her place at the beach, a special pastry or meal, or the opportunity to hang out with friends - she seemed so pleased that there were all these wonderful people and fun things to do in her world."

Lisa became the president of the MPS in 2000. Heidi Bunes, its executive director, says "Lisa Beasley became the first female president in fourteen years and the seventh in MPS history. She stepped up to become an officer in the organization during an active period with strong male leaders, and fit right in. She officiated, along with Harry Brandt, M.D., when the MPS had its 50th anniversary gala at the Visionary Art Museum. She presented the first ever MPS Lifetime of Service Award that night to Dr. Lex Smith. It was especially poignant that he died just three weeks after her untimely death."

"Dr. Beasley was the kind of member whom I expected would one day receive the Lifetime of Service Award herself. She fully understood the value of the organization and was ready to do her part in its success. She was great at nurturing the MPS community of psychiatrists, always enthusiastic about participating in MPS events and happy to see her colleagues. Her smile lit up the entire room when she walked in."

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A PERSONAL REMEMBRANCE

(Continued from page 2)

Because I was next in line as MPS president in 2001, Lisa and I spent many hours in meetings together. We decided to enliven the evening meetings by first having dinner at the City Café. Our conversations generally started out with work—discussing complicated patients or our practices. But as I've found is true with so many professional women with children, we soon wended our way to our hearts' deepest concern: motherhood.

In those days Lisa's two daughters, Katie and Liza, were both Brynn Mawr students and ballerinas at Peabody. I remember we shared an empathetic eye roll, commiserating about the cost of those genuine tutus. I always garnered ballast from Lisa's steady assuredness about the proper extent to which we as parents should go to support our children. Her daughters remained the center of her universe as they grew into competent and independent adults.

Lisa was a woman of varied interests, including travel, books, and writing poetry. The quirkiest, though, may have been this: no mere fan of horseracing, she was a serious handicapper—a skill she learned growing up from her grandmother in Arkansas.

The last time I saw Lisa was at Gilchrist Hospice. She was quite herself: chatty, positive, concerned about others. When I was about to leave, she said "I have one goal right now." I leaned forward, sensing that Lisa was about to impart words of true wisdom.

"I just want to enjoy my life."

Lisa died the next week. She had lived her life passionately, with generosity and optimism, and had died bravely, with dignity. I know that Lisa never set out to be a "role model" – she would never have entertained the idea—but it turns out that is exactly what she is for many of us.

Lisa wrote the poem, "A Dance with Death," during a several month period before she died. It reveals a remarkable woman who – while socializing with friends, seeing patients, and helping her daughter plan her wedding—was also looking death squarely in the eye. She was keenly envisioning her fate and left—in art—a way for us to imagine ours.

A Dance With Death

By: Lisa Beasley, MD

A Dance with Death

Part I: Man with the Golden Curls

I dance with death
He glides gracefully across the floor
His movements crisp, clean
Well suited in his three piece vest
and tails
His thighs large, descending
into small, quick feet

Men, women captivated
as they watch
All eager for a turn
He flirts cunningly
and laughs
throwing back a head
of golden curls

I feel a chill and shift to the side
He pretends not to notice
turning his attention to others
as I slip away

A Dance with Death

Part II: The Boatman

The day is hot, stifling
Air thick as steam
It has become hard to breathe
I lie on the riverbank
panting
under a cloudless sky

A man comes poling his skiff
Along the shoreline
For a single coin he will
take me across the river
where it is cool and shade filled
Others on the shore seem
eager for the ride

Across the river I can
barely make out a dog
grotesque, frightening
I move away from the water's edge
and bear the heat

A Dance with Death

Part III: The Hooded Man

Consumption has left
me coughing
My handkerchief holding
bloody bacillus
I sit shivering
the doctor will not come

He has become a mist
that surrounds me

(Continued on p. 4)

A DANCE WITH DEATH

(Continued from p. 3)

He is accustomed
to my resistance
and follows me
slumping in the corner
sleeping with one eye open

He shifts to squat
on my shoulder
and we move together
as he quietly waits

A Dance with Death Part IV: Body

No worm's meat but
purified by fire
and scattered in clear water
to be taken up by fishes

An Osprey family lives
on a rooftop at the edge
of this salty pond
The landlord has tried
several times to evict them
But always they are determined to rebuild

The mother spreads her wings
and flies just above the water
reaching her talons into
the pond to grab a fish
I feel myself lifted into the air
and brought back to my new twig home

My eyes open and my wings
expand as I begin to fly
free

A Dance with Death Part V: Soul

Whirling upward
as two orbs of light
I drink in the cool air
and breathe deeply
as we travel into the night sky

A white brush of paint
across the horizon
looms ahead
An incubator for baby stars
cradled in their nests
Life in constant creation

The beauty is overwhelming
but I sense that we
have traveled too far
For I must stay and watch over
Death has gotten used
to my demands
Turning slightly
we search for a perch
in the bending sky.

REMEMBRANCE:

Rolfe Finn, MD

By Bruce Hershfield, MD



Rolf Finn, MD

Dr. Rolfe Finn died on January 26th at age 93. Originally from Te Awumutu, New Zealand, he graduated from the University of Otago in 1950. He served as the Clinical Director at Sheppard Pratt—where he was the senior clinician on the inpatient service--

then left to become the medical director at St. Alban's Hospital in Radford Virginia. He returned to the Baltimore area after a few years and served as the medical director of the Walter P Carter Center in Baltimore before he retired.

He was a member of the MPS Council from 1987-91 and was Chair of our Public Psychiatry Committee from 1987-'92.

Thomas Allen ,Jr., MD commented that, " He was a very ethical person and someone who could be counted on to look out for the best interests of the patient. Sheppard was in a period of major changes under Bob Gibson and Clarence Schulz; units were being unlocked, adolescents were added to the mix of patients, there was more freedom for patients on the grounds, and a dining room was added that was used by doctors, nurses and patients. Some things worked and some did not. Rolfe Finn was seen as someone who wanted to be sure the innovations were considered from the patient's perspective, not just done for the sake of doing something differently."

Dr. Erwin Bacmeister remembered him as a gentle and straightforward man who believed in human kindness. That was visible in all his actions. He added that Dr. Finn's wife, Meg—who died in 2015-- was a nurse who also was dedicated to the "profession of doing good for people."

I remember when I met him at my interview for a job at Sheppard in the fall of 1973. I asked him how patients could expect to recover from their psychoses during lengthy hospitalizations, and he pointed out that they could model themselves after psychiatrists who were dedicated to helping them. It was clear then -- and remains clear now, so many years later-- that he was the kind of doctor who could do exactly that.

REMEMBRANCE: Lex Smith, MD

By Bruce Hershfield, MD



Lex Smith, MD

Dr. Lex B. Smith, a former president of the MPS, died on February 12 at age 96.

