THE
MARYLAND PSYCHIATRIST
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Meet the New President: Jessica Merkel-Keller, MD

by Sue Kim MD


Jessica Merkel-Keller, MD

Our new president has energy and courage. She is full of heart. She is what she is today after having walked on a few different paths. She was/is an ethicist. Originally from NJ, she went to UMDNJ Robert Wood Johnson Medical School, then attended graduate school at McGill. She started as a Resident in OB/GYN. She was not satisfied, so she did her psychiatric residency at Johns Hopkins. She loves practicing Psychiatry and feels that this field is her calling.

She was deeply involved with the Assertive Community Treatment program and worked with vulnerable populations--including pregnant women, the homeless, the rural population, and patients in state hospitals. She sometimes met with a patient in her own car. Imagine that...For the last 5 years, she has been consulting in different states and she holds several medical licenses. She provides direct patient care as well. Her engagements have reached far and wide--to the Caribbean islands and Malaysia. Thankfully, she loves to travel!

She was touched by a book entitled "Where There Is No Psychiatrist". She called it something like a field manual--how we connect, how we get to know one another, and how we share ideas and serve those who are in need. This seems to be an on-going quest for her.

She understands that the health of the MPS is not to be taken for granted, given what has happened to some of the other district branches. She plans to draw in younger psychiatrists and make our mission more relevant to their values. She expects that there will be diversity in opinions when we discuss where the MPS should be heading. She approaches the future with humility and a desire to get people to cooperate to make our organization better.

She is particularly interested in working on providing aid to the dying, developing mid-level providers as a part of the continuum of care, and assuring we have a system where supervision can safeguard the quality of training and practice.

It's noteworthy that she has been a metalsmith since her high school days. She loves the manual process, creating unique art forms. She also cherishes taking time for gardening and family.

I wish our new president a most fulfilling year. I hope her background as ethicist and artist, as well as psychiatrist, helps awaken us in this soul-searching time.

In This Issue

MARYLAND
PSYCHIATRIC SOCIETY

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Patrick Triplett, MD Promoted

By Elizabeth Wise, MD

Patrick Triplett, MD

Former MPS president (2018-'19) Dr. Patrick Triplett was recently promoted to Associate Professor of Clinical Psychiatry and Behavioral Sciences at Johns Hopkins. The clinical excellence promotions committee recognized him for his impressive body of work, spanning patient safety and suicide risk reduction to consultation-liaison psychiatry.

A former Chief Resident, and geriatric psychiatry Fellow at Hopkins, Dr. Triplett has been the department's Clinical Director since 2009, managing the comings and goings of all patients while focusing on patient safety and quality improvement. Right out of fellowship, he took on running the psychiatric emergency department, which he revitalized and revamped. For the past several years he has focused on consult-liaison psychiatry at Hopkins, creating the PHIPPS (Proactive Hospital-based Intervention to Provide Psychiatric Services) program. Now in its 7th year, it has grown to two proactive psychiatric consult teams.

A Department of Medicine colleague, during the pandemic, provided this testament to Dr. Triplett's talents. "I wanted to take a moment to send a word of praise for Pat Triplett. I was the attending … this past week and had a number of complicated psychiatric patients whose care was benefited by Pat. In particular, there was a very challenging situation with a patient with psychiatric illness, cognitive impairment, drug use, and COVID-19. I felt extremely supported by Pat who provided expert guidance and helped shepherd the team and patient through a very fraught ethical situation with ease and sophistication. I am very glad to work with such a thoughtful, intelligent and dedicated colleague."

Nationally, Dr. Triplett serves as a member of the Joint Commission Suicide Risk Reduction Expert Panel and the National Quality Forum's Behavioral Health and Substance Use Standing Committee.

This promotion serves as an example of how the new clinical excellence promotions pathway at Hopkins can help serve the department's mission – by producing and retaining insightful and extraordinary clinicians.

Dr. Jeffrey Janofsky Wins 2022 Lifetime of Service Award

by: Annette Hanson, MD

Annette Hanson, MD

Jeffrey Janofsky is a wonderful friend, mentor, and colleague. Through his years as a member of the MPS he has provided invaluable historical insights on legislative and operational issues, as well as helpful advice for advocacy. As co-director of the University of Maryland forensic psychiatry fellowship, he has donated countless hours to teach general psychiatry residents and forensic psychiatry fellows from Johns Hopkins and the University of Maryland. In addition to offering career advice, he has served as a role model for professionalism while serving as president of the MPS and of the American Academy of Psychiatry and Law (AAPL), the national organization of forensic psychiatrists. He is currently finishing his term as Medical Director of AAP-- a particularly challenging task during the COVID pandemic.

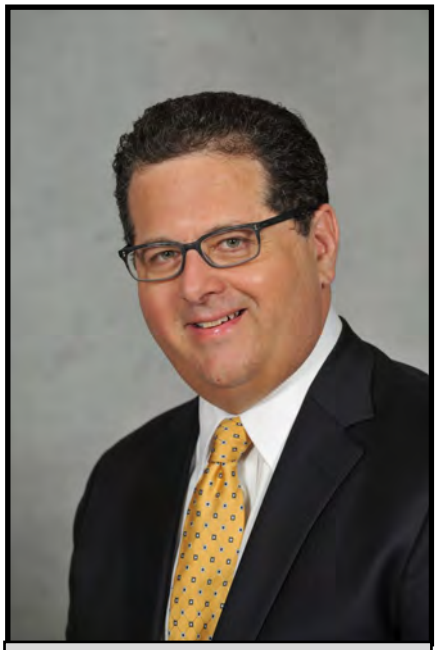
In addition to these achievements, his work has been memorialized in state law and national standards. He initiated and influenced the crafting of Maryland's "duty to warn" or statute. He also participated in the initial draft and update to AAPL's practice guideline for the assessment of insanity.

In 2007 the Maryland Court of Appeals decided DHMH v Kelly, which prohibited the involuntary treatment of incompetent criminal defendants if they were not dangerous on an inpatient unit. Following this decision, he worked with the MPS legislative committee to craft amendments to the state clinical review panel law that corrected this problem.

His academic credentials span three decades and cover a broad range of legal, ethical, and clinical topics. He has published papers regarding psychiatrist participation in interrogation and torture, assessment of decision-making capacity, the judicial determination of insanity and juvenile jurisdiction in Maryland, and the inpatient management of suicide risk. His national presentations are consistently well-attended and are highly rated by post-conference member surveys.

Through his involvement on the APA Council on Psychiatry and Law and the Committee on Judicial Action, he has guided its involvement in state and federal litigation over many issues related to the practice of psychiatry by funding and participating in *amicus* briefs. In his national presentations he has educated APA and AAPL members about this process and has helped general and forensic psychiatrists remain up to date regarding changes in the law.

His enthusiasm for psychiatry and his sense of humor makes him a delight to have as a colleague. He possesses a limitless knowledge of Simpsons trivia, and I would caution everyone not to offer him a pun unless you are prepared to respond in kind.



Jeffrey Janofsky, MD

In short, this award is going to someone who truly deserves our recognition for what he has done for the MPS and our profession.

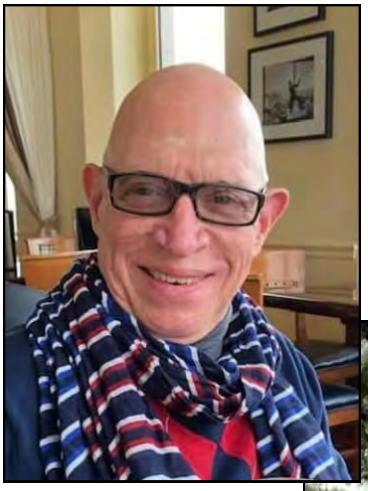
Kery C. Hummel: A Tribute

by: Brian Zimnitzky, MD

It is with a great sense of loss that I pay tribute to our former Executive Director and a dear friend, Kery Hummel. Kery passed away on March 9, 2022 from complications after cardiac bypass surgery.

He was born in Texas, and you could tell right away from meeting him that he was a true gentleman. I had the honor to work with him over the years. His caring, warmth, dedication, and humor were infectious. He seemed to know everyone, and he truly took an interest in and cared for others. He helped make the work enjoyable.

In addition to being a colleague, he was a close friend. He lived life to the fullest, and others gravitated to him. He loved collecting antiques, and his home was warm and inviting. He played the organ for his local church. During the Christmas season, he had multiple Christmas trees around the house. Particularly fabulous was the Marilyn Monroe Christmas tree.



Kery loved attending the Renaissance Fair each year. He had the most wonderful costumes and made the day a special treat. He loved traveling. This past winter, he toured Egypt. He told me that it was the best trip he ever took.

Below are tributes by colleagues and friends:

- Jennifer Palmer – "When Key announced his retirement in 2017, I said at the time that he had served in glorious technicolor for over 10 years and that his extensive experience in health policy and unique talent for fostering relationships helped make the MPS a model district branch. Our relationships with Maryland stakeholders, including DHMH and Med-Chi, flourished under his leadership."

