CHEMICAL DEPENDENCY CONTINUING EDUCATION ARTICLE FOR 2010

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Your answers must be received no later than January 31, 2011. If you have any questions, call the Concerned Dental Professionals Program Director, Dr. Wayne McElhiney, at 615-628-3200.

When Dentists Do Drugs

A Prescription for Prevention

By Eric K. Curtis, DDS, MAGD

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John M. Murray, DMD, always considered his childhood to be normal—although, as he points out, his "normal" childhood included observing frequent consumption of intoxicating beverages. He remembers family gatherings that revolved around "a lot of alcohol, where people drank too much and sang together." As a teenager, Dr. Murray attended a Jesuit prep school where the intensive academic and athletic programs didn't allow for alcohol consumption. Dr. Murray describes his college experience as "normal," too: "In the late-1960s and early-1970s, when drugs of all kinds were readily available, if all you did was drink, you were considered normal." The future dentist could hold his liquor, he thought, and he felt confident that it didn't interfere with his day-to-day ability to function.

Once he became a dentist, things began to change—Dr. Murray got into practice, life became more stressful, and drinking evolved from a social event into a convenient escape, a way to smooth the day's tensions. "I occasionally thought that I probably shouldn't be drinking so much," he recalls. Yet as normal became abnormal, denial became a powerful counterbalance: "I would think, 'I'm a health care professional. I can't be having a problem.'"

Dr. Murray explains that a dentist involved in substance abuse lives a vacillating life of Jekyll and Hyde compartmentalization. "By day, I was an upstanding professional with a young daughter," he says. "At night, though, I was secretly a heavy drinker." Dr. Murray began to seriously question his drinking habits after his father's sudden death. A running partner inspired him to attend a meeting of Alcoholics Anonymous (AA), although he remembers thinking, "I don't need this." Then, jarred by divorce and his mother's death, Dr. Murray began seeing a psychologist to sort through his feelings. "The psychologist told me to make a list of things that I needed to take care of in my life. He looked at my list and said, 'You left off one thing: You're an alcoholic. If you had realized that, your list would have been a lot shorter.'" With those words, Dr. Murray finally checked himself in for a 28-day stay at Father Martin's Ashley, an in-patient treatment center for alcoholism and drug addiction in Havre de Grace, MD.

The risks of dentist addiction

Substance abuse is not uncommon in this day and age. In 2003, nearly 20 million Americans ages 12 and older were using illicit drugs. In 2004, a full 10 percent of high school seniors reported nonmedical use of Vicodin™. According to White House Office of National Drug Control Policy data from 1999, 53 percent of adults who are currently in federal prisons are there for drug-related crimes and at least half of all violent crime is tied to drug use.

According to the U.S. Department of Health and Human Services *2008 National Survey on Drug Use and Health*, an estimated 20.1 million Americans ages 12 and older were current illicit drug users. A December 2008 U.S. National Institute on Drug Abuse (NIDA), survey revealed that 10 percent of high school seniors reported nonmedical use of Vicodin™.

If the statistics related to substance abuse are astounding, so are the corresponding financial costs. Harold Crossley, DDS, PhD, professor emeritus of pharmacology at the University of Maryland, points to Canada, where the abuse of alcohol—the most misused substance in the country—is estimated to cost each Canadian taxpayer $463 every

year. In the United States, the NIDA indicates that substance abuse treatment and control costs each American taxpayer $1,568 every year, more than diabetes and cancer combined.

Eric Z. Shapira, DDS, MAGD, MA, MHA, a dentist and clinical gerontologist in Montara, Calif., and author of *A New Wrinkle: What I Learned from Older People Who Never Acted Their Age*, points out that the individual costs and dangers involved with substance abuse and dependencies are especially enormous for medical professionals. "Depending on the drug, the risks of addiction include loss of license, malpractice lawsuits, cardiac arrest, infection, financial ruin, increased depression, divorce, loss of family and social connections, increased despair, and the possibility of death."

