

The Vermont Humanities Council
and the
Vermont Board of Medical Practice

Present

A six-part discussion program

*Doctors, Patients, and the Public Trust:
Conversations in Literature and Medicine*

Using fiction, essays, and other forms of literature, the following questions will be explored:

- Doctors: are they devils or deities? Or are they just human?
- What problems do physicians face in today's world?
- How do physicians cope with those problems?
- What effects do such problems have on our medical and social systems?
- How can the problems best be dealt with?

Second program: Wednesday, October 15, 2008

5:30 to 7:00 PM

Fletcher Free Library

Community Room

235 College St (at S. Winooski Ave.), Burlington

PUBLIC INVITED

(Refreshments Served)

FIRST PROGRAM READINGS ATTACHED OR AVAILABLE FROM
THE VERMONT BOARD OF MEDICAL PRACTICE

Further info: 802-657-4220



NUMBERS AND VOICES

HIS PAGER TOOK BOTH NUMBERS AND VOICES. IT WAS A little black card on his hip, with a green diode and a screen. It weighed almost nothing, and could vibrate or ring. He wore it all the time. The world entered him through it.

"Whatcha got, slick?" he would say into the phone, and we'd tell him, and he would get into his truck and come in. His voice was the army and west Texas, a cracker from a rough town, sly, amused, full of dark things—surgery, for example, and the blues.

Dr. Blake was the head of the trauma service. He was a short, thin man, with slick hair and a razor part. He looked remarkably like Lee Harvey Oswald. I couldn't have guessed his age. When he wasn't working he would run for miles, ten, fifteen, twenty, in the hills outside the city. He was tireless.

He lived alone, in a small apartment. No one seemed to know much about his past life, and he didn't share, but one night I saw him in a bar. The band was playing behind me as I sipped my beer. When the lead guitarist started the solo, I turned around to watch, and it was him. I was sure of it. Over the glitter of bottles and the crowd, he stood on the edge of the stage with his eyes closed, his head thrown back. His fingers shivered on the neck, and he was good, he was passionate. I knew right away as I watched him that it was something true, that he loved it.

He was pleasant to the house staff, nodding, waiting for us to finish speaking on rounds, never interrupting. "Well," he'd say. "Why don't we bump up his TPN and come down a bit on the vent." Then we'd move on, and he would stand there, restless, arms folded, waiting for the next.

The nurses called him Ray, and he went through them like a thresher. There were many stories. The medical student who passed his office late one night, glanced in the window, saw them on top of his desk. I could imagine it, though I didn't want to: his scrubs down to his ankles, his bulging eyes and face, her legs around his waist.

"Whatcha got, slick?"

"Thirty-year-old rollover MVA, hemothorax on the right, intubated, grossly positive DPL. Chest tube is going in now, he's got two units hanging, pressure's around ninety systolic."

"I'll see ya." Click, a dial tone, it starts again.

Then the one who fainted when he broke it off, right there in the unit. "She went crazy," Rosa, the surgery resident, said. "She had an acute psychotic break right here and we had

to restrain her. It was two months before she came back to work."

"He lives alone, doesn't he?"

"Yeah. But he told me once that he has two roommates: Stevie Ray Vaughan and Jack Daniels." She shook her head. "Notice how he looks hyperthyroid?"

"You're right, he does."

"That's because he is. He takes synthroid. I've heard him say how great it makes him feel. I'm telling you, he's nuts." And it explained a little: his tirelessness, his faintly bulging eyes, the slight tremor in his eyelids. The effects of excess thyroid hormone.

It didn't seem to matter what they looked like, or how old they were. The beautiful young physical therapist. The heavy, friendly clerk in her forties. I wondered what could have possessed him, and why those women had been drawn to him, with his sly west Texas accent and his agelessness, why they had gone so willingly into his office. They must have known how he used them up, that after a few months it would be over. But it didn't stop them. It was power, of course, and he was full of it.

He was full of many things. Synthroid, miles of empty roadsides, winter. And now her voice.

She began paging him. She bided her time until he was on rounds, with all of us there in the early morning. Vengeance.

"I'm in your office, Ray, I'm waiting for you."

Then his hand like a snake to the button on his hip.

"Let's fuck, Ray. I know you want to."

He stood there in front of everyone, shaking his head.

"I have something for you . . ."

She only did it a few times, knowing it would be enough, smiling and distant as she passed him in the hall. And he carried on, ignoring her because he had to. I never read anything on his face: no remorse, no anger, not even embarrassment. Just a slight narrowing of the eyes, a quick shake of the head. And a few days later he had another pager, one that took only numbers. By then it didn't matter.

On it went, during those last months I saw him. Rounds with Dr. Whistler. An unhealing wound on the belly, a vague odor, a thin green film on exposed muscle, the black threads of the sutures visible as the nurse pulled the packing free. "Looks like you mighta tied those knots a bit too tight, Dr. Whistler. She's about to split right open."

"Who knows what the incidence of wound dehiscence in diabetic patients is?" Dr. Whistler replied. "For a quarter?"

No one said anything, and Dr. Blake rocked back and forth on his heels. "Well, I didn't go to Harvard like you did but I believe it's about 15 percent"—he paused—"assuming good technique."

"It's 17 percent," Dr. Whistler replied, as their eyes met.

They were united against Dr. MacGregor. Dr. MacGregor was the chairman of surgery, grim, long-winded, given to the formal expression of rage. He was kind, but he didn't want you to know it. He would stand silently and watch them, looking much older than he was. And then, sooner or later, his face would grow pink, he would seem to swell, and we knew what was coming. Antibiotics again.

"I fail to understand," he would begin, enunciating precisely in his Alabama accent, "why anyone would see the utility of

vancomycin in this patient. This is a goddamn travesty. Why do you think we have vancomycin-resistant enterococcus in this ICU? Do you people have any idea what you are doing to this man? You might as well take him out to the parking lot and shoot him in the head."

And MacGregor would continue, full of passion, about the inappropriate use of antibiotics in the surgical patient. We'd all heard it a dozen times, but only Dr. Blake would rock back on his heels, sigh, look contemptuously at the ceiling. Once he simply walked away, in the middle of rounds, without explanation.

He was helpless with himself.

"I'm not sure," Dr. MacGregor had said that day, as he looked impassively at Blake's retreating figure, "how much longer Dr. Blake will be with us."

He was not the kind to go quietly, and when it finally happened it was front-page news in the city paper: TRAUMA SURGEON SPEAKS OUT. And there he was, Blake in a white coat, looking forceful and clean, with quotes: "I could not in good conscience continue in the face of the substandard trauma care delivered to the people of this state."

And so he was gone. To Georgia, we heard. To another life, another hospital.

I'm waiting in your office, Ray . . .

"Everyone is entitled to their opinion," Dr. MacGregor responded in print. "However, we deliver and will continue to deliver the highest standard of care to the citizens of this state."

I know you want to . . .

"The thing about Ray," Rosa said afterward, "is that he was crazy."

No news, for a while. But then, months later, it did reach us. A new child, a new wife. A brief flurry of conversation on the unit, then telephone calls. "Did you hear?"

That was all he could muster, a little ripple, like a pebble cast into a still pool, the rings opening for the banks. That was it, and I could hear that radio conversation between the paramedics and the ER in my head. A few weeks ago now, two thousand miles to the east.

"Whatcha got?"

"Male, mid-forties, in the garage with the car on, cold, pulseless, fixed and dilated, no rhythm on the monitor. Looks like he's been here for hours. I'd like permission to call the code."

"All right, sounds reasonable."

Just like that, and I imagined him there, in his Georgia garage, drunk in his pickup as the engine filled him with exhaust and his face went slack against the door, the tape player flipping back and forth. And through it all his little daughter, safe in her crib a few rooms away.

Come downstairs, I have a surprise for you, I'm waiting . . .

Then his hand on the button, cutting it off, until his wife came home and found him.

