The National Society of Dental Practitioners
RISK MANAGEMENT Newsletter
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Impaired Practice in Dentistry

The prevalence of substance use disorders (SUD) in the United States was about 8 percent in 2014, according to the Substance Abuse and Mental Health Services Administration, and it is likely higher now, given the opioid crisis. For example, 42,000 people died from prescription and illicit opioids in 2016, the most of any year on record, according to the Centers for Disease Control and Prevention, and overdose deaths have increased by more than five times since 1999.

Dentists are just as likely to develop SUD as the general population, so many will confront the problem firsthand during their career, either through their own experience or that of a colleague. Like the general population with SUD, dentists can suffer consequences such as health disorders and loss of friends and family. Unlike the general population, dentists with untreated SUD can put their patients and their practices in danger.

Dentists need to protect their livelihood and keep patients safe. To do so, they need to understand the issues surrounding SUD, including risk factors, signs, and symptoms; how to obtain help; and what to do if they suspect a colleague has a SUD. Addressing SUD will also help protect dentists from malpractice lawsuits and possible loss of licensure.

A clear mandate

The American Dental Association (ADA) Principles of Ethics and Code of Conduct states, "It is unethical for a dentist to practice while abusing controlled substances, alcohol, or other chemical agents which impair the ability to practice."

To avoid putting themselves in this situation, dentists should understand the risk factors associated with their profession.

Risk factors

A major risk factor for SUD is stress, something that dentists frequently experience. Stress can come from personal life, such as the end of a relationship, or from professional life, such as personnel issues, regulatory compliance requirements, demanding patients, financial pressures related to the practice, or difficulty in paying off student loans. Dentists may develop burnout, which they try to self-medicate with alcohol or prescription or illicit drugs.

Dentists also can write prescriptions for controlled substances and have ready access to them. Unfortunately, dentists may start down the path to SUD by self-prescribing or self-medicating to control musculoskeletal pain related to the nature of their work.

Dentists who are solo practitioners can face unique risks. Isolation, combined with long hours, can cause fatigue and even impaired judgment. In addition, employees, who depend on the dentist for their income, may find it difficult to speak up about potential problems, delaying treatment and allowing SUD to worsen.

Other risk factors for SUD that are not unique to dentists include family history—the greatest predictor of SUD in both dentists and the general population — and history of childhood trauma or sexual abuse.

Some of these risk factors can be mitigated. For example, solo practitioners can join local chapters of professional groups so they can connect with those in similar positions. Dentists in rural areas may choose to forge bonds on trusted social networks, although they must remember not to discuss potential patients. ADA's Dentist Health and Well-Being Program also provides resources to help reduce stress (www.ada.org/en/member-center/member-benefits/health-and-wellness-information).

To encourage staff to speak up if they suspect a dentist or a colleague is suffering from SUD, dentists may want to create a drug-free policy in the workplace that provides guidance for what to do if impairment is suspected. Such a policy should be developed in conjunction with human resources and legal consultation.

Signs and symptoms

Dentists should be alert to signs and symptoms of SUD in themselves and others so that help can be obtained (see Signs and symptoms of SUD). Unfortunately, dentists, like many healthcare professionals, are often able to function in their role for a longer time than others before substance misuse is recognized. Because dentists are accustomed to problem solving and being in charge, they may be reluctant to admit they need help.

Another factor in failing to seek help is the stigma of addiction. Although SUD is a disease, many still associate it with a lack of willpower and view those with the condition as having a moral weakness. All dentists can play a role in correcting misconceptions surrounding SUD.

Resources for help

Dentists who believe they have a SUD have several options for seeking help. The ADA's Well-being Directory lists states with well-being committees, which can provide resources (www.ada.org/~/media/ADA/Files/ADA_Dentist_WellBeing_Program_Dir.pdf?la=en). Another option is the behavioral health treatment services locator on the Substance Abuse and Mental Health Services Administration (SAMHSA) website. SAMHSA also offers a 24-hour helpline.

Dentists with SUD may need to transfer their patients to colleagues. The transferring dentist should give the colleague a complete report and document it in the dental record to avoid charges of patient abandonment.

Because SUD is being increasingly recognized as a disease, more states allow dentists to enter recovery programs rather than simply discipline them. These recovery programs are typically peer-based, which helps reduce embarrassment and denial.

Dentists should understand there is a high likelihood they can return to practice once their disease is managed. The recovery rate for dentists has been estimated to be as high as 90 percent.

