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Dr. Karen Swartz: A Top Doctor

"Cheers from the Chair" by Jimmy Potash, MD

There is something magical about being on a magazine cover. I grew up worshipping *Sports Illustrated*, and later interned there one summer. The eight times they featured the Baltimore Orioles on their cover in my childhood were all thrilling. *Time* provided an exhilarating Baltimore moment when they featured James Rouse on their cover in 1981, not long after the opening of Harborplace, which he created. This kind of excitement was memorably captured, albeit with tongue in cheek, by Dr. Hook and the Medicine Show in their song "Cover of the Rolling Stone":

We take all kinds of pills that give us all kind of thrills
But the thrill we've never known
Is the thrill that'll getcha when you get your picture
On the cover of the Rollin' Stone

Well, Professor Karen Swartz *prescribes* all kinds of pills… and she should be experiencing all kinds of thrills this week as she is the picture of the exemplary physician as displayed on the cover of *Baltimore Magazine*'s November edition, which features the city's top 609 doctors in 116 specialties.

Dr. Potash, added, for *The Maryland Psychiatrist*:

"Dr. Swartz is a wonderful fit for the role of poster child for clinical excellence. She embodies all that we think of when we talk about what constitutes the Johns Hopkins standard for clinical greatness: intellectual power and rigor, mastery of the literature and evidence-base, kindness, warmth, compassion, dedication to patients and accessibility, the capacity for hard work and long hours, and the ability to inspire hope. In the nearly 30 years that I have known Karen, I have seen all of these wonderful qualities in action time and again. And I have sent countless patients her way and so often heard them sing her praises afterwards.

Karen's accomplishments as an educator are equally inspiring. She has been central to our department's ability to train great psychiatrists, and she has made an impact across the country with the Adolescent Depression Awareness Program, or ADAP, providing education that demystifies depression and empowers young people and those around them to take action to deal with it. It has been so uplifting to see how Dr. Swartz has grown and nurtured this valuable program, just as she has nurtured so many trainees within our walls."

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In This Issue

Report from the SPA/MPS September Meeting

by: Bruce Hershfield, MD

Bruce Hershfield, MD

Here are some notes from the scientific sessions held at the Royal Sonesta Hotel:

The meeting began with a Firearms & Psychiatry Panel. Steve Lippmann started by discussing Guns & Violence. He cited some upsetting statistics: more Americans are killed by guns than by motor vehicle accidents and guns are the # 1 cause of death in children. The USA had a ban on assault weapons from '94-'04. Buyback programs in Australia and NZ were successful. Background checks, minimum age requirements, and registering serial numbers are all popular ideas. Congress passed a Safe Communities Act in June. He pointed out that the per capita death rate from guns is actually higher in rural areas than in urban ones. There has been recent discussion of who can be held legally liable for firearm deaths beside the people who actually fire the weapons. He ended by asking what we can do to lower the rate of firearms deaths.

He was followed by Paul Nestadt of Johns Hopkins, who spoke about "Suicide & Lethal Means". Suicide is the 2nd leading cause of death among those under 40 years old. He went on to discuss risk factors: for example, living alone doubles or triples the risk. Of the 47,000 suicides, 53% result from gunshots. Firearms cause death in 89.6% of attempts, while cutting only causes 0.7% to die. It turns out that 71% of attempts occur within one hour of deciding to do it. Since the choice of method depends on availability of means, allowing more access to guns increases the risk. The rate is 4 times higher in soldiers who take their weapons home with them. Making gun laws more stringent decreases the suicide rate by 20%. Lock boxes and gun safes are options for decreasing the rate, as are plans for safely storing weapons when there is a crisis. Curt West then told us about Talking to Patients about Firearms & Safety. There are 10 million more guns in the U.S. each year and more than 40% of households have them. To increase safety, he suggests storing guns unloaded, disabled, locked, and separate from the ammunition. He then discussed the barriers that prevent people from talking about safe storage. He said that 78% of people believe it's OK to talk with their doctors about firearms and 64% report that when they received counseling it changed their practices.

The next speaker, Carol Vidal, talked about Trauma – Informed Care: When Work Safety is at Stake & the Trauma is in the Workplace. During trauma, the amygdala is activated and frontal lobes shut down. The concept of what is traumatic has spread; not everything that happens is really traumatic and some things that appear to be traumatizing do not have that effect on everyone. Trauma-informed care involves treating the whole person, not just the symptoms. She went on to talk about burnout's characteristics: emotional exhaustion, depersonalization & a diminished sense of professional efficacy. It may be present in as many as 54% of physicians in the USA. She noted that MD's and RN's suffer high rates of experiencing aggression and she listed 10 ways of combatting aggression and preventing burnout.

Monica Rettenmier then spoke about Neuromodulation & Treatment Refractory Illness, pointing out that ECT is still the most effective and reliable treatment for severe depression. Delivering the current in brief pulses leads to fewer side effects than delivering it in sine waves. ECT leads to 80-90% remission in depression—even to 50-60% in the severely resistant ones. There are no absolute contraindications. Side effects can include headache, muscle aches, and anterograde and retrograde amnesia. It is still not clear how it works. She went on to describe TMS, which has been approved for MDD (without psychotic features), OCD, smoking, and migraine. It is provided 5 days per week for about 6 weeks. Side effects can include scalp sensitivity and headaches, but they tend to go away within one week. The response rate in MDD is 50-60%, with 33% remission.

Vagus nerve stimulation provides a small electric current for 30 secs every 5 minutes, on a 24/7 basis, but it is difficult to get insurance companies to pay for it.

To close the day's scientific sessions, Andrew Tuck of Duke U. spoke about Execute Death Row Offenders with & without a History of Psychosis. This was the Resident Research Award-winning paper. He reviewed the history of this punishment, noting the moratorium that existed between 1972 & '76 and telling us that Texas has recently executed more than any other state. People who are psychotic are more at risk for violence, particularly homicide, and are less likely to be intoxicated than non-psychotic offenders. Of the 332 executed in Texas, 2000-15, 7.5% had a history of psychosis. They were more than twice as likely to admit guilt when arrested, more likely to eventually acknowledge guilt, and less likely to express love in their final messages.