Old Doc Rivers

WILLIAM CARLOS WILLIAMS

Adapted for Readers' Theater by Gregory A. Watkins

CAST

Reader 1 (male): Grimley, Jerry, Milliken, Trowbridge, Brother

Reader 2 (male): Rivers (standing), Druggist, John

Reader 3 (male or female): Doctor

Reader 4 (female): Nurse, Miss Jeannette

Reader 5 (female): Woman 2, 4, 6, 9, Lady, Mary

Reader 6 (female): Woman 1, 3, 5, 7, 8, Librarian, Mrs. Shippen, Girl

Reader 7 (male): Boy, Man, Dr. Jamison, Mr. Shippen, Super

The parts each reader takes can vary as required by the number of male and female performers available. An alternate distribution of parts could be:

Reader 1 (male): Grimley, Boy, Jerry, Man, Milliken, John, Super, Brother

Reader 2 (male): Doc Rivers, Dr. Jamison, Shippen, Druggist, Trowbridge

Reader 3 (male or female): Doctor

Reader 4 (female): Nurse, Mary, Miss Jeannette

Reader 5 (female): Woman 2, 4, 6, 8, Librarian, Lady, Girl

Reader 6 (female): Woman 1, 3, 5, 7, 9, Mrs. Shippen



NOTES

This story is a bit more of a challenge to perform than the others because of the number of characters and the lack of a recognizable progression of events leading to a climax. "Old Doc Rivers" is a series of recollections by a physician colleague about the life of the almost legendary (in that town) Dr. Rivers. The audience hears various townspeople and physicians, including the physician-narrator, describe some of their encounters with and opinions of Rivers.

Cast members other than the one who plays Doctor (the physician-narrator) will read a number of parts, perhaps employing various accents, styles of speaking, and standing and sitting positions to distinguish one character from another. The script is keyed for seven readers. If this configuration of readers is used, then the discussion leader should announce at the start of the performance that Reader 2 is Dr. Rivers when standing and other characters when seated.

Physician impairment is a difficult but important issue. Who is responsible for reporting physicians who potentially or actually put their patients in danger because they are impaired or incompetent? What risks do colleagues and patients take in reporting such physicians? In preparation for leading a discussion of this story, the discussion leader might wish to investigate the way physician impairment is handled in his/her state by contacting the local or state medical society or by looking on those organizations' Web sites.

Readers for this script are designated R1 through R7.

R3, DOCTOR: Grimley was a young doctor [*Grimley (R1) stands.*], a first-rate physician who began practicing in town a month or two prior to my arrival. He had it in for Rivers. My wife would sometimes say to me, "If you know Rivers is killing people, why don't you doctors get together and have his license taken away?" I would answer that I didn't know.

R1, GRIMLEY: I had a young Hungarian girl under my care with a strangulated hernia who was scared as hell of the knife. I tried my best to reduce it, but without success. I knew she was in danger, and I urged her to go to the hospital and have the operation. She refused.

R3, DOCTOR: Grimley told her that, unless she had the operation, he would no longer handle her case, that she would die.

R1, GRIMLEY: The next day she called me again. As soon as I entered the

room, I could see it was all over. She had called in Rivers. He had told her he could cure her. God knows what condition he was in at the time. He'd pressed on the sac until it burst. She died the next day.

R3, DOCTOR: I met Grimley at the corner by the drug store. He wanted to have Rivers arrested.

R1, GRIMLEY: I wanted to have him prosecuted for malpractice, to put him out of the way once and for all.

R3, DOCTOR: He never did.

[Grimley sits.]

R7, BOY: *This* happened many years ago. I was sick, and my old man was worried. Finally, the druggist tipped us off. "Get Rivers," he said. "He's a dope addict, but when he's right you can't beat him. I'll call up Rivers and get him down here at the store. If he's right, I'll send him up." Later in the day, the Doc came into my room and took one look at me. "This boy's got typhoid fever," he said. Just like that — that's how he did it. And sure enough, he was right. He had the jump on the thing. The result was I had a light case and we had Rivers for years after that as our family physician.

R3, DOCTOR: This is how he practiced:

[Rivers (R2) and Jerry (R1) stand and face each other.]

R2, RIVERS: Come in, Jerry. How's the old soak?

R1, JERRY: For Christ's sake, Doc, lay off me. I'm sick.

R2, RIVERS: Who's sick? Have a drop of the old Crater. *[Note: He's offering Jerry a drink.]* Did a dog bite you?

R1, JERRY: Look at this damned neck of mine. *[Pause]* Jesus! What's the matter with you, Doc? Easy!

R2, RIVERS: Shut up, you white-livered Hibernian!

R1, JERRY: Aw, Doc, for Christ's sake. Give me a break.

R2, RIVERS: What's the matter? Did I do anything to you?

R1, JERRY: Listen, Doc, ain't you gonna put anything on it?

R2, RIVERS: On what? Keep those pants buttoned. Sit down. Grab onto these arms. And don't let go until I'm through or I'm likely to slit you in half.

R1, JERRY: Ow! Jesus, Mary, and Joseph! What'd you do to me, Doc?

R2, RIVERS: I think your throat's cut, Jerry. Here, drink this. I didn't think you were so yellow. Go lie down over there for a minute.

R1, JERRY: Lie down? What for? What do you think I am, a woman? You got any more of that liquor? *[In gratitude]* You're some man, Doc. Some man. What do I owe you?

R2, RIVERS: That's all right, Jerry. Bring it around next week.

[Rivers freezes; Jerry sits.]

R3, DOCTOR: Or like this:

[Woman 1 (R6) stands, faces Rivers.]

R6, WOMAN 1: *[Weakly]* Doctor?

R2, RIVERS: Yes, I know. Where is it? In your belly?

R6, WOMAN 1: Yes, Doctor.

R3, DOCTOR: A quick examination, slipping on a rubber glove after washing his hands at the basin in the corner of the room. The whole thing took less than six minutes.

R2, RIVERS: *[Rivers faces Woman 1.]* Get this prescription filled. Take thirty drops of it tonight, in a little water. And here, here's a note to Sister Rose. Get up to the hospital in the morning. And don't eat any breakfast.

R6, WOMAN 1: What's the matter with me?

R2, RIVERS: *[Dismissive]* Now, now. Tomorrow morning. Don't worry, Mother. It'll be all right. Good-bye.

[Rivers freezes; Woman 1 sits.]

R7, MAN: He loved to ride. Loved to sit back in the carriage, have a smoke, and ride. He was proud of his teams of horses, too. Of course, it was the teams got him where he needed to be.

R3, DOCTOR: He must have given value for value, good services for money received. He had a record of thirty years behind him, of getting there (provided you could find him), anywhere, anytime, for anybody — no distinctions. And of doing something, mostly the right thing, once he was there.

[Woman 2 (R5) stands.]

R5, WOMAN 2: My son had had diarrhea for about a week, and my husband and I were frantic.

We had already called in several doctors, and they had each pre-

scribed medicines, none of which had any effect. We finally called in Doctor Rivers. He pulled down my son's pants, and said . . .

R2, RIVERS: Hell, what he needs is a circumcision.

R5, WOMAN 2: And he did it, there and then. He wouldn't let our son eat for a day or two (because of the operation, he said), and the diarrhea went away.

R7, MAN: He was very smart. Quite a psychologist.

[Rivers and Woman 2 sit.]

R3, DOCTOR: It occurred to me to drop in at St. Michael's Hospital, where he took many of his surgical cases. To satisfy my curiosity as to the man's scope.

R6, LIBRARIAN: May I help you?

R3, DOCTOR: I'd like to look at some of your older record books.

R6, LIBRARIAN: That would be the Registry of Cases. They cover back to 1898.

R3, DOCTOR: I chose the years 1905 and 1908 and I began to thumb through the entries, looking for Rivers's name. It was all there in that hospital register. Surgically there were the usual scrapings. Appendicitis was common. Endometritis, salpingitis, contracture of the hand, ruptured spleen, hernia. There were malignancies of the bowel, breast amputations, and here an ununited fracture of the humerus involving the insertion of a plate and marked "cured." The normal maternity cases, Cesarean sections, ruptured ectopic pregnancies, fistulas, hysterectomies, gall bladder resections, even a deviated septum. And at the far edge of the page the brief legend, "cured," followed his name as often as that of any other doctor. The same was true of the medical cases he treated.

[Dr. Jamison (R7) stands.]

R7, JAMISON: Sometimes, though, we doctors well knew, he'd have to quit an operation and have one of us finish it for him. Or he'd retire for a moment (we all knew why) and return, change his gloves, and continue. The transformation in him would be striking. From a haggard old man he would be changed "like that" into a resourceful and alert operator.

