Advancements in Health Equity Through Barbershops and Town Halls

New Health Laws Effective October 1

Allyship: Two Physicians Discuss What It Means to Them
From the President...

Shannon P. Pryor, MD, President, MedChi

It has been an honor to serve as President of MedChi. It’s ironic and somehow fitting that my final outgoing message in *Maryland Medicine* since becoming President is dedicated to racial and health equity. How well I remember my experience when for three years of my residency I was on the receiving end of overt gender bias. That daily reminder, and the fact that no one ever spoke up about it, made me feel “less than” my white male colleagues in a post-grad setting. I can only imagine how much more difficult it must be for those who experience this sort of treatment almost every day of their lives. Now, as MedChi’s fifth female President, I reflect on how far we have come. Yet I also know that our work is far from complete.

This issue of *Maryland Medicine* carefully considers racial and gender equity in the context of medicine, and how examination of our past informs how we can best achieve our aspirations for diversity, equity, and inclusion moving forward.

Since the launch of our IDEA Task Force in January of 2020, MedChi has created reforms and programs across the state and developed new ways to engage with members of the community. Members of the IDEA Task Force also contributed generously to this issue, and provided advisory recommendations to the final product, of which I am very proud.

It is through the IDEA Task Force, scholarly articles, Town Hall meetings (p. 13, Dr. Thomas Town Hall Meeting article), workshops, webinars, and watercooler discussions that we foster the type of reflection and self-examination that helps us learn from past mistakes and bridge the gaps in gender bias and racial discrimination. Gaining more knowledge about our history and community will only help us as we rise to meet the challenges of the future.

As medical providers and, in many cases, educators at colleges and universities, and as members of society who aspire to lead in the larger world, we have a special obligation to enhance diversity, equity, and inclusion and uphold our most cherished values. We cannot be excellent without being diverse in the broadest sense of the word. And we must also ensure that our community allows all individuals an equal opportunity to thrive. As physicians, it is our role to help our society heal, and healing in the face of discrimination and exclusion is an ongoing process. It is my hope that we will continue to engage in this work together. Thank you for letting me serve as your President; it has been an honor.

New Health Laws Effective October 1

**House Bill 429/Senate Bill 537: Pharmacists – Required Notification and Authorized Substitution – Lower-Cost Drug or Device Product** allows a therapeutically equivalent brand-named drug to be substituted for a generic drug by a pharmacist in the instance when the brand-named drug is less expensive. The pharmacist is required to notify the patient of the substitution or keep a record of it.

**House Bill 849: Public Health – Medical Records** – Changes the current law governing fees that may be charged to patients seeking copies of medical records. It prohibits a fee being charged if the record will be used for the purpose of filing a claim or appeal regarding denial of social security disability income or benefits under the Social Security Act.

**House Bill 107/Senate Bill 499: Prohibition on Vending Machine Sales of Drugs and Medicines.** Repeal allows over-the-counter medications to be sold through a vending machine. Maryland was one of only four states that maintained this prohibition.

**House Bill 1349/Senate Bill 777: Public Health – Maryland Prenatal and Infant Care Grant Program Fund** expands the current Prenatal and Infant Care grant program to include funding for the provision of prenatal care services to low-income residents who do not have access to Medicaid or other health care services. The legislation provides mandatory funding to be structured as follows; $1 million in FY2023, $2 million in FY2024, and $3 million in FY2025.

**House Bill 372/Senate Bill 420: Criminal Law – Drug Paraphernalia for Administration – Decriminalization** decriminalizes possession of items that can be used to inject, ingest, inhale, or otherwise consume a controlled dangerous substance.

**House Bill 605/Senate Bill 164: Veterans – Behavioral Health Services – Mental Health First Aid** requires MDH to include mandatory funding for the provision of mental health first aid among the behavioral health services for which MDH provides service coordination for eligible veterans.

**House Bill 289/Senate Bill 105: Peace Orders – Workplace Violence** authorizes an employer to file a petition for a peace order on behalf of an employee who alleges the commission of violence against the employee at the employee’s workplace. The employer must notify the employee before filing for the peace order. Until October 1, 2023, an employer will have immunity from any civil liability that may result from the failure of the employer to file a petition for a peace order on behalf of an employee. After that date, the immunity provision is repealed.
“Why I Became Involved”: Reflections from IDEA Task Force Members

“I wanted to be part of the IDEA Task Force because organized medicine has not always been a friend to marginalized and minority groups in our country. I am determined to be part of the solution to this shameful history.”
— Carolyn B. O’Conor, MD, FAAFP

“Women in medicine should educate themselves about contract negotiations and how to make use of an employment attorney to ensure that their special expertise to an organization is compensated adequately.”
— Marian LaMonte, MD, MSN, FAAN, FAHA, D.ABSM

“Elie Wiesel said, ‘We must always take sides. Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented.’ It behooves us never to be silent.”
— Stephen Rockower, MD, FAAOS

“In 2020, disparate outcomes of the COVID-19 pandemic and racially motivated violence converged to create a true public health crisis. A sobering light was shone on facts that many already knew. Unfortunately, there are many in our society that do not have access to excellent health care. They are marginalized and their health care outcomes suffer as a result. I truly believe in treating each one of my patients like family. And as a health care provider, I know that excellent, patient-focused, personal care is the ultimate goal. Meaningful and intentional diversity within the health care system is paramount to achieving this goal. While the recent events have been disheartening, I’m grateful that our current national conversation and collective energies are more focused on this issue. We now have a real opportunity to make meaningful change to create equity in health care. This is why I do the work.”
— William W. Ashley, Jr., MD, PhD, MBA

“As physicians we have a great opportunity to impact the lives of our patients and the vitality of our community. We should take advantage of this role and lead in the effort to create a just and fair society. We must educate ourselves and others to the importance of inclusion, diversity, and equity so that all individuals can be healthy, achieve their fullest potential, and participate in any activity of their choosing. This is what I fought for as Maryland Health Secretary and it’s why I serve on this Task Force.”
— Martin Wasserman, MD, JD

“I originally participated in the IDEA Task Force because of my interest in the biases in health care and how they affect providers and patients. I have learned a great deal about the implicit biases which we are not aware of, as well as the more overt biases toward women and minorities. It is so important for us to move forward as we strive to find ways to address this issue and make headway in creating an equitable environment for providers and patients.”
— Loralie Ma, MD
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A Discussion on Allyship Between Two Physician Colleagues

Tuesday Cook, MD, and Carolyn O’Connor, MD

Allyship is a process, and everyone has more to learn. Sometimes, people say “doing ally work” or “acting in solidarity with” to reference the fact that “ally” is not an identity, it is an ongoing and lifelong process that involves examination and education. An ally can be of any background that experiences power in sections of society. In reference to race, which is truly a social construct, an ally who is White acknowledges the limits of his or her knowledge about other people’s experiences but doesn’t use that as a reason not to think or act. An ally does not remain silent but confronts racism as it comes up and seeks to deconstruct it institutionally. Being this kind of ally entails building relationships with both people of color and with White people in order to challenge them in their thinking about race and ethnicity.