(Continued on next page)

SPA/MPS September Meeting (Continued)

Day 2

Scott Aaronson began by telling us about The Emerging Evidence for the Use of Psychedelic Psychotherapy in Mood Disorders. He said that after 60 years of being bound by the monoamine theory, we are entering the age of interventional psychiatry—doing things to patients. He gave a brief history of our knowledge of psychedelics. Psylocybin enhances the brain's capacity for plasticity, which is diminished in most psychiatric disorders. The "default mode network" is active when the brain is at "wakeful rest"—and in most depressed people. Psychedelics stimulate synapse formation.
The first psychedelic that is likely to be approved is MDMA, for PTSD, next year. In a study at Johns Hopkins, 71% of major depressive patients showed response to psilocybin and in another study 75% showed response and 58% went into remission. Patients with bipolar II depression also can respond dramatically to it. Psychotherapy is an important part of the success—the treatment in his office is delivered in a 9-hr session with 2 experienced psychotherapists available. It is too expensive to be a 1st-line treatment now.

Glenn Treisman, who had been called away for a family emergency, then delivered a videotaped talk about Chronic Pain & the Opiate Epidemic. He pointed out that opiates are effective for acute, but not chronic, pain, and their use can lead to rebound. Doctors have been pressured to prescribe opiates, but there have been a huge number of opiate-related deaths. Patient satisfaction with their opiates is unfortunately correlated with increased mortality. There has been a decrease in prescriptions since 2012, but the death rate increased because patients then switched to to illegal opioids like fentanyl. Depression worsens the other contributory factors and makes prescribing more difficult. He pointed out that extroverts are more vulnerable to developing opiate abuse.

Mary Helen Davis then lectured about The Long Arm of COVID. There have been over 1 million deaths from it in the USA and 6 million in the world. From 20-25% have had sequelae. There have been increases in alcohol and opiate-related deaths and in the incidence of mood and anxiety disorders. Half of patients who were hospitalized for COVID have at least one symptom two years later. Of patients who have the disorder, 33-62% have a neurological sequel after 6 months. Most of the long-COVID patients eventually recover. The condition is more common in females and increases in patients over 70.

Dale Bratzler then spoke more about Long-term Consequences. Life expectancy has been decreasing, particularly for minorities. He spoke about long COVID's psychiatric features, noting that anxiety and depression, though common, tend to be transient. The virus tends to stay in the body a long time and one can see patterns of immune system dysregulation. He pointed out that the delta variant was more likely to protect patients from getting it again, compared to the alpha type.

After lunch the sessions shifted to a Geriatric Psychiatry Panel. Karen Neufeld began by talking about delirium in the acute hospital. Delirium is a disturbance in attention/awareness with new cognitive deficits, due to underlying physiological factors. It is easy to miss delirium on screening, particularly in hypoactive patients. Beware of the "sleepy" patient, who may quickly become comatose. Find the underlying cause and correct it (or them). No medication specifically prevents or treats it. Mobility helps decrease the duration; haloperidol can calm the patient down, but does not decrease how long the condition lasts.

Louis Marino then told us about Psychosis in the Elderly. About ¼ of people who develop psychosis do it after they turn 40. Those who have purely delusional disorder are otherwise not noticeably impaired. They are highly resistant to the idea of taking medication. About 1/3-1/2 of Alzheimer's patients show increased aggression, and those have a shorter lifespan. Pimavanseran can help with delusions. Up to 75% of those who have dementia with Loewy bodies can become psychotic, as do about 10% of those with frontal-temporal dementia.

Julia Riddle next talked about Treatment in Pregnancy. She described the changes in sleep patterns that pregnant women have. She talked about postpartum depression, noting it can be present in up to 20%. She said all new mothers (and some new fathers) have "intrusive thoughts" and 85% have the "baby blues". Discontinuing medications during pregnancy can lead to a relapse rate for depression of 70%. She suggested developing a sleep plan during pregnancy, having a conversation about the risk of continuing vs. stopping medication, and trying to avoid suddenly stopping medication. The dose may have to be increased after delivery because of biological changes in the fluid volume. About 20-30% of newborns experience withdrawal if their mothers were taking SSRI's. Avoid using Depakote and tegretol. Brexanolone, a synthetic neurosteroid, affects GABA receptors and is delivered in a 60-hour IV drip.

Day 3

David Casey began the Saturday talks with one about Vincent Van Gogh. He had a family history of psychiatric problems, was odd as a child and was an academic under-achiever. He had his first breakdown after a failed love affair, became ascetic and

(Continued on next page)

SPA/MPS Meeting Continued

served as a lay missionary, then studied art (though he failed to finish). He had his second breakdown and moved to Antwerp and then Paris, and then to Arles at 35. He felt that Gauguin had rejected him and he cut off his ear. He had repeat hospitalizations, moved closer to Paris, then shot himself. He is now regarded as one of the most important figures in western art. Diagnostic possibilities include porphyria, bipolar disorder, and temporal lobe epilepsy. It is ironic that the most important part of his life occurred in the last two years, when he was most ill.

Todd Peters & Deepak Prabhakar next comprised a panel on Children & adolescents, discussing the Impact of Pandemic on Child Development. In 2009-19 there was an increase in youth suicide and a dramatic increase in those planning to do it. The increase in social media/tech bullying, and school shootings, may account for much of that. Once the pandemic struck, depression and anxiety symptoms doubled. Visits to ER's for suicide attempts in adolescents increased about 41-51%. Being in an urban area, having a parent who was a frontline worker, disruptions in routine, and losing someone to COVID were factors. One child in 4 lost a parent or a grandparent/caregiver.

Mary Jo Fitzgerald then spoke about how her hometown of Shreveport was a leader in treating addiction to opiates about 100 years ago. She pointed out that opiate abuse was more common in the south then and she talked about the Pure Food & Drug Act and the Harrison Narcotics Act. There was a clinic in Shreveport after one in New Orleans closed, but that soon also closed because of harassment.

The sessions closed with a talk by Nitin Gogtay of the APA about DSM-5-TR. He talked about Prolonged Grief Disorder and the changes in schizophrenia spectrum disorder and autism spectrum disorder. He pointed out that "unspecified mood disorder" was restored. "Dysthymia" was removed from "persistent depressive disorder. The USA is still using ICD10-CM instead of XI. He concluded with comments about suicidal behavior and non-suicidal self-injury.