R3, DOCTOR: I asked some of the people who had worked with him their opinion of him as a doctor, starting with his nurse.

[Nurse (R4) stands.]

R4, NURSE: Dr. Jamison, an intern at the hospital, woke up one morning and found Doctor Rivers asleep on his bed, outside the covers, snoring away. And once, on a trip to Nashawan Hospital for Mental Diseases, an orderly found him leaning against a wall, in a semiconscious condition.

R3, DOCTOR: Something had gone wrong with his usual arrangements, and he was coked to the eyes.

R7, DR. JAMISON: He had an uncanny sense for diagnosis. He never floundered. He made up his mind and went to it. And he wasn't radical or eccentric in his surgical technique, but conservative and thoroughgoing throughout. He was cool and painstaking — so long as he had the drug in him. And he wasn't an exhibitionist in any sense of the word.

[Jamison sits. Rivers (R2), Woman 3 (R6), and Milliken (R1) stand.]

R6, WOMAN 3: My husband had a case of appendicitis, and we called in Doc Rivers. The only room big enough to handle him in was the parlor, so we rigged up a table there. Doc told my husband to climb up on the table, and he did.

R4, NURSE: Her husband, Mr. Milliken, was quite a drinker. Doctor Rivers told his assistant to give him some ether. It didn't take long — not more than twenty minutes — to see that ether wouldn't touch this fellow any way you gave it to him. He was big as a horse, and seemed as strong, too. Doctor Rivers started anyway.

R6, WOMAN 3: My husband asked Doc to hold on a minute, so Doc told his assistant to go ahead and use the chloroform.

R4, NURSE: He administered it himself, enough to put down an army. To no effect. Every time the Doctor touched Milliken with a scalpel, the man's knees flew up to his chest. Finally, we had to hold him down, all of us, while the Doctor performed the operation. It was all we could do to keep him still. It's a wonder the operation went as well as it did.

R6, WOMAN 3: I was with my husband, a month or so later, when we ran into the Doc in front of the firehouse.

R2, RIVERS: You look well enough, Milliken. Did you feel anything during the operation?

R1, MILLIKEN: Did I feel anything? My God! Every bit of it. Every bit of it.

R6, WOMAN 3: But he was well.

[Rivers, Woman 3, and Milliken sit.]

R3, DOCTOR: And there was Frankel, a friend of mine. I was called in to assist, and when I arrived, they had already rigged up the kitchen as an operating room. There were sterile dressings, instruments boiling on the gas stove, and everything was in good order.

R4, NURSE: The Doctor called Mr. Frankel into the kitchen.

R3, DOCTOR: I was stunned. Frankel had been in bed in the front of the house. He came into the kitchen in bare feet and an old-fashioned nightgown, holding his painful belly with both hands.

R4, NURSE: Doctor Rivers told Mr. Frankel to climb up on the table.

R3, DOCTOR: Frankel was simply too sick for that. Still, he got up on the table, where we put another sheet over him and started the anesthetic. Rivers asked Frankel's wife if she had any whiskey, and she brought him a bottle. He poured himself nearly a tumblerful, filled the glass with water from the sink, and began to drink.

R4, NURSE: He offered us a drink, but we declined.

R3, DOCTOR: He finished his drink, and after that things went pretty much according to surgical practice. He made the incision. He took one look and shrugged his shoulders. It was a ruptured appendix. He shoved in a drain and let it go at that, the right thing to do. But Frankel died the next day. People talked:

[Man (R7) stands.]

R7, MAN: Another decent citizen done to death by that dope fiend.

R3, DOCTOR: It was hard not to agree. And yet . . .

[Nurse and Man sit.]

R5, LADY: *[Elegantly]* He played the violin excellently. He would often join me for an evening, playing duets at the church.

R3, DOCTOR: And the Shippen girl.

R7, MR. SHIPPEN: My daughter, Virginia, was five, and had just had scarlet fever. There was some kind of complication with her kidneys. Doc came in day and night. He did everything that could be done to save her. Still, she didn't come around. She stayed unconscious, and her kidneys weren't working. Doc finally gave up. He told us she'd be dead by morning. But my wife wasn't ready to give up.

R6, MRS. SHIPPEN: I asked him if I could try putting flaxseed poultices over Virginia's kidneys. He said it would be all right.

R3, DOCTOR: It worked. The next day, the child's kidneys started to function — slowly; muddy stuff at first, but she was conscious and her fever had dropped. Rivers was delighted. He praised Mrs. Shippen, and told her she had taught him something. Virginia lived another thirty years.

[Rivers (R2) and Mary (R5) stand.]

R2, RIVERS: *[Rough throughout this exchange]* Well, Mary, what is it?

R5, MARY: I have a pain in my side, doctor.

R2, RIVERS: How long you had it, Mary?

R5, MARY: Today, doctor. It's the first time.

R2, RIVERS: Just today. That's all?

R5, MARY: Yes, doctor.

R2, RIVERS: Get up on the table and pull up your dress. Throw that sheet over you. Come on, come on. Up with you. Come on now, Mary. Pull up your knees.

R5, MARY: *[Hurts]* Oh!

[Rivers and Mary sit.]

R3, DOCTOR: He could be cruel and crude. And, like all who are so, he could be sentimentally tender also, and painstaking without measure.

R6, GIRL: My foster parents would never have anyone else. For months I went to him, two or three times a week. He was always gentle and patient. I had a sinus condition, very difficult to manage. Little by little, he brought me along, until I was well. He charged us next to nothing for his services. I admire him. I always will.

R3, DOCTOR: That, not money, was his reward.

R2, DRUGGIST: He came in my drugstore one day. There was a little fellow there, had a big abscess on his neck. Family hadn't been able to find

Doc in his office, so the boy had followed him to the store. "Come here," Doc says, "let's see." And with that he takes a scalpel out of his vest pocket and makes a swipe at the thing. Boy was too quick for him, though. Jerked back and the knife caught him low. He turned and ran, bleeding and yelling, out the door. Doc chuckled a bit, and went on about his business.

R4, MISS JEANNETTE: He used to visit my father, Mr. Jeannette, a lot. Not as a doctor, but as a friend.

R3, DOCTOR: The Jeannette mansion, two miles north of town along the ridge, was one of Rivers's favorite places. Mr. Jeannette, like most of the other French who had settled in that area, kept principally to his manor.

R1, TROWBRIDGE: Jeannette was Alsatian. Went back to France later, and someone else lives there now.

R3, DOCTOR: And that's how Doc got on the dope?

R1, TROWBRIDGE: Oh, Jeannette was a high liver. He built himself a greenhouse in the back of his mansion and put all kinds of plants in it. He must have spent hundreds and hundreds of dollars on it.

R4, MISS JEANNETTE: Father and Doctor Rivers would sit in the greenhouse and play cards with friends. They would talk and laugh, enjoy a cigar. Especially in winter. They would sit in the heat, sipping wine, with the snow piled all around.

R1, TROWBRIDGE: If Jeannette was a high liver, Rivers was no laggard before any lead Jeannette might propose. Still, I don't believe Jeannette doped. No, I think Rivers went there looking for safety, for haven from the crude environment of those days. The mansion was foreign, incongruous, and delightfully aloof.

R4, MISS JEANNETTE: Doctor Rivers always seemed so gay during his visits. So relaxed. Out of the reach of patients.

[Pause]

R3, DOCTOR: There were times, too, when he didn't hit the dope for months at a stretch. Then he'd get to taking it again. Finally, he'd feel himself slipping, and he'd head off, overnight sometimes, leaving his practice, for the woods.

R2, JOHN: He loved to hunt. Hunt the deer. He'd bring them home and give cuts of venison to all his friends. But that ended pretty badly. One day, after his eyes had got bad from all the abuse and illness, he accidentally shot his best friend, a guide he always followed, shot him through the temples as dead as a doornail.

R3, DOCTOR: He made amends to the family, though, as well as he could. Gave them everything that was asked of him, to the last penny.

R5, WOMAN 4: He made a hobby one time of catching rattlesnakes, which abound in the mountains. He enjoyed the sport and the danger, apparently, while there was a scientific twist to it in that the venom they collected was used for laboratory work in the city.

