# The Optimist

## Confessing Disability

Some years ago at a medical grand rounds, Yale chaplain Bill Coffin told how when he was in the hospital for pneumonia, he shrank away from his physicians who were brimming with such good health. He was so weak and they were so strong, he just couldn't stand all that vigor.

Yet, that is the image doctors prefer, fearing that sickly or weak doctors inspire little confidence. That may be true, but recently, I have become interested in "impaired" physicians, who may do more harm than sick ones and are not as readily recognized.

An impaired or disabled physician is one who can no longer perform his or her professional role with reasonable skill and safety. Disability, which usually refers to a bodily disfigurement, is obvious, whereas impairment, which often goes unseen, has become a code word for alcoholism or substance abuse, in the medical world at least.

"Burnout" is another problem. Once almost unknown among physicians, it began to gain attention in recent decades as emotional exhaustion, with little expectation of anything good (some might call it depression).

Aging and burnout get some consideration from professional groups, but mostly the groups focus on impairment, ignoring the physically disabled among us. It is almost as if to practice medicine, you must be physically healthy, like those docs that Bill Coffin came to resent.

A crucial difference between doctors and others who are sick, however, is that physicians know how to cover up their problems, like mental illness, HIV, or hepatitis. And they prefer not to tell patients about their medical problems because, as they explain, "It doesn't make any difference."

A good example came in the news recently about a Long Island surgeon, a few of whose patients contracted hepatitis C after his operations. Informed consent got little consideration from that surgeon, doubtless a good man, or from the authorities who must have agreed with him: "If there's no danger, why should we worry our patients?"

Yet, physicians, like the clergy we once resembled, must remember that trust has to be earned over and over again. Once it is lost, you have to start all over again to try to reclaim that trust.

In turning a blind eye to such decisions, we doctors quite humanly must be thinking first of our colleagues and friends, and only after that of our patients. We are very good at justifying whatever we do, something that may stem from Morbidity and Mortality confessions or morning rounds, where trainees learn to rationalize errors as "judgment calls."

Yale Medical School, my workplace for 44 years, like most others, has been home to more than a few impaired physicians. One of the most outspoken, Thomas Krizek, Chief of Plastic Surgery there from 1968 to 1978, has not been too proud to confess that he is a recovering alcoholic, who "achieved sobriety" (his words) after leaving Yale, though he draws no connection, happily, between those events.

About the same time, a Yale internist, whom many regarded as "flaky," turned out to have earned that reputation with daily dollops of alcohol. Even so, he was permitted to carry on his work, a leniency that his section chief explained by saying, "The first time something happens, I'll stop him." In such kindness, he could not have been thinking about the first unlucky patient. Nothing did happen, and the physician took his career elsewhere, and we all hope that decisions like that are no longer made.

There are other considerations: AIDS is often considered a private matter for the physician, but the dementia that may accompany it in some people should give pause. Nor can I ignore the cognitive defects of age and patienthood. When asked about my own cognitive loss after a bypass operation some years ago, I like to claim that I lost only my impatience!

By hiding ill health from their colleagues as well as their patients, sick doctors lose out, as I learned from a collection that Harvey Mandell of Norwich, Connecticut, and I put together (*When Doctors Get Sick*, Plenum, 1988). Or you may have attended get-togethers like "Physician Heal Thyself," where accounts of burnout and substance abuse have a prominent place. (But no one there confesses to senility, from which there is no return.)

*As a profession, we need to be honest with our patients about our own frailities, but we will learn about our growing limits only from someone else.*

Denial, detachment, and loneliness stand out in the stories of sick doctors. One young Yale physician hoped that a 50-lb weight loss and bloody diarrhea came only from overwork, until his delusion was destroyed by sigmoidoscopy.

And that is typical. Thanks to the hypochondria of medical school, students learn that what looks like

a wart will not prove a melanoma, or that a headache does not mean a brain tumor. Experience teaches them that they are invulnerable, which may be why they treat their symptoms with steroids, antibiotics, and psychotropics, until studies reveal what really is going on.