There was a lot of material and much of it was very relevant to clinical care. Many thanks not only to the speakers (and the audience members who contributed) and also to the Program Committees and those who so skillfully organized the meeting!

In Memoriam: Brian Crowley, MD

By Bruce Hershfield, MD

Brian Crowley, MD

Dr. Brian Crowley, a well-known and esteemed member of the Maryland Psychiatric Society and the Southern Psychiatric Association, died on July 17th at age 89.

Originally from New York, he attended Washington & Lee and then graduated from the Yale School of Medicine. He trained at St. Elizabeth's and graduated from the Washington Psychoanalytic Institute. He practiced for about 60 years--until very shortly before he died-- earning a reputation for his work in forensic psychiatry and serving as an expert witness. He was Chair of the Department of Psychiatry at Suburban Hospital in Bethesda for two terms. He was in the Navy and Navy Reserve, attaining the rank of Lieutenant Commander, and for 19 years contributed to the efforts at Walter Reed, where he did research on PTSD.

He held teaching positions at the Uniformed Services University of the Health Sciences and George Washington U. School of Medicine, and also at the law schools of the U. of Maryland and at Catholic University. He was also an accomplished writer, contributing many important statements on the MPS e-mail list and also articles for Southlands.

Active in psychiatric organizations, he was President of the Washington Psychiatric Society in 1996 and served two terms on the APA Board.

Leonard Hertzberg, MD said of Dr. Crowley:

"My friendship with Brian extends beyond 40 years, when we were on the Clifton T. Perkins staff and attended meetings at The American Academy of Psychiatry and the Law (AAPL) and our Chesapeake Bay Chapter. He was a highly competent clinician in his practice and his forensic work. He was warm, kind and witty. His wife, Natalie joined with him at meetings and also was a good friend.

Brian was an expert witness at the John Hinckley trial and his presentations about his testimony were memorable. I last saw him in April and, although he was 89, he was still active with his practice and planned to attend the upcoming annual AAPL meeting in October.

I was fortunate these many years to have Brian as a mentor and friend."

Watch Out: The Dangers of On Line Ketamine

By: Milena Smith, MD, PhD

Milena Smith, MD, PhD

There is nothing new about our patients choosing substances to treat their symptoms that we do not prescribe or recommend. As an intern I treated a young woman during several medical admissions for complications of heroin use. She had had unsuccessful trials of SSRIs and therapy for OCD. Near-constant obsessions and rituals meant she went from being an excellent student to dropping out of school. A friend of a friend offered her heroin, and for the first time in years she experienced relief. Then came addiction, abscesses from skin popping, and finally endocarditis. After one particularly close brush with death, she assured me that she would come back soon for another go at psychiatric treatment. I never saw her again, though I never stopped hoping I would. I thought it was clear to both of us whose plan was truly in her best interest. I knew that there were better treatment options for OCD. Perhaps naïvely, I thought she did, too.

A couple of decades later, dealers still sell heroin on the street, though currently what they sell is even more likely to be lethal. And there a lot of other ways our patients can access psychoactive substances. Kratom is sold legally at tobacco and convenience stores. Analogues of most controlled substances, including stimulants, opiates, and hallucinogens, can be ordered for home delivery on the "dark web". Detailed instructions on how to purchase and dose psilocybin are on Reddit along with contacts to hire a "trip sitter".

Then there are the psychoactive substances obtained with the assistance of a medical professional. One can spend a couple of hundred dollars and a few minutes to obtain a medical marijuana card, then take that to an emporium where staff will point out recommendations to improve anxiety or insomnia. They will not be on call if psychosis or intractable emesis ensues.

And there is ketamine. I am not a "super-skeptic"; I follow the research on ketamine for the treatment of depression, PTSD and other conditions with interest. Last year I referred a patient for the only FDA-approved form, IV esketamine (Spravato), which may very well have saved his life. I watched a close friend's response to IV ketamine infusions restore her motivation and interest in life, which several medication trials had not. The physician administering Spravato established rapport with my patient, followed the REMS drug safety program, and kept in close contact with me to coordinate care. My friend's ketamine clinic sent notes after each treatment to her referring physician and therapist, and carefully adhered to standard (if off-label) treatment protocols.

However, much of the ketamine currently prescribed is without in-person monitoring, coordination with other clinicians, or established treatment protocols. It is prescribed via telemedicine, and it is big business. A recent Wall Street Journal video article reads like an infomercial—the head of *PsyMed*, an investment firm that focuses on ketamine startups, is quoted as estimating a billion-dollar market currently, set to expand "2 to 3 x" in the next 5 years and already "changing the face of psychiatry". Many of those startups have clinicians with licenses in multiple states, and websites offering ongoing oral ketamine treatment for a monthly "subscription". If someone obtains stimulants through an online medical provider, that prescription will appear on the Prescription Drug Monitoring Program. A prescription for ketamine troches sent to a compounding pharmacy, or put in the mail, will not. The only way for us to know is if we are told. It was only very recently that I knew to ask.

The suspension of the Ryan Haight Online Pharmacy Consumer Protection Act due to Covid-19 has allowed clinicians to prescribe controlled substances without seeing patients in person. Some telemedicine clinicians have obtained licenses across the country and prescribe medications including stimulants and benzodiazepines to people located in multiple states. One of the largest online telehealth providers of mental healthcare, Cerebral, launched in January 2020 and grew rapidly with the increased demand for online mental health care. Cerebral's prescribing practices are being investigated by the DEA, and in May 2022 the company announced that it would stop prescribing controlled substances. On August 19 the *WSJ* published an article describing the relapse and death of a man who had boasted to friends about the ease of getting Adderall through another such start-up, *Done*, while living in a sober-living house in recovery from substances including stimulants, and with a recent prescription for suboxone available for clinicians to see on the PDMP.

