American Dental Association
Council on Dental Practice

The ADA Dentist Well-Being Programs Handbook

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Foreword

Dental society staff and well-being volunteers have asked for a handbook that can support their efforts to give a helping hand to their colleagues. Here it is!

The needs and resources of each dental society are unique; some dental societies have elaborate assistance programs in place to help dentists whose practices have suffered from personal impairment. Other dental societies have simple programs, some dental societies work cooperatively with multidisciplinary programs that serve a range of professions in the state, and some dental societies allow their state licensing boards to be the sole determinant of what kind of assistance a dentist may receive.

Some dentist assistance programs focus only on issues directly related to chemical dependency; others have expanded to address a range of issues, including stress, depression, and support to infected providers. We have attempted to draft this handbook in such a way that it can be a resource to all kinds of programs.

In 2013, we asked the Dentist Well-Being Task Force to review this handbook which was created in 2004. We have many people to thank. The manager of the Dentist Well-Being Programs drafted the text. The text was extensively reviewed and revised by past and present members of the Dentist Well-Being Advisory Committee. Their names appear below. Other dentists graciously shared their personal stories, which help bring the importance of professional assistance issues to life. Our deepest thanks go to them.

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Introduction

There were no warning signs telling me that alcohol would become a problem in my life. I came from a loving, middle class home with two parents, and no history of alcoholism. With hard work, I could do or be anything. I certainly did not grow up wanting to be an alcoholic. My story is not unique, but one that is echoed by countless others.

— Anonymous, D.D.S.

What's The Problem?

The conferral of a professional degree and the granting of a license to practice do not carry with them immunity from addictive disorders, psychiatric illnesses, infectious disease, family and relationship problems, or the many varieties of human misery.

- Professional training instills values and behaviors antithetical to self-care — deferring other life goals during long and rigorous educational programs and always placing a patient's needs ahead of one's own, to name a couple.
- Many professionals have focused on professional goals from an early age, and may have jeopardized their development of crucial emotional and relationship skills. Dentists who were highly competitive students may have had little experience with intimate partnerships or the normal unpredictability and challenges of family life.
- Some aspects of dental practice — isolation, for example, and access to controlled substances, a DEA number, nitrous oxide, the knowledge about how drugs work, and an office in which to use — may create an environment that actually aids the development of problems.
- Dentists in solo private practices work without the interaction and scrutiny of peers that is often available in a hospital or clinic setting. In the solo practice setting, coworkers are subordinates and the dentist holds the power of authority and money, making it very difficult for staff to intervene in a problematic situation.
- Healthcare professionals who come from families that have experienced illnesses or addictive disorders may have a genetic predisposition to conditions with the potential to impair their practice. In a 1997 ADA survey, for example, slightly over 20 percent of dentists indicated they have a blood relative that has had problematic alcohol or drug use.[1]

And so, it can happen that good dentists become impaired in their practice.

Little scientifically valid information is available about the prevalence of particular personal difficulties that can adversely affect the practice of dentistry.

1 American Dental Association, *1997 Survey of Current Issues in Dentistry.* American Dental Association: Chicago, IL, 1998, unpublished data.

There is an important distinction between having a diagnosis and being impaired, as one does not automatically equal the other. A dentist who is HIV-positive, for example, has a diagnosis — but his or her practice may never be impaired. A dentist with an active opioid dependence, however, is likely to exhibit some level of practice impairment, where the same dentist with opioid dependence in full remission may be completely competent.

— L.K.

A good guess is that dentists experience about the same prevalence of addictive illness and mood disorders as the general population. Divorce rates seem to be lower.[2] Dentistry by its nature demands precision and perfection, and some dentists, though it is not known just how many, qualify for a diagnosis of obsessive-compulsive disorder. Some dentists find the stress of practice, with its dual demands for clinical expertise *and* small business management, to be unmanageable; some find themselves, at midlife, burned out.

It is also true that, as in all professions and occupational groups, there are a few poor practitioners.

Dentist well-being programs and other professional assistance and advocacy efforts operate on the belief and experience that, in the majority of cases, practice impairment comes as the result of an illness that can be treated.

There are those who would argue that no licensed health professional should be allowed to continue to practice after having become impaired, for whatever reason. Impaired practice *can be* and sometimes is seen as such a breach of public trust and a threat to public safety that the practitioner should be removed from practice, sometimes indefinitely.

Countering this are the excellent recovery rates of professionals who have been adequately treated for addictive illness and who are diligent about their participation in monitoring programs and ongoing treatment recommendations.[3] These individuals will often report striking qualitative differences in their practices, as their experiences with personal illness and recovery have made them more empathic, more compassionate, and better able to deal with stress on many levels.

Health care professionals are a national resource. Professional training programs represent a considerable investment of public and private funds. The completion of professional training often has required considerable sacrifice (financial, emotional and social) on the part of the student and, often, the family. Debt incurred during training may be substantial. Retention of highly trained professionals — provided there is a reasonable expectation of competence and safety — is certainly in the best interest of the public.

2 American Dental Association, *1995 Survey of Dentists.*

3 Talbott, GD, Gallegos, KV, Angres DH, "Impairment and Recovery in Physicians and Other Health Professionals." In *Principles of Addiction Medicine, Second Edition.* Chevy Chase, MD: American Society of Addiction Medicine, Inc., 1998, pp. 1263-1279.

Chapter 1

One day, another dentist had the courage to come to me and say, "It is time to do something about your drinking."

— Anonymous, D.D.S

Why? How?

For over twenty years, dentists have been available in an organized way to help each other with personal problems. It started with recovering dentists, and others with a sympathetic understanding of the disease of alcoholism and drug addiction, working to put a system in place to reach out to those who were still suffering. Over the years, helping hands have also been extended to dentists with depression or other mental health disorders, those whose edges are frayed from chronic stress and burnout, and to dentists infected with bloodborne pathogens (i.e., HBV, HCV, HIV). Some constituent dental societies also have outreach activities for dentists impacted by the stress of malpractice litigation.

Why?

Self-regulation is one of the characteristics of a profession. For dentists, it is part of the public esteem and trust conferred with the title of "Doctor" and with issuance of the license to practice. Self-regulation is in stark contrast to the 'rules' of the playground or the street or even of college peers.[4] The adage, "nobody likes a tattletale," is a powerful injunction against self-regulation. Corporate America, government agencies and protective peer networks ("the good ol' boys/girls' club") provide ample evidence of the persistent nature of adolescent defiance of authority. The concept of professional self-regulation, however, is that the profession as a whole and its individual members take on the adult mantle of being their own authority, accountable to the public.

The American Dental Association has felt so strongly about this as to incorporate a statement about personal impairment into its *Principles of Ethics and Code of Professional Conduct*:

It is unethical for a dentist to practice while abusing controlled substances, alcohol or other chemical agents which impair the ability to practice. All dentists have an ethical obligation to urge chemically impaired colleagues to seek treatment. Dentists with first-hand knowledge that a colleague is practicing dentistry when so impaired have an ethical responsibility to report such evidence to the professional assistance committee of a dental society.[5]

The other reason for dentists to be involved in these activities, and perhaps the most compelling, is that no one understands dentistry like other dentists. Who else knows

4 White, WL, T*he Culture of Addiction, The Culture of Recovery.* Bloomington, IL: Lighthouse Training Institute, 1990.
5 American Dental Association, *Principles of Ethics and Code of Professional Conduct:* Principle: Nonmaleficence, 2.D.

what it's like to do precise work in a small, wet space belonging to a person with fears and trepidation? Who else knows what it's like to be a master clinician *and* the owner/manager of a small business? Who else knows what it's like to go through dental school, to make all those early practice decisions, and to start out with student debt? Who else knows how good a good day in the office can be — or what a really bad one feels like?

What?

The American Dental Association made a strong statement when the 1996 House of Delegates adopted Resolution 18H-1996, the *Guiding Principles for Dentist Well Being Programs*. In this, the constituent societies are strongly encouraged to be actively involved in peer assistance — through assistance activities, education of its members, students and the licensing board, collaboration with other communities of interest, and support of its well-being volunteers.

About This Handbook

With these things in mind, this handbook is intended to be a guide to the constituent dental societies and their volunteers in extending a helpful professional hand to dentists in need. In it, you'll find a wealth of information about program development, maintenance and marketing. There are many ways to provide assistance to dentists, from elaborate programs to a simple referral system, and in here you'll find suggestions for how to keep the dental society involved in a way that works in a particular locale.

Chapter 4 *("Designing an Assistance Program") contains a* list of questions*, the answers to which will define the structure of a particular program. For those looking for a place to start, this inventory will help to clarify the issues and areas where more information is needed.*

Chapter 2

Resolved, *that constituent and/or component dental societies be urged to include these guiding principles in establishing or structuring peer assistance programs for dentists:*

That statewide dentist peer assistance programs be established.

American Dental Association, Resolution 18H-1996

Structural Models Of Well-Being Programs

Peer assistance programs offer dental societies an opportunity both to serve members of the profession and to participate in the protection of the public. Dentists, with their skill and specialized training, are an important national resource.

The public needs the services that only dentists can provide, and needs to have the confidence that they are protected from impaired and/or unsafe practitioners. The missions of professional (in this case, dental) licensing bodies are protection of the public, competence of licensees, and the promotion of fair competition.[6] Organized dentistry can have a dual mission in regard to peer assistance — stewardship of the national resource of dental professionals *as well as* partnership in protection of the public.

There is great variety, from state to state, in the way the professional assistance needs of dentists are met. Law — statute or rules — establishes diversion programs. As such, the state has, at minimum, oversight responsibility for the program. In some states, the state directly administers the program, and in others it contracts for services by an outside agency.