- Heidi Bunes and Meagan Floyd, MPS Staff: "We worked with Kery from 2007 to 2017 and remember fondly his bright smile, contagious laugh and larger than life personality."

- Nancy Wahls: "He was devoted to our organization for many years and created a sweet and kind atmosphere for us."

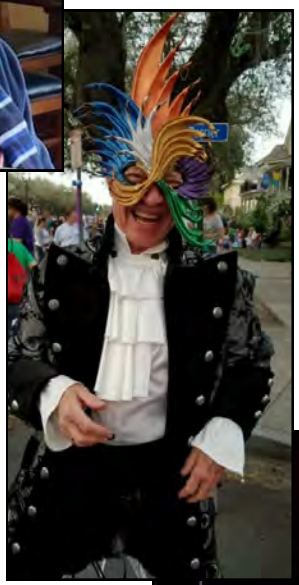
- Mahmoud Jahromi: "Kery always greeted everyone as if you were a celebrity."

- Tom Franklin: "Kery was a kind, genteel man in an age with not enough of either."
- Arman Taghizadeh:" Such a compassionate and genuine man. He was so supportive of me early in my career and so kind to my father late in his."

- Steve Daviss: "I was on the MPS Search Committee to find a new Executive Director in 2007, and recall Kery's warmth, genuineness, and humor being palpable, even in a job interview. His light always shined, and his humor cut through any difficult situations."

A memorial service for Kery will be held in Cumberland on May 28th at 11AM. It will also be held via Zoom, and you will be able to find the link here the day of the service.

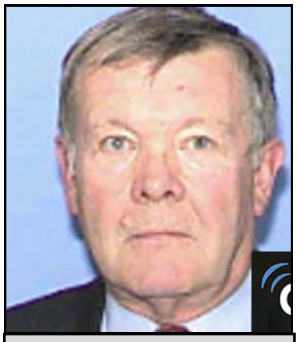
With his passing, the world does seem a little less "technicolor." We thank him for having been a part of our lives.



MPS Annual Meeting

"We Meet for the Joy of Being Together"

by: John Buckley, MD



John Buckley, MD

The MPS does it again! 80 or so members zoomed in for the annual meeting on April 28th and were welcomed, informed, and entertained for an hour---without transportation worries. A few days later, the May newsletter arrived, full of names and numbers to keep us all "in the know".

Within the 60 minutes, the following:

• A series of personal snapshots submitted by members to give a glimpse of normal life during this time of Covid.

• Dr. Neil Warres presented the Foundation's award for reducing the mental illness stigma to Deepak Prabhakar, MD for his op-ed piece in the SUN last August about Simone Biles. As he pointed out, "Even the best athletes with 'steely' inner strength can be vulnerable to mental illness."

• The 2021 MPS annual report; showing a $2000 surplus and an increase in membership.

• Awards (Thank you to The Maryland Foundation for Psychiatry for funding these cash awards!) for best papers and posters to resident/fellows and early career members. The winners were impressive in their accomplishments and gave hope for the new generation and for the MPS. (Click here to see all submissions for 2021)

• The Lifetime of Service award was given to Dr. Jeff Janofsky for his many roles. His gracious acceptance speech credited several past presidents who had helped him on his path.

• Dr. Robert Herman provided a practical example of the PAC work, essential to our professional survival.

• The outgoing presidential message from Dr. Ginger Ashley: It is "a stronger organization, heading in the right direction."

• The incoming message with a list of issues from Dr. Jessica Merkel-Keller. "We have an opportunity to shape the practice of care for the mentally ill of Maryland...We need to continue to support each other, to face critical challenges....I am confident that the year will hold good things."

• Door prizes.

There was a 5 minute break for conversation with several peers assigned by MPS, a nice opportunity to meet those we never see.

There was also acknowledgment of the need for sponsors. This year's meeting was supported by: APA, Inc., Johnson & Johnson, Med Mutual, Sheppard Pratt Health System, PRMS, Neurocrine Biosciences, and Maryland Addiction Consultation Service.

If there was a message to this year's get-together, it was that the attendees, mostly older, need to continue engaging the newer, younger members. The prize-winning entries are a signal: we have much to learn from the next generation.

Before the close, Dr. Marsden McGuire appeared from his back yard with the most important message: "we meet for " the joy of being together". In our time of isolation, small virtual peer groups can be a respite from being on-duty all the time. (For how-to instructions, ask Dr. Laura Gaffney.)

And—Dr. Anne Hanson was again the winner of the unofficial contest for best backdrop.

SAVE THE DATE!

MOVING FORWARD TOGETHER: PROMOTING MENTAL HEALTH IN CHALLENGING TIMES

September 7-11, 2022
Royal Sonesta Harbor Court Hotel
Baltimore

Join the Southern Psychiatric Association and the Maryland Psychiatric Society for our annual, multiday meeting in Baltimore, Maryland! We are excited to once again present this event in person after a two year hiatus. Participants will have the opportunity to earn up to 14 CME credits, explore Baltimore, and connect with colleagues during this three-day, in person event.

Daily registrations available!

Notable Recent Research by MPS Young Members

The MPS Academic Psychiatry Committee awards annual prizes to the best paper in the preceding year (3 categories) as well as the best poster by a Resident-Fellow Member (RFM). The MPS would like to recognize all of the nominees' research and facilitate a connection for members practicing in the community. Following are the submissions, in no particular order:

2021 RFM Poster Submissions

- Julia Nardi Riddle, MD (fellow, JHU), Anxious Thoughts in Pregnancy and Heart Rate Variability
- Angeline Pham, MD (resident, UMMC / Sheppard Pratt), Case Report: Acute Extrapyramidal Side Effects from Smoked Haloperidol
- Eric Goldwaser D.O., Ph.D. (resident, UMMC / Sheppard Pratt), Hippocampal blood-brain barrier damage and peripheral vascular compromise in schizophrenia
- Joan J. Han, DO (resident, UMMC / Sheppard Pratt), Improving Reproductive-Age Patient Education on the Effects of Prenatal Marijuana Exposure
- Maureen Cassady, MD (resident, UMMC / Sheppard Pratt), Psychosis and Depression in Spinocerebellar ataxias: 2 Case Presentations

2021 Paper Submissions

Medical Student Member (MSM)

- Michael Johnathan Charles Bray, MS (medical student JHU), Racial Differences in Statewide Suicide Mortality Trends in Maryland During the Coronavirus Disease 2019 (COVID-19) Pandemic in *JAMA Psychiatry* 2021 Apr 1
- Nicholas Daneshvari, MS (medical student JHU), Neuroimaging Correlates of Syndromal Anxiety Following Traumatic Brain Injury: A Systematic Review of the Literature in *Journal of the Academy of Consultation-Liaison Psychiatry* 2021 Sep 14

Resident-Fellow Member (RFM)

- Eric Goldwaser, D.O., Ph.D. (resident, UMMC / Sheppard Pratt), White matter in prolonged glucocorticoid response to psychological stress in schizophrenia in *Neuropsychopharmacology* 2021 Dec
- Boris Tizenberg, MD (resident, University of Maryland / Sheppard Pratt), Biological and Psychological Factors Determining Neuropsychiatric Outcomes in COVID-19 in *Current Psychiatry Reports* 2021 Oct 1
- Rachel Dillinger, MD (resident, UMMC / Sheppard Pratt), From Requisite to Right: Assessing and Addressing Paid Maternity Leave in US Psychiatry Residency Programs in *Academic Psychiatry* 2021 Sep 24
- Rachael Blackman, MD PhD (clinical fellow, NIMH), Antipsychotic Medication-Mediated Cognitive Change in Schizophrenia and Polygenic Score for Cognitive Ability in *Schizophrenia Research Cognition* 2021 Nov 9
- William Hall, M.D. (addiction psychiatry fellow UMMC), Paliperidone induced neutropenia in first episode psychosis: a case report in *BMC Psychiatry* 2021 Feb 6
- Christopher Morrow, M.D. (geriatric psychiatry fellow JHH), Functional Disabilities and Psychiatric Symptoms in Primary Progressive Aphasia in *American Journal of Geriatric Psychiatry* 2021 Jul 28
- Stephanie S. Kulaga, M.D. (resident, UMMC/SP), Viral respiratory infections and psychosis: A review of the literature and the implications of COVID-19 in *Neuroscience & Biobehavioral Reviews* 2021 Aug

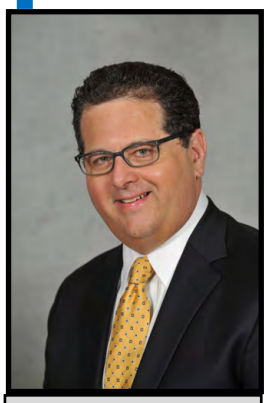
Early Career Psychiatrist (ECP)

