NARCOTIC ADDICTION AMONG PHYSICIANS: A TEN-YEAR FOLLOW-UP

PETER L. PUTNAM, M.D., AND EVERETT H. ELLINWOOD, JR., M.D.

Drug addiction has been described as an occupational hazard of physicians(5), as well as one of the major manifestations of emotional disorders in physicians(2, 3, 5, 6, 7, 9). Little is known about the eventual status or adjustment of the physician addict. This study compares 68 male physicians discharged in 1952 from the U. S. Public Health Service Hospital in Lexington, Ky., with 68 other physicians listed in the same American Medical Association directory, controlled for age and geographic distribution.

The AMA directories are compiled from information supplied by a variety of sources, including every state medical license agency, which furnishes complete information regarding the physicians licensed to practice medicine in the state. Attrition from the AMA directories and location changes over a ten-year period(1952-1962) are the primary focus of this study, but other highlighting information will be mentioned.

METHOD

The subjects were all male physician addicts discharged from the Lexington hospital. The names were obtained from discharge forms for the year 1952. The number and dates of all previous and subsequent admissions were noted. The names were then checked with the 17th, 18th and 19th editions of the AMA directory and all subjects whose names were not included in one of these editions of the directory were deleted.

Controls were selected from the directory by picking the first listing in the state following the listing of the subject which met the following criteria: a) a birth year corresponding to the subject's birth year, plus or minus one year; b) a masculine first name; and c) the principal address within the same state as the principal address of the subject.

Information obtained from the directory for both subjects and controls included date of birth, name of medical school and date of graduation, date of licensure in the state, type of practice, membership in any medical organization and specialty. The indices of the subsequent editions of the AMA directories were searched in order to determine if our physicians were still listed and if there had been any changes of address.

Statistical tests were performed by using two by two Chi-square test of significance.

DATA

Eighty out of 2,999 males discharged from the Lexington hospital in 1952 gave their occupation as physicians. This represents more than two percent of those discharged in that year.(The figure was one percent in 1963, or 26 out of 2,011). Six patients were dropped from the list because they were not listed in the 17th, 18th or 19th editions of the AMA directory. This left 68 patients with a total of 72 discharges for the year.(Four patients had been hospitalized twice.)

During this same period of time in which a total of 80 patients gave their occupations as physicians, there were only 18 giving their occupations as pharmacists or druggists, five dentists or dental surgeons, one veterinarian and 17 lawyers or attorneys. Vocations in the health field are heavily represented, with a total of 165 listing their occupations as nurses, technicians or other hospital personnel.

Read at the 121st annual meeting of the American Psychiatric Association, New York, N. Y., May 3-7, 1965.

Dr. Putnam is a participant in the Mental Health Career Development Program of the National Institute of Mental Health, assigned to the Training and Manpower Resources Branch, NIMH. Dr. Ellinwood was formerly Chief, Women's Addiction Service, U. S. Public Health Service Hospital, Lexington, Ky. He is presently with the Department of Psychiatry, Duke University Medical Center, Durham, N. C.

The opinions and views expressed by the authors are their own and do not represent official policy nor the opinion of the U. S. Public Health Service.

The most common age of the physician patients was between 41 and 50, the average being 46.5 years. Of the 68 patients, 38 came from one of the southern states, 11 from one of the Middle Atlantic or New England states. (The Lexington hospital admits male patients only from east of the Mississippi River.) All but five were married, and all but five were Protestant.

Forty-five of the admissions were voluntary, 16 were volunteers under medical examiner or court pressure, one was a special study and two were probationers. Thirty-six were admitted for the first time in 1952, and 57 (including the four who were admitted twice in 1952) had no subsequent admission. Forty of the discharges were authorized, and 28 left against medical advice.

Morphine was the primary drug used by 29, meperidine (Demerol) by 22 and the remainder used a variety of other narcotics. In addition, three were considered to be addicted to alcohol and 12 to barbiturates. Of the 51 cases given a psychiatric diagnosis in addition to drug addiction, 29 were personality disorders. There was no correlation between psychiatric diagnosis and drug used.

Because many physicians claimed that the initial self-administration of narcotics was to allay physical ailments, these were tabulated. Twenty-eight of the patients had 40 physical diagnoses listed. Most of them were either cardiovascular or gastrointestinal disorders; few could be considered valid reasons for the use of narcotics.