So, why would a constituent dental society sponsor a well-being program in a state that has a diversion program? There are at least five reasons:

1. The dental society program can provide a vehicle for a concerned colleague, employee, family member or patient to seek some help for a dentist, without bringing the dentist to the attention of the diversion program.
2. An established program can support the work of the diversion program by making recovering dentists available to assist with interventions or monitoring, or to assist with practice coverage when a dentist is in treatment.
3. Members of the dental society well-being committee can speak at component meetings, and to dental students, and can help the staff and officers of the society be aware of the needs and issues of recovering dentists.
4. A dental society program can reach out to a broader group of dentists, dental team members, dental students or dental family members — or to dentists with other needs than those under the purview of the diversion program — if they choose, suggesting programs for annual meetings on stress and burnout prevention or healthy family

6 Yuen, S. The Form and Function of a Practice: How State Boards of Examiners Affect Dental Practice. *Journal of the American College of Dentists*, 63(2), p. 22-26.

The term "diversion program" is often a confusing one, especially to people who are familiar with the substance abuse terminology of "drug diversion."

In this case, "diversion" refers to the process where an individual is 'diverted' from regulatory (i.e., licensing) board action into an alternative track or program. This is done so that those licensed professionals who have been reported to the regulatory board for incompetent practice or violations of the practice act can first receive appropriate evaluation and treatment when it is likely that the impairment in practice has resulted from addictive, psychiatric or medical disorders. Licensed professionals whose misconduct is related to criminal, fraudulent or otherwise illegal activities are generally not eligible to participate in a diversion program.

— L.K.

dynamics. Some states offer services to dentists experiencing the turmoil of a lawsuit, for example, or to infected practitioners.

5. The dental society program can promote awareness and early utilization of the diversion program, so that dentists could receive assistance before their impairment brought them to the attention of the licensing board itself.

Each of the structural designs of well-being programs has advantages and disadvantages. And, of course, whether something is seen as advantageous (or not), will vary between states. For example,

Volunteer programs are inexpensive and can provide very meaningful professional involvement for members. These programs are under the direct control of the dental society. On the other hand, there is a risk of volunteer burnout, dependence on one or a few individuals and, perhaps, difficulty in coordinating adequate monitoring of recovering dentists. Since volunteers are not credentialed mental health professionals, the limits and boundaries of their activities must be very clear.

Staffed programs have a high level of accountability to the dental society. Dentists may be well served when the staff member has the time and skill to coordinate volunteers in intervention, outreach and educational efforts. Calls of concern to the dental society about impaired dentists can be easily transferred to program staff. In addition, these professionals are likely to be keenly aware of dental practice issues in specific locations and to be able to use this information in developing monitoring agreements. Staffed programs are expensive, however, and there may be issues of liability if the staff person is not a credentialed mental health professional.

Multidisciplinary programs are agencies charged with administering identification, referral and monitoring services to several professional groups (typically physicians, dentists, nurses, pharmacists, veterinarians, etc.) These programs are usually adequately funded, staffed by individuals with credentials and expertise in behavioral health and addiction medicine, have established procedures and appropriate liability coverage. These

programs are funded through license fees so that they are, therefore, ultimately accountable to the state and *not* to the professional associations of the licensed professionals in their care.

If a dental society discontinues its involvement in well-being activities, however, relinquishing all activities to the multidisciplinary program, there can be significant gaps in outreach and educational activities to dentists. Services may be provided to dentists by professionals whose understanding of dental practice issues may be limited. This can mean that dentists in treatment or under monitoring contracts may not have the benefit of appropriate peer assistance and support, which can result in continuing professional isolation and less-than-optimal monitoring arrangements. Since dentists are a smaller professional group than physicians and nurses (typically the largest groups served by the multidisciplinary programs), they are at risk to receive less attention from staff outreach and education efforts.

Contracted programs offer many of the advantages of the staffed programs in accountability, dedicated time and familiarity with the needs of the state's dentists. When the contract is with a medical society program or an employee assistance provider, access to expert consultation and liability coverage are usually assured.

As with the multidisciplinary programs, there is the danger of dental society relinquishment of direct responsibility for well-being activities, and the consequent decline in quality of outreach to groups of dentists.

Having **no program** may be seen as an advantage in that a dental society may not be forced to grapple with the troublesome issues raised by impaired practitioners. A dental society with no program would not need to dedicate any of its resources, whether financial or human, to these efforts.

The drawbacks are considerable, however. Dentists at various stages of impairment may not receive attention until they have been reported to the regulatory board, and dentists with illnesses may only be disciplined rather than referred to treatment. Organized dentistry in these states may be missing an opportunity to take a proactive stance in self-monitoring.

Each state dental society, of course, will decide which structure works best in its circumstances. Things to consider could include:

- the mission and priorities of the dental society;
- perceived and actual need;
- available funds;
- interest and support from the volunteer leadership;
- logistics;
- staffing needs and availability;
- potential for collaboration with other professional assistance programs; and
- stipulations of the state dental practice act.

In summary, there are many ways to fulfill the professional responsibility of accountability for the profession, to the public — in the involvement of organized dentistry.

Chapter 3

One day, I was given an article from (the constituent dental society newsletter), written by a member of Dentists Concerned for Dentists about his battle with alcohol. For the first time, I realized I was not alone. He understood, as only another alcoholic can. With guidance, I admitted myself into an inpatient treatment center. In spite of what I thought, I received support from co-workers, family and friends. My dental practice survived and the world still revolved in my absence.

— Anonymous, D.D.S.

Peer Assistance: What It Is and What It Is Not

Peer assistance is just what it sounds like, one colleague being available to assist another with a particular need. There is the implication that the one offering assistance has had similar experiences as the one in need of assistance, and can share his or her "experience, strength and hope." If peer assistance activities are sponsored by a dental society, there is also the implication that volunteers have some level of accountability to the dental society and some agreed-upon procedures for handling particular situations.

Several professional groups — dentists, physicians, nurses and lawyers, to name a few — initiated peer assistance activities about the same time. These early efforts were most often an extension of individual professionals' involvement in Alcoholics Anonymous (AA) or other 12-step fellowship groups. The Twelfth Step is *about* outreach — "Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs."[7] Dentists and other professionals felt a need and desire to reach out to their *professional* peers in particular, believing that their efforts would be especially valuable because of their intimate understanding of the practice issues and cultural norms of their particular profession.[8]

Peer assistance, as a dental society or any other professional association undertakes it, has some significant differences from 12-step outreach:

- by law, it is confidential, but unlike 12-step activities, it is not anonymous — i.e., both the peer volunteer and the recipient know the identity of the other;
- the peer volunteer is accountable to the dental society;
- in some instances, peer volunteers are asked to make periodic reports to the dental licensing authority on behalf of a dentist on a monitoring contract;
- even if reporting to the dental licensing authority is not required at the time a dentist enters the peer assistance program, issues may arise where this is later required;
- the peer volunteer may refer a dentist to a specific facility for evaluation; and
- the peer volunteer is not necessarily a member of a 12-step group, but may have had experience with some other area of well-being concern.

7 Alcoholics Anonymous- Big Book 4th Edition. New York: Alcoholic Anonymous World Services, Inc, 1976.

8 Williams, AG, ed., *Dentistry Faces Addiction: How to Be Part of the Solution.* St. Louis: Mosby-Year Book, 1992, pp. 84-91.

Peer assistance also differs in some important ways from professional treatment programs:

- peer volunteers do not make diagnoses, though they may recommend or refer a dentist to a professional evaluation; and
- peer volunteers do not provide therapy or other professional treatment services.

Peer assistance is a vehicle for professional self-accountability, as identified in the ADA's Principles of Ethics and Code of Professional Conduct. *It can be a mechanism for a profession to truly care for its own in a time of crisis and fear. And, not least of all, peer assistance provides a means of service for volunteers.*

The peer assistance program is one member of the "recovery team," working on behalf of dentists affected by chemical dependency, mental health problems and other conditions with the potential to impair practice. Depending on the individual circumstances, the peer volunteer may or may not be the leader of the team. This may be an unfamiliar role for a dentist volunteer who is accustomed to leading the team in a private dental office. Other recovery team members may include:

- treatment center staff (physician, primary counselor, continuing care counselor, psychologist, etc.);
- continuing care providers;
- addiction medicine specialist;
- psychiatrist;
- other mental health professionals;
- diversion or multidisciplinary program staff;
- practice monitor;
- AA/NA/12-step group sponsor, and
- other mutual help groups.

The team can work most effectively when each member is clear about the responsibilities of the others, and when the others support the recommendations of one.

Dentist peers have a great deal to offer the team. No one understands dentistry and dental practice like other dentists. The compassion, acceptance and understanding of another dentist can do a great deal for a dentist confronted in an intervention, or who is in early recovery. Addiction, by its very nature, is an isolating illness. Private dental practice can be very isolating as well, so that a dentist peer can be a bridge back into connections with colleagues.

Chapter 4

Today I am very grateful to all of those people that participated in that event (an intervention) that changed my life. It was only during the initial stages of my recovery that I found out how many people my alcoholism was affecting — my wife, my daughter, my friends, my staff, my patients and myself.

— Anonymous, D.D.S.

Designing An Assistance Program

Dental societies are in an ideal position to facilitate much-needed support to dentists with personal problems, and in fact, many have been doing so for years. This chapter is primarily intended for those dental societies that are the direct sponsors of a well-being program, run by volunteers or a dental society staff member working with volunteers.

In the dental societies where a professional consultant is hired, the sections on volunteer training and accountability to the dental society may be helpful. In these situations, the dental society may want to utilize formal job descriptions so that expectations of all parties are clear.

For those dental societies in states where well-being services are provided to dentists through outside (usually multidisciplinary) agencies, this chapter will contain some suggestions on collaborative efforts to optimize outreach efforts to dentists.

Last, but not least, this chapter may be of help to those dental societies that perhaps have never had well-being outreach efforts, or who have seen their programs wither.

Dentist Well-Being Committees

The purposes of a dentist well-being committee are to support dental practices by assisting dentists with substance abuse and/or other disorders to utilize treatment and other resources, and to support the dental society in providing well-being education and support to its members.

Different states choose different titles for their peer assistance committees, though the Council on Dental Practice at the ADA uses the broad, inclusive title of Dentist Well-Being Programs. Most state societies include the phrases "well-being," "concerned dentists," or "chemical dependency" in their committee or council names.

The dental society president may wish to appoint a chair of the well-being committee. It may be helpful to designate a reporting relationship consistent with other committees in the society, if that seems appropriate. While the volunteers may wish to serve indefinitely, a defined term of office for the chair would provide an opportunity for more leaders to become familiar with these needs and issues.