- Mark Kvarta, M.D., Ph.D. (ECP, MPRC / UMMC), Multiple dimensions of stress vs. genetic effects on depression in *Translational Psychiatry* 2021 Apr 29
- Elizabeth Wise, M.D. (ECP, JH), Psychiatric Presentations and Medication Use in Older Adults With Intellectual and Developmental Disabilities in *American Journal of Geriatric Psychiatry* 2022 Jan, Epub 2021 Jun 4
- Lindsay Standeven, M.D. (ECP, JH), Allopregnanolone and depression and anxiety symptoms across the peripartum: an exploratory study in *Archives of Women's Mental Health* 2021 Oct 29
- Traci Speed, M.D., Ph.D. (ECP, JH), Temporal Association of Pain Catastrophizing and Pain Severity Across the Perioperative Period: A Cross-Lagged Panel Analysis After Total Knee Arthroplasty in *Pain Medicine* 2021 Aug 6
- Natalie Gukasyan, M.D. (ECP, JH), Psychedelics, placebo effects, and set and setting: Insights from common factors theory of psychotherapy in *Transcultural Psychiatry* 2021 Jan 26
- Sandeep Nayak, M.D. (ECP, JH), Classic Psychedelic Coadministration with Lithium, but Not Lamotrigine, is Associated with Seizures: An Analysis of Online Psychedelic Experience Reports in *Pharmacopsychiatry* 2021 Sep

Interview: Jeffrey Janofsky, MD
MPS Lifetime of Service Awardee 2022

April 30, 2022

by: Bruce Hershfield, MD



Jeffrey Janofsky, MD

Q: "I am delighted the MP has recognized all you have done for it and our profession. Please tell me some of the highlights of your work for us."

Dr. J: "I started with the Legislative Committee in the basement of Sinai Hospital, where the old psych units used to be. Jonas Rappeport, John Urbaitis and Stuart Silver got me interested. I was very much involved for a number of years and I testified before the Maryland General Assembly. Those were the days when you couldn't retrieve the bills electronically. I remember sitting around the table, sorting out which bills to review. Around that same time, I became involved with the American Academy of Psychiatry & the Law (AAPL). I eventually became President of the MPS. I was always very involved with the Ethics Committee; I was its Chair for a long time and I'm still on it as a member. "

Q: "I know you have also done things for the APA."

Dr. J: "I was in the APA Assembly when it started a pilot project to allow representation by the specialty societies and I was AAPL's first Rep. That was a lot of fun. I got to understand the APA's process. On the other side of APA governance I was involved in the Components. I think my first appointment was to the Commission on Judicial Action. Then I became the first chair of the a new committee, the Committee on Litigation Funding. That focus was basically on pushing back against psychologist prescribing."

Q: "Please tell us about your work with AAPL."

Dr. J: "I was a Councilor and then VP and Secretary and then I became its President. Eight years ago I became the 3rd Medical Director, replacing Howard Zonana (who had replaced Jonas Rappeport). I am planning to retire from the AAPL Medical Director position in October, 2023. It's a great organization. Originally, the wives of the members did most of the administrative work, but then the organization grew too big for that to happen. So they hired a professional management company, right at the end of Jonas's tenure. Jackie Coleman is still our Executive Director, and she is wonderful. It's so easy to be Medical Director when you have that kind of support behind you. So, my real job is to help the presidents be successful."

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

Dr. J: "I was always interested in psychology. I got into Hopkins in the old "2-5" program. That meant you applied after two years of college and you got accepted into med school. You did an additional year of college and then a transitional year and then you entered the first year of med school in what was called "year 2". So you saved a year. In my undergrad time at Emory I had been interested in psychological research. When I entered med school I found that the most interesting specialty was Psychiatry. We had inspired teachers. Lex Smith was a wonderful psychotherapy supervisor. Paul McHugh was the Chair. and Ray DePaulo, who was running Bayview for a time, came back to the Hopkins main campus to found the Affective Disorders program. We had a lot of wonderful teachers.

I decided to go into forensics because of Jonas. As a 4th year student I knew I was going to go into Psychiatry and I had some free elective time and I looked at the course book. It said something about treating the criminally insane. That sounded interesting! So I met Jonas, who was doing the Hinckley case around the same time. What could be more interesting than that? I spent more time with Jonas when I was a Resident and I did a Fellowship with him."

Q: "I understand Maryland is very important in forensics in the US."

Dr. J: "I think Maryland had the 2nd oldest medical office in the country. The Maryland fellowship in forensic psychiatry is the oldest such fellowship in the US."

Q: "Please tell us about your research."

Dr. J: "I have done some, but I am not primarily a research psychiatrist. I am primarily an educator and a clinician. I have done some work in improving systems to decrease inpatient suicide risk and violence prediction. But my major interest has always been in educating Residents. I especially enjoyed that when I was an inpatient psychiatrist. Geetha Jayaram and I shared an inpatient attending physician job at Hopkins for almost 30 years. Paul McHugh worked it out for us so it was a win-win situation. We both enjoyed doing inpatient work and the department needed the unit to be covered so the other faculty could

(Continued on p. 9)

Dorothea Dix: A Reformer for the Ages

by: Steven Sharfstein, MD

Steven Sharfstein, MD

Dorothea Dix (1802-1887) was the most remarkable single-citizen reformer in the history of this country. She sponsored and drafted legislation that led to the construction of psychiatric institutions around the country over nearly 40 years. Her work led to 38 asylums (not a bad word in the day) founded in 18 states, as well as others in Canada, UK, and Europe. She thrust "insanity" or mental illness into the center of public policy debate in the U.S. She held that it was the obligation of the state to provide decent help to those who could not care for themselves due to severe mental illness.

Dorothea Dix (1802-1887)

In colonial America the indigent insane were lumped together with a broad class of "deviants" ---beggars, vagrants, petty criminals, the chronically ill, and the aged. They were managed by their families if they were better off, or were in jails or almshouses, or were homeless. After Dorothea Dix, the insane became a special class of beings who needed special treatment in a special kind of hospital--the asylum.

In 1841 she was teaching Sunday school in the Middlesex County jail in Cambridge, MA in the dead of winter and there was no heat. When she complained to the jailer, he responded "Madam, the insane require no heat". At age 40 she realized that this was to be her calling. She went to the legislature and obtained an official inspection commission that led to heating in the jail. Thus began her prodigious campaign that transformed the treatment of mental illness. She visited towns and villages, inspecting alms houses, jails, and private homes. She took copious notes and made striking observations in her report. This "Memorial" and others were an amalgam of public health---facts and numbers--and vivid descriptions of the conditions she found. These Memorials combined humanitarianism and religious imagery. She provided tours of hell on earth--vivid tableaux of cruelty and neglect. She collected immense data, not only on the individuals and conditions, but also on such details as the measurement of the rooms/cells she found and how people were dressed and what they ate. Most importantly, she described her moral affront and emotional reactions. She was able to render the unthinkable in terms that were believable.

Her presentation of her Memorial to the legislators in Massachusetts, as well as the stories about her work in newspapers, persuaded them to allocate funds for the expansion of the Worcester Asylum and the building and staffing of additional asylums. This was her model: study and survey, make a dramatic presentation, advocate for funds, then follow through for constructing asylums. Over the next decade she visited 13 states in pursuit of her mission.

Her last survey and Memorial were in Maryland in 1851. During the 1830s, even before she had launched her one-woman crusade, and the 1840s, she had made dozens of trips to Baltimore, staying with the prominent Unitarian minister, George Washington Burnap. His close friend was Moses Sheppard, a wealthy Quaker and leader in the Friends Meeting. Over many years they corresponded about the wish to build a private asylum modeled on the York Retreat in England, a 18th century Quaker institution that revolutionized hospital psychiatry by providing "moral treatment". This included humane care with lack of restraints and occupational therapies, instead of the shackles and bloodletting that were common in those times.

In her Memorial and petition to the Maryland General Assembly she reviewed the history of care for the insane: the establishment of a public hospital in Baltimore in 1797 that evolved into the Maryland Hospital, the Sisters of Charity Mt. Hope Hospital, and the Baltimore almshouse and penitentiary. She surmised that these institutions were inadequate, with the rate of insanity increasing in the state. Comparing the Census of 1840 with 1850, she noted that the general population increased 24% while the population of the insane jumped 72%. She stressed the importance of early institutionalization to "cure" insanity in young people. She

(Continued on p. 9)

Interview: Jeffrey Janofsky MD
(Continued from page 4)

spend more time on research.. I have always been a big proponent of encouraging Residents and young faculty members to join organized Psychiatry. I think the worst thing you can do as a physician is to become isolated. The MPS is particularly important in fostering such relationships among psychiatrists. It's such a great group of thoughtful people."

Q: "What have you enjoyed most about your professional life?"

Dr. J: "Meeting other folks. When I was on the MPS Council, Tom Allen started the process so that after you are president you got to run the Council. So you would be together with a small group of people you really got to know for five years. The MPS staff is wonderful, too."

Q: "What would you do differently if you had a chance to do it again?"

