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Aged or Disabled Physicians

*Peter P. Zawaly, Jr.**

I'm surprised that you find this subject sufficiently front burner to merit an article.¹

*Walter C. Bornemeier, M.D.
Immediate Past President
American Medical Association*

THE PROBLEMS POSED TO THE GENERAL PUBLIC by the aged or disabled physician are more than just sufficiently front burner to merit an article. They are, as should be all questions of life and death, to be considered with utmost scrutinization and to be met with uncompromising action. A self-proclaimed indictment is made by every physician as he embarks upon the profession of healing others:

I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone . . . I will preserve the purity of my life and my art. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.²

This article will not concern itself, per se, with the recently much written about subject of medical professional liability. "The concept of professional liability should never be equated with the concept of incompetence",³ for the former is a malperformance at a given time, whereas the latter is the lack of ability to perform at all. Those illnesses, whereby a physician is rendered incompetent, that will be treated in the following text with particular attention, are senility, drug addiction, and alcoholism. Once establishing the scope of the problem, a brief examination of the disciplinary measures available within the profession and their effectiveness, will be made. In the way of a conclusion, some of the recommendations that have been espoused will be offered, along with this writer's personal comments.

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¹ Questionnaire response from Walter C. Bornemeier, M.D., Immediate Past President of the American Medical Association.

Note: Comments were solicited from prominent physicians and attorneys throughout the country by use of the following questionnaire:

- 1.) The medical profession, as well as the public, is confronted with the senile aged physician everyday. Do you advocate a mandatory retirement age for physicians in a hospital environment and in private practice?
- 2.) A disabled physician, either physically handicapped, mentally ill, or impaired by alcoholism or drug addiction is of great concern to the public. Do you feel that enough is being done within the medical profession to protect the public?

The attorneys questioned have either served or are presently serving on medical profession oriented committees of the American Trial Lawyers Association. In almost all instances, the physicians who responded have served or are presently serving in some capacity within a medical society.

Reference to this questionnaire shall hereinafter be cited as, Questionnaire response.

² The Hippocratic Oath.

³ Interview with Richard M. Markus, Immediate Past President of the American Trial Lawyers Association, taken at his office at 1400 Leader Building, Cleveland, Ohio in September, 1971.

Most of the authority to be relied upon has been obtained from medical journals, personal interviews, and questionnaire surveys.

The Scope of the Problem

Several studies and works⁴ concerning the mental illnesses of physicians have been published by well-known physicians. The fact that emotional stability in a physician is considered important by the general public is shown by a survey which involved a group of 1,604 respondents who ranked emotional stability as No. 17 out of 87 positive physician qualities.⁵ The qualities were ranked from the most important to the least important. Out of a ranking of 29 physician qualities based on the ratings of the same 1,604 respondents, chronic alcoholism and narcotic addiction were ranked No. 4 and No. 5 respectively.⁶ The qualities were ranked from the most undesirable to the least undesirable.

It has been said that suicide is a barometer of mental illness. "More than one in every fifty male doctors takes his own life, nearly two hundred times the rate for the general population."⁷ Depression and melancholy effect most of the physicians who commit suicide. Noteworthy is the fact that one-half of the physician suicides consumed drugs.⁸ The manifestation of a mental illness, be it in the form of senility, drug addiction or alcoholism, is potentially dangerous to both the doctor himself and those under his care.

During the term of his presidency of the Federation of State Medical Boards of the United States, Dr. Robert C. Derbyshire prepared a report wherein he discussed a five year period, 1961 to 1965, where a large proportion of over a thousand reported disciplinary actions of state boards of medical examiners were based upon various forms of incompetence.⁹ He acknowledged that something was obviously wrong and that "regardless of where the fault lies, the problem of the incompetent physician is a real one and must be met."¹⁰

Senility

A recently adjudicated case¹¹ involved the plight of a man who was confronted with a seventy-one year old physician who upon exam-

⁴ Duffy and Litin, *Psychiatric Morbidity of Physicians*, 189 J.A.M.A. 939 (1964); Small, Small, Assue, and Moore, *Fate of the Mentally Ill Physician*, 125 AMER. J. PSYCHIAT. 1333 (1969); DUFFY and LITIN, *THE EMOTIONAL HEALTH OF PHYSICIANS* (1967); Pearson and Strecker, *Physicians as Psychiatric Patients: Private Practice Experience*, 116 AMER. J. PSYCHIAT. 915 (1960); a'Brook, Hailstone, and McLaughlin, *Psychiatric Illness in the Medical Profession*, 113 BRIT. J. PSYCHIAT. 1013 (1967).