So far, I have not seen similar news regarding the several startups providing ketamine to be used at home. The most recent issue of *Psychiatric Times* contains an article entitled "At-Home Ketamine: A Clinician's Dilemma" and an accompanying

editorial, "Virtually Malpractice". Both are excellent and sobering, describing the ways the at-home ketamine companies fail to comply with the standard of care in the provision of ketamine, including a physical exam, lab testing, EKG, and monitoring during and after treatment for effects including sedation, dissociation, and hypertension. Spravato is approved to be utilized in combination with an antidepressant, to provide rapid relief and tide a person over until the SSRI or other medication begins to work. The REMS treatment protocol requires a patient stay in the office for two hours after each treatment for monitoring.

Frustrated by a prolonged depressive episode, one of my patients decided to give at-home ketamine a try. No labs were ordered, or records requested; a history of alcohol overuse and bipolar spectrum illness were not identified as contraindications. My patient was instructed that someone else should be at home when to check every 10-15 minutes post-ketamine. After the patent took the ketamine a couple of times, I was contacted. I obtained a signed release of information and contacted the company, requesting a conversation with the (non-psychiatrist) clinician. My experience was unlike any other call I have had with someone with whom I am sharing a patient's care. I found myself trying to educate "Dr. K" about the ways mania can present and be assessed. I was assured that people with a history of mania are told to stop taking ketamine and contact the clinician "if they feel too good or are very energetic", but that that is very rare. Moreover, a person who describes a history of mania and wants to take ketamine must be on a mood stabilizer. If they are not on one already? "Oh, we start one". I could not bring myself to ask Dr. K how he chooses which one, how it is monitored, and how long after initiating it ketamine is prescribed. Dr. K told me of all the positive results patients are getting, and that if people were interested in abusing ketamine, they can get it more cheaply on the street or dark web. I did not ask how he can ensure people take the ketamine orally as instructed, with a bioavailability of around 30%, rather than crushing it and using it intranasally (45%), intramuscularly (93%) or IV (100%). Instructions for how to do so, as well as recommendations on how to answer questions to ensure being given a prescription, are available on Reddit.

I ended with an appeal to Dr. K's conscience, reminding him that we physicians must coordinate care, even if we don't fully agree with one another on the optimal treatment plan. He agreed, conceding "that's somewhere we have to do better". I do not doubt that Dr. K believes he is helping people, but I also do not doubt that his judgement is biased by the bottom line. The description on ketamine subscription websites of the range of conditions they treat, and the paucity of contraindications, call to mind Maslow's saying that if the only tool you have is a hammer, you tend to see every problem as a nail.

The appeal of ketamine for many people is that they can avoid taking daily medication, but at least some on-line providers recommend ketamine three times a week for the first six months, then continuing weekly or more frequently for 18 months, or even indefinitely. A "subscription fee" of $250-500 a month covers medication and a monthly appointment. It is no surprise that investors might be interested. The October issue of the *Journal of Affective Disorders* includes an article entitled "At-home, sublingual ketamine telehealth is a safe and effective treatment for moderate to severe anxiety and depression." It reads as not much less of an infomercial than the Wall Street Journal investment video. The journal has already published a letter detailing the article's shortcomings and the inaccuracy of its title.

The at-home ketamine business boom may not last much longer. Many entities are calling for the reinstatement of the Ryan Haight Act. Peak. An on-line ketamine company criticized by *Rolling Stone* for its advertisements on TikTok has since announced it has stopped taking new patients and is "winding down" treatment of those who are established.

In the meanwhile, we psychiatrists are where we have always been, balancing beneficence and autonomy, educating and providing recommendations while avoiding paternalizing, navigating risk-risk discussions. Attempting to coordinate care with colleagues who do not always want our counsel. It has never been easy to tell patients that we disagree with another clinician, or that they must choose between our treatment plans. But becoming more comfortable with that discomfort will serve us well.

Conscientious Objection in Medicine: Threats and Opportunities

by: Mark Komrad, MD

Mark Komrad, MD

In our pluralistic society, many value systems compete against the backdrop of our laws and statutes. The laws in our country, especially lately, are much more fluid than values informed by culture and religion, which change more slowly. So, it is increasingly common for physicians' personal values to clash with legal requirements governing the practice of Medicine. A contradiction between personal values and the requirements of the law can result in the potential for conscientious objection.

In recent years, more physicians have been experiencing conscientious objections to the dictates of their societies about how Medicine must be practiced. The legalization and emerging practice of certain procedures have been especially provocative. Prominent examples include withdrawal of life support, abortion, gender reassignment, physician-assisted suicide, and medical euthanasia. Sometimes the law compels us to do something we may find objectionable — for example, informing eligible patients they have the option of assisted suicide or euthanasia. Sometimes we are choked from discussing some topics — e.g. asking about gun ownership in a medical assessment, or advising an abortion.

Do individual physicians' values have any power in a society that licenses doctors, provides infrastructure for their practices, and has expectations of what they should provide? Must we all fall in line? When society says "Jump!" must we say, "How high?"

Conscientious objection in the face of the rapidly expanding euthanasia laws in Canada is now a hot issue there. In 2016 Canada legalized euthanasia for people with "unbearable suffering," whose natural deaths were expected in "the foreseeable future" (never statutorily defined, though interpreted to be similar to "terminally ill," but without specific prognostic parameters). The ethical values of justice and fairness led those outside the limitations of terminal illness to agitate that they should be included. As a result, in March 2021, the Canadian parliament extended eligibility for euthanasia beyond the end of life--to anyone with a CHRONIC illness, who is "intolerably suffering" with an "incurable" condition." At the last minute, they included a provision that those with psychiatric disorders could be eligible for euthanasia as well, beginning in March, 2023. In Canada, over 10,000 people have been euthanized on request since 2016--more each year. Though assisted suicide by self-ingesting prescribed poison is a legal option, because euthanasia by doctor's IV injection is allowed, 99% of patients have chosen the latter.

Though physicians are not required to perform euthanasia themselves, or even evaluate their patients for it, they are required to inform an eligible patient it is an option. If they won't proceed with evaluation or performing the deed, they must make an "effective referral" to another doctor who is willing to evaluate and/or do the procedure.

This raised a strong reaction from many physicians, who have had profound conscientious objections to turning the House of Medicine from a place of cure, treatment, or palliative comfort, into a place where doctors actively terminate lives. Not only have conscientious objectors resisted the mandate to include euthanasia as an option when giving informed consent in "treatment" plans, but they have also objected to the requirement of "effective referral." They feel that this made them part of the chain of culpability.

