The Care and Management of the Sick and Incompetent Physician

ROBERT C. GREEN, JR., M.D.
Past President, Virginia State Board of Medicine

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Chairman, Psychiatric Advisory Committee
Virginia State Board of Medicine

An in-depth study of the sick, incompetent or unethical physician is presented in this timely monograph. The authors concentrate on the identification, management and prevention of incompetence among physicians and discuss methods of rehabilitating inadequate physicians. Alcohol, drug addiction and mental illness are among the specific problems discussed. The legal rights of the incompetent physician are also covered and a review of significant related literature is included.

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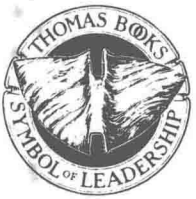

CHARLES C THOMAS • PUBLISHER
Springfield • Illinois • U.S.A.

Published and Distributed Throughout the World by

CHARLES C THOMAS • PUBLISHER
Bannerstone House
301-327 East Lawrence Avenue, Springfield, Illinois, U.S.A.

ISBN 0-398-03727-2

Library of Congress Catalog Card Number: 77-21401

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Printed in the United States of America
R-1

Library of Congress Cataloging in Publication Data

Green, Robert C
The care and management of the sick and incompetent physician.

Bibliography: p.
Includes index.
1. Physicians--Diseases and hygiene--United States. 2. Physicians--Mental health--United States. 3. Physicians--United States--Discipline. 4. Medical laws and legislation--United States. I. Carroll, George J., joint author. II. Buxton, William D., joint author. III. Title. [DNLM: 1. Physicians--United States. 2. Clinical competence. 3. Ethics, Medical. W21 G797c]
RA399.A3G77 610.69'52 77-21401
ISBN 0-398-03727-2

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FOREWORD

AMONG the more altruistic of our colleagues are those physicians who voluntarily serve on statutory boards of medical licensure. They assume this onerous and often thankless obligation on behalf of the practitioners who live and practice within a given jurisdiction.

The practice of medicine presupposes adherence to an ethico-moral code. Every medical student on the occasion of his graduation has sworn to abide by the Oath of Hippocrates since the Golden Age of Pericles in the 4th century B.C. These lofty ideals have come to us, these twenty-odd centuries later, as a secular rite of passage. It has been the spirit of that oath as well as the social conscience of Socrates, a contemporary of Hippocrates, that has required that the profession of medicine, in the words of Robert Louis Stevenson, "... stand above the common herd." It is the duty of the several state medical boards to monitor adherence to these high standards of competence and ethical conduct.

David Hume, the Scottish moral philosopher, pointed out, over two hundred years ago, the logical gap between factual statements and moral judgments; or as it is put these days — between "is" and "ought." This is-ought dilemma is surely the central moral problem that besets the human condition.

A pivotal tenet of organized society holds that the warrant to compel an adult member to perform or to desist from performing an act, rests squarely on the benefit or harm that the action is likely to produce. This fundamental principle shapes the social structure of society. It is the basis of legal as well as moral order that governs conduct and regulates interpersonal relations. It legitimates rights as well as grants privileges. It confers license; by the same token it levies sanctions for transgressions.

In this regard, medicine occupies a unique position among the professions by virtue of its practitioners being granted an unusual privilege that vests in them the grave, societal responsibility of care and tending of the sick and disabled. Incidental to the discharge of these medical ministration, physicians have to be privy to the entire person of each of their patients. The tacit stipulations of the informal contract that governs such total access by physicians are the substance of the Hippocratic tradition. The patient is expected to fulfill his part of this contractual relationship by trusting his physician and therefore complying with the physician's instructions. There are inferential historical data that hold that from time to time these bilateral requirements have been more honored in the breach than in their compliance.

The reasons for the noncompliance are obvious. Physicians are human and consequently fallible, subject to the same vagaries and defections as other men and women. Patients as humans too are even more prone to human frailties being sick and thus susceptible to suggestion and exploitation. *Autre temps, autre moeurs,* human rights and ethico-moral obligations have become politicized these days. As such they are now ripe subjects for litigation. Then too, these days few values enjoy the status or the permanence of the traditional eternal verities. Cultural evolution continually changes our perspectives and consequently our perceptions. No longer is "truth" ascertained by ordeals of water or fire. Technology since the Industrial Revolution has innovated values both by creating previously unobtainable options as well as by changing the relative costs of existing options.