A member of the Council, who is appointed by the Council chair, chairs the Dentist Well-Being Advisory Committee of the ADA's Council on Dental Practice. These have

often been dentists who had little or no experience with well-being activities prior to their appointment. What they have brought to the Committee is valuable experience with volunteer involvement in their component and state dental societies and clear ideas about how to make things happen. In the process, they've become strong spokespersons for the importance of organized dentistry reaching out to dentists and their families, ultimately strengthening practices.

Some of the states have found it helpful to have a committee membership that represents different component societies or regions of the state. This is particularly important in some of the geographically larger states if volunteers need to be available statewide for interventions, monitoring, and other activities.

The dental society may also wish to give careful consideration to the types of expertise needed by the committee. Dentists who are themselves recovering from addictive disorders are often able to offer valuable depth of understanding, judgment and experience. Dentists who have experienced depression, burnout, divorce or other family problems are likely to be sensitive to those issues and can assist the committee in outreach efforts. Dentists with experience with infected provider issues can help to raise awareness and can assist the committee to assess and address this topic. If the well-being program may be used by other dental professionals — hygienists and assistants, for example — it may be very helpful to have those groups represented on the committee. Some committees also have a representative of their Alliance, to strengthen outreach efforts to dental families.

It would be in the dental society's best interests to have some sort of contract or agreement with a physician qualified to provide consultation to the committee on addiction medicine and mental health issues. This is an established practice in the physician and multidisciplinary programs. The dental society may also wish to have an infectious disease consultant. On an ongoing basis, these consultants could assist with training and continuing education of volunteers and development and review of policies and procedures. Peer assistance activities have the potential to uncover situations of possible liability for the dental society where additional expertise is needed. Examples of this could be where a dentist refused to seek a professional evaluation following an intervention, or discriminating between a "slip" and full-blown relapse for a dentist in danger of losing his/her license.

The Committee Chair

The chair should be a member of the dental society in good standing, who is compassionate with colleagues experiencing difficulty, and who is committed to such outreach efforts on the part of organized dentistry. It is helpful if the chair is someone who can encourage the participation of a team of volunteers so that he or she does not do all the work.

The chair's duties may include the following:

- recruiting and supervising volunteers to work with the committee/program;
- coordinating volunteers, outreach activities to the dental school(s), and speakers for component meetings, to help educate the membership about the support program and its benefits;
- convening the committee for case review, continuing education, networking, program evaluation and making program recommendations to the dental society;
- cooperating with other professional peer assistance programs when appropriate, representing the dental society, and
- reporting committee activity to the sponsoring dental society.

Committee Volunteers

Committee volunteers should also be members in good standing, willing and able to assist colleagues in crisis. Personal experience with similar crises is helpful in volunteers; they should be screened, however, for ability to avoid over reliance on their own experiences in reaching out to others. The ability to respect privacy and a clear understanding of the limits of peer assistance are important qualities as well. Many dental societies have required that their volunteers have unencumbered licenses, so that the volunteer does not have an active case before the board of dentistry.

The dental society may wish to establish a policy that volunteers who are in recovery from addictive disorders meet additional criteria. These may include a 2- to 4-year period of sobriety prior to beginning the volunteer work, ongoing abstinence from the use of alcohol and other drugs of abuse and continuing participation in mutual-help activities such as 12-step groups. Why such criteria?

- **Program integrity:** In the current regulatory climate, licensing boards need to feel confident that dentists are being monitored and supported by volunteers or professionals who are committed to the goal of abstinence. Similarly, it is important that regulators, the dental society and dentists enrolled as participants in well-being programs have confidence those activities on their behalf are free of personal agendas or bias. Peer assistance programs have a role in the assurance of public safety — as well as compassionate outreach to peers — so that it may be wise for their volunteers to be mindful of this in all settings.
- **Ability to hold peers accountable:** Volunteers may have a key role in monitoring a dentist's compliance with a recovery contract, and may be less effective in doing so when they themselves are using alcohol or other drugs.
- **Role model:** Volunteers in well-being efforts may be viewed as role models for recovery across a whole range of professional and personal activities. Volunteers are representatives of the dental society. It is important the leadership of the dental society believes its image to be enhanced by its well-being volunteers.
- **Protection of the volunteer:** Early recovery itself is a time of change, adjustment and sometimes instability so that volunteer efforts are best undertaken when the volunteer is in a mature recovery phase. Mutual help/12-step involvement provides support for the volunteer's own recovery, and an important source of feedback about beliefs or behaviors that may interfere with the ability to provide assistance to others.

There may be times when it is necessary to ask a volunteer to discontinue participation in the well-being program, in order to preserve the credibility and integrity of the program.

Some dental societies have relied on a single individual to carry out all their well-being activities. As these individuals have grown tired, become ill, retired or otherwise been unable to continue doing this, those dental societies have found themselves without trained and experienced replacements. This has meant that the dental society has been left in a poor position to either respond to individual dentists or to be a leader in this aspect of professional self-regulation.

The dental society may wish to require that all volunteers participate in specified training prior to beginning activities on its behalf. Such training may include:

- an orientation to the purposes, policies and procedures of the well-being program;
- a review of the disease concept of chemical dependency, including information on genetics, brain chemistry, signs and symptoms and pharmacological treatments;

- introduction to intervention;
- the role of 12-step or mutual help groups in supporting recovery;
- an introduction to other impairments — such as other compulsive disorders, depression, anxiety, etc. — if they will fall within the scope of the committee's activities; or
- review of available resources, including assessment providers, other professionals, financial assistance, consultation, etc.

Committee meetings could provide an opportunity for continuing education. Potential topics might be new developments in addiction medicine, the use of medications by people in recovery from addictive illness, co-occurring psychiatric disorders, early recognition of relapse triggers, chronic pain management for dentists under monitoring contracts, etc.

What resources may be available to assist with training volunteers?

- Staff of the ADA's Well-Being Programs keep current resources for presentations; there are also some videos available for loan.
- The program's consulting physician may welcome the opportunity to provide at least some of the training.
- Staff from local treatment centers may be available at little or no charge.
- Other professions' peer assistance groups (physicians, pharmacists, nurses, etc) may welcome collaboration in planning a program.
- The American Society of Addiction Medicine has a number of continuing education opportunities throughout the year.
- Regional AIDS Education and Training Centers (AETCs) offer a wide variety of training resources.
- The Council on Dental Practice of the ADA sponsors a Dentist Well-Being Institute every two years (in the odd years) with much of the program designed specifically for peer assistance volunteers.

Protocols And Procedures

Established and approved protocols and procedures provide a number of benefits:

- they reflect the consensus of all the interested parties, and thus provide both consistency and support;
- they provide a framework for training new volunteers;
- they may protect the dental society from complaints of inconsistency in the way cases are handled, and
- they help affected dentists and their concerned others — family, office staff, treatment providers, etc. — know what can be expected from the dental society.

Many times, there are actual or potential legal implications to the crisis that motivated a request for help from the well-being committee. Impaired practice, whether from substance abuse or some other condition, constitutes a violation of any dental practice act. There may be actual or potential issues of malpractice associated with the impairment. Federal and/or state drug control laws may have been violated.

For these reasons and others, it is in the dental society's best interest to have its well-being protocols and procedures developed in consultation with legal staff familiar with professional impairment, licensure/regulation and applicable law related to peer assistance and confidentiality.

There are other parties the dental society may want to consult as it develops protocols:

- the society's addiction medicine consultant and, if appropriate its psychiatric and infectious disease consultants;
- staff from the dental licensing board, particularly if the dental society will want its program offered to dentists as an alternative to regulatory discipline;
- staff or volunteers from other professional peer assistance programs in the state to evaluate the possibility of cross-disciplinary consistency in such programs; and
- student services staff from the dental school(s), if appropriate to determine which if any dental society well-being services will be made available to dental students.

Seventeen Points To Consider

With these caveats, no single handbook can be written that will meet the needs of every dental society, for each is so different. What follows is a list of topics and issues that are addressed by most well-being committees as they determine the scope and design of their activities.

1. What is to be the scope of the dental society's well-being committee's activities? Will outreach, assistance and advocacy efforts be limited to dentists with substance abuse/chemical dependency problems? Would the program offer support to dentists with depression or anxiety? Sexual misconduct? What about physical disabilities? Infected providers? And how involved does the society want to be in education and prevention compared to crisis intervention?

2. What kind of support is the dental society willing and able to give to the well-being program? Budget? Dedicated staff time (both supervision and support)? Phone, printing, mailing? Legal consultation?
3. How will liability for volunteers and the dental society be addressed? Does the state have law in place to provide well-being volunteers immunity from civil liability, except for willful or wanton acts? Who will provide insurance coverage for the volunteers and the program?
4. How often would the committee meet? What kind of communication between the chair and committee members would assure consistency in the implementation of program protocols? How can volunteers get to know each other so they can work together effectively? How can information be shared about the experiences of dentists enrolled in the program? How can the committee monitor its members and activities for accountability to the dental society — and in some cases, to the regulatory agency?
5. What kind of system should be used for accessing the program? Should there be a dedicated phone line? What about after-hours coverage, given that crises often arise in the evening, on weekends or on holidays?
6. Apart from the nature of the presenting problem, what would be the criteria for inclusion in the well-being program? Would the volunteers work with dentists charged with legal offenses, and if so, which ones? What about relapse or recidivism? Would the program participate in monitoring a dentist whose license was suspended for an extended period of time, with the goal of advocating a return to practice after that?
7. Will services be available to other dental team members beside dentists? What about hygienists? Dental assistants? Office staff? How might referral and/or monitoring recommendations differ between the groups?
8. At what point would a committee investigate a call about a dentist, and what kind of investigation would be done before further action would be undertaken?
9. What role would volunteers play in an intervention with a colleague believed to be impaired? What would be the preferred model of intervention? Should a professional be involved? How would interveners be trained and supervised? What kind of outcome would be expected of the intervention? What action would the committee take if their recommendation (that the dentist seek a professional assessment, for example) was refused?
10. On what basis will the committee recommend providers of professional assessment services to dentists who are the focus of concern? Would the committee want to use a formal set of criteria to recommend 'approved' providers? Would a dentist be permitted to select a provider based on cost, location or convenience?
11. What kind of relationship would the committee want its volunteers to have with the professionals who might be working with a dentist in treatment? Would they want periodic reports of treatment compliance and progress? Would they want to participate in the development of a return-to-practice contract?
12. What role would the committee want to play in assisting with practice coverage while a dentist is in treatment? Would there be a network of dentists willing to volunteer time in the office? Would there be a list of retired or part-time dentists willing to assist? Would the committee keep information on locum tenens services?
13. What role would the committee want to play with the family of a dentist who is away in treatment? Might there be volunteers who would introduce family members to their own support groups? What financial assistance might be made available?