One colleague said, "It's like being a German citizen, telling the Nazi SS where a family of Jews was hiding; not personally responsible for their deaths, but culpable nevertheless."

Conscientious objectors have been accused of being heartless, religious zealots. Many have felt their jobs in jeopardy in the new moral climate. Ellen Warner MD, testifying to the Ontario Legislative Assembly in 2017, described the atmosphere:

"At my institution, physicians are being bullied into accepting the role of the responsible physician for MAID patients. . . .There's a horrendous stress level at our hospital. Physicians are afraid to speak up, afraid that they will lose their jobs if they say anything. . . .We feel sometimes like we're in some sort of dystopian novel."

Several ethicists, and physician leaders, are strongly encouraging a moral litmus test for applicants to medical school in Canada -- those who have moral objections to euthanasia should not be admitted to medical school. Similarly, some have suggested that those with conscientious objection to euthanasia switch their specialty to something that doesn't involve direct patient care, like Pathology.

Attempts to pursue protection for conscientious objection has been thwarted throughout Canada. In Ontario, a court ruled that a

(Continued on p. 9)

(Continued from page 11)

physician cannot refuse to make an "effective referral" and must tell patients about the euthanasia option as part of "informed consent." The licensing board there agreed, and in Sept, 2022, issued a draft opinion re-affirming, "a physician must provide effective referral in a timely manner." A bill to protect conscience rights in Alberta was defeated in 2017, and a similar one was defeated in the national parliament in 2022. So, being a true and complete conscientious objector, is neither legal nor ethical in Canada.

The World Medical Association (WMA) is the largest medical organization in the world, with representatives from 115 countries. It also has the strongest language opposed to medical euthanasia of any organized medical group:

"The WMA is firmly opposed to euthanasia and physician-assisted suicide . . . No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end"

In October, 2022, the WMA revised its International Code of Medical Ethics. It now states that physicians have the right to inform patients of their conscientious objection to any procedure, but need to remind them that they have the right to seek information and consultation from another physician about the matter, and where they can find it. However an "effective referral" to a specific willing provider is not required (Item 29 in the new code). Though vulnerable to interpretation, and less robust than desired, most conscientious objectors thought that this language was acceptable.

Medical ethics is a work in progress that has evolved over two millennia, its Hippocratic origins making it even older than Christianity or Islam. It has been shaped informally by practice and formally by serious scholarship, and the consensus of professional societies that became keepers of professional ethical codes, beginning in the 19th Century. On the issue of assisted suicide and euthanasia, deep and protracted reviews, scholarly consultation, and public hearings have led organizations like the AMA, APA, ACP, and the International Association for Hospice and Palliative Care to publish positions rejecting assisted suicide and euthanasia. So, for many physicians, conscientious objection is a professionally-based value, a principled stance that is not necessarily grounded on subscribing to a religion's value, or just personal distaste.

A powerful historical example of how rapidly changing social mores and laws can depart from the values professed by the profession of Medicine, was the T4 program in Nazi Germany. In this program, Hitler directed physicians to euthanize those hospitalized with developmental disabilities and mental illnesses. Over 400,000 were exterminated, utilizing techniques developed by physicians (psychiatrists as a matter of fact!) and later used in concentration camps. Neither individual conscientious objection nor protest by medical professional societies was voiced, not even early on, when the dangers of objecting were minimal. Nor were there laws that said physicians must participate. Yet, so many did, because society encouraged, expected, and rewarded the practice. It was considered virtuous, compassionate, desirable, and liberal. The T4 doctors and nurses thought of themselves as moral pioneers of a new era of compassion for those whose lives were deemed "not worth living." This contributed to the new ethos, becoming the "new normal"--what Robert J. Lifton called a "malignant normality."

Could physician conscientious objectors have turned the tide? Maybe not, but the failure to do so was an ineradicable stain on the very meaning of professionalism in Medicine. It was not until 2010 that the German Medical Association formally apologized to the world for its ethical lapse and for missing an opportunity to be a voice of conscience during the Nazi era.

Conscientious objection has the potential to change societies and the course of history. The right to express ourselves through our practices is critical, not just for professions, but for individuals.

As Holocaust scholar Raul Hilberg reminds us: "At critical junctures, every individual makes a decision and every decision is individual."

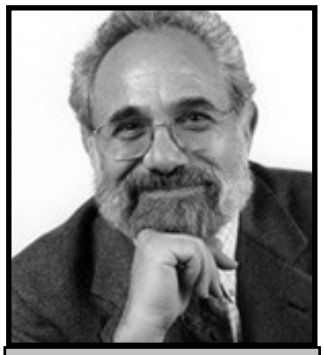
Poster Contest for Residents & Fellows

The MPS poster competition for our Resident-Fellow Members will be held again this year, with all entries displayed at our annual meeting in April 2023! Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the meeting. Two finalists will also be selected and will receive **$100 each** in addition to complimentary tickets.

The winners in past years are listed here. Please click here for complete details about the process and requirements. **The deadline to enter is January 31.** Electronic copies of posters are due **February 10**. For more information, or to apply please click here.

Stigma is Being Used as a Political Weapon: Reject It

by: Michael B. Friedman, LCSW



Michael Friedman, LCSW

Mental illness is not the cause of mass murder in the United States.

The continuing assertion that it is, by the political right, has become a core element of the vituperative and dangerous political division that besets the USA today. It is effective as political rhetoric because of the widespread misbelief that people with serious mental illness are violent and dangerous—i.e., because of continuing pervasive stigma about mental illness. In the hands of the political right, **stigma has become a political weapon**.

The mental health community, whether liberal or conservative on other issues, needs to conceptually disarm those who rely on the slogan that the problem of violence is mental illness--particularly those who refuse to confront guns as a major vector of death.

People with mental illness rarely commit homicide. About 5% of homicides are committed by people with psychotic conditions.

People with serious mental illness are far more likely to be victims than perpetrators.

