The Sick Physician

Impairment by Psychiatric Disorders, Including Alcoholism and 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.

Occasionally such accountability is jeopardized by physicians whose functioning has been impaired by psychiatric disorders, including alcoholism and drug dependence. An equally important issue is the effective treatment and rehabilitation of the physician-patient so that he can be restored to a useful life.

A sampling of boards of medical examiners and other sources reveals a significant problem in this area. Also indicative of the problem, and the difficulty organized medicine has in coping with it, are the numerous requests for guidance received by the American Medical Association.

The Council on Mental Health makes the following observations and recommendations:

1. It is a physician's ethical responsibility to take cognizance of a colleague's inability to practice medicine adequately by reason of physical or mental illness, including alcoholism or drug dependence. Ideally, the affected physician himself should seek help when difficulties arise. Often, however, he is unable or unwilling to recognize that a problem exists. When exhortations by family and friends are ineffective and when the physician is unable to make a rational assessment of his ability to function professionally, it becomes essentially the responsibility of his colleagues to make that assessment for him, and to advise him whether he should obtain treatment and curtail or suspend his practice.

In carrying out this task, advising physicians should begin with informal talks and proceed to more formalized approaches only as necessary and according to the following sequence:

(a) Discussion of the problem with other physicians who are in close working relationship with the affected physician, to the end that they will exert their influence in a positive and beneficial manner.

(b) Referral of the problem to the medical staff of the hospital on which the affected physician serves.

(c) Referral of the problem to a specific committee of the state or county medical society if the physician is not a member of a hospital staff, or if the staff is unable or unwilling to act. It should be one created exclusively for the purpose, not an existing one, such as an ethics or a grievance committee. Its function should be to determine whether the physician is suffering from a disorder to a degree that interferes with his ability to practice medicine. The committee should comprise examining physicians including, but not limited to, psychiatrists and neurologists. In carrying out its function, the committee should be guided by procedures that are appropriate to the local situation as worked out by the state or county society.

(d) Referral of the problem to the appropriate licensing body in the state if the physician is not a medical society member, or if the medical society is unable or unwilling to act. The licensing body should have a committee comparable to the one established by the medical society.

2. Spouses can be helpful in bringing physicians into treatment. The spouses should become as fully informed as the society's members about the overall problem and the medical society's approach to its solution. The Woman's Auxiliary should be asked to take an active part in this educational program.

3. AMA's Office of the General Counsel should be requested to draw up a model law to deal with physicians who have such problems, and to disseminate that model to state and county medical societies for legislative action in their jurisdictions.

4. Educational programs should be developed for the medical student and the physician in training, emphasizing their high vulnerability to psychiatric disorders, alcoholism, and drug dependence.

Scope of the Problem Among Physicians

The literature since at least the mid-1950s presents numerous reports on studies of drug problems among physicians; several of the reports will be cited here. The number of physicians reported in each study is small, but the findings are consistent.

In 1964, Modlin and Montes[1] noted that estimates of the incidence of narcotic addiction in physicians varied from 30 to 100 times that found in the general population, and they classified such addiction as an occupational hazard. They found that narcotic addiction ordinarily depends on three conditions: (1) a predisposing personality, (2) the availability of narcotics, and (3) a set of circumstances that brings 1 and 2 together. They further noted that the majority of the 30 physicians studied consistently denied serious addictive difficulties and shared the illusion that they could stop using drugs at any time they wished. Reports from the United States, England, Germany, Holland, and France indicate that, of the known drug addicts, about 15% are physicians and that an additional 15% are members of the nursing and pharmacy professions.

In 1969 Vaillant et al[2] reported a prospective study carried out over a 20-year period that showed that a group of 45 physicians took more tranquilizers, sedatives, and stimulants than 90 matched controls. As college sophomores both groups had been selected for the study because of better-than-average physical and psychological health. The physicians drank alcoholic beverages and smoked cigarettes to the same extent as the controls.

Reporting later on a similar con-

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Disciplinary Action Against Physicians					
			Condition		
State	Period of Study, Yrs	Average Annual Active Registration	Alcoholism	Drug Dependence	Other Mental Disorders
Arizona	11	1,627	53 (3.2%)	28 (1.7%)	22 (1.3%)
Connecticut	6+	4,682	NA	42 (0.9%)	NA
Oregon	10	2,388	55 (2.3%)	48 (2.0%)	21 (0.9%)

trolled study, Vaillant et al[3] noted that physicians, especially those who treat patients, were more likely than nonphysicians to be involved in heavy drug and alcohol use and to have relatively unsuccessful marriages. The presence of these occupational hazards," however, appear strongly associated with life adjustments before medical school, and those physicians who had the least stable childhoods and adolescent adjustments seemed to be especially vulnerable to these hazards.