None of the specialties in this series appeared particularly prone to addiction. When compared with controls, more patients were noted among the general practitioner (45 vs. 37), internal medicine (3 vs. 2) and obstetrics-gynecology (4 vs. 2) specialties, but none of these differences was statistically significant. Three in the patient group and six in the control group were Board-certified. Forty-six patients versus 42 controls were AMA members.

A striking difference between the two groups was reflected in the frequency of changes of address. In the four AMA directories, 1956 to 1963, new addresses were listed 51 times for the patient group and only 19 times for the control group ($p. < .001$). Sixteen patients moved into a new state 25 times while only five controls moved into a new state eight times.

Ten years after the 1952 admission, there were only 57 percent of the patient group listed in the 1963 AMA directory, while 81 percent of the control group were listed (see Table 1). The difference in attrition is significant (at $p < .01$).

TABLE 1
Ex-Lexington Physician Patients and Controls Still Listed in AMA Directory

YEAR	PERCENT PATIENTS	CONTROLS
1950 (Total)	100	100
1956	81	88
1958	68	85
1961	59	84
1963	57	81

There was no significant (at $p > .20$) relationship between number of hospitalizations and attrition. Of the 11 patients who were admitted subsequent to 1952, ten were still in the 1963 directory. Three of the ten had served federal prison terms, and one had been admitted as a federal probationer.

DISCUSSION

Little is known of the physician addicts' eventual adjustment or status. Mortality most likely has been high, due to pre-existing disease, effects of the drugs and suicide. Suicide among physician addicts was reported to be as high as 8-9 percent (6, 7). Repeated hospitalizations and finally incarceration were noted in the chronic addictions. Loss of medical license and repeated hospitalizations led to marginal economic and social adjustment (7). Others simply disappeared leaving no forwarding address (3).

Reports on prognosis and relapse rates in physician addicts have been quite varied (2, 5, 7); favorable outcome varied as much as 27 percent to 92 percent. The follow-up periods, conditions of follow-up and the samples were markedly different in each of these studies. The criterion of

success was cessation of drug habit. This criterion does not reveal whether alternate psychological maladaptations ensued. In general, the incidence and outcome of mental illness in physicians is not well known. It is therefore important to have controls when defining the effects of mental disease in physicians. Measures by which subjects and controls can be contrasted are not readily available.

In this study AMA directory listing and change of address were thought to reflect the disruptiveness often associated with drug addiction. The attrition rate among controls was 21 percent over ten years; among physician addicts the rate was 43 percent. In contrast to Winick's finding (9) that physician addicts move infrequently, we found that 41 percent of patients compared to 17 percent of controls moved at least once to a new city. In many physician addicts, the history points to more than one bout with addiction(2, 5, 6, 7), yet they frequently maintain their professions and marriages. This is borne out in the presented data.

Multiple factors are involved in physicians' drug addicion. Drug availability, dependency conflicts, isolation and lack of shared short-term satisfactions have been discussed in the literature(1, 3). In the general problem of addiction, self-administration of narcotics has been compared with operant conditioning(4, 8). Self-treatment by physician addicts is usually a key to the beginning addiction sequence. As has been noted before(2, 3), alcoholism, chronic fatigue and physical disease are the main reasons given for the beginning of self-medication.

Along with discerning the factors leading to physician addiction, more studies of treatment and follow-up are certainly needed. The present type of follow-up gives only an inkling of the prognosis in physician addicts. We would like to suggest an AMA central, coded registry for the longitudinal study of addict physicians. This would be for study purposes only and by necessity would involve cooperation with state medical board examiners. It should be a part of a general effort to evaluate mental illness in physicians. More information on mental health problems and adequate follow-up would help immensely in elucidating how best to deal with our colleagues.

SUMMARY

Physicians represented approximately two percent of the total male discharges from the USPHS Hospital in Lexington, Ky., in 1952. Most were over 40 years old. About 50 percent had only one admission to the hospital, while the remainder had from two to eight admissions from 1940 to 1962. Morphine and meperidine were the most commonly used drugs; many used barbiturates and alcohol in addition to the narcotic. There was no correlation between type of drug used and psychiatric diagnosis. Many had organic disease of varying severity. Most were married, Protestant and came from one of the southern states.