Dr. O’Connor: I appreciate the formal definition as a great starting place, but sometimes real-life examples can be more concrete and powerful. Can you give a positive example of real-time allyship?

Dr. Cook: A Black attorney friend of mine told me the story of going with her mom to see a surgeon in DC. The surgeon was flippant and unclear in her explanation of what treatment was needed. Noticing the patient’s confusion, another White physician asked the surgeon to slow down, be clearer and insisted that she answer all of their questions to alleviate the patient’s concerns. Even with the possibility of being ostracized from her same-race colleague’s circles and experiencing backlash herself, the second physician spoke out against what she recognized as implicit bias.

Physician allies should hold their subordinates, colleagues and even their superiors accountable for shoddy communication in the care of minority populations.

Dr. O’Connor: Can you give examples of misguided efforts at allyship that may actually make things worse?

Dr. Cook: There are certainly statements that immediately come to mind. When people say “All lives matter” or state that they “don’t see color” or the common false adage that “Diversity lowers the hiring bar”, they clearly don’t get it. Not seeing color is a way of dismissing the historical and daily-lived experience of people of color in society. It is a privilege to be able to ignore a person’s ethnicity and experiences in an environment in which policies clearly demonstrate that they are not valued as equal. It is also demeaning to speak on behalf of people, especially people who are your physician colleagues, but it dates back to when a person of color was not allowed to speak for themselves and grown men could be called “boy”. An ally can speak in support of but should not speak for.

Dr. O’Connor: I’ve heard the term “performative allyship.” Can you explain it?

Dr. Cook: Sure. Performative allyship isn’t about actually helping underrepresented communities. The focus is really on the ally being rewarded and getting benefits from being “one of the good ones”, whilst doing the bare minimum. More often than not, when he or she is challenged, defensiveness from this “ally” will kick in, as their core belief is that people should be “grateful” for their efforts, even if intention and impact did not align.

There was a local company whose employee went on a racist rant in a virtual meeting in front of a Black lawyer and his client, unbeknownst to the employee who thought he was muted. As a symbol of atonement, the owner of the company donated money to an unrelated organization without consulting the lawyer or his client. He then became angry when his actions were questioned and seemed to feel they should have been grateful for his history of involvement in civil rights.

Dr. O’Connor: If someone wants to speak up and be helpful but doesn’t know what to say, can you suggest some helpful phrases to start with?

Dr. Cook: Absolutely! There are many ways in which an unjust situation can be addressed. I see silence as complicity. Dr. Martin Luther King Jr. said it well when he stated “In the end, we will remember not the words of our enemies, but the silence of our friends.”

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MedChi, The Maryland State Medical Society, established the Maryland Physician Health Program (MPHP) in 1978 by physicians, for physicians.

REMEMBER, YOU ARE NOT ALONE
Family Physicians Address Health and Racial Equity and Advocate for Patients

Shana O. Ntiri, MD, MPH, FAAFP

The past year and a half have brought vast changes to the practice of medicine. While COVID-19 has undoubtedly been the impetus for many of these changes, the pandemic also laid the stage for many other crucial health issues to be brought to light. The public murder of George Floyd and countless other African Americans spurred social justice uprisings and widespread acknowledgement of the implications racially charged issues such as police brutality have on health outcomes and health equity. Medicine has turned an intentional eye to understanding where, why, and how racism impacts the health of patients and to creating avenues to attain health equity. The increased consciousness of racism and its impact on health has prompted many medical organizations to move from awareness of the impact of racism and need for health equity to actions to install meaningful and lasting improvements to tackle racism and improve health equity.

The Maryland Academy of Family Physicians Statement on Health Equity and Racism

The purpose of the Maryland Academy of Family Physicians (MDAFP) Helath Equity and Racism Task Force is to recognize the negative impact of racism on health care and implement high-impact strategies to improve health equity for all Marylanders...

The MDAFP Task Force aims to implement high-impact strategies that provide our physicians with tools to combat racism in all segments of medicine.

To read the full MDAFP Statement on Health Equity and Racism, please go to http://mdafp.org/mdafp-statement-on-health-equity-and-racism/.

In July 2020, the Maryland Academy of Family Physicians’ (MDAFP) Board of Directors established the MDAFP Task Force on Health Equity and Racism. The Task Force was charged with identifying ways to contribute to positive and productive solutions around health equity and to ensure addressing health equity and racism remains at the forefront of the MDAFP strategic plan. The first charge of the Task Force was to develop an organizational position statement (see boxed statement at right) to direct the efforts of the MDAFP. The work of the Task Force is led by workgroups in the public health and family medicine pipeline that are complemented by existing organizational committees. In 2021, the committees initiated health equity-focused programming including the education committee’s featured keynote by Brian Williams, MD, entitled “Race, Violence, and Medicine: Showing Up for Justice” during the MDAFP 2021 Winter Refresher, which supported past legislation to address implicit bias through physician training. Each of these groups is working to ensure the provision of resources and education for the MDAFP membership to address implicit bias and health inequities for their patients.

Though in its early stages, the Task Force has already implemented a number of activities. The pipeline workgroup was tasked with increasing and diversifying the pipeline of students entering family medicine. The focus of the pipeline subgroup is to connect with high school, college and medical students through Health Equity and Racism centered programming in Family Medicine. The pipeline's inaugural event, held in April 2021, was a virtual panel featuring family physicians of color who spoke about the versatility of practice in family medicine for medical students. Feedback on the event indicated participants increased their knowledge on Family Medicine physician’s breadth of scope, holistic and equitable approach to care, and variety of the patient population. A fall 2021 webinar on pathways to career leadership took place for medical students and residents in October. The public health subgroup is focused on identifying public health issues impacted by health disparities and inequities that can be addressed through MDAFP educational, advocacy, and resource development initiatives. Given the global pandemic, the primary focus of this subgroup’s efforts has been COVID-19.

In April 2021, the subgroup participated in a townhall with the Maryland Public Health Association entitled, Constructing Covid-19 Resilience. This was followed by a MDAFP-sponsored virtual community forum in June that targeted Maryland’s Eastern Shore. The forum was designed to address the public’s concerns about COVID-19 – particularly for children and teens, focusing on areas with low vaccination rates. Community members participated during the live event via social media, and the forum may now be viewed on-demand on MDAFP YouTube. Additional forums are planned for this fall for communities in Prince George’s County and

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Kim Jones-Fearing, MD

The barriers to receiving equitable medical treatment in the United States have been “laid bare” by COVID as well as policies and treatment algorithms created by an inadequately diverse workforce of medical professionals. Since early 2021, several mainstream American medical societies have created initiatives intended to break down barriers to patients receiving equitable medical treatment. Some of these barriers to treatment stem from barriers to a diverse workforce, including African-American and Black doctors.