Born in Teague, Texas, he completed his premedical studies at the University of Texas and then completed medical school at UT-Galveston in three years.

After serving in the Navy, he returned to Texas, where he did a residency in internal

medicine in Dallas and then opened a private practice in Midland. He was recalled to active duty in 1952. During his second semester of a one – year program in psychiatry at Johns Hopkins that he took in order to go along with his internal medicine work, he decided to switch to our field. He became Medical Director and Assistant Professor at the Hopkins School of Hygiene. In 1969, he completed training in psychoanalysis. He served as MPS President in 1977 – 78 and also served as its ethics committee Chair, the director of the Maryland Foundation for Psychiatry, and Chair of the Maryland political action committee. In 2000 he received the first Lifetime of Service award from the MPS.

Dr. Smith, who was interviewed by Dr. Jonas Rappeport in December 2008 for an oral history file, said some interesting things about his life then. He remembered doing the three – year medical school program “around-the-clock”. He reminisced that in the early 1940s “the largest percentage of patients in the hospital were patients with tertiary symptoms of syphilis, known as general paresis of the insane.” They were treated with fever therapy – – intravenous typhoid and hot boxes. He said that when World War II ended he was in transit – – around the time his ship was hit by a typhoon – – which he described as a “very interesting experience”. He said he came to Baltimore to study Psychiatry at Johns Hopkins because he had met the immediate past Chief Resident. He joined the MPS in 1956 and had a private practice from 1958 to 1994 .

Dr. Jimmy Potash, Director of the Department of Psychiatry & Behavioral Sciences at Hopkins, commented that, “ Dr. Smith is remembered by many of us as a psychotherapy supervisor. He joined the part-time faculty in 1956 and remained on it for a remarkable 51 years before becoming an emeritus member in 2007.” His impact on several generations of residents in our department constitutes a memorial with real meaning. I salute Dr. Smith’s many contributions and his lifelong dedication to our department.”

Dr. Jeffrey Janofsky wrote, “ He was my best psychotherapy supervisor. I still hear his voice in my head (‘Be quiet and listen to the patient’) when I’m seeing difficult psychotherapy cases.”

Many of us in the medical and psychiatric communities in Maryland admired him greatly. On February 12th, the Med Chi Faculty Maryland House of Delegates passed a memorial resolution in his honor, requesting that it be” given to his children as an expression of the high esteem in which Dr. Smith is held by his colleagues.”

REMEMBRANCE: Maurice Van Besien, MD

By Bruce Hershfield, MD



Maurice Van Besien, MD

Dr. Maurice Van Besien, who practiced in Towson for many years, died January 15 in Hoschton, GA.

The valedictorian at the Bronx High School of Science, he earned both a bachelor’s degree and a medical degree at Columbia University. He came to Sheppard Pratt in 1957 to do his residency. He later was Adolescent Division Director at Spring Grove-- in charge of 580 patients-- and then set up a private practice, first in Baltimore and later in Towson. He trained at the analytic Institute in Washington DC for five years. He was a psychiatric consultant at Goucher College for about 10 years. In 2009 the Maryland Foundation for Psychiatry selected him as one of the 19 distinguished psychiatrists of Maryland. He retired in 2006 and moved to Georgia in 2010.

When interviewed for the “oral history project”, he reminisced about his early days. He entered the military with the Berry Plan and took a 4 – month course at Brooke Army Hospital. He said he had heard of Dr. Lewis Hill, who died around the time that Dr. Van Besien started his training, and that is one reason he came to Sheppard Pratt. He remembered that they were doing insulin coma and using wet sheet packs at the time-- in addition to intensive psychotherapy - - and that each Resident had 10 or 12 cases to handle.

Dr. Thomas Allen said of him that, “He kept finding ways to adapt to the many changes in Psychiatry throughout his career. In a way, he was ‘a man for all seasons’”. I knew him in the last few years before he left Maryland, because Tom and I several others would have lunch with him on the first Wednesday of the month. He was a thoughtful, gentle man and it was easy to see why he had helped so many patients.

Cheers From The Chair

By: James “Jimmy” Potash, MD, MPH

Director, Johns Hopkins Dept. of Psychiatry & Behavioral Sciences



Jimmy Potash, MD, MPH

Ed's Note: This is a version of Dr. Potash's note to the faculty on 3/15/19

This week I was thrilled to see our department ranked #2 on the 2019 *US News and World Report* Best Psychiatry Programs list. This is a relatively new ranking, having only gotten started last year, when we were rat-

ed #5. It is compiled in the context of assessing medical schools, and thus is not to be confused with the *US News and World Report* ranking of Best Hospitals for Psychiatry, which has been around since 1990. The hospital list is based on the quality of *clinical care* for patients, whereas the new ranking is focused on the quality of the *educational experience* for students and trainees, as voted on by Deans and other senior faculty across the nation's 185 medical schools. Thanks to our educational leaders for doing the hard, impressive, and creative work required to establish this kind of superb reputation for us. Thanks especially to Vice Chair for Education Meg Chisolm, to Drs. Susan Lehmann and Avi Gerstenblith, who direct the medical student clerkship, and to Dr. Dean MacKinnon, who directs the first-year medical student course on Brain, Mind, and Behavior. Of course, the educational experience extends much further, to graduate students, interns, residents, and post-doctoral fellows. I appreciate the efforts of so many.

Today is a big day in the medical training world, as it is Match Day, when more than 51,000 medical students and international medical graduates find out where they will go for residency. Within psychiatry, this year saw the largest number of applicants to our field since at least 2010, with 2,148 US and Canadian medical graduates, and 2,407 international medical graduates (IMGs) applying. The average applicant in each of these two groups applied to 52 different residency programs, and the average program received 464 applications from the US grads and 551 from the IMGs. That makes for a large and demanding task of sorting and vetting for Residency Director Graham Redgrave, MD and for his team of Drs. Anne Ruble and John Lipsey, and coordinator La Shawn Johnson-Thomas. Thanks to this terrific group and to the resi-

dents and faculty who have helped them to interview and recruit the applicants.

One of our earliest successes in terms of psychiatric education, both in our medical school and residency, was in producing a star psychiatrist, Dr. Esther Richards, who graduated from the School of Medicine in 1915, and from the Phipps training program a couple of years after that. She went on to direct the Phipps outpatient clinic from 1920-51, and to also lead the Psychopathic Division of Baltimore City Hospital. She authored over 100 papers and two books, *Behavior Aspects of Child Conduct* and *Introduction to Psychobiology and Psychiatry*. In 1940, she was featured in a national magazine. It was not, alas, *US News and World Report*, but rather *Cosmopolitan*. Here's an excerpt: "The rooms are grim and dingy...The low ceilings press down with their weight of woe. The long benches sag with men and women sitting with hands taut and eyes fear-haunted. Until Dr. Richards bounces in. Then suddenly the whole place seems like a meadow after a summer rain. The queer fearful shadows recede; commonplaces emerge defined and dependable...[Patients] come to this, the Phipps Psychiatric Clinic of Johns Hopkins Hospital in Baltimore, because they know that if it is humanly possible Esther Richards will sweep away the cobwebs...Dr. Richards' treatment varies with each case, but she has a routine approach to each of her problems. 'What is the stuff of which this individual is made?' she asks herself. 'What are his intellectual, biologic and temperamental qualities?' "

Dr. Richards was clearly an impressive woman! May we all work to create the kind of environment that makes fearful shadows recede and renders this whole place seeming like a meadow after a summer rain.



