

The Donald Klein Lifetime Achievement Awardee

Interview with Dr. Jenessa Johnston

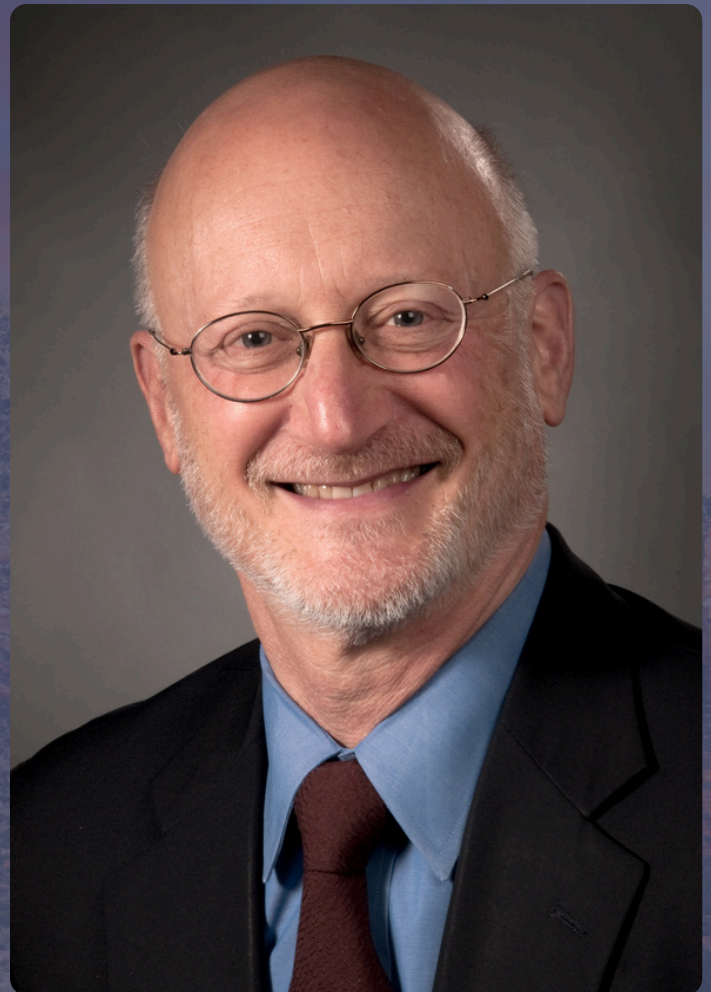


John Kane, M.D., the recipient of this year's Donald Klein Lifetime Achievement Award, is a pioneer in the field of psychopharmacology. From conducting groundbreaking work on the use of clozapine in treatment resistant schizophrenia to championing new strategies for patient engagement, his breadth of work has influenced generations of clinicians and researchers. His thoughtfulness permeates both his acceptance lecture and our interview, as he discusses the overlaps between art and science and demonstrates his genuine care for patients and families.

John Kane, M.D.

The Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

2025 Donald Klein Lifetime Achievement Awardee



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JJ: You mentioned within your lecture that as a medical student, you checked yourself into a therapeutic milieu for drug addiction as a patient, to experience what it is like from a patient's perspective. How has that shaped your approach to medicine?

JK: Medicine in general has not used 'mystery shoppers' the way some other industries, certainly retail institutions, do and I think that it would be sobering. One hesitates to encourage deceit, but I think to have the perspective of a patient is difficult unless one actually is a patient. At that time, being a medical student it was eye-opening to spend two weeks living with them. I learned a lot about their lives and their backgrounds because I was trying to talk to people as a peer and learn as much as I could.

JJ: Similarly, you have championed the concept of functional recovery throughout your career – I was wondering if you could speak more on that and what inspired you to prioritize patient reintegration into communities.

JK: Talking to patients and families really underscores what it is all about – people want to lead normal lives and not think of themselves as having an illness. When I was starting out in psychiatry, patients were referred to as schizophrenics – implying that this person was a disease and not a person. You have to put yourself in the patient's place and try to visualize what you would want – you would very quickly get to functional outcomes. I think in medicine we get caught up in what we can measure easily, but in the end, it is really the patient-centered outcome that matters. In schizophrenia research, sometimes I get frustrated since some clinicians believe functional recovery is not possible and just accept the status quo. I think that is unfortunate.