R7, BOY: [Awed] He was a great hunter. I remember one time he was telling my father how he was bitten by a rattler, on the arm. Being a doctor, he knew what he was up against. He asked his guide to take his knife and cut the place out, but the guide didn't have the nerve. So Doc took his own hunting knife in the other hand and sliced it wide open and sucked the blood out of it. I suppose he took a shot of dope first, to steady himself. He rolled up his sleeve and showed us the scar, right down the middle of his arm.

R4, NURSE: I came into the office one evening to help out as his nurse while he was in with Charlie Hansel. There were several people in the waiting room, and we all heard Doctor Rivers tell Charlie to put on the gloves — boxing gloves. He always had a couple of pairs lying around the place somewhere. Charlie told me later that he'd actually had to hit Doctor Rivers, lightly, to get him to stop. Charlie was a fine young man, you see, in much better condition than Doctor Rivers.

R3, DOCTOR: There were times when even his brother couldn't do anything with him. He'd go completely mad. He put in several sessions at the State Insane Asylum, six months and more, on at least two occasions.
[Rivers (R2) and Super (R7) stand.]

R2, RIVERS: Well? What do you think superintendent? Can I go out to work again?

R7, SUPER: You're as good a doctor as I am, Rivers. If you think you can make it, go ahead.

[Rivers and Super sit.]

- R3, DOCTOR: And back he'd turn again to the old grind.
- R4, NURSE: One winter he got so low with typhoid fever it looked as if, this time, things might be over. Everyone insisted he have a nurse, but he refused. And nobody, no other doctor, wanted him as a patient, either. He was completely gone with dope and the disease. Finally, he gave in and asked for a girl he had known at Blockley Hospital, a nurse he had once seen there and admired.
- R3, DOCTOR: She took on the case. As soon as he was able to be up and around again, he married her. They went to Europe for a honeymoon. No doubt, she loved him.
- R6, WOMAN 5: Yes, I can remember his wife. When she first came out she was a pretty little thing, just like anybody else. But I can still see her the day she came into my store, knocking against the counters, first on one side, then the other. She was covered with diamonds — on her hands, on her neck — but she didn't seem to know where she was going. Her face seemed as small as the palm of my hand.
- R3, DOCTOR: A great many of his more respectable friends left him. They'd still call him — if he was right — but he was very much distrusted.
- R4, NURSE: He'd sit at the table writing a prescription and you could see his head fall down lower and lower. He'd fall asleep right there, right in front of your eyes. We would shake him every once in a while, and finally he would just get up and go out.
- R1, BROTHER: When he started to hit the dope, I, as his brother, tried to get him in a hospital in the city. I knew if I could get him in the proper atmosphere I could save him. He was just too foxy, though. He liked it out there, his friends, the life, whatever it was. I couldn't move him.
- R4, NURSE: One of the main things that got the other doctors down on him was his habit of going off, just disappearing sometimes. He liked to go fishing, and he was a crack shot. He'd have important cases, but that didn't make any difference. All patients could do was find another doctor.
- R7, BOY: *[Still awed]* One summer, my old man had gone off on a trip somewhere and sent me to the only boarding house in town. He'd left me

- alone in the house the year before, and was none too pleased with some of the things I did. Doc — I don't know how he did it — got me out of there, had me come stay with him. I think he insisted I was sick, that I needed treatment, and that he needed me at his house so he could keep an eye on me.
- R3, DOCTOR: Sunday mornings were the times. It was a regular show. Most of his patients were poor, and they could only come on Sundays. They'd be sitting all over the place, out in the hall, up the stairs, on the porch, anywhere they could park themselves.
- R7, BOY: If it was somebody that didn't know me, he'd say I was a young doctor. I was just seventeen then. He'd give me a white coat and tell me to come on. Jesus! I thought he was great. And I'll tell you, in all those four months I never saw any of the butcheries they'd talk about. Everything he did was right. I suppose I'd think different now, but then I thought he was a wonder.
- R4, NURSE: He never kept any track of money. There wasn't a book around the place. Any money he got he just shoved in his pocket. Of course, he never paid for anything; either.
- R7, BOY: Clever? Boy, the Doc was there! He'd go over to his desk and you'd see him fumbling around with some instruments and right in front of you he'd give himself a shot. Unless you were wise, you wouldn't even see him do it. He was foxy, too. He'd stall for a few minutes to give it time to take effect. That was when he had anything important to do. He'd wait a few minutes, and then he'd come out steely-eyed and as steady as the best of them.
- R5, WOMAN 6: His wife didn't handle it nearly as well. It made her crazy. She didn't know how to control it.
- R7, BOY: I can remember one night while I was living there, he waked me up at two o'clock in the morning. It was summer, one of those hot, muggy nights. I'd been operated on too, the day before. He'd taken out my tonsils or something, and I was feeling rotten. I had to go out with him just the same. We got the old buggy and started out. We went down in the meadows — at 2 A.M., mind you — down to Mooney's saloon. He went in and left me there. Anyway, I sat there slapping mos-

quitoes. Mooney came out after a while and told me Doc was asleep and they didn't want to wake him. I, like a kid, said all right and just sat there. He left me in that buggy 'til 5 A.M. Jesus!

R5, WOMAN 6: Then the two of them show up at my husband's butcher shop, stamping and banging 'til my husband went down and fetched them some lamb chops out of the icebox.

R7, BOY: We went home and he cooked them up in the kitchen. He was a wonderful cook. He could make a piece of meat taste like nothing in the world.

R2, JOHN: He also spent some time with a woman who kept a regular hang-out for him. It might have been a common joint, I don't know, but that isn't the way I heard it. It was certainly in an isolated location, though. One of the old houses, like the mansions on the hill only smaller — a farmhouse likely. She was a descendant of the original builders.

R6, WOMAN 7: Hello, Jimmy. How are you? Come in, and bring your cigar with you.

R2, JOHN: That's the way it began. That's the way it always began. He would just be starting a stogie.

R6, WOMAN 7: How's the boy?

R2, JOHN: The house is still there, in much the same condition. The Doc practically lived there.

R3, DOCTOR: What was the attraction? Just one thing. Something else to take him out of it. She was a good drinker. She gave him a rest. She had also put quite a bit away. The increase in land valuations had grown enormous, and she had become wealthy selling off sections of the original farm to Polacks and promoters. She was one of those who, hearing of cities and seeing trains passing right before their eyes day and night, remain isolated — unusually childish. Hot and eccentric. Rivers would find an abandoned corner like that to crawl into.

R2, JOHN: The drink would have been enough to attract him, but Doc's lady friend, she was a woman. Maybe he never thought much of that, but she was. Plenty of woman. And she could put up a hell of a fight if she wanted to. She didn't give a good God damn for the whole blankin' world — if you could believe her when she was drunk.

R3, DOCTOR: I saw her just once, many years later, when she was completely abandoned. It was the night we had her up at the police station for running through the gates at the railroad crossing. There were five in the car. I was the police physician at the time, and they wanted me to determine whether she was drunk.

[Woman 8 (R6) stands.]

R6, WOMAN 8: *[Drunk]* Have you a sister? Have you a brother? Then tell me I'm drunk. Look at me.

R3, DOCTOR: Then she went off into an unrepeatable string of profanity.

R6, WOMAN 8: And that's what I think of you. I said it. You heard me.

[Woman 8 sits.]

R4, NURSE: As far as I know, he took all the ordinary hypnotics — morphine, heroin, and cocaine also. What dose he ever got up to, it's hard to say. I've seen three grains of morphine do no more than make a woman, lying in a maternity ward, normally quiet.

R1, TROWBRIDGE: Of course, it finally got him. He began to slip badly in the latter years, to make pitiful blunders. But this final phase was marked by that curious idolatry that sometimes attracts people to a man by the very danger of his name. They seemed to recreate him in their minds, the beloved scapegoat of their own aberrant desires — and believed that he alone could cure them. He became a legend, and indulged himself the more.

R3, DOCTOR: But he did do awful things. It's said he made the remark that all a woman needed was half her organs. The others were just a surgeon's opportunity. Half the girls of Creston were without half of theirs, through *his* offices, if you could believe his story.