Yet even with stakes this high, dentists regularly gamble with addiction—and may be even more likely than their patients to succumb. "About 10 to 12 percent of the general population becomes addicted to alcohol or drugs at some point in their lives," says Michel A. Sucher, MD, medical director of the Arizona State Board of Dental Examiners' Monitored Aftercare Treatment Program. "For dentists and physicians, the prevalence is probably 12 to 19 percent." In Dr. Sucher's experience, dentists' drugs of choice are typically alcohol, opiates—mostly hydrocodone and oxycodone—and nitrous oxide. According to John W. Drumm, DMD, chair of the District of Columbia Dental Society's Well Being Program and former chair of the American Dental Association's (ADA) Dentist Well-Being Committee—subsequently renamed Dentist Health and Wellness—alcohol is the drug of choice for 37 percent of dentists with substance-abuse problems, while prescription drugs (particularly opiates such as hydrocodone and anti-anxiety agents such as benzodiazepines) are used by 31 percent, nitrous oxide by 5 percent, and street drugs (including cocaine) by 10 percent.

Why dentists get addicted

Dr. Sucher believes that the higher frequency of dentist addiction is due to the compulsive personality type found in medical professionals, which can predispose those individuals to addiction. Dr. Crossley confirms that addicts typically display behavior that is "anal retentive, compulsive-obsessive, controlling, and manipulative." These various patterns often allow addicts to find "enablers"—colleagues, employees, and family members—who allow drug dependencies to progress and worsen.

Dr. Shapira notes that external stressors also contribute to addiction. He says, "Dentist addiction is often attributed to stress. Dentists may not be able to handle the financial burden of a practice or they have family problems and find that drugs ease their emotional and physical pain." The NIDA cites exposure to stress as one of the most powerful triggers of substance abuse in vulnerable individuals.

According to Dr. Drumm, the ADA's *2003 Dentist Well-Being Survey* shows that dentists are more susceptible to addiction than other populations. "Our practice environment is an enabler," he says. "Seventy-six percent of dentists are sole proprietors. We are strongly independent and isolated from our peers." Such isolation, coupled with long work hours of focused concentration in direct patient contact, leads to fatigue—as does the stress of competition. "We see other dentists as competitors instead of colleagues," Dr. Drumm says. "This is a perception that results in pressure to be better than our peers."

Such pressure manifests itself in various ways. "We labor under the myth of [placing] the perfect restoration," Dr. Drumm says, "and the myth that we must always perform pain-free dentistry." Career stressors—balancing the competing roles of providing clinical care and managing a small business, often under the burden of crushing dental school and practice debts—also add up, as do life stressors that include personal, familial, and communal expectations of success.

Dr. Drumm notes that the *2003 Dentist Well-Being Survey* found that only 65 percent of dentists were very satisfied with their job, while 6.3 percent were very unsatisfied. "Unhappy dentists are very unhappy," he says. "As a result, we may look for something to relax, [so that we can] forget, avoid, and escape our troubles."

And of course, the dental office itself may offer an easy method of escape. Nitrous oxide is readily available, and dentists not only have ready access to drugs, but they can write their own prescriptions as well. Dr. Shapira once worked with a dentist who was eventually discovered to be abusing cocaine and prescription narcotics. "He wrote prescriptions for specific patients," Dr. Shapira recalls, "then asked the patients to give the drugs back to him in trade for free dental work." The owner-dentist ultimately exhibited a range of bizarre behavior that Dr. Shapira, as a young associate, had to cover for. "He would do odd things during the day, like just get up and leave the office, abandoning his patient in the chair. I would then have to finish his work and make excuses for his absence." Dr. Shapira ended up reporting his boss to authorities.

Dealing with addicted colleagues

In theory, dentists should take a direct and forthright approach to addressing a colleague's problem with drinking or drugs. "The *ADA Principles of Ethics and Code of Professional Conduct* states that it is unethical for a dentist to practice while abusing controlled substances, alcohol, or other chemical agents that impair the ability to practice," Dr. Drumm says. "It also states that all dentists have an ethical obligation to urge chemically impaired colleagues to seek treatment." Dentists, he says, have an ethical responsibility to report evidence of an impaired colleague to the professional assistance committee of a dental society.