Figures obtained from three state boards of medical examiners, shown in the table, give the percentage of the total of actively practicing physicians in each state subject to disciplinary action for alcoholism, drug dependence, and mental disorders for the period of study noted—eg, in 11 years, nearly 2% of Arizona's physicians came before the board for disciplinary actions because of drug dependence; in 10 years a similar proportion of Oregon physicians; and in about 6 years, almost 1% of Connecticut's physicians.

Thus, in just a decade, 118 drug-dependent physicians have been brought before their disciplinary bodies in three of the smaller states, with an equal number of physicians appearing for alcoholism, and a smaller but significant number for other mental illness.

In 1958 the California State Board of Medical Examiners estimated that at some point in their careers 1% to 2% of the physicians in that state abused narcotics. Currently that board handles 125 disciplinary cases a year, well over half of them involving narcotics.

Apart from the cases of alcohol and drug dependence that come before disciplinary bodies with relatively high frequency, there are, as in the general population, other less-visible diagnostic entities of mental disorders occurring with perhaps greater frequency among physicians. Specific studies of the epidemiology of mental disorder in physicians are few, but Duffy,[4,5] in a survey of physicians treated at the Mayo Clinic, found the following diagnoses (in order of prevalence): affective psychosis, psychoneurosis, schizophrenia, personality disorder, and organic brain syndrome.

The psychotic reactions, without question, impair the ill physician's judgment and ability to practice, and a psychoneurosis or a personality disorder of sufficient degree can constitute a similar risk to the safety of the patient.

Suicide is generally accepted to be one of the major behavioral consequences of mental illness. Demographic data were compiled on 249 physicians listed in the *JAMA* obituary columns from May 1965 to November 1967 as having died by suicide.[6] Suicides exceeded the combined deaths from automobile accidents, plane crashes, drowning, and homicide. In addition, 56 deaths were reported as possible suicides. The total of all these violent deaths is 534, or over 5% of all the physicians' deaths during that period, according to Blachly et al.[6]

The mean suicidal age was 49, at or near the usual productive peak for a physician. Abuse of alcohol or drugs was an important factor in two fifths of the cases, and depressive illness was very common. Medical specialty was an important variable: Suicide ranged from a low of 0.01% among pediatricians to a high of 0.6% among psychiatrists.

About 100 physicians commit suicide annually, equivalent to the size of the average medical school graduating class. The comments of two widows of physicians who died by suicide[6] were: "I sought a colleague but for reasons of his own, he would not try. Could there be a board or group of doctors to whom a wife can turn?" and "If it were possible to have a telephone number available to persons in remote areas as this, and trained personnel who would help, suicides such as his could be prevented. *This was such a waste!*"

No information could be found on the incidence of organic brain syndromes among physicians; but no county medical society can disclaim knowledge of this slowly developing and chronic disorder in one or a few of its members, usually associated with advanced age or gradual impairment of cerebral blood supply. Watchful colleagues can usually protect the patients concerned, but eventually a crisis develops because of a major omission or commission, an improper prescription or dosage, or a frank error in practice judgment. Acute organic disorders, as with psychotic illness, may cause a rapid change in physician behavior that is less amenable to controlling intervention by colleagues.

Programs by State Medical Societies

Threat of suspension or revocation of the license to prescribe narcotics or the license to practice medicine may, in some cases, be an incentive toward rehabilitation or a deterrent to drug abuse. In many other cases, however, it may work against the physician admitting to himself or to others that he has a problem.

A letter to the Council, quoted here in part, is illustrative:

I am a member of your association and I should greatly appreciate any information relating to the all-too-common problem of physicians becoming addicted to narcotics.

As can be surmised I had such a problem myself for one year and have been free of drug abuse for six months. The wrath incurred shall be many years in subsiding, however. I found much help from a few MD's who (themselves) had overcome such a problem—really more help than from psychiatrists, who tend to categorize the physician with the street-dwelling heroin pushers. I spent a month at the Federal Narcotics Hospital at Fort Worth, Texas, and I found I barely spoke the same language.

One of the many things to be warned against is the insidiousness of onset and the inevitable denial which follows—especially with the most commonly used drug, meperidine.

Another physician, a drug-dependent pediatrician, writing in a medical news journal,[7] stated:

I am that common but rarely mentioned problem, the drug-addict doctor. Depending on whom you talk to, I am an amoral bum, an ill-used and tragic figure, an em-

barrassing statistic, a blameless sick man, or a disgrace to the profession.