Dr. J: "Not much! I joke with my wife that in another life I would have been an electrician or plumber because I like that kind of stuff. But it's just a joke—I do like what I do.

That's one of the great things about Medicine—you can find something you really like and that you're good at. "

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

Dr. J: "We are going to have our first grandchild in a few months and I expect to retire sometime in the future and I plan to travel with my wife. I will be taking some time off, but I probably will stay involved with the profession.

I really have enjoyed teaching. I really enjoy it when an ex-Resident calls me for advice on forensic matters. I mentioned how much I owed to my teachers when I accepted the award. There have been so many who have passed on—like Lex Smith and Jonas and John Urbaitis—or have retired. But we do have a flow of new Residents who will be making exciting discoveries in the future. The Residents are so smart!

I do also want to thank my wife for putting up with me taking so much time away for APA, AAPL and MPS matters over the years!"

Dorothea Dix
(Continued from page 8)

also stressed the importance of rendering comfort for the "incurable". Because she found that the costs were of great concern to the delegates, she devoted 1/3 of her Memorial to economy. She argued that the economics of a well-managed asylum would prove to be cost-effective and reduce the state's funding burden, as more of the insane would be "restored to useful employment". She was successful in getting a $100,000 appropriation over several years that eventually led to the construction and staffing of what became Spring Grove Hospital in Catonsville. She was aided by the strong support of Moses Sheppard.

So, in Maryland, Dorothea Dix not only expanded asylum care at public expense, but also was an important influence on Moses Sheppard and his bequest of $571, 441.41 and the founding of the Sheppard Asylum, which was chartered in 1853.

Her Memorials and advocacy led to the founding and construction of 38 asylums, public and private, throughout America. She helped the design, staffing, and funding of these institutions. She would make surprise visits (like the Joint Commission today) to inspect them and then challenge the Trustees or the state legislators to implement her findings. Over time, however, due to the pressures of economics as well as a change in the understanding that insanity was chronic and incurable, many of these asylums became mostly custodial in their care of the mentally ill. She was dismayed by these changes, but, aged and frail, she was unable to convince the large state hospitals to provide other than mostly-custodial care.

Deinstitutionalization, beginning in the 1950s, depopulated the large state hospitals. Many, initially founded because of Dix's advocacy have closed. One wonders what she would say about the many homeless and incarcerated people who are seriously mentally ill who are getting sub-standard, or no, care in our cities and towns today.

References:

1. Voice for the Mad: The Life of Dorothea Dix by David Gollaher The Free Press, 1995
2.
2. Moses Sheppard: Quaker Philanthropist of Baltimore by Bliss Forbush J.P. Lippincott, 1968.

In Memoriam: Rudolf Hoehn-Saric, MD

By Jimmy Potash, MD

Chair, Dept. of Psychiatry & Behavioral Sciences, Johns Hopkins

Rudolf Hoehn-Saric, MD

From "Cheers from the Chair" May 2, 2022

I am writing to let you know of the passing of a giant in the field of anxiety and a pillar of our department for nearly a half century, Dr. Rudolf Hoehn-Saric. I knew Rudi when I was a resident and young faculty member here. A couple of years ago, as Department Director, I reached out to him following the death of George Floyd, to ask him about his memories of our department's first Black faculty member, Dr. Earl Nash, with whom he worked in the psychotherapy research group led by Dr. Jerome Frank. Rudi recalled Dr. Nash as a lovely and talented man, and also recounted some disquieting stories about those days from the 1960s. It was great to catch up with Rudi and to hear about how satisfying his retirement seemed to be.

Let me give you a brief professional biography of Dr. Hoehn-Saric, which comes from comments composed at the time of the creation of the Rudolf and Evanne Hoehn-Saric Professorship for Obsessive-Compulsive Disorder and Anxiety Disorders Research in 2014, established in honor of Rudi and his wife by his son Chris, along with his daughter-in-law Pamela, and Charlie Scheeler and Mary Ellen Pease. It is currently held by Dr. Gerry Nestadt.

Dr. Hoehn-Saric received his medical degree from the Karl Franzens University in Austria. He did residencies in psychiatry at McGill in Montreal and neurology in Vienna, and a fellowship in Clinical Psychopharmacology at Hopkins. He joined the psychotherapy research group of Dr. Frank in 1961 and was particularly interested in the interaction between emotions, cognition and behavior. After the retirement of Dr. Frank, Rudi established one of the first research groups in the country focused on anxiety and obsessive-compulsive disorder (OCD), and led the clinical, research and education initiatives in anxiety disorders at Hopkins until his retirement in 2007. His name is synonymous with this domain in academic medicine. Dr. Hoehn-Saric also shepherded the clinical programs and has been a key figure worldwide in areas related to the neurobiology of anxiety disorders, particularly OCD, generalized anxiety disorders and panic disorders. He was a pioneer in advancing our understanding of the underlying substrates of anxiety disorders and was at the forefront of advances in neuroimaging methods. In addition to his many scientific contributions, Dr. Hoehn-Saric was a superb teacher and mentor to hundreds of students and junior faculty members while at Hopkins. He was also an extraordinary clinician. Rudi authored several books, including *The Anxiety Disorders (Concepts in Clinical Psychiatry)* with Russell Noyes Jr., MD; *Biology of Anxiety Disorders (Progress in Psychiatry)* with Daniel McLeod, PhD; and *Effective Ingredients of Successful Psychotherapy* with Dr. Frank.

There is much more to be said about Dr. Hoehn-Saric. His son Chris has crafted a wonderful tribute to his father, and you will find it on the next page. Chris let me know that "there are no plans for a service at this point. I am happy that [dad's] life work continues through the good work at Johns Hopkins." May we all do our best to keep up the good and meaningful work. And may Rudi rest in peace.

SAVE THE DATE

MPS Presents

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November 19th 8:00AM - 1:00PM

Join us at Martin's West for an in-person CME meeting!

Tentative Presentations Include:

- Impact of Social Determinants of Health on Adolescent Mental Health
  Hal Kronsberg, MD
- Treating Opioid Use Disorders in Pregnancy
  Alexis Hammond, MD
- Pharmacological Approaches to Targeting the Sleep-pain Interaction
  Traci Speed, MD
- The Enduring Effects of Psilocybin on Emotion, Brain Function, and Cognition
  Manoj Doss, MD

Dr. Rudolf Hoehn-Saric

By R. Christopher Hoehn-Saric

Rudolf Hoehn-Saric, MD

The Yugoslav spring of 1945 brought cold weather and flyers posted around family home in Radenci declaring that Ante Šarić, a prominent physician and businessman had been executed by the Nazis for being part of Partisan Resistance. My then 16-year-old father had endured the loss of his biological father at age 5, his older brother earlier in the war and now his adopted father Ante Saric.

Rudolf Franz Walter Höhn-Šarić (Hoehn-Saric) (Feb 5th, 1929 – April 28th, 2022) was born in Graz, Austria to a family steeped in medicine and entrepreneurship. The family traces its roots to South German royalty and distantly to Martin Luther. Growing up, my father lived the tumultuous but fortunate life of a family that built a storied water and hotel/spa business in what is today Radenci, Slovenia. Growing up years coincided with the transition from the Austro-Hungarian Empire and end of WWI through the First Austrian Republic to the Anschluss and WWII. Rudolf attended 12 schools during his youth moving near constantly between Graz, Radenci and other towns in the region.

The end of the War brought challenges to his young life with the ascent of Communism and Josip Tito. Tito nationalized the family's business and property ending a 100-year-old family business in favor of state control. Having lost his father and brother, my father, his sister, and mother moved back to Graz to rebuild their lives. He would finish his studies and complete his medical school at the Karl Franzens University in 1954. He did his post-graduate training in Vienna, in Montreal at McGill University and Johns Hopkins University. He immigrated permanently to the United States, became a citizen and was on the faculty at Johns Hopkins for 49 years focusing his research on anxiety disorders. Rudolf worked to untangle the mysteries of cognitive, neurologic, and behavioral issues involving anxiety disorders including having written multiple books and numerous peer-review papers. He ran the Anxiety Disorder Clinic at Johns Hopkins.

He retired in 1999 as a Professor Emeritus and in 2012, he and my mother Evanne, also a Hopkins trained physician, were honored by the establishment of the Rudolf and Evanne Hoehn-Saric Chair for Obsessive-Compulsive and Anxiety Disorders at Johns Hopkins Medical School.

My father met my mother while at Johns Hopkins. Evanne Loh had immigrated to the United States in 1948 at 12 years old as the Communists in China had ascended to power. Having also grown up as immigrants born of Communist displacement and as echoes of WWII, Evanne similarly pursued life with unapologetic optimism and grit. She had recently graduated Johns Hopkins Medical school as one of four women, and the unlikely pair found true love. They married in 1960 in Maryland because anti-miscegenation laws in Virginia prevented mixed race marriages. They would go on to have three boys, R. Christopher, Edward, and Alexander. Their family has grown to include three wonderful daughters-in-law, Pamela, Amy, and Loren, eight grandchildren, two amazing grandchildren-in-law and five great grandchildren.