Dr. Sucher agrees. "If dentists are concerned about a colleague," he says, "they should not ignore it or cover it up. They should initially try and talk with the individual about their concern for his or her well-being."

Having said that, Dr. Drumm concedes that many dentists are uncomfortable with the idea of confronting a colleague, and notes that moral imperatives may be hindered by social ones. "Unfortunately, in dentistry there is a conspiracy of silence," he says. "Dentists resist acknowledging a colleague's impairment and are reluctant to accuse a colleague without 'proof.' They don't want to cause more problems for a colleague. Most dentists simply don't want to get involved."

In fairness, hard evidence of impairment may be difficult to come by. As Dr. Drumm observes, "Dentists protect their job and professional status at all costs. It is not unusual for dentists to have their entire life in chaos before there is evidence that a problem exists."

Dr. Murray concurs with this assessment. "One of the last things to go is your practice," he says. "You try to keep your livelihood as well-protected as you can."

While confronting a colleague with

suspicions of addiction can be awkward, Dr. Murray insists that "if we become aware of a colleague practicing while impaired, we have a responsibility to make his or her name known to somebody."

Dr. Murray recommends a careful course of action for helping addicted dentists. First, talk to the dentist. This step may be best accomplished through an intervention staged by the state dentist well-being committee, which, when well-rehearsed, can make it very difficult for the patient to reject. The intervention group should include at least one dentist who is in recovery, although having more than one is even better. "It has been shown that having one or more dentists who have 'been there' has a comforting effect," Dr. Murray says.

Dentists who refuse to cooperate must understand that their names will be given to the state dental board. However, if a dentist agrees to cooperate, he or she should be referred for evaluation by an addiction professional, such as an addiction psychiatrist, an American Society of Addiction Medicine (ASAM)-certified physician, or treatment center evaluation staff members. If the addiction professional determines there is an addiction issue, the dentist must agree to treatment—either in-patient residential, intensive out-patient, or both. All of these steps will be confidential.

Addicted dentists should also be made aware that as they follow through with treatment, the state dental board may become aware of the problem. Should this happen, the Dentist Health and Wellness Program can advocate on their behalf.

The emergence of well-being programs

Dentists admittedly tend to make poor patients, at least at first. "As patients, dentists want to be in control," Dr. Drumm explains. Dental professionals have their pride and egos to protect, and they are used to being in charge. They are often unwilling to admit their needs and seek help. "Dentists believe they can think their way out of their problem," he says. "They may exhibit extreme denial of symptoms. They have difficulty accepting the role of patient and do not readily let down their professional guard." Dentists also tend to be accustomed to procedures with tangible outcomes, making them innately suspicious of the softer, psychological aspects of addiction treatment. "Dentists cover up emotions," Dr. Drumm says. "We don't do 'feelings'."

Ironically, the recovery rate for dentists who receive the appropriate treatment is very high; according to Dr. Murray, "It's about 90 percent for health professionals…. Dentists become highly motivated once they realize that their license, their livelihood—their whole identity—depends on getting well."

Dr. Drumm describes three kinds of well-being programs in dentistry: peer assistance programs, diversion programs, and multidisciplinary programs. Peer assistance programs are mainly composed of trained volunteer dentists who supply information and resources for impaired dentists—colleagues helping colleagues in need of assistance. "Peer assistance is a vehicle for a concerned colleague, employee, family member, or patient to seek some help for a dentist with a problem without bringing the dentist to the attention of a licensing board," says Dr. Drumm. "It is not a treatment program; rather, it's a way to direct and guide an impaired dentist into treatment."

Diversion programs involve a process by which an individual is "diverted" from regulatory (licensing board) action onto an alternative track, provided the impaired individual complies with the program's recommendations of treatment and mandatory testing. Multidisciplinary programs are formal programs in which an agency—usually state-mandated—is charged with assisting licensed health care workers. "Dentists have higher success rates when treated within their peer group, which helps to reduce shame and break patterns of denial," Dr. Drumm says, citing 2003 California well-being program statistics that show a 74 percent success rate over a 20-year period. "Adequate treatment with long-term professional monitoring gives the highest rate of success."