While some research has been done regarding discriminatory policies and algorithms in treatment, it is widely known that patients of color tend to have better outcomes when they have physicians of similar background and/or a racially and ethnically diverse team of physicians. In my preliminary review of the literature, I have not yet found specific studies of Black or African-American physicians’ views with regard to their own discriminatory treatment in the workplace, nor their views with regard to support received when discrimination existed.

Therefore, I decided to embark on my own informal research among Black physician colleagues whom I had met at a medical society event. I asked them how they felt about employment discrimination and if they felt supported by their peers.

All of the colleagues “surveyed” responded that they had experienced discrimination in the workplace. Some of them did not want to talk about it. Of the colleagues who were willing to talk about it, many of them admitted to having lingering effects from the unfair treatment such as diminished self-esteem, insomnia, days missed from work, mood issues, and anxiety. The colleagues who won their discrimination lawsuits reported not having a negative impact to their self-esteem and well-being. My leading theory about this is that the colleagues who won their lawsuits felt validated, and therefore their overall sense of worth and well-being remained intact. However, they are the minority of Black professionals who found a way to prevail within a legal system that is currently weighed against people of color. According to the sociological literature, when a group of people are hurt by systematized oppression (meaning: they are discriminated against in a system where unfair treatment goes undetected and unnoticed) which leads to a diminished sense of self-worth and well-being, it is called “internalized racism.”

In the 1940s, psychologists Kenneth and Mamie Clark designed and conducted a series of experiments known as “the doll tests” to study the psychological effects of segregation on African-American children, among other things. The Clarks used four dolls, identical except for color, to test children’s racial perceptions. Black children were shown White dolls and Black dolls and asked the question “which doll is most like you.” The results of the test showed that the majority of Black children preferred the White dolls to the Black dolls, or refused to answer the question, or became upset. In similar experiments, Black children were more likely to choose vanilla cake over chocolate cake, and so on. Experiments such as these are an example of internalized racism. This particular experiment later became crucial testimony in the famous “Brown versus The Board of Education” outcome. As a result, the Supreme Court ruled unanimously that racial segregation of children in public schools was unconstitutional.

The physicians of today are the so-called children of the Clark experiments. We are negatively impacted by the structural racism that persists in our current health care system — even now. We lack an integrated and diverse workforce of physicians, and a system that addresses the effects of racism. Now that we know this exists, what are we to do about it?

Kim Jones-Fearing, MD, DFAPA, is Distinguished Fellow of the American Psychiatric Association. She can be reached at kimjonesfearing@gmail.com.
While the team at Unity Insurance has been serving the medical industry since 1975, we are excited to celebrate our first full year as Unity Insurance! After 45 years of operating as MedChi Insurance Agency, an extension of MedChi - The Maryland State Medical Society, we felt it was time to rebrand to better align with our commitment to serving you and your teams. Thus, Unity Insurance was born! While we remain focused on insurance solutions for the healthcare industry, we now also offer comprehensive business insurance, group benefits, and personal insurance solutions to serve a variety of industries across Maryland and the Mid-Atlantic region!

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MCMS & MedChi Work to Right a Past Wrong As African American Physician Was Denied Membership

Susan G. D’Antoni, FAAMSE

When Carolyn O’Conor, MD, was President of Montgomery County Medical Society in 2019, she was asked to introduce a speaker at the Montgomery County History Conference as MCMS had chosen to be a sponsor that year.

Dr. O’Conor introduced Terry Lachin, a Montgomery County historian, who spoke about “Webster Sewell, MD, and the Struggle for Equal Care.” Dr. Sewell was a 1930 graduate of Howard University College of Medicine. He practiced medicine during the 1930s after returning from World War I. He opened his office in part of his family’s farmhouse adding a wing for a waiting room. There he operated a medical clinic and “birthing center” in Norbeck, Maryland in Montgomery County and was a tireless advocate for equality in medical care.

Upon learning more about Dr. Sewell, the staff of Montgomery County Medical Society uncovered an article in a series of books which were dedicated to the history of different locales and neighborhoods of Montgomery County. In this particular book, there was a photo of Dr. Sewell in his WWI uniform and of the house in which Dr. Sewell practiced. This article indicated, “As the only Black doctor in Montgomery County, he was denied membership in the county medical association because he could not be served at their dinner meetings at local country clubs.”

Upon reading this disturbing information, I began to research this wrong further with an attempt to learn more about Dr. Sewell and why this may have occurred, only to find out that the reason given for denying membership, was fairly common for the time period. Clearly, Montgomery County Medical Society could have chosen to meet elsewhere.

Dr. Sewell died at the age of 98. His obituary noted, “Before World War II, he donated his time as county medical officer for Montgomery County’s Black schools and eventually was appointed to the Maryland State Mental Hygiene Board of Review. He also helped organize drives to better medical care for the county’s Black community and raised funds for both Suburban and Montgomery General hospitals.”

Dr. O’Conor raised the importance of righting this wrong first with the Montgomery County Medical Society’s Executive Board which approved submitting a resolution to the MedChi House of Delegates to bestow membership posthumously to Webster Sewell, MD. This resolution was approved by the MedChi House of Delegates along with a process for handling similar situations in the future.

At its Fall 2020 General Membership Meeting, Montgomery County Medical Society honored Webster Sewell, MD, with a special posthumous Emeritus Membership recognition in consideration of his contributions to his patients and our community for his vigilant efforts to improve access to health care in Montgomery County.

A new Webster Sewell, MD Access to Care Award was announced at that meeting and will be awarded by the Montgomery County Medical Society and the National Capital Physicians Foundation in the future. The membership presentation was made by Dr. Carolyn O’Conor, Immediate Past President, to Dr. Sewell’s daughter, Ms. Dorita Sewell who provided remarks and appreciation for the recognition of her father’s efforts.

Dr. O’Conor is now chairing the committee which is developing the guidelines for the award. MCMS anticipates the award will be presented in the spring of 2022 to a deserving recipient dedicated to Dr. Sewell’s goals of enhanced access to care and health equity.

Susan D’Antoni is the CEO of Montgomery County Medical Society and the National Capital Physicians Foundation. She can be reached at sdantoni@montgomerymedicine.org.
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The confluence of last summer's protests following George Floyd's death and the COVID-19 pandemic mobilized our physician members to examine our history of institutional racism and why Black and Brown communities were reluctant to accept vaccinations. When the members of the Baltimore County Medical Association's (BCMA) Program and CME Committee met in the fall of 2020, they sought to address these concerns as the release of viable vaccination was imminent. The BCMA Committee collaborated with MedChi's IDEA Task Force in its mission to move beyond acknowledging racial and health disparities and find solutions.