Growing up in an unusual family in 1960s/70s America, when conformity and social upheaval fought culture wars, our little united nations family was similarly a place of the conventional focus on education and hard work coupled with a maelstrom of wonderful cultural experiences.

My father was an imposing 6'2" Austrian, psychiatrist with the full Freudian accent and demeanor. Yet, he was a playful prankster who loved a good joke, swore in Slovene, and spoke English, German, French, and Italian. He was as comfortable debating Byzantine history, traveling camelback on the Silk Road, analyzing the Nabatean Kingdom and the architecture of Petra as discussing the latest medical imaging technologies. The house was filled with joy, caring, the sounds of opera and Alfred Brendel, his cousin, with grace notes of Baez, Dylan, and Pete Seeger as conversation would drift to Vietnam and social justice. My father was a gourmet and my mother, a chef, made family dinners a melting pot that ranged from Chinese Red Cooked Pork to Austrian deserts, good Bordeaux, and Hungarian goulash.

His love of learning and a commitment to a life of contribution inspired my brothers and me. As kids, we would come to my parent's bedroom and find stacks of scientific journals heaped on each side of their bed and each of them deep in reading. Family trips meant one had to be prepared to get on the orient express, fly to Tibet, or visit every church in Europe.

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But the intellectual interests were always anchored in a commitment to hard work. My father's passion for research and commitment to educating his children was only possible by a level of work commitment that inspired all of us. Growing up, he would work six day a week including two non-academic jobs to pay the bills. He would work until he was 79 when it became more difficult to receive support for long-term research grants. My parents always made clear that work was a privilege, that passion was for what one did and not for some unattainable goal, and that the work must help others. Their work required confidentiality but over years
numerous people would tell me how my father had helped them during a difficult period of
their life.

In their retirement years, my parents never slowed down. Just a few years ago, my parents moved to Beijing for a month to study Mandarin. They would walk to a school filled with 20 somethings each day while they were in their 80s. While age has taken its toll on mobility, I still found my father in the past year working on his Chinese calligraphy. Over twenty-five years ago, my father began an effort to have the Slovenian government return the Radenska water company and the land stolen by the Tito government. This dream has been unfulfilled and it is now up to our generation to right this wrong.

Our family is heartbroken but, in his passing, each of us is inspired to be just a bit better father and spouse, work just a bit harder, complain a little bit less, help others just a bit more and make one's life one of wonder and contribution.

Implicit Bias Training Required for License Renewal

The Maryland Board of Physicians posted a notice implementing the new law effective April 1, 2022 that requires all renewing licensees to complete an implicit bias training program approved by the Cultural and Linguistic Health Care Professional Competency Program. Licensees whose last name begins with A-L and expires 9/30/2022 must complete one course of the program as a condition of license renewal. Those whose last name begins with M-Z and expires 9/30/2023 have another year to complete the course. Click here for a list of approved training program courses.

A Pew Stateline article reported on the trend of requiring training to help health care providers understand that implicit bias is part of being human so they can begin to take steps to change the role that bias plays in health disparities.

988 Is Coming

By Heidi Bunes

Starting **July 16**, everyone in the U.S. can dial 988 to access the National Suicide Prevention Lifeline, which will connect callers to local crisis centers across the country. 988 is not just easy to remember, it's a direct connection to compassionate, accessible care and support for anyone experiencing mental health-related distress – whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support. The new 988 access number is one of several initiatives underway to strengthen and transform crisis care.

To assist the transition to the 988 three-digit dialing code in July, HHS awarded $1,972,989 to the Maryland Department of Health out of almost $105 million total distributed nationwide. States and territories are expected to use the funds to improve response rates, increase capacity to meet future demand, and ensure calls initiated in their states or territories are first routed to local, regional, or state crisis call centers. Recipients may also use the funds to build the workforce necessary for local text and chat response.

Member Updates & Survey

Next month the MPS will send member information update forms and the 2022 member survey. Please watch your US mail and return your updated information promptly!

Member Update Form
The MPS membership directory will be published in late Summer. Please ensure that your information on file with MPS 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. You can also log in to your member account on the MPS website to directly enter updates.

Member Survey
Please help guide how MPS committees, Council and staff will work for you in the coming year by completing the survey. **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.

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

Who Corrects False Information?

by: Ann Hanson MD

Annette Hanson, MD

In March the Indiana legislature passed a law prohibiting health care practitioners from providing false or misleading information regarding the practitioner's profession, education and training, licensure, or board certification in any advertising. It forbids any non-physician from using any one of more than 40 terms commonly employed to describe medical specialists or sub-specialists.

"Advertisement" refers to any printed or electronic statement that the practitioner uses and controls to communicate with the public. But what about public communication that the practitioner doesn't control? The internet abounds with web sites that link advertising to a practitioner's name and identity: LinkedIn, Doximity, Healthgrades, and many others. Where do these sites get their information, and should a practitioner be held responsible if professional credentials are false or misleading on them?

A case study in misrepresentation was recently discussed on the MPS listserv, when a member discovered that a nurse practitioner was incorrectly listed as a psychiatrist on a number of sites, including in the Department of Health and Human Services' own NPI database. The nurse was correctly identified in a search of the Maryland nursing board. Unfortunately, the licensing board also disavowed any responsibility over third party web site information, seeing it as being outside of its jurisdiction.

The third party web sites themselves have pertinent disclaimers and take no responsibility for misleading or false information, stating that this is the responsibility of state licensing boards. One NPI lookup site posts this information: ""All contents of this website are provided on an 'as is' and 'as available' basis without warranty of any kind. NPI records are maintained by the National Plan & Provider Enumeration System. The contents of the NPI Profile website are for informational purposes only. Reliance on any information provided by the NPI Profile website or other visitors to this website is solely at your own risk."

So, I checked the National Plan & Provider Enumeration System (HHS NPI). The nurse practitioner still is listed as a psychiatrist on the federal government's own web site. Of more concern: the federal government also distances itself from health care identity fraud. The NPI database states, "Please Note: Issuance of an NPI does not ensure or validate that the Health Care Provider is Licensed or Credentialed." It conveniently provides a link to where someone could correct the misinformation, but apparently this correction can only be made by the fraudulent practitioner him or herself.

This appears to be a case of everyone pointing to everyone else. The federal government relies upon the states, and our state is saying it can't control third party private web sites. Fixing this problem is a game of whack-a-mole.

In Maryland, the medical practice act forbids any licensed physician from making a "willful misrepresentation in treatment" or making a "false representation when seeking or making application for licensure or any other application related to the practice of medicine." Similarly, the Code of Maryland regulations state that a nurse may not knowingly participate in or condone dishonesty, fraud, deceit, or misrepresentation. The board also states that nurses have a mandatory duty to report unethical behavior. It appears that the duty of policing false advertising has been left to the professions themselves.

Perhaps it is time for Maryland to follow Indiana's lead.

MPS ADVOCACY FUND

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

To support the MPS over and above your membership:

1. **Visit: https://mdpsych.org/contact-us/**
2. Click on the yellow "Pay Now" button
3. Enter your credit card information

Drs. Swartz & Roca Become Clinical Professors

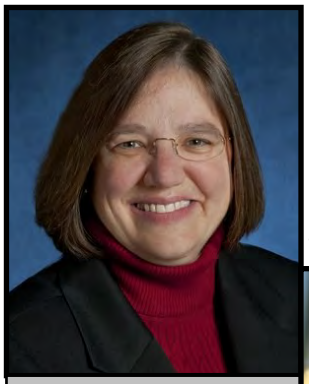
by: Elizabeth Wise, MD

Elizabeth Wise, MD

Drs. Karen Swartz and Robert Roca recently became the first two faculty members to achieve promotion to Professor of Clinical Psychiatry and Behavioral Sciences at Johns Hopkins.

Created in 2019, the Clinical Excellence Track recognizes outstanding clinicians who devote at least 60% of their efforts to patient care, disseminate their clinical knowledges to other members of the academic and clinical community, and generate new clinical knowledge, thus fulfilling Hopkins' tripartite mission of excellence in care, education, and discovery.

"I am very pleased that Johns Hopkins has created a promotions track that emphasizes clinical contributions. I hope this will allow more psychiatrists beginning their academic careers to believe their clinical work and leadership will be valued and recognized," Dr. Swartz said of the promotion.



Karen Swartz, MD

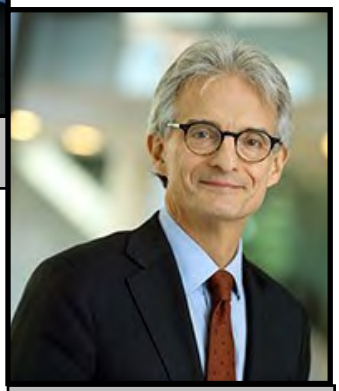
Dr. Swartz has been at Hopkins for over 30 years, having completed medical school, psychiatry residency, and fellowship training before joining the faculty. She is the department's Vice Chair for Faculty and the director of clinical and educational programs of the Hopkins Mood Disorders Center, as well as the founder and director of the Adolescent Depression Awareness Program (ADAP). A school-based program that educates high school students, faculty, and parents about adolescent depression, ADAP has been disseminated across the United States and has reached over 66,000 high school students.