There seems to be a growing consensus that the laissez-faire attitude of earlier times that upheld the autonomous, self-regulating character of professional medical organizations is viewed as potentially exploitive. This belief has been restated by a related 1975 Supreme Court decision which held that regulations creating state boards of control are ". . . at the core of the state's power to protect the public." In recent times in support of this thesis, there has been a proliferation of federal,

state and local regulatory bodies. In response, various medical groups, in the belief that this encroachment must be forestalled, have undertaken moves to assure the public of adequate safeguards: periodic examinations are given to attest the competence of their members. Such increasing emphasis of quality control is reflected in the *pro bono publico* movement; manifestly these watch-dog groups are designed with the expressed conviction that there may be laxity on the part of public institutions in the discharge of their fiduciary responsibility and the citizenry has an inalienable right-to-know.

These elements constitute the psychosocial and chronological contexts which have to be seen and understood as motivating factors in Doctors Green, Carroll, and Buxton's undertaking the survey of "The Care and Management of the Sick and Incompetent Physician."

The monograph is a compilation of information that, as officers of the Virginia State Board of Medicine, the authors have learned to define the many problems of physicians whose incompetence causes them to come within the purview of the board's official concern.

Their stated purpose is twofold. Admitting the deficiencies in the available data they provide a demographic account of the stewardship of the Virginia State Board of Medicine. Incidental to this parochial reflection on the types and prevalence of problems of Virginia physicians, the survey is interlarded with the related experience of others. The second purpose is a laudable therapeutic effort to respond in a positive fashion to the biblical admonition: physician, heal thyself. With the establishment of a Psychiatric Advisory Committee, the Virginia physicians practice what they preach. The Psychiatric Advisory Committee is composed of a neutral, professional competent group formed to assist the board in its deliberations.

The book is an annotated elaboration of a widespreading movement on the part of many state medical societies. It is a welcome extension of the work of the Council on Mental Health of the American Medical Association. Further, it provides preliminary data on the knowledge of etiology

and prevalence of these morbid conditions in a physician population.

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Past Chairman of the Council on Mental Health, American Medical Association

PREFACE

MANAGEMENT of physicians whose competence is compromised by mental or physical illness, alcoholism, drug addiction, lack of diligence in keeping abreast of current practices, or other factors traditionally has been considered the responsibility of the medical profession itself. A trusting society has tended to assume that the profession would conscientiously regulate its own members. Increasingly, however, it has become evident that existing disciplinary mechanisms have been poorly utilized and that hospital staffs and state licensing agencies have evinced little enthusiasm for effective action against violators of even the most basic professional and ethical standards.

The public, government officials, and leading members of the profession are now showing increasing concern in the matter of physician competence and deviant behavior and are demanding prompt and effective action by medical disciplinary bodies.

Management of the sick and/or incompetent physician is not simple. In fact, even identifying these physicians often represents a problem for those responsible for disciplinary action. At the same time, an absence of effective and realistic laws and guidance at all levels further limits a resolution of the problem.

The purpose of this monograph is to present an in-depth study of the sick, incompetent, or unethical physician. Utilizing the experience of the Virginia State Board of Medicine and that of others, we try to identify various types of mental illness among physicians and to provide guidelines for recognizing such illness. In addition, we will outline mechanisms at both the state and local levels for adequately handling these problems. The management and rehabilitation of those physicians so unfortunate as to become professionally incompetent because of drugs, alcohol, mental illness, senility, or physical

disability will also be discussed.

It is our hope that the bringing together of extensive information concerning sick and/or incompetent physicians will provide an impetus to better management of a growing problem within the medical profession and thereby provide the public with safeguards and protection which have not existed in the past.

ACKNOWLEDGMENTS

THE authors are indebted to Walter L. Penn, III, former Assistant Attorney General of the State of Virginia, for his authorship of Chapter 7 on "Legal Rights of the Sick or Incompetent Physician." We also wish to give recognition to the other members of the Virginia State Board of Medicine and to the members of the Psychiatric Advisory Committee for their support and encouragement of this work. However, the opinions expressed in this book are the responsibility of the authors and are not necessarily those of the Board.

The authors wish to thank F. Juanita Mayo, Executive Secretary, Peggy Neville and Nancy Spain, secretaries, for their help in assembling our data, and Sylvia S. Covet for her patient and careful editing of the manuscript.

R.C.G.
G.J.C.
W.D.B.

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The Care and Management of the Sick and Incompetent Physician

—Chapter 1—

THE DEMAND FOR PROFESSIONAL DISCIPLINE

SINCE the end of World War II, a change has gradually evolved in the attitude of the public toward the medical profession. During the preceding century, the public's attitude had been one of reverence. In many instances the relationship between the patient and his physician was more "sacred" than his relationship with his clergyman.

