As Pandemic Rages, So Does Demoralization in Our Profession

Do Med School Applicants Feel Stigmatized About Mental Health Issues?

Remembering Our Friend and Colleague Dr. Barton Gershen
What’s In a Name?

Gene M. Ransom III

In response to the American Association of Physician Assistants’ recent announcement that they are attempting to change the title “physician assistant” to “physician associate,” the American Medical Association issued a strong statement of opposition. MedChi strongly supports the AMA on this issue.

From the AMA:

“AAPA’s recent move to change the title ‘physician assistant’ to ‘physician associate’ will only serve to further confuse patients about who is providing their care, especially since AAPA sought a different title change in recent years, preferring to only use the term ‘PA.’ Given the existing difficulty many patients experience in identifying who is or is not a physician, it is important to provide patients with more transparency and clarity in who is providing their care, not more confusion. Yet, AAPA’s effort to change the title of physician assistants to rebrand their profession will undoubtedly confuse patients and is clearly an attempt to advance their pursuit toward independent practice. We believe this latest effort is incompatible with state laws and are prepared to work with interested state and specialty medical societies to address any efforts to implement this title change in state or federal policy.”

“[W]e remain strongly committed to supporting physician-led health care teams that use the unique knowledge and valuable contributions of all health care professionals to enhance patient outcomes. It is also what patients want, which is why clarity in health care titles is so important. That is why the AMA has advocated in support of truth in advertising laws and stands in strong opposition to AAPA’s title change.”

Titles have meaning. MedChi spent a significant amount of political capital last Maryland General Assembly session killing a bill that would have renamed “podiatrists” to the name “podiatric physicians.” House Bill 182/Senate Bill 169: Health Occupations — Podiatric Physicians (failed) would have allowed podiatrists to use the term “podiatric physician,” as is done in numerous other states. MedChi successfully opposed the bill for the third year in a row, arguing that the term “physician” should be reserved to MDs and DOs; that it creates confusion for patients; and that, of all years, this is not the one to dilute the title of physicians after all they have done. Despite pressure put on some Delegates to not speak on the bill, Delegate Jon Cardin nevertheless stood up for the physician community on the House floor and spoke in opposition to the bill. MedChi continued to strongly advocate our position and while the Senate bill was heard by the Education, Health, and Environmental Affairs Committee, it was never brought up for a vote, so the bills both died there.

MedChi will continue to fight in Maryland and will continue to support the AMA on national battles to protect the public from laws that would confuse patients. Words have meaning. A medical school degree has value. These are principles that should not be eroded through legislative fiat.

Gene M. Ransom III, is CEO of MedChi, The Maryland State Medical Society.

What You Need To Know Now

1. Effective October 1, 2021, practices may not charge a fee for copies of a medical record requested by the patient or patient representative for the purpose of supporting a claim or appeal for Social Security Disability income or Social Security benefits, due to the passage of HB 849 in the last legislative session.

2. Effective October 1, 2021, pharmacists in Maryland must inform retail consumers of the availability and cost differences of generically equivalent drugs, therapeutically equivalent brand name drugs that are the lowest-cost alternative to the originally prescribed drug, or interchangeable biological products.

3. As of January 1, 2022, all controlled substance prescriptions under Medicare’s Part D drug plan must be transmitted electronically. Providers should take steps now to comply with the new requirement. Please reach out to MedChi to assist.

4. Take time for yourself and your family.
From the President...
Shannon P. Pryor, MD, President, MedChi

Before the pandemic, if you had told me that I’d be quarantined in a hotel in Iceland alone for two weeks, I’d have thought you were out of your mind. But that’s exactly what I did this summer, when despite being fully vaccinated I became ill with COVID-19 after a week of vacation. It’s one thing to slow down and spend quality time in your own home and with people around you. But being stuck in Iceland without family, without friends, without work and numerous sideline activities was a whole different kind of animal — especially for an over-committer like me. I was not used to or prepared for so much “down time”; and I certainly wasn’t used to so much time alone.

Frustration and fatigue notwithstanding, I was eventually able to accept my situation for what it was and cast it in a semi-positive light: When would I ever again get this kind of “me time” to pause, to reflect, perhaps even bring about positive change? Examining my circumstances made me realize that while our profession has many positive attributes, the prospect of work-life balance is sadly missing for many of us. Physician burn-out is real; in fact, studies involving nearly every medical specialty indicate that one in every three physicians will experience burnout at some point in their career.1 In recent years, the rising prevalence of burnout among clinicians (more than 50 percent in some studies) has led to questions on how it affects access to care, patient safety, and care quality. Burnout is real and can even be fatal. A sad but true fact is that physician suicide rates top those of any other profession, as well as the general public.

For this reason, we have dedicated this issue of *Maryland Medicine* to physician health and well-being. Where do you see yourself — professionally speaking — on the “locus of control” spectrum? (page 9). What resources are available to you if you are experiencing symptoms of burnout? (page 11). How do you recognize the signs of burnout? (page 15). Is physician well-being an issue that organizations need to solve or address or is it a core institutional value best demonstrated by what we do and the decisions we make. While we don’t have answers to these questions just yet, at least we are asking all the right questions.