Dr. Claire Zachik is among the numerous former students and residents whom Dr. Swartz has inspired with her clinical standards of excellence. "I know I speak for many when I say how thrilled I am that Dr. Swartz has now been recognized as a Professor at Johns Hopkins for her substantial clinical and educational contributions to our field," Dr. Zachik said. Dr. Swartz taught her as a medical student and psychiatry resident, and now they are together working to expand ADAP to middle school students.

Of her promotion, Dr. Swartz added, "I was particularly honored to be promoted at the same time as Dr. Roca, as he was one of my first clinical teachers. It is wonderful to see his many contributions recognized."

Dr. Roca, another Hopkins "lifer" who is a leader in the field of geriatric psychiatry, recently edited "Geriatric Mental Health Care: Lessons from a Pandemic." He spent the early years of his medical career at Hopkins, doing both internal medicine and psychiatry residencies and then directing the consult-liaison service for 7 years at what is now Bayview. In 1993, he left Hopkins for Sheppard Pratt, where he served as medical director of geriatric services before becoming Chief Medical Officer of the Health System.

He returned to Hopkins as Vice Chair of Clinical Business Development in 2019. In that role, he helps lead program development efforts, while doing what Hopkins psychiatry faculty value highly: patient care and teaching. "I am extremely happy (and honored) to be a Professor of Clinical Psychiatry," Dr. Roca said. "The creation of the clinical excellence track recognizes that a truly outstanding academic medical center has to be an outstanding place to come for care. And that requires having outstanding clinicians who have the endorsement of the institution to devote most of their energy, time, and talent to the clinical enterprise."



Robert Roca, MD, MPH

Dr. Susan Lehmann, clinical director of the Division of Geriatric Psychiatry and Neuropsychiatry at Hopkins, said that Dr. Roca has distinguished himself as a leader for geriatric mental health both in Maryland and nationally. "He brings compassion as well as clinical expertise to his care of older patients and their families," she said, adding that he "has an extraordinary way of bringing people together to work on many important issues related to patient care and advocacy."

What to Do When the Pharmacy Refuses to Fill a Valid Rx

by: Kim Jones Fearing, MD

Kim Jones-Fearing, MD

If you are still treating patients, you have likely been frustrated by the following scenario. You write a prescription or place one into your electronic system with the same information as previously. The patient arrives at the pharmacy, but no prescription has been filled. The patient calls you during non-office hours to inform you. The administrative clock begins to tick as you begin the burdensome task of trying to figure out what the problem was and where in the figurative pipeline the problem started. Most of the time, my first question is "Why didn't the pharmacist call me about this?"

There are a variety of reasons why patients do not receive their prescriptions:

1. Prior authorization is required yearly because the patient has some type of federal government insurance Tricare/Humana, Medicare, or other PBM not under state of Maryland jurisdiction.
2. Expired electronic prescription-electronic scripts are supposed to be active for 2 weeks. But some recent audits by our members showed that these scripts by some electronic apps are active for only 24 hours.
3. Pharmacist refusal to honor paper prescriptions.
4. Electronic orders are not seen by pharmacy technicians.
5. Electronic orders are "not received" by the pharmacy despite a message from the electronic app stating "the prescription was successfully processed."
6. Pharmacy staff or pharmacist are refusing to fill a prescription for a controlled medication because they do not think your patient should get it.

Maryland has passed two laws over the past 10 years to lessen the likelihood that your patients' medication will be randomly denied by the pharmacy. The first prior auth law was passed in 2014. The second prior auth law was intended to strengthen existing legislation and was passed in 2020 under title 15. It is listed in the MD Insurance code Ann. 15-142-Step Therapy or Fail First...-15-142/

The APA has recommended that members "Push for Change" by working with state legislators to "push for legislation" and "collect stories from members describing both challenges and impact on patient care and outcomes". It was also recommended that the MPS share these findings with the State Department of Health and Human Services.

Case #1

While working on a contract in the U. S. Virgin Islands, I got a text on a Saturday from a patient who has been under my care for the past 20 years. He had been unable to pick up his medication from the pharmacy and was already suffering from withdrawal. The psychiatrist who was covering for me would not have the ability to effectively handle prior authorization issues because he cannot access the details, which may require several hours to review. Therefore, I requested the patient to advise the pharmacist to call me. Approximately 30 minutes later, I got a call from "Jo". "Jo who?, I replied. "I am the pharmacist calling about your patient's medication." He told me the medication had been denied, based on the dosage. I informed him that the patient is a rapid metabolizer and he had been stable for several years on the same dose. He asked if I had proof of his rapid metabolizer status. I said, "No, because his insurance does not pay for that type of testing." The conversation continued for at least 20 minutes. He asked several clinically irrelevant questions, which had nothing to do with patient health or safety-- such as, "Has he ever paid out of pocket for the medication?" Finally, I advised him that we needed to resolve this issue as soon as possible. He told me that the patient would NOT receive the medication. I informed him that he "must get this medication or he will get sick! He is already having symptoms of withdrawal!" Jo said, "This dose is higher than normal and the insurance denied it." I asked if he had looked at the two or three years of previous prescriptions at this same dose or asked any of the other pharmacists what to do. I also asked for a supervisor. He said no supervisor was available. Then I asked "Jo" for his last name, but he would not tell that to me. I replied emphatically, "Sir. If you deny this script, the patient is going to get sick. And that is medical negligence!" " Ma'am, that is a threat, so I am going to hang up now!"

OUTCOME Case #1:

I got a text message from him about an hour later, stating that he had learned how to manually override the denial. The patient had already suffered withdrawal symptoms, due to not having had his medication for several days before this. It took him one or more weeks to restabilize after this incident. During that time, he failed to deliver a management presentation at work, due to a panic attack. This patient complains that now he gets panicky any time he has to talk to a pharmacist because of this and other past instances.

Case # 2

The pharmacy refused to fill the olanzapine that the patient has been stable on for the past

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Pharmacy Refusals

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15 years. Why? Because it cost $2000 and would put the patient "into the donut hole"--Medicare would no longer cover her medications for the remainder of the year. The patient was advised by another customer to go on-line to "the yellow discount card site", where she found it at Giant for only $11. But I had--again outside of scheduled office hours-- to send a new prescription to a new pharmacy.

OUTCOME Case #2
The patient had begun rationing her medication to only half the dose and had completely run out of it 3 days prior to reaching me. She was becoming anxious and irritable--symptoms of relapse. Several electronic scripts had to be sent, due to the new pharmacy not receiving it initially. I spent approximately 2 hours reading messages, making phone calls and investigating what had happened.

Case #3
Patient called between scheduled appointments because the pharmacy would not fill a prescription for low-dose lorazepam (prescribed for akathisia) that she had been stable on for more than 20 years. She had recently changed insurance. Her current pharmacy stated they had run out of Lorazepam. Her refills were not valid at the new pharmacy.

OUTCOME Case #3
She had to take medical leave for the remainder of her workday due to the severity of her stress. Her need for personal leave, one month after she had been promoted, was noted in her record by her human resource department.

I have solved several other prior auth cases this past year, but, regrettably, I have lost patients to follow- up due to what I suspect is their frustration with the process. Since the pandemic started, I have lost at least four patients to follow up whom I have been treating over the past two decades, due to prior auth problems.

The stress associated with hours of uncompensated work, constantly being "on call", and forced to intervene outside of office hours for patients to receive their medication has hurt my overall health. I have joined a support group at my church in Columbia for healthcare workers. It was started during the pandemic by our Reverend, Paige Getty. The group has given me advice about how to handle many processes. We have lost several healthcare workers due to retirement in the past few months. Some of them retired many years before they were "supposed to" due to the chaos of the pandemic and other workforce issues.

I hope that improvements in prior auth and other health care laws will lead to a system of more stable and transparent patient care, both in Maryland and nationally. What more can be done to make the healthcare of our state more fair, equitable, and cohesive? What can we do to make sure that we and our patients are heard?

In Support of Medical Assistance in Dying

by: Douglas W. Heinrichs, MD

Douglas Heinrichs, M.D.

The very narrow defeat of a medical assistance in dying (MAID) bill in last year's legislative session and the likelihood of a similar bill being introduced next year keeps this controversial issue very much alive. Last year, the MPS chose to oppose the bill. This year, there has been a very lively debate on the MPS listserv. As someone who is very much in support of this sort of legislation, I have struggled to make sense of the basis for opposition. In a culture such as ours, where individual autonomy and freedom are highly valued, we generally hold that persons should be free to choose how they want to live their lives. Choosing how to die in the face of a terminal illness is certainly an important life choice. Thus, the burden is on opponents of MAID to make the argument as to why a person's freedom should be curtailed in this matter.