⁵ Price, Lewis, Loughmiller, Nelson, Murry, Taylor, *Attributes of a Good Practicing Physician*, 46 J. MED. EDUC. 229, 232 (1971).

⁶ *Id.* at 234.

⁷ LEWIS and LEWIS, *THE MEDICAL OFFENDERS*, 217 (1970) [hereinafter cited as LEWIS].

⁸ Margolis, *M.D. Suicides, Why?*, 67 MICH. MED. 589 (1968).

⁹ Derbyshire, *What Should the Profession do About the Incompetent Physician?*, 194 J.A.M.A. 1287 (1965) [hereinafter cited as Derbyshire].

¹⁰ *Id.*

¹¹ *Chandler v. Cook*, 438 Pa. 447, 265 A.2d 794 (1970).

ination indicated that an appendectomy was required. Concerned over who would perform the operation, this man repeatedly asked the aged physician who would operate, and was told that it would be the head surgeon of the hospital. This, however, was not the outcome, and due to the signing of a general consent form, the patient's action for battery against the physician was unsuccessful, despite a nurse's testimony that the aged physician had limited use of his left hand. The alternative cause for negligence per se against the hospital for allowing a doctor to be on its staff to perform a complicated operation also failed, in that expert testimony controverted the assertion that the doctor was unfit to perform surgery.

Senility is the malfunctioning of the body and the mind in old age and is often the consequence that one must face for having lived long.¹² A physician who is stricken with this illness begins to acquire sloppy habits such as shortcutting surgical techniques and missing diagnoses. He frequently loses all insight and continues to maintain that he is as good as ever.¹³ As exemplified by the following account, the only way to safeguard the public from the senile physician is to prohibit his attempting patient care.

In Arizona, an eighty-four-year-old doctor was visited by an eighteen-year-old boy who complained of pains in his abdomen. The doctor's diagnosis: "Bad stomachache." It was actually appendicitis. Untreated, the boy died of peritonitis that developed when the appendix burst.¹⁴

The problem of the aged physician is less serious within the atmosphere of a controlled institution. "In hospital staffs you have very little difficulty Where you have the difficulty is in the smaller communities and those physicians without hospital affiliation or staff membership."¹⁵ When asked whether or not he advocated a mandatory retirement age for physicians, Dr. Wasmuth, Chairman of the Board of Governors of the Cleveland Clinic, responded that the "greater good for mankind is to have a cut-off age. I think it's sinful to have some of these obviously senile physicians toying with the lives of people."¹⁶

Though all agree that the senile physician is a problem, there is a difference of opinion as to whether a mandatory retirement age is the answer. In not recommending a mandatory retirement age, one attorney, while asserting that the medical profession has gotten away with murder, suggested that physicians "should be periodically re-examined with respect to their competence, skill, morals and manners

¹² Lewis, *supra* note 7, at 227.

¹³ Derbyshire, *supra* note 9.

¹⁴ Lewis, *supra* note 7, at 228.

¹⁵ Interview with Carl E. Wasmuth, M.D., Chairman of the Board of Governors of Cleveland Clinic, Cleveland, Ohio, in September 1971. In addition, Dr. Wasmuth offered that according to the Cleveland Clinic rules: "We must retire at 65, and you may not under any circumstances see patients after the age 65".