COVID-19 Effects on Physician Burnout

Physician burnout was a public health crisis long before COVID-19. A recent survey shows that the pandemic is exacerbating this issue, leading to higher rates of burnout, retirement, and increased physician shortages. The numbers at right are from “The Physicians Foundation 2020 Survey of America’s Physicians: COVID-19 Impact Edition,” a survey that examined how the Coronavirus pandemic affected and was perceived by physicians nationwide. The survey series was conducted for The Physicians Foundation by Merritt Hawkins (for full results of this survey, visit https://bit.ly/3xDO3nr).

- 58% of physicians often have feelings of burnout, compared to 40% in 2018.
- 22% of physicians know a physician who has committed suicide.
- 13% of physicians have sought medical attention for a mental health problem caused by COVID-19’s effects on their practice or employment situation.
- 37% of physicians would like to retire in the next year.
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As the Pandemic Rages, Demoralization Deflates Health Care Workers

Suzan Song, MD, MPH, PhD

There’s a surge in calls. We need more backup,” read the text I got last week from my colleague Mona Masood, a psychiatrist and co-founder of the Physician Support Line, a peer-to-peer hotline that she, I, and others developed in response to the COVID-19 pandemic.

With 700 volunteer psychiatrists staffing the hotline, my first thought was, “How is that possible?”

My second thought was “Ah, yes. We are still demoralized.”

Back in March, I watched from the front row as the pandemic overwhelmed health care workers with moral injuries — acts that conflicted with our values. We felt betrayed by government messaging that flew in the face of science; powerless when administrators restricted protective equipment; apprehensive when treating patients who might expose us — and subsequently our loved ones — to COVID-19; and incompetent in our ability to cope with this new disease without clinical guidance. Attending physicians became interns again as we scrambled to understand the novel SARS-CoV-2 virus.

These moral injuries don’t necessarily have long-term consequences. They can spark growth, insight, and redefined life purpose. But during this year of constant unrest and disorientation that underlies our everyday routine, clinicians are left with a collective demoralization.

Introduced by psychiatrist Jerome Frank in in 1961, demoralization is defined as a persistent, subjective inability to cope in the face of overwhelming situations. Rattled to the core by existential distress, one’s usual beliefs and convictions give way to uncertainty, frustration, and restlessness. Trust in humanity dissolves, leaving a sense of futility in its wake.

Ten months into the pandemic, we know more about the virology and clinical management of COVID-19. The president-elect has prioritized science, public health, and effective management of the pandemic, giving doctors and other health care workers a second wind.

But a window of opportunity seems to have closed, shut in part by the public’s fatigue and burnout from the pandemic. Cognitive dissonance settles in: The public knows there is a risk of infecting loved ones, yet they want to — need to — justify their choice to not follow public health precautions as they minimize the odds of contracting or spreading COVID-19.

This likely contributes to why there are more people hospitalized with COVID-19 than ever before. While the lack of protective equipment seemed the rate limiting factor during the spring, this winter it will be a lack of health care professionals to manage the overwhelming number of patients as medical practices close or clinicians become infected. The supply chain for clinicians isn’t as easy to fix as the one for PPE.

Health care workers are losing compassion for the general public.

continued on page 13
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A Tip of the Hat to Medical School Applicants: Chipping Away at Stigma

Michael Myers, MD

One dimension of my daily work that I really enjoy is interviewing applicants to medical school. I serve on the College of Medicine Admissions Committee, which I’ve been doing for a number of years, and being a psychiatrist, I’m often tasked with interviewing a specific group of applicants, the ones who openly write that they have suffered from mental health symptoms in the past.

This is a sea change in medical education, refreshing and long overdue. Most applicants to medical school do not, nor are they required to, reveal that information. Competition is fierce for a spot in each year’s matriculating classes across the nation and compounding that is how much the entire process is mired in stigma. And not just stigma attached to psychiatric illness. Applicants are reluctant, if not terrified, to disclose anything about themselves that they fear could signify them as inferior, unworthy, or other, and that they would be denied entrance into the “hallowed halls” (quotation marks are intentional, as is a bit of sarcasm) of medical education.

And that is why I look forward to interviewing these courageous young women and men. I review their applications the day before so that I’m well prepared to ask not only the standard questions about their interest in medicine, their GPA and MCAT scores, study habits, volunteerism, research and stress-relieving activities, but also their disclosure. I’ve created below a composite and disguised example of what I might read embedded in the Personal Comments section of an application.

In my final year of high school, my parents separated. I was okay at first because I could see it coming, and I was relieved. I couldn’t wait to get away to college. But their divorce was ugly and they both leaned on me. During my second semester, my grades fell badly. But I studied harder and pulled them up, sort of. Then in my sophomore year, I couldn’t focus and got down. It took me a long time to go to student health counseling. But I did. That helped, and so did pills for depression. I still take them. But this explains why I made the Dean’s List only in my junior and senior years. There’s a lot of depression in my family. And my dad’s dad killed himself before I was born.