R5, WOMAN 9: I didn't know him very well, but we called him in anyway. When he arrived, he asked me if I had a spare room with a bed in it. I said "yes," and he went in and stayed. I was terrified. I called everyone I could think of, and no one would have anything to do with him. At five in the afternoon his driver showed up, and away they went. I've heard his driver always knew when to show up, to the minute. Knew exactly when the dope would wear off.

R3, DOCTOR: How did he get away with it? It's a little inherent in medicine

itself — mystery, cures, charms of all sorts — and he knew and practiced this black art. Toward the end of his life he had a crooked eye, and was thought to be somewhat touched.

R7, BOY: There was this lady once, and Doc managed to put her under with hypnosis. I think he was surprised it worked. But he couldn't bring her around again when he was through with the experiment. I think he got scared, and he called me to come help him get her out of his office. We finally woke her up, but it took quite an effort.

R3, DOCTOR: Some felt sorry for him. Most, though, feared him. They couldn't even attack him when they knew he had really killed someone.

R4, NURSE: He cured the sick.

R3, DOCTOR: A cure for disease? He knew what that amounted to. For of what shall one be cured? Work, in his case, through sheer intuitive ability, flooded him under. Drugs righted him. Frightened, under stress, the heart beats faster, the blood is driven to the extremities of the nerves, floods the centers of action and makes us burn. That's what he wanted, must have wanted. But the reaction from such a state must have its tonics, too. That awful fever of overwork we feel especially in the United States, he had it. A trembling in the arms and thighs, a tightness of the neck and in the head above the eyes — fast breath, vague pains in the muscles and in the feet. Followed by an orgasm, crashing the job through, putting it over in a fever heat. Then the feeling of looseness after. Not pleasant, but there it is. Then cigarettes, a shot of gin, and that's all there is to it.

R4, NURSE: When a street laborer was clipped once by a trolley car, his arm was almost severed at the shoulder. Doctor Rivers was the first one there. Such cases were his particular delight. With one look, he took in the situation as usual, made up his mind, and remarking that the arm could be of no further use to the man, amputated it there and then with a pair of bandage scissors.

R3, DOCTOR: People sought him out. They'd wait months for him. Finally, though, he did give up maternity cases toward the end. When everyone else failed, they believed he'd see them through — a powerful fetish. He would save them.

R6, GIRL: My father had always had him. He fell and broke his arm, so we

called Doctor Rivers in. He came, and doped himself up right in front of us. He didn't even bother to hide it.

R3, DOCTOR: That finished it.

R6, GIRL: It was the look in his eyes. "He's crazy," my father said, "Take him away. I don't want him fooling around with me. I'll get another doctor."

R2, JOHN: He bought a good-sized lot on the square before the Municipal Building, in the center of town. Built a fine house, with a big garden and double garage, where he kept two cars always ready for service. And he continued to practice for several years, while his wife bred dogs — Blue Poms, I think — and he would take them out in the car with him on his calls, holding them in his lap. In those days, he himself never sat at the wheel.

When Good Doctors Go Bad

Hank Goodman is a former orthopedic surgeon. He is fifty-six years old and stands six feet one, with thick, tousled brown hair and outsize hands that you can easily imagine snapping a knee back into place. He is calm and confident, a man used to fixing bone. At one time, before his license was taken away, he was a highly respected and sought-after surgeon. "He could do some of the best, most brilliant work around," one of his orthopedic partners told me. When other doctors needed an orthopedist for family and friends, they called on him. For more than a decade, Goodman was among the busiest surgeons in his state. But somewhere along the way things started to go wrong. He began to cut corners, became sloppy. Patients were hurt, some terribly. Colleagues who had once admired him grew appalled. It was years, however, before he was stopped.

When people talk about bad doctors, they usually talk about the monsters. We hear about doctors like Harold Shipman, the physician from the North of England who was convicted of murdering fifteen patients with lethal doses of narcotics and is suspected of killing some three hundred in all. Or John Ronald Brown, a San Diego surgeon who, working without a license, bungled a series of sex-change operations and amputated the left leg of a perfectly healthy man,

who then died of gangrene. Or James Burt, a notorious Ohio gynecologist who subjected hundreds of women, often after they had been anesthetized for other procedures, to a bizarre, disfiguring operation involving clitoral circumcision and vaginal "reshaping," which he called the Surgery of Love.

But the problem of bad doctors isn't the problem of these frightening aberrations. It is the problem of what you might call everyday bad doctors, doctors like Hank Goodman. In medicine, we all come to know such physicians: the illustrious cardiologist who has slowly gone senile and won't retire; the long-respected obstetrician with a drinking habit; the surgeon who has somehow lost his touch. On the one hand, strong evidence indicates that mistakes are not made primarily by this minority of doctors. Errors are too common and widespread to be explained so simply. On the other hand, problem doctors do exist. Even good doctors can go bad, and when they do, colleagues tend to be almost entirely unequipped to do anything about them.

Goodman and I talked over the course of a year. He sounded as baffled as anyone by what had become of him, but he agreed to tell his story so that others could learn from his experience. He even put me in touch with former colleagues and patients. His only request was that I not use his real name.

One case began on a hot August day in 1991. Goodman was at the hospital—a tentacled, modern, floodlit complex, with a towering red-brick building in the middle and many smaller facilities fanning out from it, all fed by an extensive network of outlying clinics and a nearby medical school. Situated off a long corridor on the ground floor of the main building were the operating rooms, with their white-tiled, wide-open spaces, the patients laid out, each under a canopy of lights, and teams of blue-clad people going about their business. In one of these rooms, Goodman finished an operation, pulled off his gown, and went over to a wall phone to respond to his messages while waiting for the room to be cleaned. One was from his

physician assistant, at the office, half a block away. He wanted to talk to Goodman about Mrs. D.

Mrs. D was twenty-eight years old, a mother of two, and the wife of the business manager of a local auto-body shop. She had originally come to Goodman about a painless but persistent fluid swelling on her knee. He had advised surgery, and she had agreed to it. The week before, he had done an operation to remove the fluid. But now, the assistant reported, she was back; she felt feverish and ill, and her knee was intolerably painful. On examination, he told Goodman, the knee was red, hot, and tender. When he put a needle into the joint, foul-smelling pus came out. What should he do?

It was clear from this description that the woman was suffering from a disastrous infection, that she had to have the knee opened and drained as soon as possible. But Goodman was busy, and he never considered the idea. He didn't bring her into the hospital. He didn't go to see her. He didn't even have a colleague see her. Send her out on oral antibiotics, he said. The assistant expressed some doubt, to which Goodman responded, "Ah, she's just a whiner."

A week later, the patient came back, and Goodman finally drained her knee. But it was too late. The infection had consumed the cartilage. Her entire joint was destroyed. Later, she saw another orthopedist, but all he could do was fuse her knee solid to stop the constant pain of bone rubbing against bone.

When I spoke to her, she sounded remarkably philosophical. "I've adapted," she told me. With a solid knee, though, she said she can't run, can't bend down to pick up a child. She took several falls down the stairs of her split-level home, and she and her family had to move to a ranch-style house for safety's sake. She cannot sit on airplanes. In movie theaters, she has to sit sidewise on an aisle. Not long ago, she went to see a doctor about getting an artificial knee, but she was told that, because of the previous damage, it couldn't safely be done.

Every physician is capable of making a dumb, cavalier decision like Goodman's, but in his last few years of practice he made them

over and over again. In one case, he put the wrong-size screw into a patient's broken ankle, and didn't notice that the screw had gone in too deep. When the patient complained of pain, Goodman refused to admit that anything needed to be done. In a similar case, he put a wrong-size screw into a broken elbow. The patient came back when the screw head had eroded through the skin. Goodman could easily have cut the screw to size, but he did nothing.

Another case involved an elderly man who'd come in with a broken hip. It looked as if he would need only a few pins to repair the fracture. In the operating room, however, the hip wouldn't come together properly. Goodman told me that he should have changed course and done a total hip replacement. But it had already been a strenuous day, and he couldn't endure the prospect of a longer operation. He made do with pins. The hip later fell apart and became infected. Each time the man came in, Goodman insisted there was nothing to be done. In time, the bone almost completely dissolved. Finally, the patient went to one of Goodman's colleagues for a second opinion. The colleague was horrified by what he found. "He ignored this patient's pleas for help," the surgeon told me. "He just wouldn't do anything. He literally wouldn't bring the patient into the hospital. He ignored the obvious on X rays. He could have killed this guy the way things were going."