The learned detachment so commended by William Osler also has a part in how physicians react to getting sick. Even today, physicians are urged not to get too involved with their patients, lest a little bit of them die with each death. Yet, habit makes that protecting distance our manner, so much that many doctors no longer recognize any emotions in themselves. Just ask their wives or husbands.

For many reasons, many doctors are embarrassed to talk with their sick or impaired colleagues, even after recovery. "I didn't tell and they didn't ask" is the comment of many doctors recovered from alcoholism or addiction, or pneumonia for that matter. Whether physicians pretend not to notice out of courtesy or embarrassment or as a way to avoid involvement is not always clear.

Doctors in wheelchairs tell how invisible they feel when no one asks why or what happened. One young physician imagined that friends were respecting her privacy, but their silence ultimately lost her sympathy. She felt invalidated and dismissed.

On the other hand, the "No Visitors" signs outside a sick doctor's room may be there as much to protect the doctors passing by from intimations of their own mortality as it is to keep the patient from being disturbed.

Listening to a retired doctor answer the phone as "Doctor so-and-so" lets you understand how vital our work is to our identity. We admire the physician dying of cancer who continues to make rounds no matter how bad she feels, and we praise the surgeon who plugs away even if his arthritis requires help in putting on his surgical gown. But when sick or aging doctors continue working, we also should wonder a little more about their impaired judgment.

Most doctors have special empathy for colleagues who fall sick and try to treat doctor-patients just the same as others, only faster. Once doctor-patients would get shortcuts to diagnosis, but that was before the imaging revolution. One physician I knew underwent a cardiac bypass without even a preoperative angiogram.

Now that physicians have concluded that every pain will have a site if they look hard enough, doctor-patients get all the extra tests there are, to be sure. God save the physician-patient whose abdominal pains are psychosocial in origin, for the gastroenterologist will leave no orifice unexplored (and in their enthusiasm may create one or two new ones), forgetting that old aphorism, "the sorrow that has no vent in tears makes other organs weep."

Respect for autonomy and for telling the truth have replaced the hardliners of an earlier generation, who would dispense advice and direction, as well as optimism.

But autonomy is not often endorsed by sick physicians, who want to be taken care of, even as they try to remain in control. Here, we are, possessed of very special knowledge, and yet almost to a man or woman, sick doctors tell how they want to exchange their lonely vigil for comforting care.

Sick doctors usually trust their own physicians to make the right choice for them, and I am convinced that physicians who are loyal to their patients can bring more peace of mind, without lies, than doctors who spread their wares like cafeteria workers.

The stress of sleep deprivation and overwork during training is receiving attention these days, but the stresses on practicing physicians deserve equal emphasis. Indeed, after the suicides of four academic surgeons in 1 year, Dr. Krizek concluded that surgery itself may be an impairing profession, thanks to the lack of support, competitiveness, and aggressive behavior of many academic surgeons (and, many academic internist would add, physicians).

In response to a question about whether academic medicine was ever the paradise we once deemed it in the 1950s, a former chairman of medicine at Yale responded, "If you take a bunch of rats and give them a lot of food, they'll get along fine. But if you halve the amount of food and double the number of rats, they will eat each other up."

Another physician commented that whenever something went amiss at her academic institution, her colleagues went on the attack. But when something happened at the community hospital to which she had fled, her colleagues gathered round in support. In academic medicine, in this 21st century, there is much competition but little conversation and less conviviality.

We may not be able to forestall disability and impairment in our colleagues, but our profession should try to detect it earlier in all of us. The earlier that impairment is recognized, the easier it may be to help the doctor change course to continue in some kind of useful activity. The profession should also try to find a workplace for impaired physicians (and the elderly).

I have great respect for the diligence of sick and aging physicians. For that reason, routine assessments of impairment in mind and body are essential for all of us. Regular checkups for competence, not only for disability, could come to be accepted by doctors inured in training to such routine evaluations. As a profession, we need to be honest with our patients about our own frailities, but we will learn about our growing limits only from someone else.

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