A member of both groups, Carol Ritter, MD, (pictured at right with Stephen Thomas, MD) knew someone who could help. She contacted one of the nation's leading scholars in this area, Stephen B. Thomas, MD, a University of Maryland School of Public Health professor and Director of the Center for Health Equity.

Fifteen years ago, Dr. Thomas founded a barbershop-based public health program to educate on the importance of colon cancer screening. In 2014, he created the Health Advocates In-Reach and Research (HAIR) Network to bridge the gap between health professionals and communities distrustful of medical institutions, using a place well-known for “straight talk” — the local barbershop. With funding from National Institutes of Health (NIH) and the CIGNA Foundation, the program’s aim was to train barbers to become certified community health workers and to establish barbershop health campaigns. During the pandemic, Dr. Thomas converted this barbershop model into virtual “Town Hall” meetings so as to educate the community about institutional racism — such as the Tuskegee Syphilis Study, as well as the COVID-19 virus and vaccination. Panelists for these virtual town halls included physicians, university presidents, public health professionals, community leaders, and of course the HAIR Network barbers.

Dr. Thomas collaborated with the IDEA Task Force and BCMA to create a virtual meeting this past February titled “The Color of COVID-19: A Black History Month Webinar with Dr. Michael Osterholm.” Michael Osterholm, MD, an epidemiologist who advised President Joe Biden’s transition on the COVID-19 crisis, was the lead speaker on the panel. IDEA Task Force members Tuesday Cook, MD; William Ashley, MD; and Dr. Carol Ritter were panelists. Other contributing panelists included: Gregory Branch, MD, Baltimore County Health Officer; Aliya Jones, MD, Maryland Deputy Secretary of Health; Sandra Quinn, MD, Associate Director of the Maryland Center for Health Equity; Mayor McKinley Price of Newport News, Virginia, and President of the African American Mayors Association; Mike Brown, Hyattsville barbershop owner and HAIR Network-certified community health worker; and Omar Neal, former Mayor of Tuskegee, Alabama. In addition to the panelists, more than 100 attendees joined the virtual event, which later received praise from attendees and participants alike.

On May 17, 2021, Dr. Thomas and the Maryland Center for Health Equity brought the first COVID-19 vaccination clinic to Mike Brown's barbershop in Hyattsville, Maryland. News of the event quickly travelled, eventually reaching the White House. Cameron Webb, White House Senior Policy Adviser for COVID Equity, worked with Dr. Thomas to scale up the HAIR Network to a national level. The new project, renamed “Shots in the Shops,” currently works with 967 barbershops nationally, connecting them with local public health departments using the original training model developed by the University of Maryland.

On September 18, 2021, the Maryland Center for Health Equity moved the barbershop and vaccination clinic to the Baltimore County African American Cultural Festival, where pharmacists could educate the public on medications, medical professionals could give vaccinations, and barbers could give free haircuts. Dr. Thomas said barbershops and salons can potentially be a place where misinformation is heard and shared, which may go against physicians’ advice. But they don't have to be. “I want doctors to know that they have a partner here,” he asserted. “We can bring physicians into the barbershop so they can have a more personal relationship with the community.” He went on to thank MedChi members for “stepping up to provide medical oversight and expertise” at the town halls.


Russel J. Kujan is the Executive Director of Baltimore County Medical Association and can be reached at RKujan@medchi.org.
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Finding the Hidden Talent in Your Organization: A Call for Diversity

Tuesday Cook, MD

The title of this article may be a little misleading as it implies that talent in the organization is hidden rather than in plain sight. The talent is not always hidden; oft-times it is the people in the organization who are blind to it, despite it being there, ready for promotion and to serve as a resource.

This stems not singularly from personal choice but rather a system that was set up to exclude, that we are work inside of, and which it is our responsibility to improve with the goal of inclusivity.

In this article I chose to highlight many different aspects of our varied population and demonstrate how leveraging diversity can improve organizational performance.

A study published in a Harvard Business Review article from July 2018 found that diversity significantly improves decision-making and financial performance on measures such as profitable investments at the individual portfolio-company level and overall fund returns.

We have heard in certain spaces that “diversity has negative connotations” by those who seek to conserve their power, based on what has been the status quo. A February 2021 podcast of the Journal of the American Medical Association, hosted by the journal’s deputy editor and an editor at JAMA internal medicine and CEO of NYC Health and Hospitals, declared that racism does not exist in medicine. While we may wish this to be the case, unfortunately, as with other industries, racism remains an issue to be addressed. Both for practitioners and for patients.

A study done by the AAMC showed that in 2018 only 17 percent of active physicians identified as Asian, 5.8 percent LatinX, 5 percent Black, and 0.3 percent as Native American or Alaskan Native. The proportion of Black physicians in the health care workforce does not reflect the population we serve and has only increased 4 percentage points in the last 120 years.

Several studies demonstrate lower morbidity and mortality rates and generally improved health outcomes when there is concordance between patients and physicians. (Concordance is measured in gender, age, national origin, ethnicity, and sexual orientation.) This is well-documented in primary care literature, and emerging evidence suggests that surgical sub-specialty patients value similar physician-patient concordance.

In a study done by Dr. Lisa Meeks, nearly one-fifth of the U.S. population has a disability, and many of these individuals experience disparities in the healthcare they receive. In part, this health care disparity result from a lack of understanding about disability by their providers. A physician’s formal education is grounded in a biomedical model emphasizing pathology, impairment, and dysfunction, rather than a social model of disability that focuses on removing barriers for individuals with disabilities and expanding their capabilities. According to a recent report, only 2.7 percent of medical students disclosed having disabilities—far fewer than the proportion of people with disabilities at large.

As a bariatric surgeon and board-certified obesity medicine specialist I must extrapolate this to my own patient population. Research has found that when compared to their heterosexual counterparts, lesbian and bisexual females have a higher risk of obesity, whereas gay males have a decreased risk. Population-based studies on LGB and body weight correlation are limited, with much of what is currently known coming from small or regional sample studies and/or convenience sampling.

The high prevalence of obesity among sexual minority populations is thought to be related to prejudice, homophobia, and higher levels of stress faced by sexual and gender minorities. The minority stress model postulates that stigma and discrimination contribute to heightened stress levels among sexual minority populations. In addition, research suggests that the health disparities observed among sexual minority populations, such as a higher prevalence of substance use, depression, and anxiety, may arise from stressors induced by hostility, discrimination, and victimization. The minority stress framework may provide valuable information for policy-making that would address these health disparities among sexual minorities.