The attitudinal change has been due in part to the explosive growth of medical knowledge during the twentieth century. With the advent of the sulfonamides in the 1940s, an even more rapid growth in medical knowledge occurred. Unfortunately, this "explosion" of scientific knowledge has brought with it many new problems for the practicing physician.

One major problem is the increasing pressure on the individual physician to keep abreast of rapidly changing patterns of health care delivery. These pressures are part of the reason for ever-increasing numbers of problems among physicians. Another factor is the overall increase in the number of doctors. Applications to medical schools each year number in the hundreds of thousands. This increase in applications results in many problems in the selection process which, in turn, leads to an increase in the number of "problem physicians."

Studies conducted as long ago as the 1930s illustrated the potential for problems in medical school classes. One 1937 study showed that "slightly more than 46 percent of senior students in a representative medical school suffer from neurotic handicaps of a major character."[1] Dowling,[2] in 1955, revealed that 10,000 doctors surveyed, 0.5 percent replied affirmatively regarding the presence of a psychiatric disorder. In this same survey, two different medical school classes reported an incidence of 6.5 and 13 percent respectively of each class who had

been or were currently under the care of a psychiatrist.

The physician of the mid-1970s has had to make some major adjustments to changes in the practice of medicine. For example, although government controls on the medical profession are not new — serious efforts in this direction began in the 1940s — they have increased tremendously in recent years. As a result, the physician is faced with ever-increasing surveillance of his practice.

Two trends which have had a profound effect on physician-patient relationships and on the incidence of problem physicians are apparent in the latter half of the twentieth century. First is the increase in specialization and subspecialization, and second is a major move toward group practice.

With group practice, clinics, and health maintenance organizations (HMOs), the patient does not develop the same kind of relationship that he may have had with an individual physician practicing alone. The number of specialties and subspecialties often bewilders patients and decreases their sense of trust in the profession. This results in a general change of attitude toward all physicians — often to one of impatience, frustration, or hostility. No doubt this has contributed to the increase in malpractice suits that has plagued the profession in recent years.

Physicians involved in medical licensure and disciplinary procedures are aware that these conditions often lead to serious problems for individual physicians. There is a continuing search for optimum ways to handle problem physicians. The goal is rehabilitation when possible, but effective and fair disciplinary action when necessary. The Virginia State Board of Medicine strongly believes that a large percentage of physicians who come under its scrutiny can be salvaged and returned to active practice and that in only a small percentage of cases will permanent disciplinary action be necessary.

Historically, the medical profession has accepted the responsibility of disciplining its own; society, intimidated by the complexities of medical practice, has willingly allowed the profession to assume this responsibility. Unfortunately, past self-disciplinary efforts have been inadequate, due largely to the

traditional fraternal bonds that exist in the profession and to an unwillingness to acknowledge that the incompetent or deviant physician is not a rare phenomenon. Consequently, until recent years, significant disciplinary action has been a rare occurrence, except in the most extreme cases. In short, physicians have been loath to act as their brothers' keepers.

As the government has increased its intrusion into all aspects of medical practice — hospitals, laboratories, private examining rooms, and pharmacies — and as the public has become embued with "consumerism," the medical profession suddenly has "more keepers than physicians."[3]

The press is full of reports of fraud, abuse, and the more sensational malpractice suits. Congress is considering legislation to strengthen the capability of the federal government to detect, prosecute, and punish fraudulent activities under the Medicaid and Medicare programs.[4] In addition, major Medicare and Medicaid reimbursement reform legislation is pending, as is a bill to stringently regulate clinical laboratories. Various plans for national health insurance are under consideration which, if enacted, will place the government right in the center of the practice of medicine. The medical profession *must* take cognizance of this activity and *must* begin to discipline its own members more effectively. Physicians themselves are more qualified for this task than any other group, but if they do not do it, others will, with less effectiveness and less compassion.

In 1958, the American Medical Association (AMA) formally acknowledged the problem of self-discipline within the profession by establishing the first Medical Disciplinary Committee. The committee's purpose was to provide effective factual information and to assess accurately the status of medical discipline. The result of that study, published in 1961, was a devastating conclusion that there was "apathy, substantial ignorance, and a lack of a sense of individual responsibility by physicians as a whole toward discipline in organized medicine."[5] Following this statement, thirty specific recommendations were made by the Medical Disciplinary Committee in its report to the AMA Board of Trustees. For example, medical schools were urged to develop courses in ethics and socioeconomic principles; state