Esther Richards, MD



Interview: Todd Peters, MD

Director, Sheppard Pratt Children & Adolescent Services

By: Bruce Hershfield, MD

April 15, 2019

Q: "Please tell us about the work you are doing at Sheppard."

Dr. P.: "I am the Medical Director for child and adolescent services here and I am also the Chief Medical Informatics Officer for Sheppard Pratt health systems. This is a new role at Sheppard, but one that is found in other major health systems. I try to work on liaisons between the major parts of the staff here just to make sure they are having success in translating the clinical work they are doing best into the medical record. I work with our IT team to make sure that all our documents are set up in the way they need to be, working on the best approaches to data sharing, looking into comprehensively capturing all that we are doing, electronically."

Q: "How did you learn about that?"

Dr. P.: "Starting with medical school at Penn State, I had always been at places that were transitioning from paper records to electronic ones. Because of my interest in technology, I was able to get involved as the Resident Representative when I was at Brown. Then, when I was at Vanderbilt, I was involved in a lot of system – wide meetings, as a representative from Psychiatry. I was in a lot of meetings with the chief informatics officer and a lot of the IT team. There was an opening to be the assistant chief and I was able to take that job. I was able to address how we could better care for the patients, using the tools we had within the electronic health system."

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

Dr. P.: "I was initially going to be a pediatrician. I don't think that when I entered medical school I even fully knew what a psychiatrist *was*. It wasn't until I went into my third year of medical school

that I realized what I had been missing. I had always been the person who was always interested in somebody's stories. I was the one who wondered if Jimmy's asthma was different from Johnny's because one was living in squalor and the other had a nice place as a home. I took the child psychiatry rotation as an elective and I fell in love with the work there and made the leap of faith to go into a psychiatry residency."

Q: "How did you get from Rhode island to Tennessee?"

Dr. P.: "At the time, my wife and I had a 1 ½ year old and we were trying to find a "larger small city". In the interview process, I fell in love with Nashville, which is a really nice city. Vanderbilt had the type of position I was looking for. It offered opportunities to do administrative work and also the kind of clinical work I wanted to do. I did inpatient work and even became an ECT provider during the early part of my time there."

Q: "So how did you come to Sheppard?"

Dr. P.: "About one year ago my wife and I, who were both originally from Pennsylvania, decided it would be a good

idea to relocate close to our families because by then we had two sons. We both came from large families ourselves and thought it was important to try to move closer, so our boys could have the same experience we did. At the time, Sheppard was looking for both a Medical Director for Child and Adolescent Psychiatry and also an informatics person. I knew a lot about Sheppard Pratt because I had considered going to the U. of Maryland for both medical school and psychiatric training. We are within about two hours now of both sides of the family. The last few months, our boys have gotten to see more of the family than in all their lives before then."



Todd Peters, MD, FAPA

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Q: "I understand you have done quite a bit of work in psychiatric organizations."

Dr. P.: "I have been involved as the ACAP's liaison to the APA technology committee, so I've been working with them throughout the years. I have been more involved on the ACAP side of things. I am the Chair of our health education technology committee and I've been a member of our healthcare access and economic committee for about 10 years now, since I was a Fellow. I've done a fair number of presentations both, both at APAC and the APA annual meetings."

Q: "What are your interests in research?"

Dr. P.: "My interest in academia has always been about teaching. That includes teaching people how to best work with families. I am the consulting editor for the *Child & Adolescent Clinics of North America* journal because a lot of it is in a review article format. If I wasn't doing any of this I probably would be a high school teacher in something like biology because I really enjoy making things click for people. If I am able to digest material and explain it in a way that people can understand, that brings me a lot of joy-- even more than finding out what gene does what. I was a biochem major, but I really enjoy being able to turn complex things into material that is understandable to patients and colleagues."

Q: "It sounds like you've already accomplished a lot, but what ambitions do you have for the future?"

Dr. P.: "I'm hoping to be at Sheppard for a long time. I would like to grow out our IT structure here to improve our "patient recorded outcomes", making it easier for people here in our clinical organizations to do work that they really want to do. I like to have the computers and electronic health record seen as assets-- not just the *thing* that one has to do. In the past, the position of Director of Child and Adolescent services has been focused on acute inpatient services but I have been working heavily with our residential programs. We have been trying to make some inroads about how we can improve medical services across all of our different service lines."

What Happens When MedChi Meets?

By: Anne Hanson, MD



Annette Hanson, MD

On April 28th Dr. Elias Shaya represented the MPS as our delegate to Med Chi's semi-annual meeting. As our official delegate, Dr. Shaya had the right to speak and vote on behalf of MPS. I attended in order to watch, learn, and listen in my non-voting role as Chair of the MPS legislative committee and a member of the Howard County Med Chi chapter.

The first thing I learned was that in comparison to the MPS it is much larger and more complicated. With ten times the membership, their organizational structure is similarly more complex. It has 24 component medical societies and several affiliated specialty societies. Unlike the APA, which has a single national Board of Trustees, Med Chi itself has a state Board of Trustees and it sends delegates to the AMA's national House of Delegates meetings.

This particular state meeting covered a broad variety of topics; its resolutions are analogous to the APA's action papers. I knew that insurance parity was an issue for psychiatrists, but I learned that Maryland physicians generally are reimbursed at lower rates than similar physicians in other states. One resolution that passed called for studying the causes of this disparity. Another resolution required Med Chi to make recommendations to the Medical Cannabis Commission regarding training requirements for health professions who issue medical marijuana certificates. Finally, the medical student section of Med Chi introduced a resolution requiring family consent for cadaver donations to medical schools. Under current Maryland law, unclaimed bodies can be used for anatomical study without authorization, and have even been sold out-of-state. This resolution was surprisingly controversial, but ultimately passed. Some resolutions, such as those involving scope of practice and the mental health implications of certain procedures, had much in common with MPS interests.

I was fortunate to meet the current president, Dr. Benjamin Stallings, as well as the Chair of the Maryland opioid task force. We discussed common concerns and will likely be coordinating legislative efforts in the 2020 General Assembly.