14. What level of responsibility does the committee want to accept for monitoring dentists returning to practice after treatment? Does the committee want to assume the responsibility of administering a biologic monitoring program (i.e., urine or other toxicology screens), including random notification, witnessed specimen collection and contractual arrangements with a laboratory? What kind of reports would the committee want related to 12-step meeting attendance and compliance with other treatment recommendations (medications or counseling services, for example). What might be the criteria used for practice monitoring?
15. What would determine when the committee would report a dentist to the dental board/licensing authority? What about for dentists who enter the program voluntarily? Dentists who are referred to the peer assistance program by the board?
16. What kinds of records will be kept? Where will they be stored? What kinds of protections will be in place for confidentiality? Who will have access to the records?
17. What would be the criteria for volunteers who wish to represent the dental society in its well-being activities? What are the dental society's expectations about behavior of volunteers and compliance with program procedures? What circumstances would trigger the removal of a volunteer from involvement in the program?

Collaboration With Outside Agencies

In those states where outside agencies — formal professional health programs, for example, or contracted mental health professionals — provide assistance services to dentists, dental societies have the opportunity to strengthen those programs by their active collaboration.

The following are some activities in which volunteer involvement on behalf of an individual dentist may be helpful:

- **Identification of colleagues in need of assistance:** Committee members may hear about staff or patient concerns about a dentist who may be experiencing some sort of personal difficulty.
- **Initiation of the process of getting help:** Committee members may provide referral information to dentists, their families or staff, or may participate in a planned intervention to encourage a dentist to seek professional evaluation.
- **Supporting dentists and families during treatment:** When a formal treatment program is necessary, it can be a very disruptive experience for a family and a dental practice. Volunteers may be able to help arrange practice coverage, to assist the dentist or family in seeking financial assistance, if needed, and to assist family members in connecting to their own support networks.
- **Working collaboratively with treatment providers:** As professional colleagues, peer volunteers are in an excellent position to provide collateral information to the treatment center that will assist the staff in working effectively with a dentist in treatment. (Note: the patient must authorize exchange of information with treatment providers.)
- **Providing information to treatment providers about local resources:** Who could be a better source of information than a well-being committee member, about who might be another recovering dentist in a local area, or who would make a good practice monitor, or where to find the closest doctors' AA group?
- **Serving as a dental practice information resource to treatment staff:** Unless treatment staff have a great deal of experience in working with dentists, dentist

well-being volunteers may be needed to answer questions about nitrous oxide, stock medications or office procedures, for example, or to assist in the development of an aftercare and monitoring contract.

- **Offering emotional support** to dentists returning to practice.
- **Monitoring returning dentists' adherence to the recovery contract,** if appropriate.
- **Reporting activities to the dental society, observing confidentiality:** Keeping the dental society's leadership informed about well-being activities helps build support for the program and provides another source of information for responding to member needs.
- **Promoting awareness of well-being issues:** Volunteers can write or suggest articles for state newsletters; they can recommend speakers for small or large dental meetings; they can work with lobbyists on pertinent legislative activities, and they can, if willing, share their own stories to increase awareness of the struggles of others as well as hope for recovery.
- **Volunteering to speak about substance abuse or other well-being issues at the dental school:** When a well-being volunteer can share a personal recovery story with dental students, the dental society has an opportunity to support faculty efforts and to give a powerful message about the support available through organized dentistry.

Dentist well-being volunteers have a great deal to contribute to the effectiveness of intervention, treatment, and long-term recovery of other dentists who have developed addictive and other disorders. Their participation can augment treatment efforts; support a dental family during a most difficult time; be part of an ongoing plan to assure safe practice; and be a powerful antidote to the shame and isolation felt by most professionals in the grip of active addiction.

In the larger picture too, volunteers can make valuable contributions to the dental society's efforts to reach out to all members and to provide attractive member benefits.

Chapter 5

Services To Dentists: Nuts, Bolts and Building Blocks

Once a dental society has committed to sponsoring a well-being program, the task becomes to implement it.

This chapter is intended to help constituent societies and their well-being chair and volunteers identify the areas where specific policies and procedures will be needed, and provide some information about available resources.

Each constituent society, of course, will want to take into account consistency with its other services, as well as applicable law or regulations that apply to peer assistance programs.

Calls to the Well-Being Program

Calls of concern about a dentist may come at any time of the day or night; treatment centers or other professionals may need to be able to access the well-being program at any time as well. Whatever system is utilized — a dedicated phone line, pager, answering machine, answering service, etc. — some common concerns need to be addressed:

- broad dissemination of the phone number — on the website, in every dental society publication, in special pamphlets or brochures;
- access to help within a reasonable amount of time;
- confidentiality for callers;
- professionalism of answering machine messages;
- competence and sensitivity on the part of individuals who answer the phone. (If a help line rings on a phone in the well-being chair's home, for example, it should be a phone that is never answered by children.)

Many committees utilize a form on which to record calls of concern. (A sample is included in the Appendix.) It is important that the person who takes the call knows the identity of the caller, and just as important that the caller be assured his/her identity will not be disclosed without permission to do so. Dental team members for example, are often fearful of retribution for having "told" on their employer. Spouses may have similar fears. Callers are also frequently afraid that the dentist will be reported to the licensing board, because they have called, and may want realistic assurances about that.

There is almost always a specific incident that precipitates a call to the well-being committee — the proverbial straw that breaks the camel's back. It will be helpful to ask about this incident as well as what has gone before.

The committee will want to use care in crafting its policies about investigating calls of concern so as not to expose itself to charges of mischief.

— L.K.

The committee may implement a policy to investigate calls of concern before action is taken. Not all calls to a well-being committee are made in good faith; angry spouses, disgruntled employees and others with ill will toward a particular dentist have been known to make such calls. Since well-founded calls of concern may eventually result in a referral to a professional assessment, having additional information will enable the committee to make appropriate referrals. An investigation may include the following:

- ask the caller if there is someone who can verify the concern.
- stick to *facts* — patients cancelled due to a hangover, inappropriate prescribing, odor of alcohol, etc., etc.
- if the caller is the spouse, ascertain if a divorce is contemplated or in process.
- consult with other members of the well-being committee to determine whether a concern has been expressed about this dentist before.
- check any public sources such as arrest records or published board disciplinary actions or malpractice settlements.

Criteria For Inclusion In Peer Assistance/Discipline Alternative Programs

The committee, the sponsoring dental society and the dental licensing authority all have an interest in the criteria for participants in a well-being program. Each of these groups will have its own set of priorities, as well:

- Committee members are often motivated by compassion and a sincere desire to be of service to troubled colleagues. Committee members also need to be confident they are equipped to deal with the issues presented by participants.
- The dental society's priority will be in the areas of liability, public image and resource allocation (i.e., value for budget dollars).
- The dental licensing authority is primarily concerned about (and in fact charged with) the safety of the public. A dental board will need assurance that the well-being program (1) is not a haven for unsafe practitioners, (2) can be trusted to report practitioners whose noncompliance or illegal activities make them poor candidates for a peer-driven program, and (3) is capable of administering an effective program.

The committee may find it useful to work with the dental society's legal counsel and the state regulatory agency in developing inclusion criteria. Areas usually addressed in such criteria may include:

- Defining what kinds of circumstances will fall within the scope of the well-being program. Some programs limit their services to chemical dependency; others include mental health problems, infectious disease, physically handicapping conditions and possibly others.
- A determination of what would exclude a participant. Such exclusions might be prior board actions, being judged a direct threat to self or others, some kinds of illegal behavior, some categories of sexual misconduct, etc.
- A stipulation that the participant is doing so voluntarily (i.e., not under legal coercion).
- That the participant has voluntarily withdrawn from practice, or limited the scope of practice as determined by the committee (perhaps after legal or medical consultation),

until a professional evaluation and any subsequent treatment recommendations are completed.

- That the participant is willing to accept the committee's recommendations regarding professional assessment of whatever is the presenting concern, and willing to follow subsequent recommendations.
- That the participant will enter into some sort of participation or monitoring agreement with the committee that may include compliance with treatment recommendations, biologic monitoring when indicated, participation in continuing care groups, practice monitoring and/or other activities as indicated.

One of the hallmark symptoms of addictive disorders is the inability to honestly and objectively assess the extent of one's own problem[9] — and especially the impact of the problem on family and staff. Most dentists know, for example, that it is illegal to practice dentistry while under the influence of mood-altering substances, though many dentists in the grip of addictive illness truly believe their practice is not impaired by doing so. Similarly, an impaired dentist may be unaware of the chaos felt among staff who have to deal with unpredictability, patient cancellations, moody outbursts, etc.

– L.K.

Intervention

"Intervention" is the name of the process by which concerned colleagues, family, and possibly staff and/or others share their concern with an individual about his/her drug or alcohol use, disruptive or erratic behavior, compulsive gambling or other problems. The goal of an intervention, regardless of the actual procedures used, is to motivate an individual to seek professional assistance with the problem identified by concerned others.

There are several models for intervention — professionally facilitated Johnson Model interventions, peer-driven or family-initiated meetings and the Strategic Family Intervention. The type of intervention used should be determined by the situation and knowledge of the individuals involved — for example, one dentist may respond best to the opportunity to hear specific concerns from each of his staff members, while another dentist would experience this as incredibly humiliating. It is beyond the scope of this handbook to discuss intervention procedures in any depth. Some dental societies prefer that licensed mental health professionals facilitate interventions. Well-being volunteers may participate in these interventions, but the professional assumes the primary responsibility and liability.