JJ: We know that generally clinicians want to help, but can often get focused on primary outcomes – how can we encourage this concept of functional recovery?

JK: I think it might be helpful for them to hear from patients and families outside of the clinical context. I think the typical clinician – patient interaction can be quite artificial, and I think hearing from people, hearing their stories and talking to them in other contexts is very powerful. Those who have relatives who suffer from a mental illness are much more sophisticated, and in a sense much more aware, of the impact and all the emotions that are associated with psychiatric diagnoses.

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JJ: Many initiatives in pharmacology are moving towards large-scale collaborations, such as AMP-SCZ. Do you think that large-scale approach is the only way to move forward in the field of psychopharmacology?

JK: I think it's still important to have independent labs – that's where some of the innovation might come from. When you have these huge programs, it becomes a village. It's obviously a challenge to put them together to manage them, but I think things can get lost and communication can break down. Big collaborations are extremely valuable, but I think we have to be very vigilant. You also want to make sure that individual institutions with their own characteristics are thriving and able to contribute. It's tricky.

JJ: Evidently, much of your work has focused on the use of clozapine in treatment resistant schizophrenia – why do you think the U.S. is so reluctant, when compared to other countries, to the prescription of clozapine in these cases?

JK: I think the fact that we don't have national health insurance is one factor – with national insurance, you can monitor things better and have more uniform policies, procedures, and quality measures. We also have a tendency towards a type of individualism, which can be manifested in research participation and clinical care. Clozapine is a challenging drug with a lot of side effects, but if you look at the long-term large-scale data, people live longer after being treated with clozapine. Clinicians don't necessarily appreciate that on an individual level when they're talking to their patient, and they do not want to hold blame for potential adverse effects. I think we also fall behind since we are not training our residents in a consistent fashion. Certain programs provide guidance on clozapine treatment, but some do not. If you don't have that experience as a resident using clozapine and long acting injectables then chances are you are not going to use them in your clinical practice.

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JJ: How do we reinvigorate the use of these medications that have fallen to the wayside that are still incredibly effective in severe mental illness?

JK: There are certain requirements in psychiatric training that you have to have experience with – e.g. exposure to Y number of hours with Z, and I think the use of these medicines should be included in those requirements. However, I think the people making those requirements are not sufficiently aware/convinced that this is a gap, and we need to work on that. Also, I believe we should train residents on talking to patients in a way that gives them dignity of choice. In the example of clozapine – if I'm talking to a patient and family – I would say that we have this medicine with associated risks that might be very helpful. More than 50% of people who take it derive some meaningful benefit from it and a smaller percentage derive enormous benefit. However, we can't predict for whom that will be the case. We should not deprive patients of their right to choose the risk they're accepting to take.

JJ: Within the scope of this Lifetime Achievement Award – you have achieved so much throughout your career, what are the biggest lessons you've learned and perhaps missteps you've taken?

JK: There are probably several things, but one is giving up on something too soon. Though you also must balance that against persisting at something too long. It's always tricky making those decisions. Additionally, the implementation gap has been a big learning experience and a big frustration – spending so much time trying to develop data and evidence, and then seeing it not actually utilized. Finding the balance between being passive and aggressive was also a challenge. To overcome obstacles, you need to be passionate, persistent, and patient. Another quote from Einstein said something along the lines of “It's not that I'm so smart, it's just that I stay with problems longer.

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JJ: In the spirit of Einstein quotes, I would like to co-opt a quote that Dr. Kane used within his acceptance lecture, that I think summarizes beautifully the type of physician and researcher he is:

“Most people say that it is the intellect which makes a great scientist – they are wrong, it is great character” – Albert Einstein

Congratulations again Dr. Kane on your well-deserved Lifetime Achievement Award.

Jenessa Johnston, Ph.D.

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ASCP Social Media Ambassador