The feeling that the majority has the ability to speak for the minority (whether it be LGBTQ+, Native, Black, LatinX, other people of color, etc.) and hold leadership positions in government, universities, and organizations, stems from the inaccurate notion that — according to the system, they know what is best for these categories of people.

If we don’t have representation from diverse sections of humanity, organizations cannot provide the best possible outcome. This must begin with leadership positions in medicine and across the board.

continued on page 19
Why MedChi?

- MedChi is the only medical society representing ALL physicians and medical students in Maryland.

- MedChi has the expertise to offer legal and financial resources for our physicians included in your membership fees.

- Physician members of MedChi set healthcare policy in open, transparent settings in which all voices are heard.

- MedChi is your advocate on regulatory issues including Tort Reform, Scope of Practice, Telehealth, and Economic policies.

- MedChi works closely with the American Medical Association and local component medical societies to offer the best resources for Maryland’s physicians.

- Members receive exclusive access to resources to support their profession, from clinical education to business support to well-being.

- Questions? Members@medchi.org

Why Me?

- Your voice makes MedChi and the component societies stronger as we advocate for you, your patients, and your profession.

- MedChi developed the Center for the Private Practice of Medicine and the Center for the Employed Physician to provide tailored business services to strengthen your practice.

- You will enjoy membership to your local city or county component society, participation in local events, access to complimentary CME, participation in a council or committee based on your area of interest or expertise, and receive relevant news specific to your county or city, all without any additional membership fees.

- Membership fees are currently tax-deductible by 50%.

- You will receive discounts on products through Unity Insurance Agency, a MedChi Company.

- Exclusive opportunity to work with legislators in Annapolis on issues important to MedChi physicians.

Why Now?

- The value of MedChi membership is proven every day as your resource and your advocate throughout the COVID-19 crisis, focusing on telehealth implementation, financial relief programs, business continuity support, and physician well-being.

- MedChi will champion the needs of Maryland’s physicians and patients by offering CME webinars, hosting networking events and component society meetings, and advocating on behalf of physicians and patients during legislative sessions.

- MedChi is assisting physicians and practices with the Maryland Episode Quality Improvement Program (EQIP) and the Maryland Primary Care Program (MDPDP).
The Many Faces of Racism in Medical Education
Katherine Jacobson, MD, FAAFP

The 2021 Society of Teachers of Family Medicine Conference of Medical Student Education contained multiple plenary and breakout sessions on the topic of racism in medicine. This comes as medical schools across the country are seeking not only to remove bias from their curriculum, but also to graduate physicians who may someday become advocates for justice.

Just this past year one of the preceptors commented that students enjoy going to the more rural areas of the state where they can see skin conditions on white skin, as these more closely resemble images in standard textbooks. This exchange shows the need to review every aspect in the curriculum to ensure diversity of case presentations and reduce bias. The University of Maryland School of Medicine (UMSOM) formed a review committee for precisely this purpose.

Faculty at the UMSOM receive implicit bias training while students receive education on racism in medicine. The UMSOM enrolls students who reflect the diversity of the society at large. The Class of 2025 is comprised of 31 percent underrepresented in medicine, 62 percent students of color, 10 percent LGBTQ, and 67 percent women (https://www.medschool.umaryland.edu/admissions/). UMSOM students may learn about race-based medical decision-making, including eGFR, the VBAC Calculator, and the ASCVD Risk score, and then go on to contribute to the effort to change long-standing “biased” practices.

The school seeks to eliminate systemic racism from the tools and methods used by physicians, as well as cultivate clinical environments where racist speech is deemed unacceptable. Physicians around the country are employing diverse methods to bring change in this area. One physician decided to address racism among her patients by giving out copies of Robin DiAngelo’s book White Fragility. Others have advocated discharging these patients from their practice. Although firing patients who speak in racist ways may result in a practice that is free of patients who make racist statements in their presence, it also abdicates the physician’s duty as educator.

Another option that maintains the physician–patient relationship without condoning racist speech is to provide correction by modeling appropriate speech. For example, I once had an Asian medical student shadow me for an office visit when the patient referred to COVID-19 using an anti-Asian ethnic slur. I responded to the patient by suggesting different words he might use for the virus. “When you had coronavirus last year, and you were in the hospital,” I modeled. He immediately looked at the student and said, “I hope you aren’t Chinese; I’m sorry I didn’t mean to offend you.” The student and the patient processed the new language and the visit resumed. At his next office visit the patient used the phrase “when I had coronavirus,” even though no one else was present but me.

This small success did not require an awkward confrontation nor a formal letter of warning. Our long-established physician–patient relationship is still thriving today, and we are one step closer to a health care environment that is free from racism and bias.

As life-long learners and educators, we must continue to seek ways to eliminate racism in ourselves, our systems, our colleagues, our students, and sometimes even our patients.

Katherine J. Jacobson, MD, FAAFP, is University Family Medicine Assistant Professor at the University of Maryland School of Medicine. She can be reached at Jacobsonkj@gmail.com.
When a colleague is dismissed or cut off, interject by saying, “I believe she was making a point.” Challenge racist or sexist jokes instead of remaining quiet by saying “I didn’t find that funny” or “I actually found that offensive.” Don’t leave that to the often only person of color in the room. You can say “I found that statement to make some assumptions that I don’t think are ______ [fill in the blank].”

Dr. O’Conor: Clearly many of us have much to learn about allyship. It is an ongoing process and not an endpoint. What else would be helpful?

Dr. Cook: The best thing that can be done is for an ally to better educate themselves about systems of oppression. They should:

- Recognize their own intersectionality. Being disabled doesn’t mean you can’t be homophobic. Being anti-racist doesn’t mean you can’t make racist comments. If you don’t embody a certain identity, there’s no way you can have firsthand experience of what it’s like.

- Be willing to be uncomfortable. If you’re part of a majority group, chances are you haven’t had to deal with this kind of discomfort. But people from minority groups have no choice but to deal with it regularly.

- Acknowledge privilege. Privilege refers to the higher status and benefits granted to you by society based on some aspect of your identity. White people are privileged because they can go through life without having to think about race. Black people do not have that privilege.

- Know that actions, not intentions, matter. Having good intentions alone does not make a good ally. What also matters is how your thoughtful actions impact others.

- Understand historical injustices. Work to learn how the systems that have served you well — like the health care, and education, haven’t necessarily served everyone well.

- Find ways to give back. Listen to the people experiencing it. Educate yourself and become more involved in working with them towards a solution.

Dr. O’Conor: This has been a great discussion, especially as friends and colleagues from different backgrounds. Do you think as deeper relationships develop between people of different backgrounds, that friends can point things out to each other?