Any affiliated specialty organization can submit a resolution to the House of Delegates if it is sponsored by five Med Chi members. Given that both our organizations work closely on a variety of legislative and advocacy efforts, I would welcome member suggestions for Med Chi resolutions.

Our professional organizations are strongest when we join together on a united front.

Robert McAllister, MD MPS's First Centenarian

By: Bruce T. Taylor, MD



**Bruce
Taylor, MD**

I first met Robert McAllister when he applied to join the staff of Taylor Manor Hospital in 1985. I was just six years into running the hospital, but Bob was already an accomplished professional of my father's generation. Having served in WWII prior to obtaining his master's and PhD in psychology from Catholic University, he had gotten his MD in 1956 from Georgetown and completed his psychiatric residency at Seton in 1960. Dr. McAllister joined the MPS in 1986 and is a Distinguished Life Fellow who became a 50-year Fellow in 2009.

Prior to joining Taylor Manor he had consulted for the National Security Agency, a home for boys, a CMHC, a drug treatment program and a youth center. He had been the superintendent of the Nevada State Hospital in Reno and had been in private practice. He had published *Conflict in Community* and was working on *Living the Vows – Emotional Conflicts of Celibate Religious*.

I was impressed by the depth and breadth of his experience, his publications, his dedication to psychiatric care, his mastery of difficult psychiatric tasks, and his calm demeanor. He has always demonstrated a commitment to sharing with others his understanding of the challenges, pitfalls, and rewards of those who choose to minister to others--whether as medical or religious professionals. Soon after he joined our staff, we established the Isaac Taylor Institute of Psychiatry and Religion. My grandfather Isaac's epitaph was: "Live, Let Live and Help Others to Live." Bob has been an embodiment of that motto. He recognized the key role that psychiatric care could play for ministers of any service or faith who develop emotional distress caring for others.

As an outgrowth of the Institute, *Surviving in Ministry* was published in 1990, with Dr. McAllister writing chapter four, "Anger and Guilt." The conclusion of this chapter reveals his insight: "A healthy and holy perspective on anger allows for its presence as part of the human emotion, permits its expression in a variety of non-hurtful ways, and demands responsibility for making any contributions through one's anger to the evils of hate and violence."

After leaving Taylor Manor in 2002, he maintained a private practice for another three years before "retiring" to care for family members and to continue his writings: *Emotions: Mystery or Madness*; Authorhouse, Bloomington, IN 2007; and *An Alzheimer's Love Story*; Authorhouse, Bloomington, IN 2012. He told me the other day that he is working on yet another book from his home in Columbia.

May we all have the strength to celebrate our 100th birthdays! We wish Bob the best as he reaches that mark this August.



**Robert
McAllister, MD**



Nurse Practitioners & Psychiatrists

By: Kim Jones-Fearing, MD



Kim Jones-Fearing, MD

Nurse practitioners are being supported by various organizations, including the Black Mental Health Alliance, and by large nursing educational institutions such as the University of Maryland. This is having an impact on how psychiatrists work in our state and we need to do something to organize how to deal with it.

The legislature recently supported several bills allowing them to take jobs previously meant for psychiatrists. In the last session, multiple bills were put in place to study the problems regarding mental health care access. All of them failed. Instead, laws were passed to allow nurse practitioners to take the place of psychiatrists in telemedicine. The exact same bills put forth last year -- for *psychiatrists* to expand Telemedicine as medical directors-- all failed. Senate bill 1122 passed in early April, allowing nurse practitioners to work as medical directors for outpatient mental health centers in Maryland. The rationale was that "psychiatrists are moving away from working in the public sector".

One week after I got word that SB 1122 legislation passed—allowing nurse practitioners to work as "medical directors" for outpatient mental health centers (OHMC), I lost my job as medical director of one in Baltimore.

It does not appear that nurse practitioners are being trained to work alongside or in unison with psychiatrists or under their supervision. Instead, they are being trained to work *instead of* psychiatrists. Twenty-five states now allow nurse practitioners to practice without the supervision of a physician. However, they have not been provided with any of the training or supervision regarding therapy--like transference, countertransference, or common defense mechanisms that interfere with a patient's pathway to wellness. In environments where I have worked, they have contributed to a *four-fold* increase in the amount of medications prescribed. These same environments lacked psychotherapy, group therapies, or psycho-education or support groups intended to decrease excessive medication-seeking.

Several changes within psychiatry are contributing to the situation. Part of the reason psychiatrists are "moving away from working in the public sector" is that our numbers in Maryland have been decreasing since 2003. Salaries and reimbursements for psychiatrists here are among the lowest in the country. These low salaries

combined with the high cost of living and student loan debt makes practicing psychiatry cost-prohibitive for many physicians in Maryland. I suspect another reason for the shortage of psychiatrists is that the American Board of Psychiatry and Neurology (ABPN) has been damaging the process of credentialing and hiring us. During 2018, the justice department ruled that the ABPN and the maintenance of certification process (MOC) have had the effect of a monopoly in the state of Maryland. I have been told by multiple employers that, due to credentialing burdens, they are choosing to hire NP's instead of psychiatrists. Insurance companies also interfere with psychiatrists' access to patients and employment. Psychiatrists who apply for work at large hospitals such as the University of Maryland are told that they cannot see insured patients in private practice. I was told that this is due to problems that occur with billing errors like payments being sent to the wrong address and because it causes confusion in computing outcome data as it relates to medical homes.

We need to act in an organized fashion so that these legislative changes help, rather than hinder, our field. The MPS can assist by educating legislators about the need for improved insurance reimbursements for inexpensive and efficient therapies. For example, group therapies can engage larger numbers of patients with difficult -- to -- treat comorbid psychiatric disorders and substance abuse. Legislators need to realize they should hire and retain psychiatrists to direct the mental health systems, *working together* with NP's and physicians' assistants to effectively reach more patients. In the clinics where I have worked, many children and adolescents have missed out on years of schooling due to a lack resources for psychological testing and/or basic blood tests. In my work as a medical director of an OMHC I have seen psychological testing reveal diagnoses such as intellectual deficiency (in a 14 y.o. in regular classes), autism spectrum (in an 11 y.o. in regular classes), severe hypothyroid disorder as a cause of severe depression and unemployment (in a 21 y.o. with intellectual deficiency and cerebral palsy), cannabis use disorder in a 15 y.o. with severe depression being given cannabis daily by her mother, fentanyl use disorder in a woman on methadone who was caring for three young children, and previously undiagnosed hypothyroidism in a woman who had multiple failed antidepressant trials for the past 20 years.

[\(Continued on p. 11\)](#)

Nurse Practitioners & Psychiatrists (Continued from page 10)

The MPS and the APA could do a lot to improve health care access for our patients.