If volunteers are doing the intervention, the dental society is well advised to make sure that volunteers are appropriately trained and covered for potential liability in this activity, and that legal counsel has reviewed the protocol. Drs. Talbott, Gallegos and Angres included a cautionary note in a chapter on impairment and recovery among healthcare professionals:

- Once colleagues suspect addiction, intervention needs to be carefully planned and swiftly executed. However, careful preparation is essential. Intervention is a very serious experience that can prevent the addicted individual from hitting a personal 'bottom'; however, the authors have seen improperly conducted interventions result in death.[10]

Evaluation And Treatment Referrals

A great deal is at stake when a dentist's practice is impaired. First of all is the health and well-being of the dentist, as substance abuse and depression have the potential to be life-threatening. There may be safety and competence issues related to patient care. Patients may be in the midst of treatment when a problem with a dentist is identified. Employees and the dentist's family depend on income from the practice. There are likely to have been

9 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, D.C.: American Psychiatric Association Press, 1994, p. 176.

10 Talbott, GD, Gallegos, KV, Angres DH, "Impairment and Recovery in Physicians and Other Health Professionals." In *Principles of Addiction Medicine, Second Edition.* Chevy Chase, MD: American Society of Addiction Medicine, Inc., 1998, pp. 1263-1279.

violations of the state dental practice act, though these may not have been brought to the attention of the licensing body. Federal controlled-substance laws may have been broken.

The standard of care for licensed health professionals whose practice is thought to be impaired is for a comprehensive multidisciplinary assessment, conducted by a team of professionals with expertise in working with that population.[11] Components of such an assessment usually include:

- a history and physical examination, including biologic testing;
- psychiatric evaluation;
- neuropsychological testing and psychological interview;
- family assessment;
- substance use history;
- evaluation of specific conditions, as indicated (for example, chronic pain evaluation), and
- interviews with collaterals (employees, colleagues, other significant persons with understanding of the affected professional's situation).

This specialized assessment process usually takes between two and five days. Cost will vary between providers, and will also depend on the diagnostic procedures used. Some charges may be covered by insurance with the remainder to be paid by the dentist. The assessment will result in one or more diagnoses of the presenting problem, and a set of recommendations.

Peer volunteers can be of great help to the multidisciplinary team, if this is determined to be within the scope of the well-being committee's activities. (Note: A release of information must be signed by the affected dentist for information to be exchanged between the assessment team and the peer volunteer.) Peer volunteers may have known the affected dentist for years, and may be able to provide helpful history. They are familiar with practice standards and the character of the dentist's community. Peers may know the dentist's staff and/or family. Peer volunteers may have been part of an intervention that resulted in the assessment.

Treatment programs differ in terms of treatment modalities, outpatient vs. inpatient or residential treatment, target populations, ability to treat comorbid diagnoses, etc. Because no two dentists are exactly alike, no single treatment program is right for all dentists.

Peer volunteers may be the ones to recommend facilities that would conduct a multidisciplinary assessment or provide treatment. When two or three recommendations are given, the affected dentist (and family) have the opportunity to select the one they feel will be best for them. Factors to consider include:

- geographic location;
- cost;
- usual length of stay;
- program quality and expertise; and
- program familiarity with dental practice issues.

Some people feel strongly that professionals should be treated in standard treatment programs — that it is the addictive disease that should be the common denominator

11 Federation of State Medical Boards of the U.S., *Report of the Ad Hoc Committee on Physician Impairment*, adopted as policy in April 1996. Document may be found at www.fsmb.org.

between patients rather than occupation or professional status. Part of the concern in this is that specialty (i.e., "impaired professional") programs allow their patients to continue to feel "better than" other addicts, thus reinforcing negative traits of grandiosity and isolation.[12]

Others advocate referral of professionals to the specialty programs. Rationale for this is that the staff are familiar with the professions' codes of ethics, practice acts, federal drug laws, the characteristics of professional practice settings and post-treatment monitoring resources. The patient population in the specialty programs will be professional peers as well as having addictive disease in common. They will have the training and experience to confront each other on practice issues (access to pharmaceutical samples, or nitrous oxide protocols, for example) that may be unfamiliar to the general population. Professional peers are unlikely to be intimidated by each other's education and credentials, which can happen in a general setting where the only doctor in treatment may be put on a pedestal. And, professional peers may be of great support in helping each other work through the shame associated with addictive illness when a common reaction of the general population is horror that a professional could be addicted.[13]

The chair may wish to maintain a file of current information about treatment resources, and may find it helpful to keep a list (with contact information) of key staff in each facility. Dentists who are being referred for an evaluation and/or treatment — and their families — may appreciate knowing that the peer volunteers are familiar with the facility and its staff.

12 Geller, A, "Relapse Prevention." Presentation at the University of Utah School on Alcoholism, Dental Section, June 19, 2002, Salt Lake City, UT.

13 Hankes,L and Bissell L, "Health Professionals." In *Substance Abuse: A Comprehensive Textbook, Second Edition.* Baltimore, MD: Williams and Wilkins, 1992, pp. 897-907.

Post-Treatment Follow Up

The peer assistance program may have an important role in post-treatment follow up activities, depending on how the program is structured. The treatment program will develop an aftercare (or continuing care) plan or contract with the dentist prior to discharge. The peer assistance program may also ask the dentist to sign an agreement spelling out expected behaviors if the dentist is to receive the dental society's support and advocacy.

If there is both a continuing care contract with the treatment center and a monitoring agreement with the well-being program, it is important that the two documents support each other.

Usually included in such agreements are:

- attendance at a specified continuing-care group;
- provisions for individual, marital or family therapy, if indicated;
- identification of a primary care physician;
- expectations of mutual-help meeting attendance;
- practice restrictions, modifications or monitoring;
- arrangements for biologic drug testing;
- authorized medications;
- expectations regarding abstinence;
- duration of the contract; and
- consequences of contract violation.

If the dental society's peer assistance program is to assume responsibility for monitoring dentists after treatment, things to consider in establishing protocols may include:

- establishing lines of communication with the treatment center and, if appropriate, the regulatory authority;
- establishing a protocol for random drug testing and notification of participants;
- selecting a laboratory for biologic testing (this may include assessment of the laboratory's ability to perform specific drug screens, evaluating procedures for verification of positive test results, payment arrangements and perhaps a referral agreement)[14];
- ensuring that urine specimens will meet chain of custody criteria (i.e., that collection is witnessed, the specimen is not diluted, the specimen is of appropriate body temperature at time of collection, the container is sealed, and tamper-proof transportation of the specimen to the laboratory is secured);
- determining how relapse will be handled;
- determining what behaviors constitute a violation of the monitoring agreement to the extent that a report of non-compliance would be made to the regulatory agency;
- arrangements for participants to be referred to a professionals monitoring group;
- a mechanism for the monitor to be in regular contact with the participant;
- training the monitors;
- record-keeping;

14 Macdonald, DI, DuPont, RL, "The Role of the Medical Review Officer." In *Principles of Addiction Medicine*, Second Edition. Chevy Chase, MD: American Society of Addiction Medicine, Inc., 1998, pp. 1255-1262.

- regular case review by the committee; and
- supervision of the monitors.

Some samples of monitoring contracts are included in the Appendix.

Accurate record keeping is essential when administering a monitoring program. For those dentists already known to the dental licensing agency, this will likely be required. Other dentists in the program, though, may need documentation of their participation if they wish to move to another state, if a complaint is made about them to the licensing agency at some future date, for inclusion on a managed-care panel or for an insurance application.

— L.K.

Record-Keeping

As in the dental office, records serve a variety of purposes. Peer assistance programs may find it useful to keep several kinds of records — case records of individual program participants, data on program utilization (number of phone calls, nature of concerns, number of interventions, etc.) and information about program outreach and promotional activities that may be of interest to the dental society. Depending on the scope of a dental society's well-being program, some activities — especially intervention and monitoring — may place the dental society in a position of legal accountability.

For those well-being programs that work with individual dentists, a case management record should be established, beginning with each call of concern about an individual practitioner. In some cases, the file may contain nothing more than the initial contact sheet. In other cases, a full record may need to be maintained. Such a record may include:

- a record of the initial phone call;
- notes about collateral concerns;
- an intervention record, including the names of all participants, the recommendation, and the outcome;
- a summary of the multidisciplinary assessment;
- the treatment discharge summary and continuing care plan;
- a copy of the monitoring agreement with the peer assistance program; drug screen results;
- progress notes, reports and letters; and
- copies of signed release of information forms for all involved parties.

Record storage should be secure, and records accessible only to those authorized to have access to this confidential information.

Practice Coverage

Unlike planned absences from a practice — vacations, continuing education, elective surgery, for example — referrals to assessment and possibly extended treatment are not usually anticipated, and may be a shock to the affected dentist, office staff, patients, and, not least, the dentist's family.

The peer assistance program can be of great assistance to affected dentists by anticipating the need for practice coverage while a dentist is in treatment. Fear of harm to a practice through the dentist's extended absence is a major deterrent to dentists seeking needed treatment. Some dental societies have encouraged the development of mutual aid agreements for practice coverage in such emergencies (see Additional Resources). Some peer assistance committees are aware of dentists who will assist in keeping a practice open.

Temporary professional services (locum tenens) may be utilized, and the committee chair may wish to keep current information about those resources on file. Committee members may also be of great help to the dentist's spouse, domestic partner or staff in the triage of patients.

I recall one morning when my six-year old daughter was seated at the kitchen table and couldn't make up her mind what she wanted for breakfast. I had a hangover and became angry and verbally abusive to her before leaving the room. When I returned five minutes later she looked dazed, watery-eyed and had a deep imprint between her eyes where she had pushed the edge of a drinking glass. I suddenly had a moment of terrible understanding of what I was doing to what I loved most. I think I became willing at that time to do anything that would help me.

— Anonymous, D.D.S.