Dr. Cook: Ultimately, yes, I think deeper relationships can allow friends to bring attention to unjust situations. People are more receptive to feedback once they understand that privilege does exist. And they can learn to use that power for good. People of the disenfranchised minority are more comfortable pointing things out when they feel safe and know that their friend is willing to listen and learn. I liken it to the James Baldwin quote, “Not everything that is faced can be changed, but nothing can be changed until it is faced.”

To learn more about allyship, we offer the following resources:

- White Privilege in a White Coat: How Racism Shaped my Medical Education, Max J. Romano, MD, MPH
- White Fragility: Why It’s So Hard for White People to Talk About Racism, Robin DiAngelo
- The New Jim Crow: Mass Incarceration in the Age of Colorblindness, Michelle Alexander
- So You Want to Talk About Race, Ijeoma Oluo
- When Affirmative Action Was White, Ira Katznelson
- Stamped from the Beginning: The Definitive History of Racist Ideas in America, Ibram X. Kendi

Tuesday Cook, MD, FACS, FASMBS, is Diplomate of the American Board of Obeseity Medicine and Director of Minimally Invasive and Bariatric Surgery at Adventist HealthCare Fort Washington Medical Center. Carolyn B. O’Conor, MD, FAAFP, is a Comprehensive Primary Care Physician and Family Medicine Department Chair at Adventist HealthCare Shady Grove Medical Center.
AMALAunces Health Equity Plan

In June 2021, the American Medical Association released its "Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity." The 2021–23 plan outlines AMAs commitment to equity and its comprehensive strategy for embedding a racial and social justice approach to the organization's efforts and activities.

MedChi is proud of the contributions of our past president Willarda V. Edwards, MD, to this effort. Dr. Edwards currently serves on the AMA Board of Trustees. Prior to her board service, she served as Chair of the AMA's Health Equity Task Force in 2018. Dr. Edwards helmed the development of the task force's key recommendation to establish the AMA Center for Health Equity. This new organizational unit focuses on leveraging the AMAs leadership and influence for the disruption and dismantling of racism in the U.S. health care system. The new strategic plan outlines the Center's evidence-based approach to this monumental and important task.

Learn more at https://www.ama-assn.org/about/ama-center-health-equity.

Family Physicians..., continued from pg. 7

Western Maryland. The MDAFP educational committee will continue to incorporate health equity and racism topics in its CME programming, and the governmental advocacy committee will continue to advocate for health equity-focused legislation.

As the road to eliminating racism and achieving health equity in medicine will be long and arduous, it is essential that physicians lead this work.

For more info on the MDAFP Health Equity and Racism Task Force, please contact Executive Director Becky Wimmer at becky@mdafp.org.

Shana O. Ntiri, MD, MPH, FAAFP, is the President-Elect for the Maryland Academy of Family Physicians and an Assistant Professor in the Department of Family & Community Medicine, University of Maryland School of Medicine where she serves as the Medical Director for the Baltimore City Cancer Program and the Senior Medical Advisor for Community Outreach and Engagement at the University of Maryland Greenebaum Comprehensive Cancer Center.

Finding the Hidden Talent..., continued from pg. 15

Organizations must provide transparency for advancement into leadership and support in this stead. Consider what role you can take in your organization. Recruit underrepresented minorities for leadership roles, as it is critical for diverse perspectives to be represented. People of color can lead all kinds of initiatives. We can be leaders in other avenues, given equitable resources as our counterparts, and not just pigeonholed into diversity positions. Diversity initiatives should be led by or at least include members of the population that is being addressed. Lived experience and cultural knowledge bring incredible value.


2. The podcast on structural racism based on the discussion between Dr. Ed Livingston and Dr. Mitchell Katz, "Structural Racism for Doctors — What Is It?" has been withdrawn. The apology from Howard Bauchner, MD, can be found at https://jamanetwork.com/journals/jama/pages/audio-18587774.

Tuesday Cook, MD, FACS, FASMBS, is Diplomate of the American Board of Obesity Medicine.
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from its initial place of discovery. We owe to Dr. Blumenbach white race — thus he called that racial division Caucasian him that this was a perfect specimen from someone of the Caucasus Mountains. Blumenbach's measurements convinced of these skulls was a complete and pristine skull found in the target. Thus, one who hits the pointe blanc has hit the "bulls eye" of the target. Through years of linguistic evolution point blank has come to mean “close range.”

The word blanch, meaning “to turn pale or white,” also derives from the French word blanc — as does the feminine name Blanche (describing a fair maiden). Carte Blanche is a French expression meaning a “white or blank card” (one upon which nothing has been written), and metaphorically gives the recipient complete freedom to do as she wishes. The English version – a blank check – has the same meaning – the term “blank” deriving from French blanc as well. An empty space (as in a sentence) is also blank, and blank cartridges have gunpowder but no bullets. A blank expression alludes to an emotionless or “empty” facial appearance. Blanket also derives from the French blanc, the diminutive form is blanchett: “a little white woolen cloth,” and originally referred to a small towel or bedcover. (If the American actress Cate were doused with water, would they call her a “wet Blanchette”?)

When someone blanches, they turn pale, deriving from the Latin pallidus: “wan or white-faced, ” as the heroine of a Thomas Hardy or George Eliot novel often appears. Pallor obviously stems from the same Latin root. However the derivation of the verb appall may not be so clear. It, too, derives from Latin pallidus through French apalir: “to grow pale.” Thus to be appalled is to become is to become pale with emotion. In grade composition – a blank check – has the same meaning – the term “blank” deriving from French blanc as well. An empty space (as in a sentence) is also blank, and blank cartridges have gunpowder but no bullets. A blank expression alludes to an emotionless or “empty” facial appearance. Blanket also derives from the French blanc, the diminutive form is blanchett: “a little white woolen cloth,” and originally referred to a small towel or bedcover. (If the American actress Cate were doused with water, would they call her a “wet Blanchette”?

When someone blanches, they turn pale, deriving from the Latin pallidus: “wan or white-faced,” as the heroine of a Thomas Hardy or George Eliot novel often appears. Pallor obviously stems from the same Latin root. However the derivation of the verb appall may not be so clear. It, too, derives from Latin pallidus through French apalir: “to grow pale.” Thus to be appalled is to become is to become pale with emotion. In grade B westerns the Indian chief characterizes his white oppressors with the prosaic and derogatory words “pale face.”

Johann Friedrich Blumenbach (1752–1840), a German anthropologist and physician, was the first person to attempt a racial classification of humans. He divided people into Americans (red race), Malaysians brown race), Ethiopians (black race) and Mongols (yellow race). Blumenbach’s original work upon meticulous measurements of 60 skulls. One of these skulls was a complete and pristine skull found in the Caucasus Mountains. Blumenbach’s measurements convinced him that this was a perfect specimen from someone of the white race — thus he called that racial division Caucasian from its initial place of discovery. We owe to Dr. Blumenbach and his archaic classification that familiar and wearisome designation “… a Caucasian male…” heard frequently on television programs, over police radios, and in Grand Rounds presentations. Unfortunately, Nazis also utilized his system to validate their extermination of “inferior” races.