I think we need to lobby more in Annapolis. We need to educate the legislators and our governor about what they can do to make psychiatrists more likely to seek public employment. I also want the legislators educated about commercial online ratings sites (like Yelp, Healthgrades and Web MD) that have adverse effects on patient care and patients' likelihood to seek treatment. In addition, these sites are being used as a reason for firing providers by non-physician administrators. Legislators often are unaware that these sites have been researched and have been found to not correlate clinically to professional ratings tools designed for larger institutions such as Press Ganey. Patients who use these commercial rating sites have been found to have poorer treatment outcomes and higher mortality partly because they tend to be seeking drugs and other treatments that physicians have not felt were safe or appropriate to prescribe. Another internet-related issue worth addressing is the now pervasive use of the internet for employment applications. The problem is that no one appears to be monitoring the online application sites, including state government sites, which are *not* formatted for doctors to use. There is no online phone support. Nobody is calling people back for interviews. I am still waiting for a call back from an application I submitted 5 months ago.

We need to educate all hirers of psychiatrists to stop asking illegal questions in interviews. Every interviewer I have had has asked me about my Facebook postings. (I —like the majority of psychiatrists-- lean liberal). I also had questions soliciting information about marital status, children and other irrelevant personal information. I was never offered the jobs. The online hiring process for state doctors was asking illegal questions about previous salaries. It is now illegal to ask applicants about this because it was found to lead to \$100,000 pay disparities between male and female physicians of all specialties in Maryland according to research by Med Chi in collaboration with Merritt Hawkins. Our legislature and governor *do* have the capacity to improve the situation for psychiatrists and for the patients we can best serve.

I hope that we can address the real reasons for mental health disparities and chaotic and fragmented care. We need real remedies--not legislation that replaces psychiatrists with less experienced and less qualified professionals.

Member Updates and Survey

The MPS sent member information update forms as well as the [2019 member survey](#) in May. Please watch your US mail and return your information promptly!

Member Update Form

The MPS membership directory will be published in late Summer and we need you to make sure our information is up to date. If you opt in, this data is also used for the online Find a Psychiatrist and the telephone patient referral service. We added more insurance participation options, so be sure to indicate all networks you're part of. You can also log in to your member account on the MPS website to directly enter updates. **The deadline for directory changes is July 31.**

Member Survey

Please give input to help guide how MPS committees, Council and staff will work for you in the coming year. **INCENTIVE:** Three respondents who complete the entire survey and include their names will be chosen at random for a **\$100 credit** that can be applied toward MPS dues or an MPS event. [CLICK HERE](#) to start – this should take less than 5 minutes!

Please call the MPS office at 410-625-0232 or email mps@mdpsych.org with questions.

Special Member Rate for 2019 MPS Directory Ad

MPS members can advertise their practice, change in office location, specialty, new book, etc. for a special members-only rate of \$100 for 1/3 page in the directory. The 2019-2020 directory will be out early in the fall, so be sure to order soon!

For details, contact Meagan Floyd at the MPS office 410-625-0232 or mfloyd@mdpsych.org.





The Changing Nature of Our Profession: One Psychiatrist's Story

By Robert Herman, MD



**Robert
Herman, MD**

When I graduated from my residency at NYU in 1987, the majority of my class appeared to be going into a traditional outpatient practice with an emphasis on psychotherapy. There was a psychoanalytic institute affiliated with NYU, and many of the faculty of the institute were our teachers. After residency a couple of us did child psychiatry,

and a couple more did consult, fellowships. Psychopharmacotherapy when I was a Resident was very limited. For depression we had the tricyclics and MAO inhibitors. For psychosis we had haloperidol, perphenazine, and a few others. Temazepam for sleep. And Lithium.

I rented an office from an older colleague who was a psychoanalyst, and I became a candidate at the Columbia Psychoanalytic Institute. I bought office furniture, including, of course, a couch. I got an inpatient hospital job, and gradually started building a psychotherapy practice. Gradually, things began to change. Six months after I graduated, the FDA approved fluoxetine for the treatment of depression! About six months later, I spoke to someone a year junior to me who was starting a psychopharmacotherapy practice. In 1992 sertraline and paroxetine were approved.

I began getting referrals of patients for medication treatment. One patient in his 50's told me one day that he realized that he had been depressed from the age of 11 until about three months before that, when we had found a combination that worked. I had a patient with bipolar disorder who attended a support group whose members would often ask for the names of psychiatrists; mine was mentioned and my practice grew. I took a job as an inpatient attending in a private hospital near my office; it made sense for me to follow the patients I took care of in the hospital after their discharge. Managed care was forcing shorter and shorter hospital stays; I had to take care of sicker and sicker folks as outpatients rather than inpatients.

In the late 1980s, addiction was becoming a specialty within the field of psychiatry. When I had been a Resident in the ER at Bellevue, I had seen scores of patients coming in on drugs, especially crack cocaine. In my fourth year I did electives in the alcoholism and methadone clinics. After residency I did some work in substance abuse treatment programs, and began attend-

ing conferences and reading journals in the field. I have continued to treat patients with substance abuse problems, and now have close to 100 patients on buprenorphine.

In 1996 I relocated to Maryland, as it seemed a better place to raise a family. I found it hard to close my practice in New York. At first, I took salaried jobs again, doing addiction treatment, and later in college mental health. I joined a large group mental health practice. There were many psychologists, a few social workers, and only two other psychiatrists. After a time, one of the psychiatrists retired, and the other moved away, so I became quite busy. With the advent of the internet, I joined several e-mail lists, including one about psychopharmacology that was started by a psychiatrist, Ivan Goldberg. He taught me how to use lamotrigine, and I was finding it to be a very effective medication for bipolar depressed patients. When it was approved for the treatment of bipolar disorder in 2003 I was asked to be on the speaker's bureau by GlaxoSmithKline. I met a number of leaders in the field like Hussein Manji, Nassir Ghaemi, Joseph Calabrese, Fred Goodwin, and Robert Post. Nassir Ghaemi told me I should join the International Society for Bipolar Disorders, which I did, and I began to attend their meetings.

I have been in the same group practice for the past 19 years. I have a large number of patients, many of whom have been with me for many years. They have been my most important teachers. But caring for this ever-increasing number of patients who are stable but still need to be seen periodically means that I have less time available to see new patients who are acutely ill. This is something I am currently struggling with, so I have recently been teaching psychiatric nurses who are pursuing certification as psychiatric nurse practitioners. It is my hope that some will join my practice and will see my stable patients so that I can take on new patients in a more timely manner.

When I look *back* over my career (it is, I hope, far from over!), I see that my personal inclinations and decisions have changed it over time. But I think it has also been affected by changes in our society as a whole—like the declining influence of psychoanalytic psychotherapy and psychoanalysis, the shortening of hospital stays, and the growing number of pharmacologic agents to treat psychiatric illness. As I look *forward* I wonder what changes are in store for our profession and for my practice.



The MPS Annual Meeting Hotel Monaco April 25, 2019

By: Bruce Hershfield, MD

On April 25 the MPS held its annual meeting in Baltimore's Monaco hotel for the first time.