Areas of responsibility that may need to be addressed immediately include:

- identifying which patients are in the midst of treatment plans or procedures who will need referral;
- providing for emergency call coverage; and
- making provisions for pending practice management issues such as payroll, paying bills and making deposits.

The Significant Others — Family and Staff

Family and staff should not be forgotten in the urgency of getting a dentist into treatment. Depending on the circumstances, these significant others may or may not have been aware of the problem — or of its extent. The well-being of several families may be dependent on the ability of one dentist to practice safely and efficiently, and therefore threatened by the impairment of that one dentist. Sometimes, the dentist's story is told in the newspaper, and private troubles become public knowledge. Well-being committees may be of great help in strategizing how to help family and staff in at least three areas:

1. **The need for information:** What's the problem? What should we tell patients? What should we tell other dentists? How long will the dentist be gone? Is it my fault? What will happen to my paycheck? What will the treatment program offer *me*? What's going to happen to my employer, my spouse, or domestic partner at the treatment center?
2. **The need for support:** Whom can I talk with about this? Has anyone gone through this before? How could I not have known? How do I tell the kids? What do I tell the neighbors? What do people think of me, now that this has happened?
3. **Dealing with anger, shame and stigma:** How can I show my face at the country club/grocery store/PTA/Alliance meeting/school/etc.? What if we have to pull the kids out of private school? What if I see a patient at an Al-Anon meeting? How could this happen to someone who should have known better?

Some well-being committees include a representative of the Alliance (the spouses' group) of the state dental society, who can assist in identifying family needs and resources. Others are aware of spouses of recovering dentists who are willing to extend a helping hand to spouses currently in crisis, and who may introduce the spouse to Al-Anon or some similar group. Some communities have a support group for spouses of affected professionals. The treatment center will offer a family program, and may be able to refer a family to a local resource for support while the dentist is away. Staff of a dentist in successful recovery may be of great support and assistance to their colleagues in another office.

Resolved *... That appropriate protection be sought to ensure the confidentiality of those who seek and provide help through authorized programs.*

That measures be sought to provide those who serve in dentist peer assistance programs immunity from civil liability, except for willful or wanton acts.

— American Dental Association, Resolution 18H-1996, Guiding Principles 2 and 3

Legal Issues

Peer assistance raises a number of legal considerations, which can be readily addressed with proper planning and the assistance of legal counsel.

Of course, the legal issues that may arise will vary according to program scope and structure, state law, and other factors that make each program unique. For example, the relative roles of the peer assistance program and the state licensing board may drive who does what, who is privy to what information, when and on what terms, etc. Other factors may include the society's role with respect to treatment, aftercare and practice assistance along the way.

This chapter identifies a number of potential issues that may merit attention, with an eye toward streamlining the efforts of a dental society and its lawyer. Other issues will certainly be important as well. It is essential that the dental society and its lawyer work closely to identify each key issue.

In reviewing this information, it is important to keep in mind that with the implementation of new federal privacy protections in 2003, the law in this area is somewhat in flux, especially on some issues pertaining to the intersection of the privacy regulations and longstanding confidentiality law.

The Legal Balance

To achieve its important objectives of protecting the public and providing a service to the profession, well being programs must operate in an environment that is secure both for impaired dentists and their peers. Indeed, perhaps the underlying legal imperative in peer assistance is balancing the needs of the impaired professional and the peers providing assistance.

There is obviously a compelling need to give strong privacy protections to people who are at risk for, or are or have been in treatment for, alcohol or drug problems. Without assurances that this information will remain confidential, many individuals will not seek or stay in life-saving treatment and prevention programs, out of fear that highly personal and stigmatizing information may be disclosed and have damaging consequences to their personal, family and/or working lives.[15]

15 Legal Action Center of the City of New York, Inc. *Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA*. New York: Legal Action Center, 2003, p 4.

The human part of this equation is key. Unfortunately, many people still feel a great deal of shame about substance abuse, depression, other mental health problems, infectious disease and other issues that are within the purview of the well-being programs. Assurances that personal information will be kept private, and that applicable confidentiality laws will be meticulously observed, are important. Equally important is that those providing assistance do not overpromise what they can do by way of intervention or maintaining confidentiality or privacy.

Dentists often worry that news of their personal difficulties will "leak out" to colleagues. They are fearful that the state regulatory agency will find out if they ask for help. They worry about the impact of a stigmatizing diagnosis on their disability, liability or life insurance coverage. They worry that patients will find out, and that their practices will suffer if they are known to be "impaired." Dentists also worry about their reputations within their communities, and may be concerned about causing embarrassment for spouses, children or other family members.

Peer assistance staff or volunteers are often entrusted with sensitive, personal, and private information. Not all this information will fall under the protection of confidentiality laws. Unless the assistance program notifies them to the contrary, impaired dentists will expect that all such information will be treated with similarly high standards of care and integrity.

Of course, the peers providing assistance, and the dental societies with well being programs, want assurance that they can do so without taking on undue legal risk. The good news is that federal and some state laws will provide immunity protections for certain peer assistance activities in the case of properly structured programs operated in good faith, in contrast to willful and wanton acts.

What Laws Apply?

Both federal and state laws come into play. The applicable laws all address the type of information that is protected, the nature of the protection, and when and how disclosures of the information can be made. While there is substantial overlap in spirit and sometimes substance, the laws differ in several important respects.

The key federal law that applies to all existing dental society well being programs concerns confidentiality with respect to drug and alcohol treatment. There is also a federal privacy law that may come into play covering all healthcare treatment. State law may add an additional layer of protections and obligations. Given the potential legal issues involved, dental societies are well advised to work with a lawyer who is familiar with federal, state and local laws that may apply.

- The key law for most dental well being programs is the federal law pertaining to drug and alcohol treatment, which provides confidentiality protections for the impaired dentist, and immunity for the society and volunteers. The law is 42 U.S.C. (United States Code) 290dd-2. The regulations through which the statutes are implemented are found in 42 C.F.R. (Code of Federal Regulations) Part 2.
  - Worthy of note is that the confidentiality law does *not* afford protections to activities such as litigation stress support or HIV/AIDS peer assistance, except of course to drug and alcohol treatment issues that arise in those contexts. Nor does it extend to mental health issues.
- The Health Insurance Portability and Accountability Act (HIPAA) has the potential to add privacy and security protections (and corresponding requirements) into play. And

it extends to all individually identifiable health information, not just drug and alcohol data. The HIPAA privacy regulations appear at 45 CFR Parts 160 and 164.

- With respect to the impaired dentist's privacy, a peer assistance program is a covered entity subject to HIPAA only if it conducts certain activities electronically. See "HIPAA '20 Questions': Answers to Your Inquiries About the Privacy Regulations, (Although it is spelled HIPPA on the site)," Questions 1 and 2, ADA Legal Adviser, April 2003, ADA.org/members/resources/pubs/adviser/0304/adviser_02.asp. If HIPAA were to apply, it would trigger an array of regulatory requirements that are beyond the scope of this chapter, e.g. with respect to having a written privacy policy, making a good faith effort to have individuals acknowledge receipt of a notice about that policy, and more.
  - Available data suggest that dentist well-being programs typically do not electronically conduct the transactions that trigger HIPAA, and thus would not be directly covered by HIPAA with respect to the dentist's information. However, dental societies should seek HIPAA counsel should that change, e.g., if a well being program begins to electronically submit insurance claims for urine toxicology.
- Although they might not be HIPAA covered entities with respect to the impaired dentist's information, peer review programs routinely work closely with entities that are covered by HIPAA. This could lead to one of the following scenarios, depending on the facts of a given situation:
  - The covered (treatment) entity may be required to secure a HIPAA authorization from the dentist to release information to the peer assistance team (this is simple to do and would probably be made part of the consent form already used to comply with the federal confidentiality law), or
  - although it seems unlikely, depending on its activities, the well being program may be required to sign a HIPAA business associate agreement with the covered entity. This would raise the bar by requiring well being programs to protect privacy as well as confidentiality – two related but distinct legal concepts. It would also build in protections for issues not covered by the drug and alcohol law, including HIV/AIDS and mental health.
- A second HIPAA issue arises with respect to patient data in the case of impaired dentists who are HIPAA covered entities. If peer assistance activities will include covering the practice and reveal patient information, the well being program is probably a business associate of the impaired dentist, and will need to sign a BA agreement and honor its requirements.
- State laws may provide additional confidentiality protections to those in federal law, including coverage of more activities (e.g. HIV/AIDS assistance and mental health records) and/or raising the stakes by imposing greater sanctions for violations.
- State law may also afford immunity and/or 'Good Samaritan' protections for well-being committee members and their sponsoring dental societies.

In assessing their obligations, peers providing assistance should keep in mind: (1) ignorance of the law is not covered under "good faith" and is unlikely to trigger immunity and (2) maintaining the confidentiality of peer assistance program participants does not justify a lack of accountability to the dental society. As suggested above, the keys are knowing the law and implementing it appropriately given the nature of a particular program.

Federal Law

Let's dig a bit deeper into the applicable federal laws, beginning in the early 1970s, when Congress enacted what is now a single law on the confidentiality of alcohol and drug abuse records and information in federally assisted drug and alcohol programs. 42 U.S.C. 290dd-2. Under the law, covered "[r]ecords of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research … " are confidential and may be disclosed only for specified purposes and with specified authorizations. As set forth in the implementing regulations, the key such authorization is via patient consent, by which the patient has given specific permission to disclose the information.

The summary below addresses the requirements of the confidentiality regulations, beginning with an examination of the key words contained in the general prohibition of disclosure. Since peer assistance programs may also be covered under HIPAA directly (as covered entities) or more likely indirectly (as business associates of covered entities or the impaired dentist), select related HIPAA issues are mentioned along the way. As noted above, one primary difference is that rather than require confidentiality, HIPAA speaks in terms of privacy. These are two related but distinct legal concepts, the meaning and relationship of which are beyond the scope of this chapter.