Most mass murders are committed by people who are not seriously mentally ill, including:

- Terrorists
- Racists
- Religious bigots
- People who commit purposeful acts of murder or manslaughter or who commit crimes that result in unintended deaths
- Perpetrators of domestic violence
- People seeking revenge

It is notable that in its *Global Study on Homicide*, the UN Office on Drugs and Crime recognizes multiple motivations for murder and divides homicides into 3 types: socio-political, interpersonal, and criminal. But murder by people with psychosis is so rare that it is included only as a footnote.

with mental illness are far more likely to take their own lives than the lives of other people. According to the CDC, the rate of suicide has increased 32% since the beginning of the century and is now roughly double the rate of homicide, which remained about the same from 2000-2019, but jumped about 30% in 2020 and apparently is continuing to rise.

Mental health advocates need to resist the temptation to use recent increases in homicides, including mass murders, as a rationale for calling for improvements in America's mental health system. There are numerous reasons why there should be massive improvements; reducing murder is not one of them. Reducing suicide, yes. Increasing the capacity to provide and to get access to treatment for mental illness, yes. Improving the quality of available services, yes. Reducing fragmentation, yes. Addressing social determinants of mental illness, yes. But improving the mental health system to reduce murder--maybe very slightly, probably negligibly.

Calling for a better mental health system because of the rise of homicides undoubtedly results in reinforcing the misbelief that people with mental illness are to be feared because they are violent and dangerous

Reducing the stigma of mental illness is among the most important improvements we need. It could provide opportunities to people with histories of mental illness who now suffer discrimination in housing, work, education, health care, and even access to houses of worship. Addressing stigma is also needed to reduce the shame that often drives those with histories of mental illness into hiding and contributes to their reluctance to use services that could help them.

Stigma about mental illness is not just a problem for people with mental illness and their families. It has become a dangerous weapon in American politics.

Michael B. Friedman is a retired social worker who has worked in the field of mental health for over 50 years. He teaches mental health policy at Columbia University School of Social Work and serves as a volunteer social advocate as Chair of the Cognitive and Behavioral Health Advocacy Team of AARP Maryland. He can be reached at mf395@columbiauniversity.edu.

FTC Must Look Into Practice That Delays Prescriptions

By Dinah Miller, MD

Edited version first published in The Baltimore Sun August 24, 2022

Dinah Miller, MD

In June, the Federal Trade Commission (FTC) announced it would be launching an inquiry into the practices of the "prescription drug middleman" industry. These middlemen, known as Pharmacy Benefit Managers (PBMs), determine if an insurer will pay for a prescription that is prescribed for a patient. Caremark, ExpressScripts and Optum are some of the familiar gatekeepers and suppliers of medications.

The FTC statement reads, "Pharmacy benefit managers are the middlemen who are hired to negotiate rebates and fees with drug manufacturers, create drug formularies and surrounding policies, and reimburse pharmacies for patients' prescriptions. The largest pharmacy benefits managers are now vertically integrated with the largest health insurance companies and wholly owned mail order and specialty pharmacies."

I want to discuss the role of PBMs as they relate to one aspect of every physician's life: the requirement for physicians to obtain prior authorization (PA) before certain medications can be dispensed by the pharmacy and paid for by insurance. Initially, PAs were required only for expensive, name brand medications, but now PAs are often required for inexpensive generics. Doctors must justify why a specific medication is needed, and they may be required to prove that the patient has tried alternative medications first that either did not work or were not tolerated, in a process that makes guinea pigs of patients. Often, the patient's doctor does not have the option of starting with the most effective medicine with the fewest side effects, and each time a dose is changed, another PA is required.

What started as a cost-control measure has become an unregulated burden on both patients and their doctors. The requests for justification can be burdensome and obscure. They can include filling out forms online, uploading records in specific formats and long waits on hold to speak with a reviewer. And the appeals process can be onerous and time-consuming, with no guarantee that the medication will be approved or that a physician in the relevant specialty will be involved in the decision.
Let me give an example from my own practice. Recently, I sent in a prescription, then was notified to start the prior authorization process online. There was a list of "acceptable" diagnoses. I checked a box and a new question appeared — it asked if I am a certified sleep medicine physician. I'm a psychiatrist, and so the PA was denied. The patient had the option of paying cash for the medication, of going without it or of making an appointment with a specialist and waiting out that process.

I looked up the prices on the GoodRx app — a company that negotiates prices outside of insurance and can be used by patients who pay cash. The medication costs just over $288 for a one-month supply at her pharmacy, CVS. Instead, I asked her to go to another pharmacy where the prescription cost $21. This is not uncommon; drug costs may vary by hundreds of dollars from one pharmacy to another, for no obvious reason.

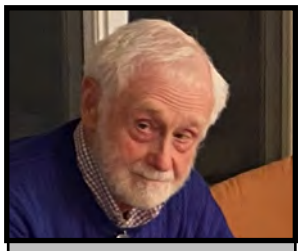
The time physicians spend on prior authorizations (or cost hunting) is uncompensated, and it is considerable. It's a hoop to jump through, and no one is overseeing the placement of the hoops. Furthermore, when patients do use their insurance, the copay may be more than the cash price, and this information is not made readily available. Nothing about the process is transparent.

How big a problem are prior authorizations? In December 2021, the American Medical Association conducted a survey of 1,004 practicing physicians. The average physician completes 41 PAs per week, nearly 1 in 5 of the prescriptions written. Forty percent of doctors hire staff solely to manage prior authorizations; 93% of doctors reported that PAs have caused delays in patients getting care, and 82% reported that PAs caused patients to abandon treatment. In terms of patient outcomes: 34% of doctors reported a serious adverse event, while 24% had patients who required hospitalization. Eighty-eight percent of physicians said this process is a high, or extremely high, burden.

The administrative burdens of medicine have killed the joy of practicing for so many physicians. Physicians are burning out and retiring earlier, and patients are frustrated with the high cost and unnecessary complications associated with getting care. The prior authorization process is a huge contributor to all that is wrong with the system. I hope that the FTC will take a long hard look at the burdens, confusion and cost shifting — rather than saving —- that this burdensome process inflicts on the medical system.