For the last several years that Goodman was in practice, he was the defendant in a stream of malpractice suits, each of which he settled as quickly as he could. His botched cases became a staple of his department's Morbidity and Mortality conferences.

Sitting with him over breakfast in a corner of a downtown restaurant, I asked him how all this could have happened. Words seemed to elude him. "I don't know," he said faintly.

Goodman grew up in a small northwestern town, the second child of five in an electrical contractor's family, and neither he nor anyone else ever imagined that he might become a doctor. In college, a local state university, he was at first an aimless, mediocre

student. Then one night he was up late drinking coffee, smoking cigarettes, and taking notes for a paper on a Henry James novel when it came to him: "I said to myself, 'You know, I think I'll go into medicine.'" It was not exactly an inspiration, he said. "I just came to a decision without much foundation I could ever see." A minister once told him that it sounded "more like a call than I ever got."

Goodman became a dedicated student, got into an excellent medical school, and headed for a career in surgery after graduation. After completing military duty as a general medical officer in the Air Force, he was accepted into one of the top orthopedics-residency programs in the country. He found the work deeply satisfying, despite the gruelling hours. He was good at it. People came in with intensely painful, disabling conditions—dislocated joints, fractured hips, limbs, spines—and he fixed them. "Those were the four best years of my life," he said. Afterward, he did some subspecialty training in hand surgery, and when he finished, in 1978, he had a wide range of choices for work. He ended up back in the Northwest, where he would spend the next fifteen years.

"When he came to the clinic here, we had three older, rusty and crusty orthopedic surgeons," a pediatrics colleague of his told me. "They were out of date and out of touch, and they weren't very nice to people. Then here comes this fellow, who's a sweetheart of a guy, more up to date, and he doesn't say no to anybody. You call him at eight o'clock at night with a kid who needs his hip tapped because of infection, and he'll come in and do it—and he's not even the one on call." He won a teaching award from his medical students. He attracted a phenomenal amount of business. He reveled in the job.

Sometime around 1990, however, things changed. With his skill and experience, Goodman knew better than most what needed to be done for Mrs. D, for the man with the shattered hip, and for many other patients, but he did not do it. What happened? All he could tell me was that everything seemed wrong those last few years. He used to enjoy being in the operating room, fixing people. After a while,

though, it seemed that the only thing he thought about was getting through all his patients as quickly as possible.

Was money part of the problem? He made about two hundred thousand dollars a year at first, and the more patients he saw and the more cases he took the more money he made. Pushing himself, he found that he could make three hundred thousand dollars. Pushing himself even harder, until he was handling a dizzying number of cases, he made four hundred thousand dollars. He was far busier than any of his partners, and that fact increasingly became, in his mind, a key measure of his worth. He began to call himself, only half in jest, "The Producer." More than one colleague mentioned to me that he had become fixated on his status as the No. 1 booker.

His sense of himself as a professional also made him unwilling to turn people away. (He was, after all, the guy who never said no.) Whatever the cause, his caseload had clearly become overwhelming. He'd been working eighty, ninety, a hundred hours a week for well over a decade. He had a wife and three children—the children are grown now—but he didn't see much of them. His schedule was packed tight, and he needed absolute efficiency to get through it all. He'd begin with, say, a total hip replacement at 7:30 A.M. and try to finish in two hours or so. Then he'd pull off his gown, tear through the paperwork, and, as the room was being cleaned, stride out the main tower doors, into the sun, or snow, or rain, over to the outpatient-surgery unit, half a block away. He'd have another patient waiting on the table there—a simple case, maybe a knee arthroscopy or a carpal-tunnel release. Near the end, he'd signal a nurse to call ahead and have the next patient wheeled into the OR back in the main tower. He'd close skin on the second case and then bolt back for a third. He went back and forth all day. Yet, no matter what he did to keep up, unforeseen difficulties arose—a delay in getting a room ready, a new patient in the emergency room, an unexpected problem in an operation. Over time, he came to find the snags unbearable. That's undoubtedly when things became dangerous. Medicine requires the

fortitude to take what comes: your schedule may be packed, the hour late, your child waiting for you to pick him up after swimming practice; but if a problem arises you have to do what is necessary. Time after time, Goodman failed to do so.

This sort of burnout is surprisingly common. Doctors are supposed to be tougher, steadier, better able to handle pressure than most. (Don't the rigors of medical training weed out the weak ones?) But the evidence suggests otherwise. Studies show, for example, that alcoholism is no less common among doctors than among other people. Doctors are more likely to become addicted to prescription narcotics and tranquilizers, presumably because we have such easy access to them. Some 32 percent of the general working-age population develops at least one serious mental disorder—such as major depression, mania, panic disorder, psychosis, or addiction—and there is no evidence that such disorders are any less common among doctors. And, of course, doctors become ill, old, and disaffected, or distracted by their own difficulties, and for these and similar reasons they falter in their care of patients. We'd all like to think of "problem doctors" as aberrations. The aberration may be a doctor who makes it through a forty-year career without at least a troubled year or two. Not everyone with "problems" is necessarily dangerous, of course. Nonetheless, estimates are that, at any given time, 3 to 5 percent of practicing physicians are actually unfit to see patients.

There's an official line about how the medical profession is supposed to deal with these physicians: colleagues are expected to join forces promptly to remove them from practice and report them to the medical-licensing authorities, who, in turn, are supposed to discipline them or expel them from the profession. It hardly ever happens that way. For no tight-knit community can function that way.

Marilynn Rosenthal, a sociologist at the University of Michigan, has examined how medical communities in the United States, Great Britain, and Sweden deal with problem physicians. She has gathered data on what happened in more than two hundred specific cases,

ranging from a family physician with a barbiturate addiction to a fifty-three-year-old cardiac surgeon who continued operating despite permanent cerebral damage from a stroke. And nearly everywhere she looked she found the same thing. It was a matter of months, even years, before colleagues took effective action against a bad doctor, however dangerous his or her conduct might have been.

People have called this a conspiracy of silence, but Rosenthal did not find plotting so much as a sorry lack of it. In the communities she has observed, the dominant reaction was uncertainty, denial, and dithering, feckless intervention—very much like a family that won't face up to the fact that grandma needs to have her driver's license taken away. For one thing, not all problems are obvious: colleagues may suspect that Dr. So-and-So drinks too much or has become "too old," but certainty about such matters can remain elusive for a long time. Moreover, even when problems *are* obvious, colleagues often find themselves unable to do anything decisive.

There are both honorable and dishonorable reasons for this. The dishonorable reason is that doing nothing is easy. It takes an enormous amount of work and self-assurance for colleagues to gather the evidence and the votes that are needed to suspend another doctor's privileges to practice. The honorable reason, and probably the main reason, is that no one really has the heart for it. When a skilled, decent, ordinarily conscientious colleague, whom you've known and worked with for years, starts popping Percodans, or becomes preoccupied with personal problems, and neglects the proper care of patients, you want to help, not destroy the doctor's career. There is no easy way to help, though. In private practice, there are no sabbaticals to offer, no leaves of absence, only disciplinary proceedings and public reports of misdeeds. As a consequence, when people try to help, they do it quietly, privately. Their intentions are good; the result usually isn't.

For a long time, Hank Goodman's colleagues tried to help him. Starting around 1990, they began to have suspicions. There was talk

of the bizarre decisions, the dubious outcomes, the growing number of lawsuits. More and more, people felt the need to step in.

A few of the older physicians, each acting on his own, took him aside at one point or another. Rosenthal calls this the Terribly Quiet Chat. A partner would see Goodman at a cocktail party or just happen to drop by his home. He'd pull Goodman aside, ask how he was doing, tell him that people had concerns. Another took the tough-love approach: "I said to him straight out, 'I don't know what makes you tick. Your behavior is totally bizarre. The scary thing is I wouldn't let my family members go near you.'"