I am careful and respectful when I interview a candidate with this kind of story. Despite what they’ve written in their essay, they may not wish to elaborate. Asking blanket questions about medical and psychiatric conditions, including substance use disorders, is illegal, but interviewers are permitted to ask applicants about their ability to perform the functions of a medical student and whether they may require reasonable accommodations. Hence, with the above scenario as an example, and his mentioning still taking medication, I might ask the applicant if he’s currently in care. And if so, are his medications being monitored by a psychiatrist or primary care physician. I would like to have a sense of how he’s doing and whether he feels back to his baseline, and if he believes he’s ready to tackle the academic expectations of medical school. I would also apprise him of the counseling service at our school that is available to medical students. I am mindful of the context, that I’m interviewing a candidate for medical school, not a new patient in my office. The rules of privilege and access are profoundly different.

continued on page 15
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Has Your Locus of Control Changed in the Past Five Years?

Victoria Hecht

You may not control all the events that happen to you but you can decide not to be reduced by them. — Maya Angelou.

Locus of control is a psychological concept that refers to how strongly people believe they have control over the situations and experiences that affect their lives. There are two types of locus of control: internal (inside) and external (outside). Internal locus of control is the belief that you are “in charge of the events that occur in your life,” while external locus of control is the belief that “chance, fate, or outside forces determine life events.”

MedChi recently polled members with a two-part question pertaining to locus of control: Do YOU, as a physician, feel that your locus of control has changed in the past five years? And if the answer is “yes,” what actions or steps have you taken to regain locus of control in your practice environment?

Responses came from all over the state. Eighty-three percent answered “Yes, they feel that their locus of control has changed in the last five years”, while 17 percent answered “no.” Actions taken as an attempt to regain control varied from “none” to “I will be retiring two years earlier than I [had] originally planned.” More than a few credited MedChi with helping them cope with the loss of control, while others turned to colleagues for advice and support, met with hospital personnel, or proactively pursued leadership positions within the organization.

Many of the respondents, however, felt powerless over their situation. Wrote one:

“How many patients I see is dictated by management. What medications, surgeries, or injections I use are regulated by insurances through prior authorizations which leads to a delay in care. I am told what I need to chart for meaningful use. Reimbursement rates are dictated by CMS and are falling with time. . . . Physicians have very little control on their practice environment. Some days, I ask why am I here?”

Although much more data is needed, understanding how locus of control is experienced and managed — or not managed — among physicians and health care workers may provide a basis for examining the factors that contribute to burnout, depression, health problems, and early retirement. With this information, we can begin to reformulate what steps organizations, management, and the health care system in general can take to give physicians a greater sense of ownership and self-determination, which will likely result in increased job satisfaction. And a re-embracing of their once and future profession.

Victoria Hecht is the Development Manager at Medchi and can be reached at vhecht@medchi.org.
VALUABLE

HELPING ONE PHYSICIAN HELPS A THOUSAND PATIENTS.

That’s why nearly 80% of hospitals in Maryland support MPHP. MPHP is part of the Center for a Healthy Maryland, a 501(c)(3) charitable affiliate of MedChi, The Maryland State Medical Society, and was established to assist, support and provide advocacy as appropriate for physicians to address any potential conditions that may affect their ability to practice medicine in a safe and competent manner. MPHP understands physician-specific issues and offers an array of resources to assist.

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

REMEMBER, YOU ARE NOT ALONE
The Maryland Physician Health Program

Terrence Morgan, LCSW-C, LCADC

The Maryland Physician Health Program (MPHP) is part of the Center for a Healthy Maryland, a 501c(3) charitable affiliate of MedChi. The mission of the MPHP is to provide a private, confidential, non-disciplinary setting for physicians in need of assistance. The MPHP has been helping Maryland physicians for forty-three years.

How Did Physician Health Programs Come to Be? In the 1940s a movement began when industrial alcoholism programs were formed in several companies. Farsighted managers recognized that it was more efficient in both human and monetary terms to rehabilitate workers suffering from alcoholism, rather than fire them and hire and retrain new ones. These early programs were the prototypes of what we now call employee assistance programs. Out of these programs grew the concept of intervention. The belief behind this process is that the alcoholic or addict doesn't have to hit bottom to be helped. Though it is certainly true that one must be willing to participate in the recovery process, one can be prompted to recognize that one has a problem from which one needs to recover.

Physician Health Programs formed as the result of a charge set forth by the American Medical Association in 1972. “It is a physician's ethical responsibility to take cognizance of a colleague's inability to practice medicine by reason of physical or mental illness, including alcoholism and or drug dependence... Accountability to the public through assurance of competent care to patients by physicians and other health professionals is a paramount responsibility of organized medicine,” stated The Sick Physician, a report to the Council on Mental Health adopted by the AMA House of Delegates, in November 1972. MedChi formed the Maryland Physician Rehabilitation Committee — now Physician Health Committee, in 1978.