Actually I am none of these things or perhaps a little bit of all of them, but eight years of fighting the problem have made one thing discouragingly clear: the most enlightened medical profession that civilization has ever known, in the wealthiest country in history, doesn't know how to treat me, and really doesn't want to know. The profession that has for generations battled to keep the government from intervening between the doctor and his patient is content to let a federal tax agency tell it what to prescribe for me.

The Council sent a letter to all state medical society executives noting its interest in drug-dependent, alcoholic, and psychiatrically disordered physicians and inquiring whether any state or county medical society has established an outstanding and effective program for handling the difficult and serious problem of such physicians. Of 54 societies canvassed (including Puerto Rico, the Virgin Islands, the Canal Zone, and the District of Columbia), 37 responded. Seven of the respondents indicated that there is an active committee at the state level charged with the problem, and that the state either has, or has pending, a "sick doctor statute." Another seven reported having no active program but indicated that either some related action was pending or that they had been stimulated into initiating action on the basis of the letter of inquiry. The remaining respondents (23) stated there was no county or state society program directed at such a problem, and three went so far as to deny vehemently that any such problems even existed in their states. It could be surmised that among the nonrespondents—almost one third of the total number of state associations—there is an indifference about these problems, or a denial of their existence.

The San Francisco Medical Society has activated an advisory committee for physicians. Its purpose is "to serve physicians who have emotional problems. Other physicians may contact the committee when they feel that a colleague is in need of its help. The physician in question will then be contacted, confidentially, in an effort to help him understand his problem."

A similar group in Oregon (Friends of Medicine), having both physicians and lay members and somewhat broader goals, has evolved outside the structure of organized medicine in the belief that the group is more effective and more acceptable to the sick doctor if it is not under the aegis of a medical association or a board of medical examiners.

The "Sick Doctor Statute"

The pioneering effort in the development of a "sick doctor statute" came in the 1969 Florida legislature, which revised grounds for professional discipline under the medical practice act of that state to protect the public further against the incompetent or unqualified practice of medicine.

A similar "sick doctor statute" became law in Texas in 1971. Prior to the passage of the legislation in these two states, as in most states today, disciplining a practitioner of the healing arts was predicated on his commission of misconduct on one or more of a variety of specified grounds, provided that fault could be proved against the practitioner. In most states, even though a physician's fitness or ability to practice may be substandard, no violation of the applicable medical practice act occurs unless his alleged misconduct violates a specified standard of behavior. Such a law leaves a board of medical examiners impotent in its desire to protect the public against a physician's incompetence or inability to practice medicine, unless the physician has also committed an act predicated on fault. Many state laws have a provision automatically suspending a physician's license if he is adjudged mentally incompetent or is committed for psychiatric care, but, as is well known, such a last-resort legal action rarely occurs in the case of a physician-patient.

The "sick doctor statute" defines the inability of a physician to practice medicine with reasonable skill and safety to his patients, because of one or more enumerated illnesses. It eliminates the need to allege or prove that a physician's clinical judgment was actually impaired or that he actually injured a patient. The defined inability can be the result of organic illness, mental or emotional disorders, deterioration through the aging process, or loss of motor skill. Further, the inability can arise from excessive use or abuse of narcotics, drugs and chemicals, alcohol, or similar types of material.

The act provides that, prior to board action against a physician, there must be probable cause of his inability to practice medicine with reasonable skill and safety to his patients. The intent of this provision is to protect physicians from harassment by capricious accusations.

If probable cause is shown, the physician is required to submit to diagnostic mental or physical examinations. He has given implied consent for such examination, under this statute, by using his license to practice or by registering his license annually. The doctrine of implied consent is further used in the law to remove privileged communications that ordinarily exist between physician and patient. A physician so ordered to examination waives this legal privilege, thus making available to the administrative trial records of the examiners' consultation and diagnostic tests, and testimony.

The accused physician has the right to receive copies of the examining physicians' reports and diagnosis, and there is provision for his taking the deposition of his examiners. Further, his own medical expert may present testimony.

Following the hearing, if the board determines that the physician is indeed unable to practice, it may suspend his license and, in addition, place him on probation. The board may compel a physician to seek therapy from a physician designated by the board, or it may restrict his areas of practice to those in which he is still believed to be competent. Suspension of licensure privileges is specified to be only for the duration of impairment, and the sick doctor is guaranteed the opportunity to demonstrate to the board that his license should be reinstated when he is competent to practice again.