Sometimes this approach can work. I spoke to a retired department head at Harvard who had initiated more than a few Terribly Quiet Chats in his time. A senior physician can have forbidding moral authority in medicine. Many wayward doctors whom the department head confronted confessed to having troubles, and he did what he could to assist. He'd arrange to have them see a psychiatrist, or go to a drug rehab center, or retire. But some doctors didn't follow through. Others denied that anything was wrong. A few went so far as to mount small campaigns in their defense. They would have family members call him in outrage, loyal colleagues stop him in the hospital halls to say they'd never seen any wrongdoing, lawyers threaten to sue.

Goodman did listen to what people had to say. He nodded and confessed that he felt overworked, at times overwhelmed. He vowed to make changes, to accept fewer cases and stop rushing through them, to perform surgery as he knew it should be performed. He would walk away mortified, resolving to mend his ways. But in the end nothing changed.

As is often the case, the people who were in the best position to see how dangerous Goodman had become were in the worst position to do anything about it: junior physicians, nurses, ancillary staff. In such circumstances, the support staff will often take measures to protect patients. Nurses find themselves quietly directing patients to other doctors. Receptionists suddenly have trouble finding openings in a doctor's schedule. Senior surgical residents scrub in on junior-

level operations to make sure a particular surgeon doesn't do anything harmful.

One of Goodman's physician assistants tried to take on this protective role. When he first began working with Goodman—helping to set fractures, following patients' progress, and assisting in the operating room—he revered the man. But he noticed when Goodman became erratic. "He'd run through forty patients in a day and not spend five minutes with them," the assistant told me. To avert problems in the clinic, he stayed late after hours, double-checking Goodman's decisions. "I was constantly following up with patients and changing what he did for them." In the operating room, he tried to make gentle suggestions. "Is that screw too long?" he might ask. "Does the alignment on that hip look right?" There were nonetheless mistakes and "a lot of unnecessary surgery," he said. When he could, he steered patients away from Goodman—"though without actually coming out and saying, 'I think he's crazy.'"

Matters can drift along this way for an unconscionably long time. But when someone has exhausted all reservoirs of goodwill—when the Terribly Quiet Chats are clearly going nowhere and there seems to be no end to the behind-the-scenes work colleagues have to do—the mood can change swiftly. The smallest matter can precipitate drastic action. With Goodman, it was skipping the mandatory weekly Morbidity and Mortality conferences, which he started to do in late 1993. As negligent as his patient care could be—he had become one of the hospital's most frequently sued doctors—people remained uncomfortable about judging him. When Goodman stopped attending M & Ms, however, his colleagues finally had a concrete violation to confront him with.

Various people warned him, with increasing sharpness, that he would be in serious trouble if he didn't start showing up at M & Ms. "But he ignored them all," a colleague of his told me. After a year of this, the hospital board put him on probation. Through it all, he was operating on more patients and generating ever more complications. Another whole year went by. Soon after Labor Day of 1995, the board

and its lawyer finally sat him down at the end of a long conference table and told him that they were suspending his operating privileges and referring his conduct to the state medical board for investigation. He was fired.

Goodman had never let on to his family about his difficulties, and he didn't tell them that he'd lost his job. Each morning for weeks, he put on a suit and tie and went to his office, as if nothing had changed. He saw the last of his scheduled patients, and referred those who needed an operation to others. His practice dried up within a month. His wife sensed that something was wrong, and when she pressed him, he finally told her. She was floored, and frightened: she felt as if he were a stranger, an impostor. After that, he just stayed home in bed. He spoke to no one for days at a time.

Two months after his suspension, Goodman was notified of another malpractice suit, this one on behalf of a farmer's wife who had come to him with a severely arthritic shoulder. He had put in an artificial joint, but the repair failed. The lawsuit was the last straw. "I had nothing," he told me. "I had friends and family, yes, but no job." As with many doctors, his job was his identity.

In his basement den, he had a gun, a .44 Magnum that he had bought for a fishing trip to Alaska, to protect him against bears. He found the bullets for the gun and contemplated suicide. He knew how to do it so that his death would be instantaneous. He was, after all, a surgeon.

In 1998, I was at a medical conference near Palm Springs, skimming through the dense lecture schedule, when an unusual presentation caught my eye: "Two Hundred Physicians Reported for Disruptive Behavior," by Kent Neff, M.D. The lecture was in a small classroom away from the main lecture hall. At most, a few dozen people attended. Neff was fiftyish, trim, silver-haired, and earnest, and he turned out to have what must be the most closeted subspecialty in medicine: he was a psychiatrist specializing in doctors and other professionals with serious behavioral problems. In 1994, he

told us, he had taken charge of a small program to help hospitals and medical groups with troubled doctors. Before long, they were sending him doctors from all over. To date, he'd seen more than two hundred and fifty, a remarkable wealth of experience, and he went through the data he'd collected like a CDC scientist analyzing an outbreak of tuberculosis.

What he found was unsurprising. The doctors were often not recognized to be dangerous until they had done considerable damage. They were rarely given a thorough evaluation for addiction, mental illness, or other typical afflictions. And, when problems were identified, the follow-through was abysmal. What impressed me was Neff's single-handed, quixotic attempt—he had no grants, no assistance from government agencies—to do something about this.

A few months after the lecture, I flew to Minneapolis to see Neff in action. His program was at Abbott Northwestern Hospital, near the city's Powderhorn district. When I arrived, I was directed to the fifth floor of a brick building discreetly off to one side of the main hospital complex. There I found a long, dimly lit hallway with closed, unmarked doors on both sides and beige, low-pile carpeting. It looked nothing like a hospital. A block-lettered sign read "Professional Assessment Program." Neff, in a tweed jacket and metal-rimmed glasses, came out of one of the doors and showed me around.

Each Sunday night, the physicians arrived here, suitcases in hand. They checked in down the hall and were shown to dormitory-style rooms where they would stay for four days and four nights. Three doctor-patients were staying during the week that I visited. They were permitted to come and go as they pleased, Neff assured me. Yet I knew that they were not quite free. In most cases, their hospitals had paid the program's fee of seven thousand dollars and told the doctors that if they wanted to keep their practices they had to go to Minneapolis.

The most striking aspect of the program, it seemed to me, was that Neff had actually persuaded medical organizations to send the

doctors. He had done this, it seemed, by simply offering to help. For all their dithering, hospitals and clinics turned out to be eager for Neff's assistance. And they weren't the only ones. Before long, airlines began sending him pilots. Courts sent him judges. Companies sent him CEOs.

A small part of what Neff did was just meddle. He was like one of those doctors whom you consult about a coughing child, and who then tell you how to run your life. He'd take the doctors in hand, but he was not shy about telling organizations when they had let a problem fester too long. There are certain kinds of behavior—what he calls “behavioral sentinel events”—that should alert people that something may be seriously wrong with a person, he explains. For example, a surgeon throws scalpels in the OR, or a pilot bursts into uncontrolled rages in midflight. Yet, in case after case, such episodes are shrugged off. “He’s a fine doctor,” people will say, “but sometimes he has his moments.”

Neff recognizes at least four types of behavioral sentinel events. There is persistent, poor anger control or abusive behavior. There is bizarre or erratic behavior. (He saw a doctor who could not get through the day without spending a couple of hours arranging and rearranging his desk. The doctor was found to have severe obsessive-compulsive disorder.) There is transgression of proper professional boundaries. (Neff once saw a family physician who was known to take young male patients out alone for dinner and, in one instance, on vacation with him. He turned out to have compulsive fantasies of sex with pubescent boys.) And there is the more familiar marker of incurring a disproportionate number of lawsuits or complaints (as Goodman had). Through his program, Neff has persuaded a substantial number of hospitals and clinics—and airlines and corporations—to take such events seriously. Many organizations have now specified, as a part of their contracts, that behavioral sentinel events could trigger an evaluation.

The essence of what he did, however, was simply to provide a patient consultation, the way a cardiologist might provide a consulta-

tion about someone's chest pains. He examined the person sent to him, performed some tests, and gave a formal opinion about what was going on, about whether the person could safely be kept on the job, and about how things might be turned around. Neff was willing to do what everyone else was extremely reluctant to do: to judge (or, as he prefers to say, to “assess”) a fellow doctor. And he did it more thoroughly and dispassionately than a doctor's colleagues ever could.