MPHP staff consists of a medical director, program director, director of operations, 4.5 clinical managers, and an administrative assistant. As advocates for the health and well-being of all physicians in Maryland, MPHP provides a confidential, private setting to address issues that may potentially impact the ability to practice medicine. The goal is to intervene before a life problem becomes an impairing illness. In a safe and confidential environment, trained professionals armed with the appropriate resources help participants overcome challenges with alcoholism, drug abuse and dependence, psychiatric illness, cognitive impairment, disruptive behavior, stress and burnout, and boundary issues. Physicians, physician assistants, residents, medical students, and any other allied health professional licensed by the Board of Physicians who experience any of these issues can contact MPHP directly.

Moreover, colleagues, and family members who are concerned about a medical professional can also contact the MPHP, as may hospital administrators, hospital committees, therapists, and treatment agencies.

The MPHP program is HIPAA-compliant and protects the confidentiality of participant records as set forth under state and federal laws. Federal and state laws ensure the confidentiality of all practitioners in the program, and MPHP records are non-discoverable and confidential to the extent covered by law.

The MPHP assesses and refers participants to appropriate treatments, supports and monitors their recovery, and advocates on their behalf. Its process consists of three basic domains:

**Initial Consultation:** an opportunity for open and honest communication regarding the issues, allowing for a thorough review of the situation that begins the helping process.

**Monitoring:** the participant enters a mutually agreed-upon, voluntary advocacy agreement which allows MPHP to engage with the participant in active monitoring of their progress. The agreement may consist of various elements to assist the participant's health and well-being. **Support and Advocacy:** MPHP provides advocacy to our participants by building a dossier of information that shows progress over the course of the treatment and monitoring process. Advocacy reports are sent solely with the permission of the participants.

MPHP participants can succeed. Our numbers show that those with substance use issues succeed more than 80 percent of the time, a success rate that far surpasses those who do not participate in MPHP. It is also more than three times the success rate of substance use recovery among the general population.

**How has the Maryland Physician Health Program changed since the pandemic?** As a result of the COVID-19 pandemic, the MPHP has been able to successfully adapt our service model to include telehealth or virtual access for participants. This inclusion has not affected our referral and utilization rate, which has remained the same for the past three years. MPHP currently operates a hybrid model of access that includes in-person and virtual options. MPHP considers the acuity of the problem, the barriers to engagement, and the expressed needs of each participant, which allows for an individualized person-centered approach to recovery. It is our goal to continue to protect and support physician well-being during this public health crisis and beyond by providing top-quality services.

The first step in the helping process is to contact the MPHP (410.962.5580; https://healthymaryland.org/physician-health/)

**Terrence Morgan is the Program Director at Maryland Physician Health Program and can be reached at tmorgan@medchi.org.**
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†For more validation publications, including PRS for all ancestries, visit https://myriadmyrisk.com/RiskScore

2. Myriad Internal Data Based on OBGYN & Primary Care Settings.
As a psychiatrist, I must care for my patients in order to engage with them and not avoid their emotional turmoil. I must rein in any apathy I feel so I can do my job: to listen for meaning, validate, and avoid judgment. But that is hard when there are indoor weddings and soccer tournaments with 500 teams occurring as COVID-19 once again surges across the U.S. I’m tired of this pandemic. Fatigued from trying to decipher my patients’ tears through screens. Burned out from witnessing how much of life is going un-lived: deferred playdates, empty college dorms, canceled family reunions, parents and grandparents alone on holidays. And stressed from working a full-time job and homeschooling my two kids under 5.

But it isn’t just the constancy of COVID-19 that causes distress. It’s also the breakdown of social values that weighs me down. I spoke with a colleague of mine, James Griffith, chair of psychiatry at George Washington University, who designed a curriculum to combat demoralization. He told me how pervasive demoralization is and yet how widely ignored it is as a concept in our society.

“Demoralization is not in itself a mental illness but rather a normal human response to circumstances perceived as overwhelming,” Griffith said. “We lose our sense of meaning.” For me, meaning comes from my roles — as a mother, wife, doctor, teacher, daughter, friend. But all these identities need me at the same time and, in 2020, at a magnitude I’m not sure I can manage. Medical school mistakenly taught me that the concerns of patients always supersede my own. With so much of my psychic energy diffused, I am losing the ability to give. And I know I’m not alone.

Consider how many continued, unresolved problems we are facing that feel morally wrong: Seniors isolated in their last years of life. Children wrenched from their formative places of education. Countless victims caught in the structural violence of inequality, most of them people of color.

The ongoing pandemic has revealed the ugly exploitation in our society: of health care workers, teachers, bus drivers, grocery store and factory workers, and others who are often forced to work in unprotected, high-risk situations.

At the crux of demoralization is despair over moral injustices and subjective incompetence — the belief that we aren’t coping as we should be. We know we need better sleep and more exercise, but the moral injury of seeing patients dying without loved ones present depletes the energy that would have been used for a run. There are no good options to reconcile the social acceptance of racism or the lack of feasible options for child care or education.

Hope can be an antidote to demoralization, and the incoming Biden administration and vaccine developments provide that. But the president-elect is also inheriting a health care system and a society that are on their last reserves from this pandemic, and it will take another season or two before vaccines become widely available.