It seems to me that the arguments put forth by opponents fall into two broad categories.

First, there are individuals who on principle feel that it is morally wrong to kill oneself, so it is wrong to do anything to assist anyone else in doing so. I strongly suspect that this almost always derives from an explicit religious belief or an ethical framework derived from a religious tradition. To the extent this is true, there is not much room for logical arguments to persuade people to change their basic beliefs. The public policy question then becomes whether one's personal ethical intuition, religiously derived or not, should be imposed on everyone else.

Second, opponents to MAID argue that there are other pragmatic considerations. It seems to me that the majority of these sorts of arguments fall into three categories:

1) Even with careful regulations, MAID will sometimes be employed in instances that the law was not intended to permit, with harmful consequences. 2) Whatever one thinks about taking one's own life, this is something in which physicians should not participate. 3) Even if a particular law allowing

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MAID in some form is acceptable, it puts us on a slippery slope as advocates will push for more and more permissive legislation.

I believe each of these arguments is fundamentally flawed, and I will consider each in turn.

1) No law about anything has ever been enacted that did not result in some unintended outcome. Any law could be attacked on these grounds. Should we never imprison anyone because sometimes an innocent person goes to jail? Should the police not be allowed to carry weapons since they sometimes do egregious things with them? The logical response is not to oppose all laws that could be misused, but to work to fine-tune them to minimize the undesirable outcomes. This is likely to be an evolving process over time, as it takes experience with any law to see which regulations work and which need to be improved. But it could be argued that in the meantime some people may experience significant harm. This must be weighed against the people who will be harmed by having to endure protracted pain, suffering or lack of dignity by not having the option of MAID. This involves a quantitative judgment that is difficult to make with any precision before significant accumulated experience occurs. Just as in assessing the risks and benefits of a new treatment in medicine, we must be careful not to be unduly swayed by striking anecdotes on either side. Models designed to project risk and harm can be useful to consider, but are notoriously unreliable, given that they always involve a host of assumptions that are only approximately true in the real world. So, the best we are likely to do is to make reasonable attempts to provide sensible safeguards, and to fine-tune them as experience accumulates. This is the equivalent of post-marketing reports of adverse effects with a new therapeutic agent.

Opponents of MAID often suggest that the terminally ill person may be unduly influenced in the decision by others who stand to gain from a hastened death. But the same concerns apply to other important decisions individuals often make near the end of their lives, such as advance directives, DNR status, choosing medical power of attorney, making a will. In these cases, we have established basic safeguards that work reasonably well. Abuses can still occur, but they are not used to argue that these choices should not be allowed.

2) The argument that MAID is something that intrinsically does violence to the physician's role appears to have two components. The first is that it does violence to the Hippocratic oath--the physician's general commitment to respect the value of life. There is no doubt that in its original form the Hippocratic oath explicitly forbids the administration of lethal medicine for the purpose of killing the patient. It should also be noted that the original Hippocratic oath involves swearing in front of Apollo as well as the promise to take care of our teachers and their children as if they were our own. Traditions are not fixed in time. Due to its many anachronisms, the oath has largely been replaced in medical schools around the country by alternative ones thought to better reflect modern realities and values. A content analysis of medical school oaths administered in 2000 (Kao AC and Parsi KP. 2004. *Academic Medicine* 79:9, 882-887) shows only six of the 122 allopathic medical schools surveyed had oaths that contained a stipulation against MAID or euthanasia.

It is true that, apart from the Hippocratic tradition, we still embrace our commitment as physicians for the valuing of life. Does this reflect the quality or just the quantity of life? For many of us, respecting the patients has as much or more to do with supporting their dignity, autonomy, and relief of suffering as it does with simply maximizing the number of days they keep living.

One of the developments that has changed the balance, certainly from the time of Hippocrates, is that we have largely eliminated BAID (bacterial aid in dying). I think it can be argued that with the discovery and development of antibiotics --overall a wonderful thing -- there has come at least one harmful and unintended consequence. The frequency and duration for which individuals had to face protracted deterioration with extensive suffering and dignity-reducing loss of function was greatly lower in pre-antibiotic times. As we have eliminated nature's most common way of alleviating such suffering, I would suggest the least we could do is to provide some merciful alternative.

A second component of this argument is that if people want to die, they can find a way of doing that themselves, thus there is no need to involve the physician. This strikes me as a profoundly insensitive attitude. Those of us who have had and loved multiple pets have undoubtedly had the difficult experience of being present as one was euthanized. I have always found this a peaceful and comforting process made possible by the supportive presence of the veterinarian. How should I feel if the veterinarian had said "As a doctor to animals, I am here to preserve and value their lives not to end them. Besides, you can do this yourself you know. If you do not have a gun, a sledgehammer will work"? I would argue that we have a valuable role to play, as physicians, in providing not simply technical assistance, but emotional support and understanding to patients if they have decided to end their lives. I have never heard anyone say that veterinarians are violating their profes-

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sional integrity by participating in euthanizing their patients. Rather, it is looked upon as a kind and humane option. It seems to me that the burden is on those who oppose MAID to demonstrate why we should be less kind to our fellow humans. Besides, humans, unlike our beloved pets, can tell us what they want.

3) "Slippery slope" arguments have played a big role in discussions about MAID. The basic form of the argument is that even if A is not so bad, allowing it, it will inexorably lead to B, which is even worse, then to C which is worse still, and on and on. Bernard Williams, widely regarded as one of the most astute and nuanced ethicists and philosophers of the late 20th century, wrote an insightful article entitled "Which slopes are slippery?" (Williams B. 1995. *Making sense of humanity and other philosophical papers.* Cambridge Univ. Press, pp.213-223). He points out that there are two assumptions here. The first is that what is at the bottom of the slope is something we all can see is truly horrible, even if the first step may seem acceptable and even positive to at least some of us. He points out that frequently the advocates of this sort of argument actually think the first step is wrong as well but are not sure they can persuade others. (If I think A is wrong but you do not, I may get you to agree to oppose A if I can convince you that it inevitably leads to B, then C and so forth, until we reach some point that we all agree is wrong.) The second assumption is that the slide down the slope, once begun, is unstoppable. This sometimes involves the notion that the advocates for A will then argue for B, then for C, and so on. But if we believe A and B are desirable, but C and D or not, is it not logical to support A and B but oppose C and D? The usual response here is that each step is essentially indistinguishable from the immediately prior one, that drawing a line in the sand at any point on the continuum is simply arbitrary and hence cannot be readily defended. One could argue, for instance that wherever one draws the line, those just outside it can understandably argue that it is unfair that they are being excluded. Why allow only those with a prognosis limited to 6 months? Why not 7 or 8 months? In cases of protracted suffering, why not extend MAID to those whose deaths are not imminent? If age 18, why not 17? IF MAID is legal, why not permit euthanasia for those who cannot self-administer a lethal drug? Surely the incompetent suffers as much as the competent, so why not allow a competent person to leave instructions to authorize euthanasia once their condition deteriorates so far that they are no longer judged competent?

Williams makes the point that this is not a valid type of argument. Firstly, he points out that "indistinguishable from" is not a transitive relationship. Just because A is indistinguishable from B, and that B is indistinguishable from C, it does not follow that A is indistinguishable from C. So, even if it is difficult to draw a precise line between "acceptable" and "unacceptable", it is likely that we can agree about a large portion of the behaviors-- that some are not acceptable, and others are. We need to draw some explicit line in the sand between "acceptable" and "unacceptable" at a practical level. Williams argues that in such cases it is a reasonable and a long-established societal practice to draw an arbitrary line as a practical approximation to our sense of what is the breakpoint between the two. We draw arbitrary lines all the time. Speed limits are an example. If it is 55, we cannot logically defend that 54 is categorically safer than driving at 56. The age for consent to marriage, the blood alcohol level that defines intoxication, and the age at which we are deemed mature enough to vote are other examples. As a society, we are free to draw arbitrary demarcations in the continuum of behaviors when they have practical utility. We are not doomed to keep sliding down the slope.

But what about the concern that advocates of MAID do not want to stop at A? Their agenda is to push for more and more permissive laws, making more sorts of people eligible as well as easing access to the process. Opponents cite changes that have in fact occurred in other states and countries that have permitted MAID. It is true that some advocates believe in much broader applications than just for imminent, terminal illnesses. But just because there is a push in this direction does not automatically make it a bad thing. We must judge the merits of each step. I personally find a lot of the subsequent developments cited as if they are obviously horrific to be positive. I think that intractable suffering, even in the absence of imminently terminal illness, should be an appropriate criterion for MAID. It seems reasonable to allow competent people to state in advance what they want done once they reach a defined level of physical or mental deterioration. The pressure to move to a next step is not automatically a bad thing. The case needs to be made for each new change as to whether it is desirable or undesirable.