Maryland Physicians Health Program: A Voluntary Program to Help MD's in Trouble

by: Arthur Hildreth, MD



Arthur Hildreth, MD

MPS members should know about The Center for Healthy Maryland, a Med-Chi subsidiary that offers The Maryland Physician Health Program. It is HIPAA-compliant and is designed to assist physicians and other health care professionals in a confidential setting to address health issues that could impact their ability to provide care. It is financed through hospital and participant fees and through donations. Participants are evaluated, clinical management plans are formulated, and referrals for treatment are made when indicated. Issues that are frequently encountered include substance abuse, psychiatric illness, disruptive behavior patterns, sexual boundary violations and medical problems that disrupt the delivery of optimal medical care. Referrals by hospitals, practice groups, families and by providers themselves can be made by calling 410-962-5580.

There is a similar, but separate, program called The Physicians Rehabilitation Program that is answerable to the Board of Physicians. It provides a similar service to providers and to the Board of Physicians but it is not HIPAA-compliant and the participants are not totally voluntary because they have been referred by the Board of Physicians. Its Medical Director is a neurologist and so helps to cover both psychiatric and medical problems. These can range from ophthalmologists who may have a tremor to internists who may have a developing dementia who are asking about their ability to practice.

As Medical Director of the MD Physicians Health Program for the last 7 years I have seen it transition from a program that primarily helped people struggling with substance abuse to one that assists when they are suffering from the problems enumerated above. Like other PHPs, through our treatment referrals, drug monitoring, and coordination of care, we have about a 75-80% five- year recovery rate for substance abuse. Our HIPAA compliance helps ensure that we help the overall functioning and careers of our participants and not harm them because of unproductive reporting requirements to regulatory boards. We are available to advise any colleague, hospital or practice group with any concerns.

In Memoriam: Constantine Sakles, MD

By Bruce Hershfield, MD

Constantine Sakles, MD

Dr. Constantine J. Sakles, a former MPS member who was a retired Professor at the University of MD, died on May 25th at age 87.

Originally from New York, he attended the University of Rochester and then graduated from Yale Medical School in 1959. He did his psychiatric training at the University of MD, then joined the faculty. He taught not only Psychiatry, but also Pharmacology, and became known as an expert in Psychodrama. He retired in 1999, then worked for the Anne Arundel County Department of Corrections and maintained a private practice.

Dr. Theodora Balis, MPS Secretary/Treasurer, commented, "I first knew Constantine Sakles when I was 10, when he and his wife became godparents to my sister. A brilliant man who loved learning about so many things, he brought an ease to conversations with his caring attitude. As I became a psychiatrist, I had the great pleasure of both his mentorship and his loving support.

I was especially moved by the way he spoke of his work with the most marginalized among us-- incarcerated men who met in group with him regularly to play out their psychological and emotional struggles where art and science meet in structured psychodrama. These were people whose families, and society, had written off as broken beyond redemption, unworthy. Connie helped them find value and healing and make some positive outcome arise from their situations.

This is how he was with everyone. He always expressed genuine interest in who you were and wanted to help you with whatever you found important. Whether students, residents, family, or patients, he was always caring and helpful."

In Memoriam: Barbara Young, MD

By Bruce Hershfield, MD

Barbara Young, MD

Dr. Barbara Young, an MPS member who was a psychoanalyst as well as a well-known photographer, died on September 28th at age 101.

Originally from Illinois, she got her MD degree from Johns Hopkins, where she later finished her psychiatric residency in 1951. She worked for two years at Perry Point, then established a private practice that she maintained until 2008. She graduated from the psychoanalytic institute in 1953.

She started taking photos of Harbour Island in the Bahamas in 1958 and returned there each year for the next four decades. Her books included "Photographs are Memories", The Plop-a-lof Tree" and "Looking Back: An Unusual Harum-Scarum Illustrated Autobiography". Her photos are in the Museum of Modern Art, the Baltimore Museum of Art, the Johns Hopkins School of Medicine, and UMBC's Albin O. Kuhn Library and Gallery (where her personal papers are stored).

Thomas E. Allen, MD, a Past President of the MPS, commented. "She was well loved by her patients and continued to practice after many of her peers had retired. She remained quite alert even very late in life. She loved photography as much as she loved psychiatry and psychoanalysis. By contrast with our field, it was something concrete and she loved finding and creating images."

Dr. Jimmy Potash, Chair at Johns Hopkins, noted "Barbara Young, a graduate of the Phipps class of 1951, focused her career on psychoanalytically oriented psychotherapy, after having been analyzed herself during and after residency.

She was justly famous for her photography.

Above is one of her most celebrated works, *Uffizi Landing*, taken in Florence, Italy. She wrote about its impact: "After I had given an illustrated talk on the creative way of life…I received a letter from a young photographer who was in analysis. She realized that she wanted to be that little blue boat docked safely in all that water. She wanted to feel safely moored to someone else. The letter said, 'I didn't know if the larger boat felt like a parent or a partner—just wanting to be connected in my gut somewhere.'"

Dr. Young leaves behind a legacy of insight, healing, creative living, and artistic vision."

LETTER FROM THE EDITOR
The Problem With Meetings

by: *Bruce Hershfield, MD*

Bruce Hershfield, MD

I enjoyed attending the MPS/SPA annual meetings in Baltimore September 7-10. The presentations were excellent and the social events were most enjoyable. It was good to see people in person again.
There was only one real problem: very few of our members attended. I understand that only about 10% of the memberships of the two organizations were there.

I have been attending meetings of the APA since 1973, of the MPS since shortly afterwards, and of the SPA since 2009. When the MPS was meeting about 6 times per year in the '70s and '80's it was possible to get to know the members—or at least those who came regularly. Now, the MPS only has an annual meeting, attended by about 10-15% of the members—and one scientific meeting per year. This is not enough to form the bonds we need in order to thrive.

We need to figure out why members are choosing not to attend our meetings.

I understand that Americans are simply not joining organizations like we did in the past. How many of us attend meetings of the Kiwanis, or the Elks, or the Chamber of Commerce like our parents and grandparents did? We have plenty of responsibilities and there are plenty of other ways to occupy what leisure time we have. We also need time to re-charge ourselves--to let our nervous systems quiet down. I think the most important reason for the poor attendance is that our members don't find the meetings to be worth the cost and the time.

I rarely learn as much at the meetings as I could by reading the relevant material, and I could do that in a small fraction of the time. It is easy to learn the facts by simply looking on the internet. I think the real value in attending is having the opportunity to connect with other people — whose opinions we should value, whom we can trust, who knows the latest about what is really going on, and who could be a friend. It is hard to justify the expense—the registration, and the flights and hotel rooms when the meetings are out-of-town--but still I find it to be worth it. (The same could be said of vacations; they are expensive and all-too-brief, but they help us make sense of our lives.)