¹⁶ *Id.*

as an airline pilot is."¹⁷ Some of the typical negative responses to the query were as follows:

Age is no criterion. Senility may occur at 40 as well as 80.¹⁸

Establishment of a mandatory retirement age for physicians, either in the hospital environment or in private practice, would deprive the medical profession and the public of much good medical knowledge and medical care talent.¹⁹

No I do not believe a mandatory retirement age is the answer to this very serious problem. With the existing shortage of doctors we need many capable physicians who are advanced in years.²⁰ Those who responded to the question affirmatively, generally qualified their answer "on the assumption that an individual at age 65, is confronted with senility, and therefore, rendering him incapable of practicing his profession competently,"²¹ or that the "determination should be made by some type of examination both physical and professional."²²

The problem of the premature senile individual is perhaps even more serious. As again related by Dr. Wasmuth, the hospital environment affords the best preventive protection to the public. He does, however, consider the problem to be the toughest situation in medicine:

I don't mind firing an incompetent person, the guy who just doesn't cut the mustard, but boy, when it gets to premature senility and he's been here for 20-25 years, that is really rough.²³

The dilemma as presented, appears to be one of human relations — "who is going to tell this revered patriarch of the local profession that he is slipping?"²⁴ If the medical profession can not rise to this task, then perhaps there should be another means whereby the element of friendship does not jeopardize the public safety.²⁵

Drug Addiction And Alcoholism

Cases involving physicians who have become dependent upon drugs are not infrequent.²⁶ A case²⁷ whereby a surgeon who, according to state board records, later admitted to being a methadone addict,²⁸ illustrates the appalling consequences of which this type of

¹⁷ Questionnaire response, J. B. Spence, attorney, Miami, Florida, Sept. 1971.

¹⁸ Questionnaire response, Eugene G. Peek, M.D., Ocala, Florida, Sept. 1971.

¹⁹ Questionnaire response, Thomas F. Burns, attorney, Minneapolis, Minnesota, Sept. 1971.

²⁰ Questionnaire response, Gerald L. Michaud, attorney, Wichita, Kansas, Sept. 1971.

²¹ Questionnaire response, Melvin O. Nuss, attorney, Great Bend, Kansas, Sept. 1971.

²² Questionnaire response, Joseph L. Bilton, attorney, Cleveland, Ohio, Sept. 1971.

²³ Wasmuth, *supra* note 15.

²⁴ Derbyshire, *supra* note 9.

²⁵ See textual material at nn. 57-64.

²⁶ Board of Medical Registration and Examination v. Armington, 242 Ind. 436, 178 N.E.2d 741 (1961); Strode v. Board of Medical Examiners, 195 Cal. App.2d 291, 15 Cal. Rptr. 879 (1961); Paley v. Connecticut Medical Examining Board, 142 Conn. 522, 115 A.2d 448 (1955).

²⁷ Hundley v. St. Francis Hospital, 161 Cal. App.2d 762, 327 P.2d 131 (1958).

²⁸ LEWIS, *supra* note 7, at 238.

impaired physician is capable of creating. As the facts show in this successful negligence suit, an unfortunate San Francisco woman required surgery for the dropping of her uterus. The surgeon, however, disabled by drugs, performed a different operation, the outcome of which culminated in the removal of the body of the uterus, her one remaining Fallopian tube and ovary. A pathological examination of the tissue of these organs proved them to be normal. Also, during the surgery, a fistula occurred between the rectum and vagina which allowed gas and fecal matter to escape from the vagina.²⁹ As a result, this woman's vagina became so contracted as to render sexual intercourse painfully impossible.³⁰ To add outrageous insult to severe injury, the physician upon appeal urged that the \$75,000 verdict against him was excessive.³¹

Equally as devastating in his misdeeds is the alcoholic physician. A 1905 case,³² which attests to the fact that the problems herein discussed are not confined to recent years, involved an alcoholic physician who, while intoxicated, began to perform a delicate operation. The account of his surgical technique is such that he thrust an instrument into the womb, abdomen, and body of his woman patient. The entrance through the womb was forced to a degree of producing a large rent in and through the area. The doctor then proceeded to pull the woman's intestines out.³³ The patient-victim died the next day.

When addiction is viewed as the result of a severe depressive illness, it is somewhat more apparent as to why it appears for the first time in the middle and later thirties, after a physician has been practicing medicine from five to ten years.³⁴ It has been reported that due to the facility and accessibility of obtaining drugs, the incidence of physician addicts is from 30 to 100 times that of the general population.³⁵ "Fifteen percent of known drug addicts are physicians, with another fifteen percent members of paramedical occupations."³⁶

The increased availability of, and easy access to drugs may not totally explain the physician's vulnerability to drug misuse. According to a psychological study, narcotic addicted physicians resemble those who obtain narcotics illegally more than they resemble non-addicted physicians.³⁷

The drug that plagues doctors the most is demerol, a meperidine drug which is used as a sedative.³⁸ It is believed that approximately

²⁹ *Hundley v. St. Francis Hospital*, 161 Cal. App.2d 762, 327 P.2d 131 (1958).