We can’t ask any more of our health care workers. As Mona Masood told me, “Physicians are holding up a sinking boat, but they themselves are drowning.” Physicians do not learn how to set boundaries in medical training. To the contrary: I — like many others — delayed dating, financial planning, and having a child all to care for patients. We are taught to be the last resort for those in dire need. It’s therefore no surprise that physicians have higher rates of suicide than the general population.

Physicians take a Hippocratic oath to “do no harm.” It’s time that oath includes doing no harm to ourselves. I will continue to serve as a backup for colleagues who turn to our hotline for help and will strengthen personal boundaries. But support lines, meditation, and walks only go so far.

For the many Americans who are taking appropriate precautions against COVID-19, thank you. It feels like we lack control over so much of our lives now. But we can do our part to be a society that values caring for each other enough to take personal responsibility: wear a mask, avoid gatherings, and wash hands.

We may desperately await a vaccine now, but soon we may instead be hoping for enough physicians to care for us.
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We are Janssen, the Pharmaceutical Companies of Johnson & Johnson. Bold thinkers. Big dreamers. Fearless advocates on behalf of patients. So that one day, the world’s most daunting diseases will be found only in the pages of history books.
I ask a question like this: “Your decision to be transparent about your mental health history in your application is commendable. Tell me about that?” Most say that this was a decision that took significant time. They have usually shared their inclination to be open with their parents, partner or spouse, pre-health committee advisor, or therapist—and may have received mixed advice. But mostly they say things like this: “At the end of the day, I felt strongly that I needed to include this, to be authentic. This is a part of who I am. I know what it’s like to be ill, vulnerable, and to seek professional help. My doctors have been wonderful. And inspirational. Having been a patient myself, I can better empathize with my patients. I also know what I found so helpful in a doctor and what I didn’t. I think that this journey will make me a better doctor.” Can’t argue with that! And after a brief pause, most add this sentence: “And if a medical school that I’ve applied to doesn’t like what I’ve written and tosses my application in the waste basket, then I don’t want to study medicine there.”

After interviewing candidates like this, I invariably reflect on how far we’ve come in medicine from when I applied to school back in the 1960s. It gives me great pleasure to know that these highly talented young doctors of tomorrow refuse to be hamstrung or deterred by their humanness, their vulnerabilities. That they have the resolve to challenge the archaic and dangerous confines of stigma that affect so many of today’s physicians. To put an end to the needless suffering. In the words of Nelson Mandela: “The youth of today are the leaders of tomorrow.”

Signs and Symptoms of Physician Burnout

- Loss of motivation
- Feeling helpless, trapped, or defeated
- Feeling detached
- Increased cynical or negative outlook
- Decreased satisfaction or sense of accomplishment
- Feeling tired and drained most of the time
- Lowered immunity
Merritt Hawkins, the nation’s leading physician search firm, is committed to physician well-being

Merritt Hawkins, the nation’s leading physician search firm, has an established track record of monitoring and seeking to enhance physician well-being. In partnership with The Physicians Foundation, we conduct one of the largest physician surveys in the U.S. with a focus on physician career satisfaction, morale and well-being.

The 2020 Survey of America’s Physicians reveals how COVID-19 has affected physician practices as well physician physical and mental well-being.

We are proud to collaborate with MedChi to provide its members with white papers, surveys, speaking presentations and other informational resources pertaining to physician well-being, compensation, and related topics.

We also are proud to recruit physicians on behalf of Maryland physician practices and hospitals, and to match Maryland physicians with outstanding practice opportunities throughout the Old Line State.

If you are seeking physician partners or associates, are interested in reviewing new practice settings, or would like a copy of the 2020 Survey of America’s Physicians, contact:

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The Patient’s Advocate
Barton J. Gershen MD
Rockville, Maryland

I am tired of hearing everyone claim to be the "patient's advocate." Medicare claims it. The Blues claim it. Many HMOs claim it. Several hospitals claim it. Victor Cohn claims it. Other consumer advocates claim it. I suspect even the Board of Physician Quality Assurance claims it.

Not true, folks.

The word advocate comes from the latin advocatus: a "counselor" (which stems from ad vocare: "to call"). The word patient is derived from the Latin pati: "to endure." It is cognate with passio: "a suffering" — which ultimately derives from the Greek pathos. A "patient's advocate" gives counsel to one who suffers — to one who has called.

I am the one called. At three in the afternoon or three in the morning I am at his side.
I ask the probing questions, observe the subtlety of facial expression, auscult the faint aortic diastolic whiff, palpate the soft barely enlarged spleen, anticipate the grave diagnosis, order the confirmatory test, begin the relevant therapy. I am the one who agonizes over his failure to respond. I am the one who spends hours interpreting clinical finding, educating the family and anguishing with them.

And in the end I am the last to surrender him to his God.

I am the patient’s advocate.
I am his sword and his shield.
I am the ultimate, definitive, exhaustive, and irrevocable advocate for his life.
I am his physician.

Those others are all pretenders to the title.

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Barton J. Gershen, MD (1933–2021)
Bruce Smoller, MD
Stephen Rockower, MD
Editors and Disciples

Our good friend and esteemed colleague, Bart Gershen, MD, passed away on June 23rd of this year. He left behind a raft of friends and admirers and a legacy of the written word which we at Maryland Medicine hope to honor.

