Hank Goodman is a former orthopedic surgeon. He is fifty-six years old and stands six feet one, with thick, tousled brown hair and outsized 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. When others 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.

One case began on a hot August day in 1997. Goodman was at the hospital—a tentacular, 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 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 was performing an operation. One case began on a hot August day in 1997. Goodman was at the hospital—a tentacular, 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 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 was performing an operation.
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 grueling hours. He was good at it. People came in with intensely painful, disabling conditions—dislocated hips, fractured 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, feeble 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 consultation 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 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.