³⁰ *Id.* at 136.

³¹ *Id.*

³² *Hampton v. State*, 50 Fla. 55, 39 So. 421 (1905).

³³ *Id.* at 423

³⁴ *Jones, Alabama Department of Public Health*, 37 J. MED. ASSOC. ALA. 816, 817 (1968).

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Vaillant, Physicians Use of Mood-Altering Drugs*, 282 NEW ENG. J. MED. 365, 369 (1970).

³⁸ *Garb, Drug Addiction in Physicians*, 48 ANESTH. & ANAL. 129, 131 (1969).

250 to 300 physicians each year become addicted to meperidine.³⁹ This number adds substantially to the existing doctor shortage, in that it equals the total number of graduates from three average sized medical schools.⁴⁰ Only one out of four attempts at curing the physician addict is successful.⁴¹

As illustrated by the aforementioned statistics and percentages, the problem of the aged or disabled physician is a real one. It is true that the incompetent physician constitutes a minority of the medical profession. However, it is also evident that the "potential dangers are disproportionate to their numbers."⁴²

Discipline Within The Profession

In a survey⁴³ of the state medical societies, to which 47 of the 51 societies replied, the following revealing information was obtained:

- 1.) 38 societies lacked a provision in their constitution and bylaws which specified that disciplinary action could be taken against a member for incompetence.
- 2.) Asked whether in the past five years their judicial body had disciplined anyone for incompetence, there were 38 negative responses.
- 3.) 26 of the state or county grievance committees had not heard any complaints based on incompetence in the previous five years.

The grievance committee, which is a committee of the local county society, is usually the first place a complaint is directed. The typical pattern followed is initiated by a request that the complainant first discuss the matter with the physician in question. If this fails, the matter is to be submitted in writing by both parties. If the facts conflict, a hearing will probably be held. Otherwise the case is settled by the written material supplemented by telephone conversations.⁴⁴

It must be noted with emphasis, however, that the medical societies' effectiveness is restricted to members only. In many instances, the chief offenders have either not joined the society, resigned from it, or have been expelled, which, as an aside, is the severest penalty that a society can impose.⁴⁵ The expulsion of a member for incompetence does not deprive the physician of his license to continue practicing.⁴⁶

³⁹ *Id.*

⁴⁰ *Id.* at 133.

⁴¹ LEWIS, *supra* note 7, at 235.

⁴² Derbyshire, *supra* note 9, at 1290.

Note: In an effort to obtain some meaningful statistics, this writer conducted a survey of all state medical societies. Only a 51% response was received, thereby rendering the effort futile.

⁴³ *Id.*

⁴⁴ LEWIS, *supra* note 7, at 59.

⁴⁵ *Id.* at 48.

⁴⁶ *Id.*

Medical licensing laws, usually in the form of state medical practice acts, have not helped a great deal in the enforcement of high standards of medical competence.⁴⁷ The reality of the situation is that by the mere possession of a license to practice, a physician, no matter how unqualified, is legally entitled to practice medicine. A retired general practitioner who retains his medical license by paying an annual registration fee, amuses himself that he can still legally perform brain surgery even though he is in his eighties, nearly blind, and totally out of touch with medicine.⁴⁸

From an American Medical Association Medical Disciplinary Committee survey⁴⁹ reflecting the 1968 status of the various state statutes with regard to major offenses subject to disciplinary action, certain statistics can be established. The board of medical examiners in forty-six states have statutory authority to discipline physicians guilty of unprofessional conduct, generally. As pointed out, however, "a license to practice medicine is a 'property right' and is constitutionally guaranteed by due process of law."⁵⁰ Therefore, if the unprofessional conduct clause is not carefully defined, a court action for a license revocation or suspension will not succeed.⁵¹ More specifically, according to the survey, three states have no statute authorizing action against drug addiction. Seven states were similarly deficient with regard to statutes directed at the physician alcoholic. The most alarming statistic perhaps, is that sixteen states are without statutes safeguarding the public from the mentally ill physician. Moreover, it should be noted that the majority of the thirty-five state statutes that deal with the mental-illness problem, do so only after the physician has been adjudged insane by a court of competent jurisdiction.⁵² This after-the-fact attempt to deal with the problem is totally unacceptable.