The benefits of after-treatment monitoring

According to Dr. Sucher, "The combination of in-patient/residential treatment followed by five or more years of structured, accountable monitoring is key to success." He describes a 2009 study published in the *British Medical Journal* that involved 904 physicians from 16 physician health programs. The study showed that 78 percent had not had a single slip or relapse after entering treatment, with an average of 7.2 years of recovery. Of the remaining 22 percent, two-thirds had a brief relapse, followed by five or more continuous years of sobriety during the study period. "That is a success rate in the low 90 percent range," Dr. Sucher says, "which is comparable to our data for dentists in Arizona and other physician health programs around the country. In fact, the success rate for dentists and physicians who go through in-patient treatment—usually for one to three months, with monitored aftercare—is so high that thought is being given to trying to apply this treatment model to the general population."

In Tennessee information regarding treatment of a dental professional is deemed to be confidential and the TDA's Concerned Dental Professionals Committee (CDPC) does not release this information to the Tennessee Board of Dentistry. Information is provided to the Tennessee Board of Dentistry ONLY if the professional being treated is non compliant with the aftercare requirements of the treating facility and the CDPC.

Most physician/dentist monitoring programs last for five years. Dr. Sucher cites a study published in the March 2005 *Journal of the American Dental Association (JADA)* that identified three relapse factors in health professionals: a strong family history of addiction; opioid addiction, particularly in combination with a co-occurring psychiatric disorder; and prior relapse. The more of these factors that an individual demonstrates, the greater the risk of relapse. Dr. Sucher sees a trend toward longer monitoring—including seven years, 10 years, or the length of one's career—for individuals who are at higher risk. "The length of these programs will probably increase as we continue to learn more," he says.

The important part of recovering from any drug dependency, Dr. Murray emphasizes, is treatment: "There are a lot of nonjudgmental people there to help." Dr. Murray, who has been in recovery from alcohol addiction for more than 13 years, is currently involved in a successful 12-step program. In addition, he performs monitoring for New Jersey's Professional Assistance Program (PAP), an independent monitoring organization sanctioned by New Jersey State health boards; he lectures to dental students at the University of Medicine and Dentistry of New Jersey about the addicted/impaired professional and treating the addicted patient; and he serves as co-chair of the dental section of the University of Utah School on Alcoholism and Other Drug Dependencies. "Realize that addiction is a disease," he says. "It's highly treatable, but left untreated, it's a fatal disease. It will kill you, and you will take a lot of people down with you." He warns that sobriety is not a do-it-yourself project. "Don't try to dig yourself out of the hole. Alone, you'll dig it deeper. 'I'll do this myself' are famous last words."

The rewards of recovery include a heightened appreciation for life. Two of Dr. Murray's great pleasures are his 11-year marriage to a sober woman whom he met in recovery and his relationship with his daughter, now 30, who was about to turn 17 when she saw him through recovery. Just recently, he says, she called him after watching an addiction scene in a movie and told him, "Dad, I just wanted to say I have so much respect for you."

"Treatment is intense, but there is serenity and happiness afterward. I'm living a much more full life today, both personally and professionally. My journey in recovery has taken me places I might never have been if I weren't sober and allowed me to meet a network of sober friends, both local and throughout the country, that have enriched my life," Dr. Murray says. "On any given day I know that I can pick up the phone and talk to a sober friend and/or colleague about anything. Sometimes we'll both comment that without recovery we might not even know each other. That is one of the wonders of a sober life."

Eric K. Curtis, DDS, is a former member of the Arizona State Board of Dental Examiners' Monitored Aftercare Treatment Committee.

Complete the exam on page 18.