Bart was born in Brooklyn and was a colorful amalgam of its culture and the crusty independence of Vermont, where Bart was raised. Bart melded those cultural immersions with a natural brilliance and curiosity, which served his chosen field of cardiology and his patients very well.

Bart practiced medicine for fifty years and played a significant part in advances in patient care, such as the first emergency transport equipped with life-saving cardiac care instrumentation and communications gear. However, it was in his role as writer and wordsmith that we came to know Bart best.

Bart Gershen was a mainstay of the Maryland Medicine, (previously Montgomery Medicine) editorial board. He served from the 1980s until 2019, when his failing health and sadness over the recent loss of his dear wife, Enid, prevented him from continuing to attend the meetings. His constant encouragement, cajoling, and curmudgeon-ness were always the highlights of our meetings.

Although he began life as a cardiologist in Montgomery County, he saw his role as so much more than that. He was an excellent wordsmith, publishing hundreds of columns of “Word Rounds” over the thirty-year span. Numerous physicians (ourselves included) turned to his column first when the issue first came out. He published two volumes of his collected columns, which are now out of print.

Bart never strayed from the belief that to be a Physician is a sacred calling, and we should do our utmost to live up to it. We present here his “Ode to a Physician,” and will continue in these pages to present some of his selected columns. For our “mature” colleagues, these will be welcome memories. For our younger ones, prepare to enjoy the sweet science of etymology.

Bruce Smoller, MD, is Co-chair of the MedChi Communications Council and Past President of MedChi. Stephen Rockower, MD, is the Chair of the Maryland Medical Political Action Committee (MMPAC) and Past President of MedChi.
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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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Frederick County Medical Society Welcomes New President

Frederick County Medical Society Welcomes New President

MedChi is pleased to announce that Julio Menocal, MD, has accepted the role of President of the Frederick County Medical Society. He has been an active and long-standing member of MedChi and the Frederick County Medical Society. Dr. Menocal has been proactive throughout the COVID-19 pandemic, providing education and vaccination to the underserved members of Frederick County. His history as a community practitioner, providing compassion and guidance, are qualities that lend themselves well to this leadership role. Please join us in welcoming Dr. Menocal in his new position. He will be instrumental as we start planning future meetings to support the mission of the Frederick County Medical Society.

Baltimore City Medical Society Foundation Turning 50!

Baltimore City Medical Society Foundation Turning 50!

Lisa B. Williams

Baltimore City Medical Society Foundation was established in 1972. In the fall/winter of 2021, the Foundation will host a “kick-off” event in anticipation of next year’s anniversary. Central to this effort will be initiatives to raise funds to assure the Foundation continues its work for another fifty years. The following excerpt on the Foundation is from the book, *The Baltimore City Medical Society: A History*, commissioned by the Baltimore City Medical Society in 2004, on the occasion of its 100th anniversary as a component of MedChi.

The Beginnings of the Scholarship Program

Scholarships proved to be the permanent legacy of the Woman’s Auxiliary, [later, just the Auxiliary, still later, the Alliance] continuing unabated within the general structure of the Baltimore City Medical Society until the Baltimore City Medical Society Foundation was formed in 1972. The amounts grew to $1,000 in 1972, when a Hopkins-bound student was chosen by a committee of the Baltimore City Public Schools. The need to raise funds for scholarships made necessary the creation of a 501c(3) non-profit legal entity that could accept tax-deductible donations for the purpose, and in September 1974 the first call went out for contributions to get the Foundation started. “The BCMS Foundation is a philanthropic organization formed to support scholarships, special post-graduate educational activities, public health programs and other worthwhile medically-oriented projects,” the call for donations explained.

By 1975, there were sufficient funds to begin a search for the Foundation’s first scholarship recipients. A letter went out to financial aid offices at medical schools across the country. Prospective recipients needed a permanent Baltimore City address, and had to be enrolled in an accredited medical or osteopathy school. The first two recipients, a student at Howard University and another at Johns Hopkins, received grants totaling $1,500 in 1976. As the fund grew, so did the awards. In 1977, five students shared a total of $4,000 and in 1981 scholarships spread among four students reached $5,000. Eight students benefitted from the Foundation’s programs in 1990, when a total of $12,000 was granted.

Note: More of the history of the Baltimore City Medical Society Foundation will be shared in future issues of Maryland Medicine.

Lisa B. Williams is CEO/Executive Director of the Baltimore City Medical Society and can be reached at info@bcmsdocs.org.
On April 26, 1986, a large swath of the area northwest of Kiev exploded. The nuclear accident would not only upend and terrify the population of Ukraine but eventually affect the rest of the world in fact and in imagination. When the truth finally emerged about the magnitude of the cataclysm, the depths of the deception by the Soviet State, and the terrifying details of the effects of radiation, Chernobyl would become the symbol of dystopian nuclear catastrophe.