When asked whether the medical profession was doing enough to protect the public from the aged or disabled physician, the overwhelming response from both attorneys and physicians, was NO. Some of these responses were:

Hell no! It can do an awful lot more. Peer review is coming in now very strongly. I think that this is going to spot many of those who have escaped so far.⁵³

The medical profession has done at best a fair job, and maybe a poor job in regulating itself.⁵⁴

⁴⁷ *Id.* at 181.

⁴⁸ *Id.*

⁴⁹ *Id.* at 352.

⁵⁰ *Id.* at 38.

⁵¹ *Id.* at 39.

⁵² See NEV. REV. STAT. § 630.030, 15 (1967).

⁵³ Wasmuth, *supra* note 15.

⁵⁴ Markus, *supra* note 3.

Only in hospitals where they are judged by their peers and those rare county societies that have the guts to censor one another.⁵⁵

Its members given the "job" of judging . . . its goofing members are ever concerned with the damage to themselves and the medical profession generally wrought by tarnish of their image, and thus they are prone to deny the tarnish or justify it by forensic vindication rather than to protect the public.⁵⁶

Recommendations

As is true of most subject areas where recommendations are in order, the recommendations concerning the incompetent physician problem run the gamut. For the sake of brevity, however, only those suggestions with which this writer feels will have some effect toward truly protecting the public, will be considered.

Certainly, those medical practice acts which do not specify incompetence as a ground for disciplinary action, should do so.⁵⁷ However, as opposed to a general statement such as "incompetency in the practice of his profession",⁵⁸ this writer favors the Florida so-called "Sick Doctor Statute"⁵⁹ which affords both the board of medical examiners and the courts a sufficient amount of specificity.

To be realistic, those states unwilling to heed the first recommendation must at least be called upon to display a more frank attitude toward the addicted physician; such as in California where the addicted doctor who wishes to retain his license must submit to five years of compulsory supervision.⁶⁰ This approach would also satisfy those within the profession who maintain that the emphasis be placed on rehabilitation, rather than discipline and punishment alone.⁶¹

For those who are reluctant to advocate a mandatory retirement from administering patient care at the age of sixty-five, which this writer personally advocates, the recommendation that an annual re-licensing be required after age sixty-five,⁶² is well taken. A legislative enactment by each state requiring all physicians sixty-five and over to submit to a complete physical examination as well as a psychiatric consultation,⁶³ annually, before licensure renewal, would definitely

⁵⁵ Questionnaire response, *supra* note 18.

⁵⁶ Questionnaire response, *supra* note 19.

⁵⁷ Derbyshire, *supra* note 9, at 1290.

⁵⁸ IOWA CODE ANN. § 147.55 note 6 (1949).

⁵⁹ FLA. STAT. ANN. § 458.1201 (n) (Supp. 1971): Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. . . .

⁶⁰ Vaillant, *supra* note 36, at 369, 370.

⁶¹ Duffy, *The Emotional Health of Physicians*, 69 ANNALS OF INT. MED. 1319, 1321 (1968).

⁶² LEWIS, *supra* note 7, at 335.

⁶³ *Id.*

be a substantial step toward protecting the public from the senile aged physician.

Once afforded the legislative power to do something about the aged or disabled physician, the state medical licensing boards must be given the staffs with which to make enforcement possible.

Perhaps it was an oversimplification on the part of whoever wrote the following epitaph for an Athenian doctor in 2 A.D.:

These are the duties of a physician: First . . . to heal his mind and to give help to himself before giving it to anyone else.⁶⁴

It must be said, however, that this last quotation imparts a great deal more wisdom than the first.

⁶⁴ Duffy and Litin, *Psychiatric Morbidity of Physicians*, 189 J.A.M.A. 989 (1964).