The metaphor of the slippery slope gets in the way here. If we're on a slippery incline and we do not want to end up at the bottom, then any movement can feel ominous. If it is slippery enough, the only safe thing to do is not get on slope at all. But I think a much more apt analogy is a "hill" rather than a "slope". This is in keeping with the Aristotelian no-

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tion of the golden mean-- the desirable position is somewhere between two extremes, both of which are morally bad. The question we need to answer is whether we are being pushed uphill and closer to the optimal position, or downhill toward one of the extremes.

How would we react to someone making the following slippery slope argument? "It was a mistake to give women the right to vote. After all, once they had it, they weren't satisfied. Advocates then were pushing for equal employment opportunities, equal pay, protection from on-the-job sexual harassment, increasing numbers of women in management. Where will it end? Before you know it, they will want women's salaries to be double that of men and all supervisors to be women." I suspect few of us would find this argument compelling. Furthermore, I suspect we all feel that the movement could and would be stopped long before it reached the projected end of a woman-dominated society. Yet the logical structure of this argument is the same as the ones made regarding MAID and its alleged slippery consequences. The mere fact that there has been pressure to move the line of what is permissible is not in and of itself ominous. We need to assess each proposed step on its own merits, and then decide whether to support it or not.

Which category of reasons led the MPS leadership to choose to oppose last year's bill? It is difficult to judge, as individuals who categorically oppose an issue such as MAID often keep their basic ethical intuitions to themselves, while trying to persuade others with arguments of the pragmatic sort. It seems to me that the opposition could have been based on two very different positions developed from two very different ethical intuitions.

POSITION 1. It is ethically acceptable that imminently terminally ill persons should have a right to elect to end their lives, and it is ethically acceptable that a physician may choose, but not be compelled, to assist in that process by prescribing or providing a lethal medication. It is important to have some safeguards to minimize the chance of unintended uses of this legislation and to protect physicians-- both those who choose to participate and those who do not.

POSITION 2. It is morally unacceptable that imminently terminally ill persons should have a right to elect to end their lives, and/or it is morally unacceptable that a physician may choose to assist in that process by prescribing or providing a lethal medication. In practice, the most effective way to oppose such legislation may include challenging the adequacy of any safeguards designed to minimize the chance of unintended uses of this legislation and to protect physicians-- both those who choose to participate and those who do not.

If we judge the safeguards to be inadequate, either position could lead to opposition to the specific piece of legislation offered last year. But the two positions embody radically different ethical intuitions. This is of considerably more than theoretical interest, which position the group is working from has a major impact in determining the appropriate strategy moving forward. If we are working from POSITION 2, then we are going to oppose future MAID legislation, regardless of what safeguards are put in place. Our arguments about safeguards then simply become a rhetorical strategy to kill the legislation, and we are likely to maintain that any proposed safeguards are inadequate. In that case it makes sense to wait until the legislation is proposed and then go on the attack.

If, however, we are working from POSITION 1, a more proactive strategy suggests itself. Wouldn't it then be advisable to approach those parties who are likely to be currently working on the next legislative proposal regarding MAID.? Our position could be that we are not inevitably opposed to such legislation in principle, and that we would like to have some input into the sorts of safeguards that would need to be in place.

I therefore suggested to the executive committee that the MPS survey the membership at large on MAID and euthanasia, so that the leadership knows the viewpoints of the members. This suggestion has been approved, and a survey will occur before a new MAID bill is likely to be introduced next year. I strongly urge all MPS members to respond to it. I also would hope that those individuals in leadership positions who have a role in determining the official position of the MPS on future legislation in this area should let the membership know their positions so that we may understand how we are being represented.

In Memoriam: Harold Eist, MD
"Let Each Man Remember"

by: Bruce Hershfield, MD

Harold Eist, MD

I was on the dais of the APA Assembly in 2003 when Harold got its Profile of Courage award. I was more impressed by that than by any of his other accomplishments. Harry Truman, who knew something about these things, commented when he gave the Congressional Medal of Honor to 15 men, including the hero of Hacksaw Ridge—Desmond Doss--that he would much rather have that medal around his neck than to be President. "It is the greatest honor that can come to a man."

Harold spent a lifetime standing up for those who needed a friend. When he was the North American Rep to the World Psychiatric Association, he met with China's Deputy Minister of Health to discuss how the Chinese were treating the Falun Gong. He stood up to the big businesses that were skimming money from patients under the heading of "managing" their care. He stood up to the Maryland Board of Physicians for years and at great cost to protect patients from losing their confidentiality.

The Washington Post said in his obituary that he was a warrior for the disenfranchised and was known as the "Winston Churchill of Psychiatry". Churchill had a long history of standing up for the friendless and oppressed. And, of course, he was brave—like Harold. Michael Olesker said in the Baltimore "Sun" years ago that you can say what you want about the British, but you can't take 1940 away from them. When he was 15, he kissed goodbye to his nursemaid, who had come to visit him at Harrow, in front of the other boys. One of his classmates commented many years later that it was still the bravest thing he had ever seen anyone do.

I was impressed, the last few times I saw Harold, at meetings of the MPS in the Baltimore area, by the effort he made to travel despite his health. I saw it with my own eyes—I don't need to be told about Falun Gong and the Board of Physicians.

Walter Mondale said when he eulogized Hubert Humphrey—who also was a friend to those who needed one—that he taught us how to live and he taught us how to die.

I have no medal to give as a token of my appreciation for what he did for me by setting these examples. I only have words. So let me quote from a 1940 poem by Josephine Jacobsen, who lived in Baltimore for 80 years. It's called "Let Each Man Remember". It speaks to how Harold's life can inspire each of us to be brave.

She talked about how many people must get out of bed and do something they dread on a particular morning:

"With nothing to gain, perhaps, and no sane reason
To put up a fight, they grip and hang by the thread
As fierce and still as a swinging threatened spider.
They are too brave to say, 'It is simpler to be dead.'
Let each man remember, who opens his eyes to that morning,
How many men have braced him to meet that light
And pious or ribald, one way or another, how many
Will smile in its face, when he is at peace in the night."

I believe the most important line in the Passover service is: "Let me recount what the Lord did for *me* when *I* came out of Egypt." It is because of what Harold---and others—have shown us by their example that we can face any morning with courage, as they have.

LETTER FROM THE EDITOR
Who Owns the APA?

by: *Bruce Hershfield, MD*

Bruce Hershfield, MD

I know that from a *legal* point of view the Board *owns* the APA. That is why the Trustees have insurance to protect them from suits. However, I believe that on a deeper level it belongs to *us*. That is why *we*--not *they*—are responsible for voting to choose its officers.

Last year, the Board, in response to a recommendation from the Presidential Task Force on Structural Racism in Psychiatry, recommended a change in the election guidelines for a two-year pilot study. It restricted candidates to taking part in live "town halls" (with a video recording to be posted on the APA website for those who could not attend) It set up a special edition of the APA election newsletter listing the candidates' platforms. It directed *Psych News* to publish their names and photos and the election details in its December issue. It also expanded the election website. The Board clarified in its meeting this March that its guidelines no longer forbid "mentioning one's candidacy or making any statement that might be interpreted as a position statement reflecting what action the candidates would take if elected". Still forbidden are letters from the candidates themselves or endorsements from other organizations.

I attended the Area 3 Trustee webinar, since I knew all three candidates personally. All three did very well and I could not have made up my mind by listening-- or by reading about their accomplishments. Only 28 people attended, out of about 3500 members in Area 3. Only 125 APA members signed up for the town halls and fewer than 100 attended the President-elect's. Out of about 37,400!

The MPS--with two of the three candidates for Area III Trustee and one of the two candidates for President -elect -- led all district branches with 28% turnout. The national turnout fell from 17.5% to 16.25 %. In 1994, when Drs. Harold Eist and Steve Sharfstein ran for President-elect, about 50% of eligible members voted, and about 10 years ago--just before the system switched to electronic voting-- the figure was around the mid-20s.

Shortly after I joined the Assembly Executive Committee in 2001 we discussed the power of the relatively small Board vs the relatively large Assembly. I said that since I had just been reading about Hamilton and Jefferson I had been thinking of whether to side with the aristocrats (the Board) or the masses (the Assembly). I said that whenever I had to make that choice I sided with the masses because I simply didn't trust the aristocrats.

Churchill told the House of Commons in 1947 that "democracy is the worst form of government— except for all the others that have been tried." About 6 years earlier he had told the US Congress—just after Pearl Harbor—that he had been brought up in his father's house to believe in democracy: "'Trust the people'—that was his message."

The beginning of the US Constitution says it all, "We, the people of these united states, in order to form a more perfect union..." I think it's pretty clear who "owns" both the USA and the APA. We do.

I suggest the APA do something now to re-expand the percentage of members who vote. Its Board should turn away from anything, even with the best of intentions, that limits our freedom to communicate freely with colleagues. We are the ones who should--in our own individual ways--decide who would best represent our interests.