When compared with a control group in 1950, there were no significant differences in AMA membership, specialty or type of practice. Members of the patient group did move from one city to another twice as frequently as the controls. There was a more rapid attrition rate of the patient group from the AMA directories, and after ten years only 57 percent remained listed, while 81 percent of those in the control group were still listed. While this difference is significant(at $p. < .01$), it is also noteworthy that 57 percent of the patient group were still listed in the directory.

REFERENCES

1. Hill, H. E.: The Social Deviant and Initial Addiction to Narcotics and Alcohol, Quart. J. Stud. Alcohol 23:562-582, 1962.
2. Jones, L. E.: Experiences with Probation in California, Fed. Bull. 45:165-173, 1958.
3. Modlin, H. C., and Montes, A.: Narcotic Addiction in Physicians, Amer. J. Psychiat. 121:358-365, 1964.
4. Nichols, J. R.: How Opiates Change Behavior, Scientific American 212: 80-88, 1964.
5. Pescor, M. J.: Physician Drug Addicts, Dis. Nerv. Syst. 3:2-3, 1942.
6. Quinn, W. F.: Narcotic Addiction; Medical and Legal Problems with Phy-

sicians, Calif. Med. 94:214-217, 1961.
7. Wall, J. H.: The Results of Hospital Treatment of Addiction in Physicians, Fed. Bull. 45:144-152, 1958.
8. Wikler, A.: Opiates and Opiate Antagonist, a Review of Their Mechanisms of Action in Relation to Clinical Problems, Public Health Monogr. No. 52, 1958.
9. Winick, C.: Physician Narcotic Addicts, Social Problems 9:174-186, 1961.

LEGAL RESPONSIBILITY AND CHRONIC ALCOHOLISM

ROBERT A. MOORE, M.D.

The consideration of chronic alcoholism as a legitimate illness has been slow in coming, even within the medical profession. It is no surprise that the public in general has continued to see alcoholism as largely a moral issue, and this is reflected in the attitudes of our courts. Court attitudes toward alcoholism are inconsistent with court attitudes toward other forms of mental illness. In this paper, court decisions in which alcohol intoxication has been an issue will be reviewed and some of the issues raised will be discussed.

DECISIONS AND OPINIONS IN CRIMINAL LAW

A review of legal literature in the area of criminal responsibility presents us with the opportunity to observe the attitudes of the courts today in the United States and other parts of the world when the intoxicated person has his day in court.

Direct quotations from legal scholars and judicial opinions reveal the uncertainty and contradictions present when the defendant is intoxicated at the time of the act. Historically, punishment was often greater for a crime committed while the person was intoxicated since it was considered that two crimes had occurred(28, p. 3). At the very least, it was felt that intoxication should not be a defense as, according to Blackstone, "one crime should not be allowed to privilege another . . ."(28, p. 35).

A nineteenth-century ruling of the Criminal Law Commissioners in Great Britain states that pleas of drunkenness should be excluded because:

> . . . the pretense would be constantly resorted to as a cloak for committing the most horrible outrages with impunity; what is worse, the reality would be incurred not only to insure safety to the most notorious offenders, but for the enabling them to inflict atrocious injuries with the greater confidence; and the very excessive brutality of an outrage would afford such evidence of the total absence of reason and humane feeling as would tend to the acquittal of the most heinous criminals(6).

California Penal Code Section 22 states: "No act committed by a person while in a state of voluntary intoxication is less criminal by reason of his having been in such a condition."

A federal judge has stated, "Many people get drunk but when honest people get drunk they do not go out and commit crimes. In other words, you could say if a person committed a crime while drunk he must have a criminal instinct in him because they say, as you probably know, that in a state of intoxication a person exhibits his true desires"(14).

This was more poetically stated in an earlier Michigan decision when a man got drunk and shot at another man but missed and was held responsible for intent to commit murder: "He must be held to have purposely blinded his moral perceptions, and set his will free from the control of reason—to have suppressed the guards and invited the mutiny; and should therefore be held responsible as well for the vicious excesses of the will, thus set free, as for the acts done by its prompting"(33).

In a Tennessee decision involving an auto accident the judge stated:

Read at the 121st annual meeting of the American Psychiatric Association, New York, N. Y., May 3-7, 1965.

At the time he presented this paper, Dr. Moore was Clinical Director of Training and Research, Ypsilanti State Hospital, Ypsilanti, Mich. He is now Director, Department of Psychiatry, Swedish-American Hospital, 1316 Charles Street, Rockford, Ill.