The presentation of the 2019 Maryland Foundation for Psychiatry Anti-stigma Advocacy Award was given to the Rev. Damion Cooper, a Baptist minister who was director of community relations for the city Council President for nine years. In an article he wrote for the Baltimore *Sun* several months ago, he pointed out that seeking help is not a sign of weakness, but of strength.

After dinner, the winners for the best paper award and the best poster competition were announced. The best paper award winners were Drs. Viviana Alvarez – Toro ("Revisiting the False Confession Problem") and Traci Speed ("An Innovative Perioperative Pain Program for Chronic Opioid Users"). The best poster board winner was Dr. Katherine Skimming.

The MPS then presented its 2019 lifetime of service award to Dr. Arthur Hildreth.

Dr. Patrick Triplett, in his outgoing presidential remarks, pointed at technological improvements that have affected us recently and mentioned that the MPS has had its strongest financial finish in over 10 years. It has also had recent successes in governmental relations, including Advocacy Day, and a number of legislative successes, he added.

Marsden McGuire, MD, the incoming president, then gave his remarks. He thanked members of this year's council and our excellent administrative staff and talked about his hopes for the year ahead. He hopes to combat stigma concerning mental health issues, to see the MPS become more inclusive-- in particular with younger members' ideas-- and to have us collaborate more with other mental health professionals. There are lots of opportunities for us to have a positive effect on the suicide rate and the problem with opioids, he commented.

This transition from one successful presidency to what promises to be another is a clear example of what has characterized MPS leadership for many years. It was gratifying to see some of the many who volunteer their time get recognized for their efforts—and to acknowledge the excellent service that our administrative staff gives us year round.



(L-R)
MPS members Drs. Jimmy Potash, Jennifer Palmer & Mark Ehrenreich



MPS Poster Contest Winners Presentation: (L-R)
Drs. Neil Warres, Shapir Rosenberg, Katie Skimming, Idris Leppla & Robert Roca



MPS Paper Contest Winners (L-R) Drs. Traci Speed & Viviana Alvarez-Toro



The 2019 Maryland Foundation for Psychiatry Anti-stigma Advocacy Award presentation. (L-R) Neil Warres, MD & Rev. Damion Cooper



Arthur Hildreth, MD 2019 Lifetime of Service Awardee

Introduction by Bruce Hershfield, MD



(L-R)
Drs. Patrick Triplett & Art Hildreth

April 25, 2019

Today is the 45th anniversary of when I first got my license to practice Medicine in Maryland. That was the same day that I met Art Hildreth, when I came to Sheppard Pratt to meet with some of the staff I'd be working with in July. I'm very pleased that he is this year's recipient of the Lifetime of Service

award for the MPS. This is the 20th Lifetime of Service award; the first was when Lisa Beasley gave one to Lex Smith. I want to acknowledge how much many of us miss those two, who recently left us.

Art did his psychiatric training at Johns Hopkins and six years later he graduated from the Baltimore-Washington Institute for Psychoanalysis. He was at Sheppard Pratt from 1970 to 1982 and served as the president of the medical staff there. Since then, he has been on the medical staff at Union Memorial, where he was Chief of the Department of Psychiatry. He was a founding member of the EHP behavioral services. Since 2014 he has been the medical director of the physicians' health program. He has taught in all three of the residency training programs and continues to be a supervisor at Sheppard Pratt.

He has done a lot for the MPS. Besides being president in 1992 – 93-- when we worked closely because we were on the executive committee together-- he was the membership Chair from 1975 to 1981 and then again from 1986 to 1989. He was our first managed-care Chair. He was a member of the Program and CME committee for 15 years and served as its Chair in 1991-92. He has been a member of the Distinguished Fellowship committee since 1997. For six years he was on the board of the Maryland Foundation for Psychiatry. That included four years as its vice president.

I remember very well the year when he was my boss on the acute admissions unit at Sheppard Pratt. He was always kind and helpful. We also had lots of fun. I remember asking him if it was true that he had been a varsity football player at the Friends school when he was in high school and he said that he indeed had been and that they were known as the "Friendly Friends". He surely was a good friend to me. He taught me plenty, helped everyone to get along, and was particularly good to the patients. I think a good test of people's character is how they treat folks who are subordinate to them in some way. That is one reason why I am so pleased to be able to introduce Art-- he was kind to me at a time when he didn't have to be. If all people treated other people the way Art treated folks then -- and there are many indications that indeed he does—we'd have a better world. So let me express the thanks of a grateful Society for all you have done for us.



(L-R)
Carol Allen, Louise Hildreth, Tom Allen, MD & Art Hildreth, MD



So Many Things Come Together In The Neck

By K. Hogan Pesaniello, MD



**K. Hogan
Pesaniello, MD**

I have about five or six patients with cervical instability, mostly from concussions, often with some other factor like a football injury, being thrown from a horse, or poor posture. All have mild sleep apnea. Often, they have photophobia, hyperacusis, and overstimulation from vision. Good psychiatric care for these patients requires advocacy, persistence, and collaboration with clinicians familiar with the diverse issues that come together in the neck region. Among the structures and syndromes

to consider:

- Is there cervical subluxation/atlando-axial ligament laxity and consequent occipital neuralgia? Impingement and/or inflammation on the occipital nerve can create problems as wide-ranging as autonomic instability, hyperacusis, and balance issues. This is in part due to the creating of disruptive brain circuits leading to a negative feedback loop from the occipital nerve into the vagal and trigeminal nuclei in the brainstem. Cognitive/brain processing, sleep, and mood dysregulation problems can result from this disruption.

- What is the role of upper body posture, related tongue position, and sleep apnea? Problems here can create air flow resistance, which can lead to brain arousal during the night. Some dentists believe tongue position can contribute to anxiety and stress-related symptoms.

- Is there a "vision processing" disorder contributing to cognitive and emotional symptoms? In *The Ghost in my Brain*, Steve Elliott, PhD describes the restoration of his own post-concussive problems with balance and cognition and self-regulation, as well as improvement in longstanding ADHD with a dedicated course of vision therapy (including specialized prisms and color filters) and cognitive rehab. Eye-movement disorders, such as nystagmus, or balance issues are often missed or dismissed by other clinicians, partly because they are so complex.

Cervical instability: The atlanto – axial junction is a veritable superhighway exchange for arteries, veins and nerves – diving from the periphery into the spinal column and cranium. All is managed with full head movement due to the unique anatomy of the C1-C2 junction. Prior whiplash and congenital abnormalities can pre-dispose patients to have trouble in this region after a sports or concussive injury.