The impaired colleague

The ADA Code of Ethics states that dentists have an ethical obligation to urge "chemically impaired" colleagues to seek treatment. Dentists who know a colleague is practicing when impaired should report the behavior to the professional assistance committee of a dental society. However, too often dentists choose not to speak up for a variety of

continued, pg 2 ...

reasons, including fear of harming the colleague professionally or fear of retaliation from a more senior colleague.

Talking with a colleague suspected of having a SUD is difficult, but it can save the person's life and protect patients from harm. Dentists should also know that the myth of someone needing to "hit rock bottom" before seeking treatment has been dispelled. The earlier someone receives treatment, the better.

If the dentist is not comfortable talking with the colleague alone, another option is to plan an intervention. Kane notes that an intervention tries to "disrupt the circle of denial." Members of the intervention team might include someone from the state dentist well-being committee and, ideally, at least one dentist in recovery.

Dentists who refuse to acknowledge their problem should be told that they will be reported to the state dental board, and this should be done. If they agree there is a problem, they should be referred for evaluation by a multidisciplinary team. If the team agrees there is a SUD issue, the dentist should then undergo inpatient or outpatient treatment, depending on factors such as comorbid psychiatric or medical conditions, financial considerations, and support networks.

Interactions with a colleague about SUD should be documented in detail. However, information should be kept confidential to avoid charges of defamation of character.

Monitoring

Dentists who undergo treatment for SUD will usually be monitored; group therapy, peer support groups, counseling, and drug testing are common.

Continued monitoring after the initial successful treatment helps improve long-term success. Monitoring typically continues for about 5 years or longer, if the dentist is at high risk for relapse (e.g., family history of SUD; opioid addiction, especially combined with psychiatric disorder; and a previous relapse). Initially, work hours may be restricted to reduce stress and possible relapse.

Nonjudgmental approach

Dentists with SUD have a disease, so a nonjudgmental approach is key when providing assistance or seeking it. Treatment is often successful, which makes it imperative that dentists seek help when needed and encourage others to do so. By doing so, dentists can protect themselves, their colleagues, and their patients from the physiological, psychological, and professional consequences of untreated SUD.

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SIGNS AND SYMPTOMS OF SUD

The items below may indicate substance misuse, however, it is also important to consider other causes. For example, difficulty concentrating may occur when a prescription medication is changed.

- Frequent absenteeism and tardiness
- Memory loss and difficulty concentrating
- Poor decision-making
- Relationship issues
- Deterioration in physical appearance
- Risk-taking behavior
- Withdrawal from social activities

Sources: www.tn.gov/content/dam/tn/workforce/documents/injuries/Employer%20Implementation%20Guide.pdf, www.ncadd.org/about-addiction/signs-and-symptoms/signs-and-symptoms

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Dental Expressions® – From the CNA Claim Files

Sedation Auto Crash

Practitioner: General dentist

Claimant: 64-year-old female patient

Risk management topics: Informed consent; patient non-compliance; controlled substance management; documentation

Facts: The patient's treatment plan called for four extractions. Because the patient was uneasy about dental treatment, the dentist intended to use an anxiolytic medication. Prior to the appointment, the dentist advised the patient to bring someone with her to drive her home after the procedure, since the

medication would impair her ability to drive safely.

On the day of treatment, the patient was accompanied by her adult sister. The dentist proceeded as planned. He administered the anxiolytic medication and later administered a local anesthetic before proceeding with the extractions. When the patient was stable and ready to leave, the dentist helped her to the car's passenger seat. She resisted and walked around to the driver's seat, explaining that her sister was not licensed to drive.

The dentist then brought the patient back into the office, again explained the dangers of driving while impaired, and cautioned her against such action. He advised the patient to call someone to pick her up. The patient responded that no other friends or family members could pick her up, but a relative lived three blocks away. She stated that she would drive straight there and wait for the medication effects to end. The dentist yet again told her that she was not to drive for the rest of the day, and suggested that she relax in his extra operatory to allow further time for the drug effects to diminish. Against his advice, the patient left the office to drive to her relative's home nearby.

The dentist called the patient for several days thereafter, but he was unable to reach her. He then sent a letter, but received no reply. The dentist's dental assistant finally reached someone at the patient's home who said that the patient had passed away on the day of her dental visit. A few weeks later, the dentist received a call from the patient's son regarding a credit card payment she had made to cover future treatment expenses. The dentist refunded the fees, but still was unaware of how the patient had died.

Not long after the son's call, the dentist's assistant spoke with the patient's granddaughter, who lived near the dental office. The granddaughter said that the patient did not drive to her home after her dental treatment. The patient's sister told family members that the patient swerved all over the road while driving home. She tried to convince the patient to stop the car and pull over, but was rebuffed. About five minutes away from her home, the car left the road, flipped and rolled into a ditch. The patient died in the single car accident, while her sister survived. The patient's sister told family members about the dentist's advice and actions after the dental treatment.