The laws and regulations pertaining to drug and alcohol abuse are written very broadly:

- Peer assistance activities meet the criteria of being a 'program' when they provide alcohol or drug abuse diagnosis, treatment or referral for treatment.
- A dental society meets the criteria for a 'federally assisted program' if it has tax-exempt status from the Internal Revenue Service, or if donations to it qualify as tax deductions.
- A patient is "any person who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program … "
- Records include "any information, whether recorded or not relating to a patient received, or acquired by a federally assisted alcohol or drug program." In other words, the regulation applies to verbal and/or written communications about an individual dentist in the peer assistance program, and applies to diagnosis or treatment information that the peer assistance program gives to any person or agency, as well as to diagnosis or treatment information that the peer assistance program receives from any person or agency.
- The prohibition on disclosure relates to information that would identify someone as a patient or as a drug/alcohol abuser, directly or otherwise.
- The regulations also prohibit the re-disclosure of information about any individual. Re-disclosure is the term used when information from one party — a treatment center, for example — is sent to a second party — the peer assistance program — and subsequently sent to a third party — the licensing board.

With few exceptions, information about a patient may only be disclosed when there is a proper written consent form to do so. Perhaps the key exception for dental peer assistance programs — one that may be prudent to put impaired dentists on notice of in advance of treatment — pertains to mental health records. Exceptions also exist for life-threatening emergencies, crimes against treatment personnel, child abuse, "authorizing" court orders (descried below) and a few other unusual circumstances.

The consent form must include each of the following components:

1. the name or general designation of the program(s) making the disclosure;
2. the name of the individual or organization that will receive the disclosure;
3. the name of the patient who is the subject of the disclosure;
4. the purpose for the disclosure;
5. how much and what kind of information will be disclosed;
6. a statement that the patient may revoke the consent at any time, except to the extent that the program has already acted in reliance on it;'
7. the date, event or condition upon which the consent expires if not previously revoked;
8. the signature of the patient (and/or other authorized person); and,
9. the date on which the consent is signed.

If the program is subject to HIPAA regulations, there must also be a statement about "the program's ability to condition treatment, payment, enrollment or eligibility of benefits on the patient agreeing to sign the consent, by stating either that the program may not condition these services on the patient signing the consent, or the consequences for the patient refusing to sign the consent."[16] There is a potential tension, as yet unresolved in the courts, between this HIPAA privacy requirement and the confidentiality regulation.

In addition, the release form must contain a statement prohibiting redisclosure without specific permission to do so. Here is the sample notice as included in the regulations:

Prohibition On Redisclosure Of Confidential Information

This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 42 C.F.R. §2.32.

Sample Release of Information forms are included in the Appendix. *One of the forms is for* programs subject to HIPAA, *and the other for programs* not subject to HIPAA. *The regulations usually require a separate consent form for each different recipient.*

There is a way to disclose certain drug and alcohol treatment information without consent: via contract with a "qualified service organization" (QSO), an outside entity that helps the treatment program fulfill its obligations to the dentist. A QSO contract must be in writing and contain certain provisions specified by law. It allows the treatment program to share information, e.g. with vendors and subcontractors, on specific terms and conditions. Depending on the facts, a well being program could be a treatment programs QSO and required to sign such a contract to protect confidentiality.

16 Ibid., p 26.

There is a similar vehicle in HIPAA with respect to privacy and security: namely the BA agreement noted above. If one or more of these is required in a particular well being program, the BA agreement must include special HIPAA language.

Subpoenas

On occasion, dental societies and/or their peer assistance personnel have received subpoenas seeking access to information about a dentist's involvement with the program. If this happens, the dental society should secure guidance from legal counsel familiar with applicable federal[17] and state law.

- The confidentiality law establishes a need for there to be both an "authorizing" court order and subpoena before a covered program can disclose records concerning current or former patients without their consent.
- Under the confidentiality law, the program should not release records in response to an in response to ordinary subpoenas. Rather, the program should advise the patient that a subpoena has been issued seeking access to his/her records, and ask whether he/she would wish to give permission for release of the information. If the patient chooses not to give permission for release of the information, that information can only be obtained by an "authorizing" court order to accompany the subpoena.

To issue such an order, the court must determine that good cause exists, by finding two things:

1. Other ways of obtaining the information are not available or effective, and
2. The public interest and the need for disclosure outweigh on the potential injury to the patient, the doctor-patient relationship, and the treatment services.

A different set of rules regarding subpoenas comes into play when HIPAA is involved and the federal protections pertaining to alcohol and drug treatment are not, e.g., in connection with HIV/AIDS or mental health treatment. Basically, the society and/or peer assistance personal will need and be legally free to respond to appropriate subpoenas issued with proper authority under state law.

Unless state law provides additional safeguards, the impaired dentist thus probably has less confidentiality and privacy protection for treatment outside of the alcohol and drug context.

Applicable State Laws

Some states will have statutes related to peer assistance activities. In some states, they are contained within the individual practice acts, and in others there is 'umbrella' legislation that covers a specific group(s) of regulated professions.

Even in those states where peer assistance activities are authorized by the dental practice act, the dental society may wish to clarify the role of its peer volunteers — or dentists who may serve in a staff position in the concerned dentist program — in relation to diagnosis and/or referral. It is outside the scope of dental practice to make a mental health diagnosis (e.g., substance use disorder, depression, anxiety disorder, etc.) and to prescribe treatment. These diagnoses and prescriptions are within the purview of licensed medical and mental health providers. Nevertheless, in some states dentist who suspects another dentist is impaired may have a duty to report that suspicion, e.g. to the state board.

17 Ibid. p 54.

Additional Implementation Considerations

Starting the Process

Here are some activities that can be done at the start of a peer assistance process:

- Confront a dentist with the information that *something* appears to be interfering with the ability to practice safely.
  - This should be done judiciously, so as not to take on any undue exposure, e.g., for libel or slander.
- Identify people trained and experienced in the assessment of potentially impaired high-accountability professionals.
  - This too should be done carefully, since a bad referral can also create exposure.
- Notify the dentist if the volunteers are legally and/or ethically required to report their concerns to the dental licensing board (in some states this may only be if the dentist does not seek an assessment and follow recommendations).

Disclosure to Staff, Patients and Family

Staff is often very aware of impairment as it develops in their employer, the dentist. After all, most dental offices are small businesses with staff members and the dentist working in close proximity. The longevity and loyalty of staff within practices is often striking. Depending on the situation, staff may have been covering up for the dentist, rearranging patient schedules for unplanned absences, reassuring patients, scheduling difficult patients or procedures for times when they knew the dentist would be in the best shape, facilitating prescription-writing schemes, worrying about the dentist and their own job security, and perhaps initiating the process of getting help for the dentist.

Once the process of peer assistance has been initiated, however, information about the dentist's situation is subject to state or federal laws as described above. Peer assistance volunteers should keep the following in mind in relation to the impaired dentist's staff:

- The peer assistance volunteer may not disclose that the dentist has been admitted to a particular treatment center, or is being evaluated at a specific facility, or has been given a particular diagnosis, without the express, written permission of the dentist to do so.
- The dentist's consent to disclosure need not be uniform for all staff. Not every staff member needs to have the same information. A full-time office manager, for example, may need to know where the dentist is and that a treatment facility may request information about the dentist's behavior in the office. A part-time dental assistant may only need to know that the dentist is on medical leave. Who sees and hears what is up to the dentist.
- Dental office staff will probably be unaware of confidentiality laws, and should be grounded in the prohibition against redisclosure, including to their friends or family or to the dentist's family or colleagues. If individual staff members do not all have access to the same information (as in the above example), it may be appropriate to caution them against discussing the situation among themselves.
- The volunteer may want to discuss with the dentist what information may be disclosed to patients about the dentist's absence from the office. Either the dentist, or the peer assistant acting on the dentist's behalf and with the appropriate permission to do so, should give direction to the staff about how patient queries are to be handled. The

dentist may decide that patients only need to be told that their dentist is out of the office, that routine care will be rescheduled, or that current treatment can be continued by referral to another dentist. It is very important that staff members are aware that disclosure of the dentist's condition or place of treatment may be a violation of federal — and perhaps state — law.

Sometimes the issue arises about sending get-well greetings to a dentist. One way to handle that without violating confidentiality, if the dentist so chooses, is to have such greetings sent to the dentist's office and forwarded to the treatment facility by the staff (assuming staff knows!). The dentist may then choose to respond — or not.

Finally, a note about the dentist's family. There may be a tremendous temptation to share information with family members, particularly those who have been helpful to the dentist or peer assistance group, or those who point blank ask for information. Sharing is fine — but only with the dentist's consent to do so.

Risk Management

In the best of all peer assistance worlds, a dental society will have a guidebook or written protocols for its well being activities. Among the possible items for inclusion are: a description of the program's activities, the players and their roles; a summary of the law; any program policies; a confidentiality agreement to insure compliance with legal requirements; examples of how the policies are implemented at each stage of the process, from intervention through treatment planning to treatment planning to after care; sample agreements that must be signed by the dentist, e.g. for after care; documentation of well being assistance volunteer and staff training. This documentation can be prepared or vetted by legal counsel.

A society would also want to make certain that its insurance would cover all of its peer assistance activities.

Chapter 7

Program Support

A well-being program is no different than other programs offered by a dental society in its needs for financial and administrative support. The annual surveys of the constituent well-being programs conducted by the Council on Dental Practice demonstrate that, with a few exceptions, the programs that are most utilized are those with the most support from the sponsoring dental society.

Well-being programs may have to compete with other worthy programs for coveted dues dollars. Well-being programs may — and often do — encounter roadblocks of fear, prejudice, misunderstanding and negative experience.

- Well-being programs are most often directed toward dentists with stigmatizing illnesses — addictions, depression and infectious disease — making the garnering of support a challenge.
- Even among professionals, there remains a persistent tendency to blame the victims of these illnesses and to be unaware of how effective professional treatment and peer support activities can be in saving practices, families and, in some cases, lives.
- Services are usually available to all dentists, regardless of dental society membership, and there may be resentment that membership dollars may benefit non-members.
- Volunteers in the well-being program are often involved in those activities to the exclusion of other dental society activities and thus they, and the well-being activities by virtue of their sensitive nature, may not be well known to those involved in budget decisions.
- Alcoholism and other drug addictions are diseases that can cause extraordinary disruption and pain for the families of sufferers, leaving an unsympathetic legacy of intolerance, unwillingness to offer assistance and hopelessness about recovery. Since few families are completely untouched by these diseases, it stands to reason that some members of a dental society's leadership may have had these negative experiences and be less than enthusiastic about supporting the well-being efforts.