Sometimes the occipital nerve and/or other structures are being pinched or have been irritated. A thorough assessment actually requires x-ray through the open mouth with the right degree of flexion and it needs to be evaluated by an experienced radiologist or neurologist. Be cautious about accepting statements that the neck MRI showed no problems. Are symptoms related to ongoing pressure on

the occipital nerve vs inflamed occipital nerve vs lax ligaments vs weak muscles vs problematic previous whiplash? Each is addressed differently, from soft collar, muscle relaxant, and anti-inflammatories, to more invasive techniques --including steroid injections to nerve ablation that can reduce pain and negative feedback via the occipital nerve. Some patients require deep and risky neck stabilization surgery.

What is the relevance to psychiatric treatment?

When the problem is a disrupted feedback loop between a compromised occipital nerve and the trigeminal and vagal nuclei, it can create havoc in the CNS, throwing off many circuits that interact with them.

An old and "healed" injury that created disruptive firing in the brain stem /midbrain nuclei and cortical networks may simply never have stopped. Normal Doidge, in a presentation a few years ago, described the powerful ability of the brain to heal itself through cognitive games and other practice if only the disruptive maladaptive circuitry can be quieted enough. Psychiatrists need to be looking for ways to accomplish the necessary quieting and to facilitate the resurrection of the old, viable circuits for better regulation. Is it the old injury or the disruptive firing (the "noise" in the brain) that is sustaining itself that needs addressing? That's where techniques and procedures that provide stimulation, and retraining the connections, may come in.

The PoNS (neurostimulation via the tongue) is a device already in use in Canada. It is laboring its way through the FDA approval process. It is used along with vestibular/physical therapy and cognitive therapy (brain and vision processing games.) To learn more, Google PoNS stimulator and uTube and Norman Doidge, MD to see the ataxic patients walking before and after their work with the PoNS. Hear them describe the quieting in their brain immediately, after years of disruption – a quieting that increased in length with repeat stimulation. The brain games they are playing with the tongue stimulator in place look much like the BrainHQ "track-the-fish" game that is available on line. I'm curious about its impact on psychiatric treatment of post-concussive neuropsychiatric symptoms. What if it can help other psychiatric conditions where brain behavior takes on a life of its own? How often might brain stimulation disrupt this and help restore function?

Assessing vision processing.

(Read *The Ghost in my Brain*, in which Steve Elliott describes the restoration of balance and cognition and self-regulation and addressing longstanding ADHD, through work with Dr. Donalee Markus, psychologist (StrongMind games), and Dr. Deborah Zelinsky, developmental optometrist

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So Many Things Come Together In The Neck

(Continued from page 15)

(www.mindeyeconnection.com). In a discussion with these two clinicians, I learned of something called the Mosgutova method (a body therapy for restoring the suppression of primitive reflexes). Examples of primitive reflexes are the Moro reflex and the tonic neck reflex. The suppression of primitive reflexes in early childhood reflects the consolidation of neural networks underlying spacial processing, arousal responses, navigation, and cognitive sequencing. These can re-emerge after head trauma/neck injury. The emergence of primitive reflexes reflects the disruption of those nuclei/relay centers in the CNS that are affected by neck injuries. Re-suppressing these reflexes can be crucial to reducing arousal/overstimulation and improving self-regulation.

Dr. Kungle, a developmental optometrist, did an exam that included this for one of my patients, which led to a referral to a sports neurologist who specialized in this area and to a neuro-ophthalmologist who confirmed the profound visual deficits. Her cognitive and mood issues were likely secondary to her neck problem. It was suggested that her difficulty in being able to engage effectively in some of the vision therapy was related to her Moro reflex, and that her childhood trauma predisposed her to having that reflex re-emerge.

Identifying vision processing issues:

The new "RightEye platform" is a computer – based eye – tracking technology that helps diagnose eye movement abnormalities and can also be used to provide some at – home therapy. If you suspect there is a vision issue underlying attention, over-arousal, or dizziness symptoms, you can find RightEye providers online who can screen for eye movement disorders. Always consider referring for an evaluation by an experienced vision therapist.

Regarding sleep apnea:

Most of my patients with post-concussive and neck issues seem to also have at least mild sleep apnea and /or other sleep dysregulation. Mild, but frequent, reduction in airflow during sleep can cause abnormalities of brain arousal and can contribute to depression or make it difficult to treat. Minimizing any sleep apnea with positive pressure or an oral device, unless that worsens the central sleep apnea or pulmonary issues like COPD, can help. The presence of a mood disorder may qualify patients for an in- house sleep study instead of one at home. When ordering sleep studies, I specifically request that the clinician reading them comment on the presence or absence of non-airway-related arousals or alpha-intrusion, and how frequently these occur. I ask whether the patients are likely to benefit from C-PAP or an oral device.

Regarding oral devices for sleep apnea/tongue position:

A dentist within driving distance of my office continues to advise using a non-traditional oral device. It focuses on tongue positioning to correct a myriad of problems, including depression and anxiety. I understood him to say he believed that childhood trauma creates posture and neck and tongue issues that affect tongue positioning. This puts the individual in a chronically stressed state from both sleep apnea and the body's response to a mildly constricted airway during "awake time". These interfere with nighttime breathing, leading to adrenal/autonomic dysfunction. He advocated using his de-

vice during the day. (The traditional devices for mild sleep apnea cause problems with appearance and speech if you try to use them then.) Instead of the daily repositioning that current orthodontists advise in the morning for 10 minutes or so after wearing an oral device for mild sleep apnea, he recommends leaving the tongue (and jaw) in a slightly more forward position. (Of course, this causes malocclusion with chewing.) He's the only one in this part of the country doing this, since the group that advocated this did not convince their professional organizations to adopt it. He felt the device was key for a number of his patients in addressing treatment-resistant depression and sleep issues. I am aware there *are* physical exercises that can be done with the tongue/mouth in the hope of improving tone. But it is less clear if this approach can be powerful enough to help with sleep apnea. I have been wondering about this as well as voice therapies for my shrill-speaking traumatized individuals, and for patients refusing /resisting first- line treatments for mild sleep apnea.

Shortly after hearing of the tongue-positioning device, I attended a workshop with Judith Penington, a researcher in meditation and EEG. She described the profound impact of relaxing the tongue. Focusing relaxation on the root of the tongue, making sure the tongue is not pushing upward against the roof of the mouth or against the teeth, and allowing the tongue to "float" are techniques for quieting the mind. This made me wonder about the impact on psychiatric symptoms of anything that improves tongue positioning and tension, as well as posture.

The first patient I encountered with occipital neuritis and atlantoaxial issues and eye movement problems is not a candidate for neck stabilization surgery, and I am hoping she can use the PoNS stimulator. The second patient with neck issues also had POTS syndrome (Postural Orthostatic Tachycardia Syndrome) and could not tolerate even tiny doses of medications. However, pirHEG (Passive-Infrared Hemoencephalography) and HRV (heart rate variability) calmed her and improved her depression and her tendency to catastrophize. A recent patient came with panic associated with vision issues from a concussion, but was helped by biofeedback and breath coaching. All of these patients had limited response to medications, as well as exquisite sensitivity to side effects.