Although there are several terms to denote “white,” there are fewer words that specify “black.” Ebony derives from the Greek Ebanos, meaning “black,” and originally referred to the hard, black wood of many species of Persimmon trees native to Africa and Asia. The term ebonics — formed from ebon and phonics — was invented by African American social psychologist Robert Williams to denote the vernacular of many African Americans.

The Latin word for black is niger, which evolved in Spanish to become negro. Niger seeds are black seeds richly endowed with oils, and a favorite food of finches — especially the Goldfinch. The countries Niger and Nigeria in Africa, however, were not named for the skin color of their citizens. They were named for the Niger River, which courses through both countries. The river’s name, in turn, derives from the Tuareg language as egereou n-igereouen, meaning “big river.” The British and French colonial powers shortened the name egereou n-igereouen to Niger.

African Americans have generally eschewed the word Negro as a racial classification, largely because of its historical use as a disparaging term, and its vulgar corruption by bigots. However, in 1999 several controversies were generated because of the word “niggardly.” David Howard, a white aide to Mayor Anthony Williams of Washington, DC, used that word in reference to the annual budget, and was forced to resign because of it. Soon afterward, at the University of Wisconsin, a member of their Black Student Union angrily denounced the use of that term by a professor who was discussing Chaucer. Apparently, none of the aggrieved individuals understood the actual definition of the word niggardly — which means “miserly” or “parsimonious.” In view of its resemblance to the loathsome “N” word, civility suggests it might be preferable to choose other words to indicate stinginess. However, in doing so we should understand that the two “N” words are not duplicates. Niggardly derives from the Old Norse word nigla: “petty or unimportant” (as in the word niggling). It has absolutely nothing to do with skin color.

That fact is written down in black and white. It’s called a dictionary.

Editors’ Note: This article has been abbreviated. The original first appeared in Word Rounds II: A History of Words (Both Medical and Non-medical) and Their Relationship to One Another, by Barton J. Gershen MD, (Gaithersburg, MD: Flower Valley Press, 2004). It was written strictly from an etymological point of view.
MedChi Annual Members’ Social
Members and staff enjoy pre-game brunch and a silent auction at the Diamondback Tavern on September 26, 2021.
First Call Urgent Care at Baltimore-Washington Thurgood Marshall Airport

On Tuesday, August 24, 2021, FirstCall Medical Center, an urgent care facility, opened its doors at its new location, conveniently situated inside BWI Thurgood Marshall airport. This new state-of-the-art urgent care facility will provide services to the public and to airport employees.

The grand opening of the facility was attended by Governor Larry Hogan, as well as Secretary of Transportation Gregory Slater, State Senator Pam Beidle (D-Dist. 32), State Delegate Sid Saab (R-Dist. 33), and MedChi CEO Gene Ransom.

Services available at the facility include urgent care and first aid along with COVID-19 testing and vaccinations. Travel vaccinations will also be available by appointment. While COVID certainly highlighted the need for such a facility, it has been “in the works” for quite some time. “We’ve been working on getting this facility for five years,” said Dr. Ron Elfenbein, the Medical Director and founder of FirstCall. Teresa Healey-Conway, Executive Director of the Anne Arundel County Medical Society, wholeheartedly agreed, adding: “As someone who once broke a toe while going through airport security, I think having an urgent care facility is fantastic”.

The facility is located inside Concourse C, just before security, and will be open daily from 6:00 a.m. to 9:00 p.m. Insurance is accepted, and there is a self-pay option for patients who are uninsured.

More information about the facility can be found at https://www.chesapeakeurgentcare.com/bwi-urgent-care-location/.

BCMS Shares Historical Documents That Value “IDEA”

Lisa B. Williams

Since 1948, the Baltimore City Medical Society (BCMS) has made great strides towards inclusion, diversity and empowerment — beginning with the unanimous vote by its 250 members to admit “Black” physicians to the society.

Katherine Borkovich, MD (pictured left, top), was the first woman elected BCMS President in 1973. She was a cardiologist, teacher, explorer, and physician for expeditions to remote places such as Antarctica. She was also President of the Maryland Society of Internal Medicine in 1964.

Roland T. Smoot, MD (pictured left, bottom), the first black man elected BCMS President in 1978, was also elected MedChi President in 1983.

Willarda V. Edwards, MD (pictured right, top), served as BCMS President in 1995, while simultaneously serving as Monumental City Medical Society’s (affiliate of the National Medical Association) President; she was elected MedChi’s second woman President in 2004.

On December 17, 1948, the 250 Baltimore City Medical Society (BCMS) members voted unanimously to admit “Black” physicians. BCMS received the Sidney Hollander Foundation Award in 1950, recognizing this act as a “… contribution toward the achievement of equal rights and opportunities for Blacks…”

Lisa B. Williams is CEO/Exec. Director of the Baltimore City Medical Society and can be reached at info@bcmsdocs.org.
Michael Myers, MD, is a psychiatrist, originally working in Vancouver, Canada, and transplanted to New York. Over the years, he became the “doctor’s doctor,” caring for other physicians who had experienced emotional turmoil and frank psychosis. *Becoming a Doctors’ Doctor*, by Michael Myers, MD, is a memoir of the arc of his career, from his earliest days as a medical student whose roommate never returned from Christmas vacation due to a suicide, to treating physicians and their families exclusively through marriage breakups, emotional travails, and even more suicides.

Dr. Myers’ overarching theme is that we physicians, despite all we might think, are just people, subject to the same emotional foibles as everybody else. He describes us as “wounded healers.” Just as the public is often ashamed of admitting to psychiatric difficulties, physicians are even more so. “Our patients are us,” he says. “How can we not identify — or overidentify — when it often feels that treating doctors is like looking in a mirror? We see so many of our own conflicts and fears, and that can be terrifying.” Dr. Myers recounts time after time physicians having difficulties completing their work, until finally coming in for badly needed treatment. He recalls a medical student, having spent three weeks with him on a clerkship, ending their time with, “Doc, do you have a minute to talk?” Transitioning from teacher–student to physician–patient, he guided the student through unseen difficulties, and allowed him to continue his career.

Psychiatric troubles in physicians and their families come in many varieties. Dr. Myers devotes one chapter to the AIDS crisis of the 1980s and 1990s, treating the PTSD of the caregivers. At the end of the book, he recounts similar problems in the COVID era. In between, he tells of the stresses on physicians and their families, on physician-physician families, and on the greater community. We self-medicate with alcohol or other psychoactive substances. We throw ourselves into our work to keep our minds off whatever else is bothering us. Sometimes we have affairs outside the marriage. Dr. Myers helps by having his patients, even the physicians, talk about and explore their feelings and work toward a solution.