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As a benefit to our members, the TDA offers your office both federal and state workplace posters far below what you would normally pay. As of November 2009, the federal workplace poster was updated to reflect the current equal employment opportunity law. **As of February 2010, the state workplace poster was updated to reflect the current wage regulations/child labor act section.**

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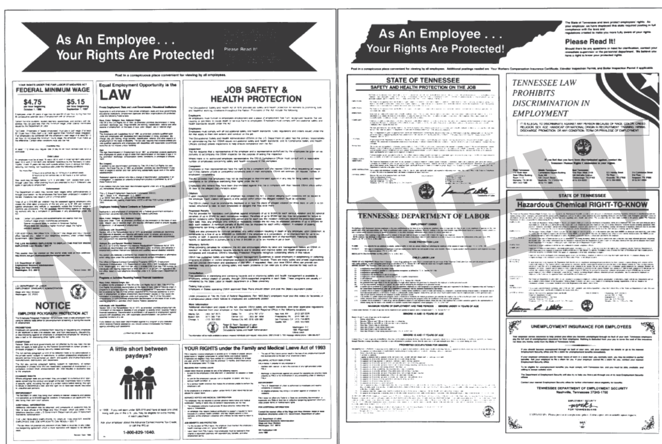

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Exam for 2010 Chemical Dependency CE Article

1. According to Dr. John Murray, as his use of alcohol went from normal to abnormal, what psychological process became a powerful counterbalance for his use?
   a. A normal childhood
   b. The fact that he was a dentist
   c. Denial
   d. That he attended a Jesuit prep school

2. A December 2008 NIDA survey revealed what percent of high school seniors reported non-medical use of Vicodin.
   a. 12%
   b. 10%
   c. 15%
   d. 18%

3. According to Dr. John Drumn, what is the drug of choice of dentists with substance-abuse problems?
   a. Hydrocodone
   b. Benzodiazepines
   c. Cocaine
   d. Alcohol

4. The NIDA cites one of the most powerful triggers of substance abuse in vulnerable individuals is:
   a. Stress
   b. Beer commercials
   c. Attending a professional sporting event
   d. All of the above

5. Dr. John Murray recommends a careful course of action for helping an addicted dentist. The first step:
   a. Ignore the problem
   b. Help the dentist cover up the problem
   c. Talk to the dentist through an intervention staged by the state dentist well-being committee
   d. Decrease the amount of alcohol or drugs consumed

6. Dentists admittedly tend to make poor patients at first because:
   a. Dentist want to be in control
   b. Have their pride and egos to protect
   c. They believe they can think their way out of their problem
   d. All of the above

7. Ironically, the recovery rate for dentists who receive the appropriate treatment, according to Dr. Murray, is about:
   a. 50%
   b. 90%
   c. 80%
   d. Treatment is of no value

8. What is the key to success in treating professionals according to Dr. Michael Sucher?
   a. In-patient/residential treatment
   b. Monthly visits to a psychiatrist
   c. Five or more years of structured accountable monitoring
   d. Both A & C are correct

9. In the 2003 Dentist Well-Being Survey what percent of dentists were well satisfied with their job?
   a. 60%
   b. 84%
   c. 65%
   d. 90%

10. Dr. Sucher cites the March 2005 Journal of the ADA that identified three relapse factors in health professionals that include:
    a. A strong family history of addiction
    b. Opioid addiction
    c. Co-occurring psychiatric disorder
    d. All of the above

11. According to White House Office of National Drug Control Policy data from 1999, at least what percent of violent crime is tied to drug use:
    a. 53%
    b. 60%
    c. 65%
    d. 50%

12. Dr. John Drumm observes that hard evidence of impairment of a colleague may be difficult to come by because:
    a. It is not unusual for dentists to have their entire life in chaos before there is evidence that a problem exists
    b. Addiction actually has no adverse effects on the practice
    c. Most dentists go to church regularly
    d. None of the above are correct

1. Circle the correct answer on the exam and complete the form below;
2. Mail, along with your check or credit card payment, to: Tennessee Dental Association, 660 Bakers Bridge Ave., Suite 300, Franklin, TN 37067, *prior to January 31, 2011.*

Date:__________________ *(Credit is granted, upon successful completion of the exam, in the year materials are read and the exam submitted.)*

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