Alla Shapiro, MD, a young pediatric oncologist in the Soviet medical system and based in Kiev at the time, would learn firsthand what the people of the Soviet Union would come to learn much later. Mobilized to treat what was untreatable and care for the unimaginable, Dr. Shapiro was initially told lies, and when she eventually uncovered the truth, was threatened with never working again…. or worse. The story of her journey through the horrors of Chernobyl, navigating the Soviet State system, and her convoluted and dangerous escape to a new life of freedom are the subject of her remarkable new book, Doctor on Call. It is the story of her flight through purgatory to a position of respect, freedom, and purpose in a new country.

Doctor on Call: Chernobyl Responder, Jewish Refugee, Radiation Expert, by Alla Shapiro, MD, is a riveting book that chronicles both a physician’s journey through what came to be known as the Chernobyl Exclusion Zone, and the secrecy and duplicity exacted by the edict-riddled bureaucracy of the Soviet government — a government intent on keeping secret the severity and magnitude of history’s most monumental nuclear accident. It is also the tale of an emigrant who chose to leave her family and home behind for the welcoming shores of the United States, a country that ultimately gave her the tools to become a medical expert on radiation safety and a home in Maryland where she eventually raised her family.

For those of us who viewed the HBO miniseries “Chernobyl” with train wreck fascination, the similarities are strikingly familiar in this autobiographical account. Shapiro was there, a witness to the radiation burns, the bravery of her fellow citizens, and the deceit of government officials trying to fool the populace about the magnitude and lethality of the meltdown (one such example: the myth that red wine can protect against radiation). Her odyssey to America, taken by many of her fellow countrymen, is lent additional drama by the threats rained down on medical personnel and first responders by State officials eager to bury the truth, along with the dead bodies.

There are a few minor problems with the book. As it is divided into two sections, the pace is different in each one, lending a minor dissonance to the rhythm and flow of the story. Moreover, where Shapiro delves into her career in the United States is too lengthy and in need of trimming. But the net effect of the book is one of illumination, as it sheds light on the story of one of the greatest man-made disasters in the world as told by a firsthand accounting. It’s a story fraught with personal, political, and occupational danger, a story made all the more immediate and real by the fact the author is, indeed, now one of us.

Bruce Smoller, MD, is co-chair of the MedChi Communications Council and Past President of MedChi.
**Searching the Stacks with Marcia Crocker Noyes**

Did you know that there's a library at MedChi that houses more than 50,000 volumes? This four-story stacks library, located in MedChi’s headquarters, is different from a lending library. Books in a stacks library are accessed by library staff, rather than patrons. From 1896 to 1946 Marcia Crocker Noyes’ was the librarian for The Faculty, as MedChi was then known.

When a physician needed a specialized book, they would call Noyes and request that she find it. She would search the stacks, and then take the book to the reading room where physicians would wait. Once the physicians found the information, they would return the book. Because The Faculty subscribed to all the state, national, international, and specialty journals, physicians knew that they would be able to access the most up-to-date information without having to take a subscription to each and every journal. These journals, which span the entire 20th century, are still in the stacks today.

When Noyes arrived in 1896, she and William Osler, MD, founded what eventually would become one of the largest and most well-respected medical society libraries in the country. What started as several hundred out-of-date books when Noyes first started gradually grew to more than 65,000 volumes by the mid-1950s, one decade after her death in 1946.

The multi-drawer wood card catalogue contains thousands of cards written in Noyes’ own “library hand,” a uniquely rounded and legible style of writing that was the standard for libraries everywhere before typewriters came into use.

Today, these journals and many more books still reside on the stacks’ shelves, and the original card catalogue remains closed and untouched, waiting for someone to come flip through its musty drawers and fondly recall the glory days of the stacks.
MedChi’s Newest Physician Members

MedChi welcomes the following new members, who joined between April 23, 2021, and July 26, 2021.