Dr. Myers often returns to the theme of physician suicide. Beginning with the loss of his medical school roommate through an extended discussion of one of his patients who was eventually lost to suicide ("Dr. Z"), he recounts how he had tried to prevent it over several years, but ultimately failed. In the aftermath, he participated in a project of the American Foundation for Suicide Prevention, which helped him explore his own feelings of grief and anger toward the loss of one of his patients. Indeed, Dr. Z’s own family was helpful to him in sorting through his emotions and provided him with written material that he was able to incorporate into his lectures on the topic of physician mental health and suicide.

He ends with this: “If anything, I feel more communal — that this challenge, saving the lives of physicians, requires building bridges and cooperative work… We must continue to be candid and rigorous — and we must keep talking about a subject that, sadly, is not going away. When that day comes, and it will, we can be quiet.” More physicians are opening up to examine their concerns, their fears, and their feelings. He is hopeful for the future.

*Becoming a Doctors’ Doctor* is a worthwhile book for all physicians, medical students, administrators, nurses, and anyone involved in the health care industry. Myers writes easily and draws us in (as a good psychiatrist should). He continues to show that we physicians are ultimately human, and prone to the same trials and tribulations as anyone else. Ultimately, we need to care for each other, and know that “when you’re broken on the ground, you will be found.”

*Stephen Rockower, MD, was a past President of MedChi. His Twitter handle is @DrBonesMD.*
Founder’s Book Added to MedChi Collection

Recently, while perusing auction catalogues, something caught our attention — a slim volume by MedChi Founder Gustavus Richard Brown, entitled *A Physical Essay on the Rising Heat of Animals*, published in MDCCCLXVIII (1768). As far as we know, this is the only book written by Dr. Brown, although there could be others now lost to time. *A Physical Essay*, written in Latin, was obviously re-bound, which may be why it has survived.

There were two men named Gustavus Richard Brown who were both founders of MedChi. One lived in St. Mary’s County and the other lived in Charles County. As far as we understand, one’s father was the other one’s grandfather, and they were born four years apart. Both studied medicine in Edinburgh, Scotland, and both were friends with George Washington. One was even at Washington’s bedside when he died. Given what we know from our 1899 Annals of Medicine in Maryland, it is more likely that this volume was written by the Dr. Brown of Charles County.

Dr. Brown of St. Mary’s County first met George Washington during the American Revolution when Dr. Brown was asked to inspect the Maryland troops and enroll able-bodied men. Dr. Brown was an advocate of smallpox inoculations, as was General Washington, as more men died from smallpox than from war wounds. Dr. Brown of Charles County was a landscape architect, most notably at Rose Hill, his Charles County home, as well as a botanist, which served him well in medicine. He was said to be “over six feet in height and well-proportioned; pleasant and affable; a fine classical scholar; and particularly fond of botany.”

Dr. Brown’s book is the second artifact from a founder that we’ve added to the MedChi collection, the first being a patient’s ledger from Francis Brown Sappington of Frederick County. (see: MMJ, Vol. 22, Issue 1, The Sappington Ledger).
MedChi’s Newest Physician Members

MedChi welcomes the following new members, who joined between July 27, 2021, and September 21, 2021.

William Ashley, MD — LifeBridge - Sinai Hospital Leadership
Robert F. Cadogan, MD
Chintamaneni P. Choudari, MD — Hagerstown Gastroenterology
Nicholette M. Martin-Davis, MD — Concentra Urgent Care
Daniel J. Durand, MD — LifeBridge - Sinai Hospital Leadership
David Dusenbery, MD
Thomas E. Ein, MD — Capital Women’s Care
Akshay Sen Garg, MD
Pallavi Gowda, MD — Premier Health
Lisa M. Kim, MD — Lisa M. Kim MD Inc.
J. Alberto Martinez, MD — Visionary Eye Doctors
Ayana C. McIntosh, MD
Haddijatou Secka Ogunsola, MD — Global Pain Management
Kerry E. Owens, MD — Avalon Plastic Surgery
Najla A. Abdur-Rahman, MD — Willoughby Beach Pediatrics
Daljeet S. Saluja, MD
Fadi N. Saikali, MD — GBMC Main Hospital
Stephanie B. Sisler, MD — Lovelight Pediatrics

MPHP

MPHP is a private, confidential, non-disciplinary program that advocates for the health and well-being of all physicians and other allied health professionals who are licensed by the Maryland Board of Physicians to safeguard the public. MPHP is HIPAA compliant, and protects the confidentiality of participant records as set forth under state and federal law. MPHP is administered by the Maryland State Medical Society’s 501 (c)(3) affiliate, the Center for a Healthy Maryland, and is separate from the Maryland Board of Physicians.

For more information and/or a confidential consultation for you or a colleague who may benefit from our help, please call 800-992-7010 or 410-962-5580.

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OCTOBER
20: Baltimore City Medical Society Treatment and Prevention of the Opioid Epidemic: What Every Physician Should Know CME
21: MMDA COVID-19 Update
29: Maryland Sleep Society Meeting

NOVEMBER
3: Baltimore County Medical Association Board of Governor’s Meeting
3: Montgomery County Medical Society General Membership Meeting (Virtual)
4: Maryland Neurosurgical Society Meeting
6: MedChi Annual Meeting and Fall House of Delegates Mtg
6: MedChi Board of Trustees Meeting
8: Baltimore City Medical Society Fndtn Meeting
10: Baltimore City Medical Society Board of Director’s Mtg
10: Maryland Psychiatric Society Webinar, Topic: Psychiatry and Legal Interventions
12–13: MMDA Annual Conference
13–16: AMA Interim Meeting
16: MMDA Membership Committee and Finance Committee Meetings
17: Baltimore City Medical Society and Baltimore County Medical Association General Meeting/Furlong Lecture
18: MedChi Board of Trustees Meeting
18: MMDA COVID-19 Update
23: MMDA Board of Director’s Meeting

DECEMBER
3: Baltimore County Medical Association Legislative Breakfast
8: Baltimore City Medical Society Board of Director’s Meeting
12: Baltimore County Medical Association Holiday Brunch
16: MMDA COVID-19 Update

BHIPP is made possible through funding from the Maryland Department of Health, Behavioral Health Administration and partnerships among the University of Maryland School of Medicine, Johns Hopkins University School of Medicine, Salisbury University School of Social Work, and Morgan State University School of Social Work. This series is supported in part by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of award U4CMC32913-01-00. The content(s) are those of the author and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.
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