We need to find out more about assessment and physiologic interventions for the neck/airway, especially for patients who have been traumatized as youngsters. We need to understand more about the role of compromise of the atlanto-axial junction-- along with sleep apnea, the re-emergence of primitive reflexes, and vision processing issues. I hope we will soon see a better team approach and new technologies like the PoNS becoming available to our patients.



MPS Hosts Workshop About Dangerous Patients

By: Bruce Hershfield, MD

On May 1, the MPS held a meeting at Med – Chi headquarters in Baltimore, designed to help practitioners deal with dangerous patients.

Charles D. Cash, JD, who is an Assistant VP for the PRMS insurance company, began with a talk about “Working with Dangerous Patients”. It was comforting to hear that 99% of cases that go to trial are decided in favor of the defendant psychiatrist. Although one cannot be expected to accurately predict suicide, the *risk* of suicide may be foreseeable. It’s important to collect information—for example, to try to get prior records. It is helpful to get collateral information from significant others. He suggested using formal guidelines, including for assessing suicide risk, and adhering to them. His second point had to do with communication. He talked about inquiring about Internet activities and when to alert others when someone is truly dangerous. It is important to document how you make your choices – – both those that you *do make* and those that you *don’t*. Try to do it so that another professional can understand why the decisions were made. It is essential not to change records, which can leave the practitioner vulnerable to criminal charges. Perfection is not the expectation, he pointed out.

This was followed by a talk by Erik Roskes, MD, entitled “The Extreme Risk Protective Order: how does it change the practice in Maryland?” He told how some people can get listed on the gun registry, including a voluntary admission of more than 30 days or an involuntary hospitalization, but pointed out that it does *not* include having been subject to an ERPO. The ERPO law, which went into effect on October 1, concerns “immediate and present illness”, but is not necessarily tied to a *psychiatric* disorder. It does not specify the diagnosis -- he commented that it is “agnostic as to the reason”. Because outpatient clinicians can start the process of getting an emergency petition, it is unlikely that we will be the ones seeking ERPO’s --family members, partners, and law enforcement personnel probably will be the ones to seek them.

The ERPO form is presented to a court commissioner, who then may serve the order to seize the firearms. The point of the law is to improve the safety of a situation where someone who possesses a firearm is presenting an immediate danger. If a psychiatric disorder is involved, there is a part on the form where it can be listed, and records can be attached. Of the first 300 filed, between October 1 and December 18, only four came from physicians. He mentioned that 16 states are in favor of this kind of firearm seizure law and another

21 are leaning in that direction. The rate varies widely from county to county, with a low level in Baltimore city. In terms of liability concerns, there is more protection if you *do* ask for one than if you decide *not* to seek one.

After that, Mr. Cash returned to talk about “Risk Assessment: protecting yourself and your patient”. Again, he suggested that practitioners use formal suicide assessments like the Columbia scale and the APA psychiatric evaluation guidelines for adults. Common problems are not doing a suicide assessment at all, delegating it to someone else in the office, not documenting it, doing a “gut” assessment, and trusting a “no harm contract”. Do not assume that self – reporting of suicidal intention is accurate. Don’t use “black and white thinking”, he added.-- weigh the risk factors and the protective factors. He suggested asking about violent/homicidal intentions. Avoid overgeneralization, don’t ignore the *context* of the threat, try to get collateral information, and try to accurately communicate the risk to police and potential victims when that’s called for.

This is an important topic, presented well by two people who clearly know what they were talking about. There was sufficient time allowed so that we could learn about it and comment about it and absorb what could be useful in our practices. These are the kinds of talks that can save lives.



(L-R)
Charles D. Cash, JD, &
Erik Roskes, MD



LETTER FROM THE EDITOR

Standard Care and the Standards of Care

Preventing Suicide in Patients & Burnout in Psychiatrists

By: Bruce Hershfield, MD



**Bruce
Hershfield, MD**

I attended the MPS presentation about suicide prevention on March 30th. I was moved, as I believe many others were, by "The Ripple Effect". In it, Kevin Hines and his colleagues spoke courageously about not only his jump from the Golden Gate bridge, but about the people they had lost to suicide. The movie was followed by Janel Cabbage, LGPC, who is the Director of Suicide Prevention at the Behavioral Health Administration.

Her talk was excellent, but I found one part of it particularly troubling.

She told us the best ways that clinicians, including psychiatrists, can predict which patients are likely to try to end their lives. This includes using screening tests and may include having every prospective patient fill out a computer questionnaire before even coming to the office. (This could be a problem because there is a wide disparity in patients' access to computers and skill with them.) She mentioned a mnemonic device—IS PATH WARM?—that includes warning signs. I interpreted this to mean that unless I do a complete evaluation of the risk factors, any suicide would leave me vulnerable to a law suit. It's similar to what attorneys tell us in lectures about how to lessen our liability.

If this really is the standard of care, then I figure most of my colleagues must be doing it. However, I look through a lot of records. I almost never come across meaningful evaluations of suicide risk, even in records prepared by psychiatrists. If there is any assessment, it is almost always a checklist in an EMR, which I don't find really useful. I do not believe that people are as open when filling out these questionnaires as they are likely to be when they are meeting with someone they see as sincerely trying to help.

When I lectured about suicide to a group of professionals almost 5 years ago, I told the audience that I ask all patients every time if they are suicidal. It's what I'd been told to do shortly before that. I asked how many in the people in the audience also did that. Virtually no one raised a hand. I went to the seminar the MPS held on May 1st about how to reduce liability risk when seeing dangerous patients. Dave Cash, an attorney and VP of the PRMS insurance company asked how many of the

attendees did formal suicide risk assessments at the initial evaluation. A minority of the attendees indicated they did.

This is happening over and over again in our profession. We are threatened that if we do not reach standards that others set for us it would be better for us not to practice at all. Yet we continue to practice, doing the best we can. I see this as a major reason for burnout. People do not feel satisfied doing work that they are told is not up to the standards. No one likes being threatened.

Who is preparing these standards? Ms. Cabbage was the only speaker at one of our own meetings. Some of it is certainly being done by non-- psychiatrists, including attorneys. The APA does have *guidelines*—usually interpreted as rules by attorneys -- for suicide assessment as part of a psychiatric evaluation and we should be learning about them and evaluating if they are useful in our practices. Many of us join professional organizations so that we can have the kind of protection only a group can provide. I can more easily accept guidelines drawn up by my colleagues and I'm more confident that they would be more "do-able". It would also be easier to change them from time to time as we learn more about how to evaluate suicide—and other—risk.

As a profession, we should be setting standards for ourselves that we could consistently reach. It would go a long way towards eliminating burnout.