A further provision, again protecting the ill physician, is the guarantee that neither the record of the proceedings nor any unfavorable order entered against him can be used against him in any other legal proceeding, such as a malpractice action, a divorce proceeding, or a suit to challenge his testamentary capacity.

During the first year after its

enactment in Florida, the statute was most frequently used for physicians manifesting incompetency due to excessive use of drugs or alcohol. These are the most common disciplinary problems coming before medical boards.

A departure from the usual centralized medical examining board approach is found in the Medical Practice Act of Delaware. About 12 years ago, a medical censor committee was created in each Delaware county, consisting of three members of the county medical society, appointed by the medical council or board from a list submitted by the medical society. The powers delegated to these committees include those of subpoena and discipline of the allegedly incompetent physician, subject only to the approval of the medical council. It seems doubtful that this decentralization, though closer to a peer-review mechanism, would be entirely desirable, since it places considerable power in the hands of persons who might be inexperienced in such matters, however well they might know the ill physician.

A desirable feature for inclusion in the medical practice act of all states is found in the existing codes of Arizona and Virginia. In both jurisdictions it is mandatory that any licensed physician report to the board of medical examiners any information he may acquire that tends to show that any physician may be unable to practice medicine safely. It also provides for civil immunity under the law for any physician so reporting in good faith.

In cases of drug-dependent physicians, all state boards of medical examiners would be wise to follow a supervised rehabilitation program of sufficient duration to give the physician every opportunity to remain drug-free. Representative of a number of state boards pursuing such a course is California. A former member of the board, Dr. William F. Quinn, states:

> We've found that rehabilitation is facilitated by allowing the doctor to practice medicine. So, with first offenders, the board takes away the doctor's narcotics stamp and revokes his license, but places a stay of execution of the revocation. The sword of revocation hanging over him is very effective, much more so than the seemingly more charitable approach of issuing warnings and reprimands for first offenders. The temptation to return to drugs is just too strong for a doctor to resist testing the Board.[9]

After a second offense, Dr. Quinn noted, 85% of the violators have their licenses immediately suspended or revoked. A recent study by the California board showed rehabilitation to be successful in 85 of 100 physicians on probation for abuse of narcotics. Of the remainder, ten returned to use of drugs and five committed suicide.[9]

The Undergraduate Problem

Of particular concern for the future are the incidence of use of, and the attitude toward, psychotropic substances among medical students and physicians-in-training. These young men and women progress into the area of total, unsupervised responsibility for patient care, where impeccable judgment and unclouded thinking are the primary bulwarks protecting them from malpractice.

A statement by the AMA Committee on Alcoholism and Drug Dependence reads, in part

> Because physicians are accessible to most types of dangerous drugs and because they often work under sustained pressure, which may enhance the seeking of drugs for relief, physicians appear to be a high-risk population in terms of exposure to drug abuse. This potential should be clearly recognized by medical students and there should be opportunities in the curriculum for them to explore their personal posture with respect to drug use and, if desirable, its impact on their role as therapists.

Medical students also should have opportunities to discuss these matters *in confidence* with appropriate experienced physicians.

Conclusion

In dealing with a "sick doctor," the preparation of guidelines to assist organized medicine to deal with the problem first necessitates delineation of boundaries of responsibility.

First, the primary responsibility for ensuring safe, competent care to the patient population affected must be reemphasized. Parallel to that concern is the welfare of the ill physician, his family, and his colleagues.

The physician-patient is first in the hierarchy of responsibility. As with the lay patient, the drug-dependent or alcoholic physician must recognize that he has a mental disorder and communicate with a competent source of assistance; he must voice his chief complaint and seek help.

Experience in such situations is often disappointing as the physician-patient denies he is ill, lacks insight into his problem, avoids medical assistance, and minimizes his problem outright. Therefore, an element of coercion is often necessary. The family is more often than not ineffectual in exerting pressure, which must then come from some other source.

Peer referral for help usually reveals an entrenched "conspiracy of silence." Physicians strongly resist recognition of the fact that any of their number can become ill. Members of hospital staffs and other colleagues of the ill practitioner should be willing to speak out, substituting, perhaps, a "conspiracy of constructive compassion."

The Council on Mental Health has therefore recommended the following referral pattern: If the individual physician cannot be persuaded informally to seek help, the problem should be taken up by the medical staff of the hospital; if that avenue is not feasible, a specially designated committee of the state or county medical society should be consulted; and if the medical society is unable or unwilling to act, the matter should be referred to the appropriate licensing body in the state.

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