Maryland Medicine

Marwa Adi, MD — Washington Eye Physicians & Surgeons
Ahmad Ahad, M.B.B.S. — Ascension Saint Agnes Maryland Surgeons
Artin Aharonian, MD — Community Radiology Associates
Tahira Ahmed, MD — Community Radiology Associates
Tessie G. Aikara, MD — Concentra
Lanre Akinkunmi, MD — Union Hospital
Tahgreed Alshaeri, MD — U.S. Anesthesia Partners - Maryland
Dilip S. Arwindekar, MD — Community Radiology Associates
Cheryl D. Bansal, MD — Medical & Aesthetic Dermatology, LLC
Irmina C. Boulier, MD — Chesapeake Dermatology
Kim L. Bright, MD
Craig A. Campbell, MD — Community Radiology Associates
Christopher D. Clark, MD — Premiere Spine and Sports Medicine LLC
Alan A. Cohen, MD — Community Radiology Associates
Heidi Cooper, MD — The Radiology Clinic
Todd Jeffrey Crocco, MD — University of Maryland Medical System
Natalya Danilyants, MD
Mukul K. Das, MD — Community Radiology Associates
Rhett Daugherty, MD
Lindsey Dawson, MD — Washington Eye Physicians & Surgeons
Parham Farid, MD — Community Radiology Associates
L. Dean Flanders, MD — Washington Eye Physicians & Surgeons
William Chadwick Fowlkes, MD — Community Radiology Associates
Sarah E. Freeman, DO — Perinatal Associates at GBMC
Jerald Froehner, MD — U.S. Anesthesia Partners - Maryland
Neil Gambill, MD — Community Radiology Associates
Brett A. Gamma, MD — MEP Group
Sultan Ghuman, MD — U.S. Anesthesia Partners - Maryland
David Gitlitz, MD
Janine Louisa Good, MD — Neurology Associates
Todd A. Goodlick, MD — Washington Eye Physicians & Surgeons
Kimberly M. Kesler-O’Rourke, MD — Perinatal Assoc at GBMC
Shahin J. Korangy, MD — The Radiology Clinic
Karim Lashin, DO — U.S. Anesthesia Partners - Maryland
Andrea Leonard-Segal, MD
Jennifer Leone, MD, MS — Perinatal Associates at GBMC
Rocela J. Lopez, MD — Towson University Health Center
Dayo Lukula, MD — U.S. Anesthesia Partners - Maryland
Paul J. MacKoul, MD
Leslie Z. Marshall, MD — Community Radiology Associates
Neil F. Martin, MD — Washington Eye Physicians & Surgeons
Anandraj Mattai, MD
Viraj Mehta, MD — Washington Eye Physicians & Surgeons
Julio Menocal, MD — Privia Health LLC
Sarim R. Mir, MD — Mir Neurology & Spine Center
Neal J. Naff, MD — LifeBridge - Sinai Hospital Leadership
Lane Neidig, MD
Giora Netzer, MD — University of Maryland Medical System
Khiet Thanh Nguyen, MD — Community Radiology Associates
Andrew J. Oh, MD — Capital Women’s Care - Division 36
Bert W. O’Malley, MD — UMMS Leadership
Robert Craig Platenberg, MD — The Radiology Clinic
Stephanie E. Pollard, MD,M.P.H. — Perinatal Assoc at GBMC
Amy Rivers, MD — U.S. Anesthesia Partners - Maryland
Anthony Rossi, DO — U.S. Anesthesia Partners - Maryland
Sanyogeeta Sagar Sawant, MD — U.S. Anesthesia Partners - Maryland
John Schreiber, MD — Community Radiology Associates
Kenneth S. Schwartz, MD — Washington Eye Physicians & Surgeons
Neil M. Siegel, MD — University of Maryland Medical Center
Alka Singh, MD — Community Radiology Associates
Sankari Sivasailam, MD
Malcolm Eugene Stennett, MD — U.S. Anesthesia Partners - Maryland
Ajay Singh Sufi, MD — Community Radiology Associates
Jackie Ta, DO — U.S. Anesthesia Partners - Maryland
Lauren S. Taney, MD — Washington Eye Physicians & Surgeons
Yong Tang, MD
Amaka J. Undie, MD — Bethany Pediatrics
Aneesha Varrey, MD — Perinatal Associates at GBMC
Howard S. Weiss, MD — Washington Eye Physicians & Surgeons
Joseph Louis Wright, MD,M.P.H.,F.A.A.P — UM Capital Regional Medical Center
Linda Young, MD — U.S. Anesthesia Partners - Maryland
### SEPTEMBER
- **8:** Baltimore City Medical Society, Board of Directors Mtg
- **13:** Baltimore City Medical Society, Snack Chat with Medical Examiner, Victor Weedn, MD
- **14:** MMDA, Board of Director's Meeting
- **16:** MMDA, COVID-19 Update
- **18:** Maryland Society of Plastic Surgeons Meeting
- **21:** MedChi Committee on Ethics and Judicial Affairs Meeting
- **22:** Baltimore County Medical Association, Board of Governor's Meeting
- **23:** MedChi Board of Trustees Meeting
- **25:** MedChi Fall Social at Camden Yards
- **29:** Baltimore County Medical Association, CME Program

### OCTOBER
- **5:** MMDA Awards Committee and Nominating Committee Meetings
- **7:** Maryland Society of Eye Physicians and Surgeons Meeting
- **9:** MedChi Presidential Gala Honoring 173rd President Shannon Pryor, MD
- **13:** Baltimore City Medical Society Board of Director's Meeting
- **15:** Maryland American College of Obstetricians and Gynecologists Meeting
- **20:** Baltimore City Medical Society CME
- **21:** MMDA COVID-19 Update
- **25:** MedChi Annual Meeting and Fall House of Delegates Mtg
- **29:** Maryland Sleep Society Meeting

### NOVEMBER
- **3:** Baltimore County Medical Association Board of Governor's Meeting
- **4:** Maryland Neurosurgical Society Meeting
- **6:** MedChi Annual Meeting and Fall House of Delegates Mtg
- **6:** MedChi Board of Trustees Meeting
- **10:** Baltimore City Medical Society Board of Director's Mtg
- **12–13:** MMDA Annual Conference
- **13–16:** AMA Interim Meeting
- **13–16:** 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
PRESIDENTIAL Gala

2021

HONORING OUR 173RD PRESIDENT

SHANNON P. PRYOR, MD

Saturday, October 9, 2021, 7:00 pm

Chevy Chase Club
Chevy Chase, Maryland

www.medchi.org/gala
#MedChiGala