As a Society, we need to decide how we can best *associate* with each other—"to form a More Perfect Union". The days when we could best learn by attending lectures together are coming to a close.

I can guess what 10% attendance—or 16.25 % of members voting, as we did in the last APA election—means. What would make our members want to meet with each other again?

MPS Best Paper Awards

To recognize outstanding scholarship by young psychiatrists in Maryland, the MPS established annual "best paper" awards in 2013. Previous winners are listed here. The Academic Psychiatry Committee is currently soliciting nominations for the 2022 Paper of the Year Award in two categories:

Best Paper by an Early Career Psychiatrist Member (ECP): Eligible psychiatrists are ECP members who are first authors of papers published or in press in 2022. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2023.

Best Paper by a Resident-Fellow Member (RFM): Eligible psychiatrists are Resident-Fellow members who are first authors of papers that were written, in press, and/or published in 2022. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2023.

Best Paper by a Medical Student Member (MSM): Eligible students are Medical Student Members who are first authors of papers that were written, in press, and/or published in 2022. Thanks to generous funding from the Maryland Foundation for Psychiatry, the winner will receive a **$200 cash prize** as well as a complimentary ticket to the MPS annual dinner in April 2023.

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

Matthew Peters, M.D. mpeter42@jhmi.edu
Traci Speed, M.D., Ph.D. speed@jhmi.edu

MPS ADVOCACY FUND

Psychiatry faces legislative and regulatory opportunities and threats in our state. The MPS works for you by advocating with lawmakers and the executive branch. To sustain government affairs activities and legal counsel for our role as the voice of psychiatry, we need financial support from all Maryland psychiatrists. **Every contributor, every member strengthens our collective position!**

To support the MPS over and above your membership:

1. **Visit: https://mdpsych.org/contact-us/**
2. Click on the yellow "Pay Now" button
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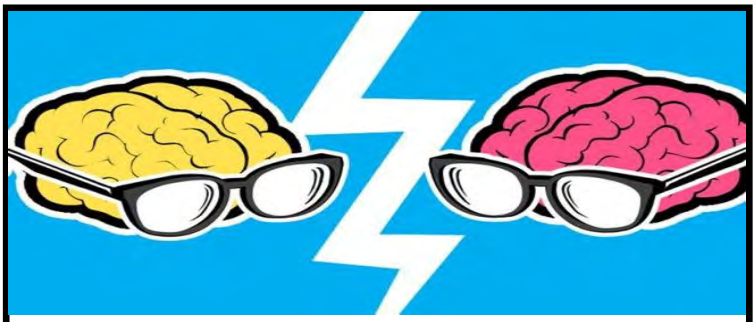

TRIVIA NIGHT FOR PSYCHIATRIC RESIDENTS AND FELLOWS!

Join us **February 1st @6pm** for trivia night at Home Slyce in Baltimore! Delicious food, open bar & **cash prizes**!

Teams of residents and fellows will vie for cash prizes. For fun we will even throw in a team from the MPS leadership to find out who comes out on top! The trivia portion of the evening will be run by Charm City Trivia. This event is open to members & non-members of Maryland based psychiatry residency programs.

MARYLAND PSYCHIATRIC SOCIETY

MPS ECP Presents

Physician Contract Negotiations

Protect Yourself. Know Your Value.

FEATURING
STEPHEN H KAUFMAN, J.D.

Mr. Kaufman's entertaining and informative free presentation explains the business, financial and personal aspects of physician employment contracts using examples and humor. Learn the pitfalls and traps of employment contracts and how to avoid them. This lecture is a must for anyone considering signing an employment agreement.

November 17th
7:30pm

ID: 419 237 9446
PW: MDPSYCH

- The negotiability of employment contracts
- The fundamental parts of employment contracts
- The differing economic interests and objectives of an owner and associate

Steve Kaufman is a founding partner of RKW Law Group. He represents physicians in a wide variety of matters, including employment contracts, employment issues, licensing issues and litigation. He can be reached at 410-802-7585 and by email at skaufman@rkwlawgroup.com.

mdpsych.org | mps@mdpsych.org | (410) 625-0232

Community Psychiatry & Diversity Coalition

MARYLAND PSYCHIATRIC SOCIETY

CME PRESENTATION

USING THE SEQUENTIAL INTERCEPT MODEL TO ADDRESS DISPARITIES THAT LEAD TO INCARCERATION

December 1, 2022
07:00 PM to 09:00PM
2 Credits of CME*

AGENDA & TOPICS

WELCOME & OVERVIEW OF MARYLAND CRISIS SYTEM REFORMS
Dr. Hackman

SEQUENTIAL INTERCEPT MODEL: AN OVERVIEW
Dr. Hightower

PSYCHIATRIC EVALUATION AND TREATMENT WTIHIN THE JUSTICE SYSTEM
Dr. Hanson

ADVOCATING WITH JUDGES: ACCESS TO TREATMENT, NOT JAIL
Honorable Marina Sabett

IMPACT OF JAIL / PRISON STAY ON THE PATIENT POPULATION
Dr. Hackman

THE SPEAKERS

Ann Hackman, M.D., DFAPA
Division Director Community Psychiatry, University of Maryland

Tyler Hightower, M.D., M.P.H., DFAPA
Director, Office of Forensic Services, Springfield Hospital Center

Annette Hanson, M.D., DFAPA
Director, Forensic Psychiatry Fellowship, University of Maryland

Marina Sabett, J.D.
Associate Judge, District Court of Maryland, Montgomery County

More information
mps@mdpsych.org

REGISTRATION

Free for MPS Members
$25 for Non-members

Thank you to The Maryland Foundation for Psyciatry for their financial support for this activity.

***Accreditation**
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the American Psychiatric Association (APA) and The Maryland Psychiatric Society. The APA is accredited by the ACCME to provide continuing medical education for physicians.

Designation
The APA designates this live activity for a maximum of 2 AMA PRA Category 1 Credits (TM). Physicians should claim only the credit commensurate with the extent of their participation in the activity.