Key Allegations: The patient's estate did not file a claim of any kind.

Claimed Injury/Damages: No claimed injury or damages were asserted. However, the state police investigation revealed the circumstances that preceded the automobile accident. Given the situation, the police investigators forwarded information to the state dental board. Consequently, the board opened an investigation in order to determine if the dentist acted appropriately and practiced within the standard of care.

Analysis: Risk Management Issues: The dentist diligently tried to protect the patient from injury. As explained previously, he took several actions to convince the patient that driving could lead to serious consequences. The dentist was emphatic in his instruction that she not drive for the remainder of the day.

Should the dentist have done more? One simple step may have been to confirm that the patient's sister was licensed to drive and that she was prepared to take responsibility for the patient after the procedure. No driver would mean no preoperative medication. The next step would have been to reschedule the procedure or proceed with local anesthetic only, with patient consent. Either option would have permitted the patient to drive herself home unimpaired. Perhaps the dentist could have obtained a taxi or other car service for the patient (which may have been refused), or have a staff member safely transport the patient. Note that staff transportation would involve other risks for the dentist/employer.

Other actions may be possible, but does a dentist have the right — or the obligation — to prevent an impaired patient from driving? Could a patient allege wrongdoing if a dentist *failed* to take such an action? A step to consider may involve taking the patient's car keys, similar to how a bartender might try to protect the safety of an intoxicated customer. While addressing public safety, this action may constitute "unlawful restraint." On the other hand, we know that victims who sustain injuries from accidents caused by intoxicated individuals (or their family members) have successfully sued restaurant/bar owners for permitting an intoxicated patron to drive. Retail establishments serving alcohol encounter this scenario, yet healthcare providers also have been targets of similar allegations.

If the impaired patient leaves the office against medical advice, is there a duty to contact law enforcement and report the situation for the sake of public safety? Can a patient accuse a dentist of wrongdoing for taking such an action? These are complex questions. Each dentist who prescribes or administers such medications for dental procedures should investigate and, if necessary, seek legal counsel within his or her own jurisdiction. As with state dental practice statutes, such laws and associated responsibilities vary from state to state.

Practice "preventive risk management" by taking steps to preclude a situation in which an individual is impaired and has no other means of transport.

With respect to the dental board investigation, the dentist and his attorney met with the investigator to review the facts of the case and the care provided. Patient records and documentation in this case failed to comply with requirements. Benzodiazepines are controlled substances. Although the dentist neither stored nor distributed any other controlled drugs, this medication was kept in an unlocked cabinet under the sink. The dentist admitted to not fully understanding the storage and recordkeeping requirements for controlled substances. The dentist was required to maintain records of medication receipt, use and safe disposal. In his report findings, the investigator described the required records and cited the pertinent regulations. The dentist indicated that he would immediately comply with requirements and also agreed to ensure that patient charts properly document medications dispensed or administered. The dentist failed to document this information in the past in some cases. Although the dentist regularly documented such information in the office appointment book, this record keeping was deemed to be inadequate. In the wake of the current opioid crisis, many states are re-assessing and revising their controlled substance statutes and requirements. New laws and requirements also have been enacted addressing state/regional prescription drug monitoring programs (PDMPs) [resource: https://www.cdc.gov/drugoverdose/pdmp/states.html]. Again, statutes may vary significantly by jurisdiction, so consult the state dental or pharmacy board, or other relevant state agencies. While the focus today is primarily on the "opioid crisis," benzodiazepines remain a significant concern for diversion and abuse as well as in combination with opioids, alcohol and other sedative medications. [Resource: https://www.drugabuse.gov/drugs-abuse/opioids/benzodiazepines-opioids]

Outcome: The dental board determined that the dentist had not been negligent in his patient care. However, he was fined $500 for improper storage, distribution, and documentation of controlled substances. He was also required to implement new protocols to correct the identified deficiencies and comply with state/federal law.

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DENTIST'S ADVANTAGE
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IN THIS ISSUE

DENTIST'S ADVANTAGE

Did you know...

...that there is a full library of Risk Management information available to NSDP members on the Dentist's Advantage website?

As a member, you have access to a full range of helpful information that you can use everyday in your practice. They include:

- **Dental Office Forms** – Our Dental Office Forms system represents one of the valuable and useful tools we provide to assist you in managing your practice in the safest way possible. Included in this library are dozens of Record Keeping Forms and Consent Forms. Some examples are:
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  - Chart Review Checklist
  - Post Extraction Instructions
  - Consent Forms
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