Neff's first step with the three doctors seeing him the week I was there was to gather information. Starting on Monday morning, and throughout the next two days, he and four clinicians separately interviewed each of the doctors. They were made to tell their stories over and over again, half a dozen times or more, in order to break through their evasions and natural defensiveness, and to bring out the details. Before they arrived, Neff had also put together a thick dossier on each of them. And during the week he did not hesitate to call their colleagues back home in order to sort through the contradictions and ambiguities in their versions of events.

Neff's patients also underwent a full exam, including blood work, to make sure that no physical illness could account for any dangerous behavior. (One doctor, who was sent to Neff after several episodes of freezing in place in mid-operation, was found to have advanced Parkinson's disease.) They were given alcohol and drug testing. And they underwent psychological tests for everything from gambling addiction to paranoid schizophrenia.

On the last day, Neff assembled his team around a conference table in a drab little room to make their determinations. Meanwhile, the physicians waited in their rooms. The staff members spent about an hour reviewing the data in each case. Then, as a team, they made three separate decisions. First, they arrived at a diagnosis. Most doctors turned out to have a psychiatric illness—depression, bipolar disorder, drug or alcohol addiction, even outright psychosis. Almost without exception, the condition had never been diagnosed or treated. Others were simply struggling with stress, divorce, grief, illness, or the like. Next, the team decided whether the doctor was fit to

return to practice. Neff showed me some typical reports. The judgment was always clear, unequivocal: "Due to his alcoholism, Dr. X cannot practice with reasonable skill and safety at this time." Last, they spelled out specific recommendations for the doctor to follow. For some doctors deemed fit to return to practice, they recommended certain precautions: ongoing random drug testing, formal monitoring by designated colleagues, special restrictions on the doctor's practice. For those found unfit, Neff and his team typically specified a minimum period of time away from their practice, a detailed course of treatment, and explicit procedures for reevaluation. At the end of the deliberations, Neff met in his office with each doctor and described the final report that would be sent to his hospital or clinic. "People are usually surprised," Neff told me. "Ninety percent find our recommendations more stringent than what they were expecting."

Neff reminded me more than once that his program provided only recommendations. But once he put his recommendations down on paper it was hard for hospitals and medical groups not to follow through and hold doctors to the plan. The virtue of Neff's approach was that once trouble occurred everything unfolded almost automatically: Minneapolis, evaluation, diagnosis, a plan. Colleagues no longer had to play judge and jury. And the troubled doctors got help. Neff and his team saved hundreds of careers from destruction—and possibly thousands of patients from harm.

Neff's was not the only program of its kind. In recent decades, medical societies here and abroad have established a number of programs to diagnose and treat "sick" physicians. But his was one of the very few independent programs and more systematic in its methods than just about any other.

Yet his program was shuttered a few months after my visit. Although it had attracted wide interest across the country and had grown rapidly, the Professional Assessment Program had struggled financially, never quite paying its own way. In the end, Neff was unable to persuade Abbott Northwestern Hospital to continue to

subsidize it. He was, when we last spoke, seeking support to set up elsewhere.

But whether or not he succeeds, he has shown what can be done. The hard question—for doctors, and, even more, for their patients—is whether we can accept such an approach. Programs like Neff's cut a straightforward deal—maybe too straightforward. Physicians will turn in problematic colleagues—the ordinary, everyday bad doctors—only as long as the consequence is closer to diagnosis and treatment than to arrest and prosecution. And this requires that people be ready to view such doctors not as sociopaths but merely as struggling human beings. Neff's philosophy is, as he put it, "hard on behavior but soft on the person." People may actually prefer the world of don't ask, don't tell. Just ask yourself, could you abide by a system that rehabilitated drug-addicted anesthesiologists, cardiac surgeons with manic psychosis, or pediatricians with a thing for little girls if it meant catching more of them? Or, to put it another way, would you ever be ready to see Hank Goodman operate again?

Hank Goodman's life, and perhaps his career, was one of Kent Neff's saves. In mid-December of 1995, after pondering suicide, Goodman called Neff at his office. Goodman's lawyer had heard about the program and given him the number. Neff told him to come right away. Goodman made the trip the next day. They met for an hour, and at the end of the meeting Goodman remembers feeling that he could breathe again. Neff was direct and collegial and said that he could help him, that his life wasn't over. Goodman believed him.

He checked into the program the next week, paying for it himself. It was a difficult, at times confrontational, four days. He wasn't ready to admit all that he had done or to accept all that the members of Neff's team had found. The primary diagnosis was long-standing depression. Their conclusion was characteristically blunt: The doctor, they wrote, "is unable to practice safely now because of his major

depression and will be unable to practice for an indefinite period of time." With adequate and prolonged treatment, the report said, "we would expect that he has the potential for a full return to practice." The particular diagnostic labels they gave him are probably less important than the intervention itself: the act of telling him, with institutional authority, that something was wrong with him, that he must not practice, and that he might be able to do so again one day.

At Neff's suggestion, Goodman checked into a psychiatric hospital. After that, a local psychiatrist and a supervising medical doctor were lined up to monitor him at home. He was put on Prozac, and then Effexor. He stuck with the program. "The first year, I didn't care if I lived or died," he told me. "The second year, I wanted to live but I didn't want to go to work. The third year, I wanted to go back to work." Eventually, his local psychiatrist, his internist, and Neff all agreed that he was ready. Largely on their advice, Goodman's state medical board has given him permission to return to practice, although with restrictions. At first, he would have to work no more than twenty hours a week and only under supervision. He had to see his psychiatrist and his medical doctor on a regular schedule. He could not operate for at least six months after returning to the clinic. Then he would be able to operate only as an assistant until a reevaluation determined that he could resume full privileges. He would also have to submit to random drug and alcohol tests.

But what practice would take him? His former partners wouldn't. "Too much baggage," he said. He came very close to securing a place in the rural lake town where he has a vacation home. It has a small hospital, visited by forty-five thousand people during the summer months, and no orthopedic surgeon. The doctors there were aware of his previous problems, but, having searched for an orthopedist for years, they approved his arrival. Still, it took almost a year for him to obtain malpractice insurance. And he thought it prudent to be cautious about returning to the stresses of a full-fledged practice. He decided to start off by doing physical examinations for an insurance company first.

Not long ago, I visited Goodman at his home, a modest brick ranch-style house full of dogs and cats and birds, tchotchkes in the living room, and, in a corner of the kitchen, a computer and a library of orthopedic journals and texts on CD-ROMs. He was dressed in a polo shirt and khakis, and he seemed loose, unhurried, almost indolent. Except for the time he spent with his family, and catching up on his field, he had little to occupy himself. His life could not have been further from that of a surgeon, but he felt the fire for the work coming back to him. I tried to picture him in surgeon's greens again—in an OR, with another assistant on the phone asking about a patient with an infected knee. Who could say how it would go?

We are all, whatever we do, in the hands of flawed human beings. The fact is hard to stare in the face. But it is inescapable. Every doctor has things he or she ought to know but has yet to learn, capacities of judgment that will fail, a strength of character that can break. Was I stronger than this man was now? More reliable? More conscientious? As aware and careful about my limitations? I wanted to think so—and perhaps I had to think so to do what I do day to day. But I could not know so. And neither could anyone else.

Goodman and I went out for a meal together in town and then for a drive. Coming upon his former hospital, gleaming and modern, I asked him if I could have a look around. He didn't have to come, I said. He had not been inside the building more than two or three times in the previous four years. After a momentary hesitation, he decided to join me. We walked in through the sliding automatic doors and down a polished white hallway. A sunny voice rang out, and I could see that he regretted having come in.

"Why, Dr. Goodman!" a smiling, matronly, white-haired woman said from behind the information desk. "I haven't seen you in years. Where have you been?"

Goodman stopped short. He opened his mouth to answer, but for a long moment nothing came out. "I retired," he said finally.

She tilted her head, obviously puzzled: Goodman looked robust and twenty years younger than she was. Then I saw her eyes sharpen

as she began to catch on. "Well, I hope you're enjoying it," she said, recovering nicely.

He made an uncomfortable remark about all the fishing he was getting to do. We began to walk away. Then he stopped and spoke to her again. "I'll be back, though," he said.