Benefits to the dental society can be significant, however, and should not be overlooked. Consider these possibilities:

- There are dentists who owe their lives, the well-being of their practices and the safety of their families to well-being volunteers and the dental societies who support their activities.

- Recovering dentists pay dues.
- A well-run program can help to promote the image of the dental society as an organization that is accountable to its members and the public through self-monitoring activities.
- Similarly, the program can promote the image of the dental society as an organization that cares for and about its members.
- The well-being program can provide a service opportunity to its members who have a high level of commitment to these particular outreach activities.

Funding Sources

Funding arrangements and dollar amounts for the constituent dental society well-being programs are as individual as the constituent societies themselves. Among the options are:

- **Dental society budget line item:** Larger budgets may require an initial dues increase. Smaller, all-volunteer programs may want to consider having enough funds allocated to pay basic program expenses (i.e., phone/beeper/etc., printing/mailing/office expenses, reimbursing volunteers for mileage, volunteer training, addiction medicine consultation).
- **Dental license fee surcharge:** This has been an appealing source of funds in some states, especially since the fee is collected from all licensed dentists, and not all dentists belong to the dental society. Depending on the state and its laws, however, funds collected by a state agency may be subject to a requirement that the state actually administer the program, or that the well-being program be put out for bid or RFP. While the dental society may submit an RFP, there is no guarantee the funds will be awarded to the dental society — and, in fact, may go to an agency with no prior experience in delivering well-being services to dentists.
- **Foundations:** In a few cases, a dental society has established a 501(3)(c) foundation to fund and administer its well-being program
- **Special fund raising efforts:** Several states either completely fund or augment funding for their well-being programs through special fund-raisers — holiday card sales, golf outings, donations from the Alliance, etc.
- **Volunteer donations:** Some dental societies expect their volunteers to cover all their own expenses. Volunteers, particularly those who are in recovery from addiction, may be willing to do this because they see it as a form of service. This may appear to be advantageous to a dental society where funds are tight. Such a policy, however, may encourage less accountability on the part of a volunteer and less supervision by the dental society, which may nevertheless be held responsible for the volunteer's actions on the dental society's behalf. There is also increased risk for volunteer burnout and resentment, and consequent harm to the dental society's reputation.
- **Support from disability or liability** insurance carriers.

Recovery is a good investment — and certainly cheaper than the disruption caused by active addictive disease.

The Council on Dental Practice at the ADA provides information on a variety of topics related to dentist/family well-being, not just on substance abuse. The goal has been to broaden the appeal of the well-being programs, to reach greater numbers of dentists/family/team members and to decrease stigma associated with use of the program.

Risk Management

Well-being activities may expose a dental society to risk. What follows are some guidelines to constituent societies to assess and, hopefully, minimize their risk. Immunity from civil liability was covered in Chapter 6, and is one component of risk management. In addition to something about immunity, it is also possible that the state dental practice act may contain some language about peer assistance activities. A review of the medical practice act may also provide some information about the state's professional norms in this area.

The dental society's legal counsel may wish to periodically review the program's policies and procedures, to be sure they are not in violation of any regulations related to confidentiality, privacy, disability status or professional practice.

In addition, liability coverage for volunteer peer assistance activities should be clarified. It is not common for a dental society to be sued for its well-being activities, but it has happened.

Program Marketing

The subject matter of well-being programs — chemical dependency, depression, infectious disease, stress, burnout, the stress of litigation, disillusionment, etc. — evokes uncomfortable reactions in most audiences. "Selling" a well-being program takes patience, sensitivity, persistence, the ability to communicate hope in a difficult time, and a sense of humor.

For a well-being program to be effective — i.e., utilized and respected — the people who will need to use it or refer to it will need to know where to turn for help and what to expect. Beyond the basics of the program's existence and contact information, different target groups need different information, too. For example:

- Dentists in crisis and their families will want to know they can get help quickly and that their privacy will be protected.
- Staff concerned about their employer-dentist will want to know that something will be done about their concern and that they won't lose their jobs.
- Dental boards will want to know the program can be trusted to monitor compliance with continuing care contracts and to report violations of the contract.
- Dental society executives and leadership will want to know they are getting value for membership dollars.
- Dental students need to know about their personal risk factors — and potential pitfalls in practice. They may also be grateful for information that may help them make good decisions about joining a practice.

Considering some basic marketing principles may help.

- **Know Your Audience:** What are the needs, goals, concerns and values of a specific group? Is the group *primarily* interested in membership service? Public safety? Compassion for impaired colleagues? Identifying red flags in a potential partner?
- **Tailor the Marketing Message:** How can you get the attention of that particular audience? What will their support of the well-being program do for them? How much do they want and need to know about the program?
- **Delivering the Message:** When it comes to finding ways to communicate *any* of the benefits of membership in the dental society, more is better! And, since potential recipients of well-being services often are not motivated to seek help until a crisis arises, one-time messages may not be effective. How to do it?

Articles on some aspect of well-being may be submitted. Some dental societies have used a "Dear Abby" format, and several have run entire feature issues every few years.

- **Newsletters**
- **Some dental societies print advertisements** with contact information for the well-being program in every edition of the newsletter.
- **Statewide Meetings:** The well-being committee can recommend a speaker on a topic with broad appeal (professional marriages, stress and burnout, stress from the litigation process, grief and loss, etc.), making brochures about the well-being program available to the audience. What about an exhibit space for the program, with information about the program itself and also about potential issues of concern — substance abuse, depression, family dynamics, etc.? (The Council on Dental Practice sponsors such a booth at Annual Session each year. Information on low-cost pamphlets, handouts and giveaways is available from the office. See Additional Resources for contact information).
- **Component Meetings:** These smaller meetings can provide a wonderful opportunity for a recovering dentist to share his or her personal story, with the goal of showing how the unthinkable (i.e., addictive illness) could happen to a dentist in practice.
- **Direct Mail:** "Statement stuffers" may call attention to well-being activities — or, maybe better yet, send a magnet or Rolodex card with the well-being phone number.
- **State Journals**
- **Email Distribution Lists**
- **The Dental Society Website:** Consider including basic program and contact information — phone number or email address — and possibly some links to other websites.
- **Personal Contact:** Who, outside of the dental society, may need to know what help is available to dentists/families? Treatment centers? The dental licensing board? The state physician health committee? The professional wellness committees of hospitals with oral surgeons on staff?
- **Reinforce the Message:** There's that old marketing adage, "Tell them what you're going to tell them, then tell them, and finally tell them what you told them." Reinforcement is another word for repetition of the message. Problems with stress, depression or chemical dependency can surface at any time. Leadership changes in dental societies. Treatment centers experience staff turnover. New students come into dental school. Terms of dental board members expire.

And, just as a dental crisis provides a "teachable moment" in a dental office, a local or national issue can provide the opportunity for the dental society to remind the dental community of this valuable service.

Chapter 8

***Resolved**, the American Dental Association supports efforts by constituent and component dental societies in the development and maintenance of effective programs to identify and assist those dentists and dental students affected by conditions which potentially impair their ability to practice dentistry*

— Resolution 18H-1996

When the Problem is 'Something Else'

When the Board of Trustees wrote the language for Resolution 18H-1996[18], it was with the intent that the Association's Well-Being Programs would be able to be broad and flexible in their outreach. Most of this handbook has emphasized peer assistance services to dentists with substance use disorders, but in fact the Well-Being Programs include a support network for infected dentists, guidelines for constituent dental societies that want to do litigation stress support programs, and informational resources on stress, burnout, depression, psychological adjustment to retirement, and more.

The annual surveys of the constituent society well-being programs document that well-being staff and volunteers are being called upon to assist in a variety of situations that may be unrelated to substance use disorders. These include: Mental health disorders (depression, anxiety disorders, bipolar illness, etc.); other compulsive behaviors (gambling, sex, internet use); stress; family problems — marital troubles or divorce-related disruption, kids who are acting-out, the strain of caring for elderly parents or family members; death in the family; death of a colleague; career dissatisfaction; physical disability, or post-exposure anxiety.

It has certainly been the trend in treatment settings, peer assistance services, and professionals health programs, to address the whole spectrum of disorders, situations and maladaptive coping mechanisms that may result in practice impairment. Co-morbidity of substance use disorders and other psychiatric disorders is significant.[19]

A situational stressor can contribute to moderate drinking going out of control. Chronic pain from an injury or degenerative process can be exacerbated by the physical demands of dentistry; reluctance to seek professional advice and ready access to narcotics may trigger a slide into addiction. Major depression can be the diagnosis underlying sleep disorder, emotional liability, memory and concentration problems and sloppy office management. The presenting problem is rarely the whole story.

Volunteers and staff of dental society well-being programs may not have as much familiarity — and, hence, comfort — with the 'other' issues as they do with alcoholism or chemical dependency. Given the high rates of comorbidity of substance use disorders

18 *Transactions*. (1996:693)

19 Petrakis IL, Gonzalez G, Rosenheck R, and Krystal, JH, Comorbidity of Alcoholism and Psychiatric Disorders: An Overview. *Alcohol Research and Health*, Vol. 26, No. 2, 2002, pp. 81-89.

with a host of other conditions (mood disorders, problem gambling, eating disorders, sexual acting-out, etc.), it makes good sense to have a plan for how to respond.

This chapter is intended to help well-being volunteers or staff to think about ways to assist dentists, dental team members, and dentist families to deal with some of these other requests, if it is decided to put them under the purview of the well-being program. Three of these 'other' issues will be discussed, support for infected providers, the impact of mental health disorders on practice, and other compulsive disorders.

There are common denominators in assisting colleagues with any personal problem, as volunteers have discovered. It is not necessary for a committee to have expertise in every possible area. What is important is to know where to turn for expertise, to treat all sensitive information with care and respect for privacy, to be compassionate, to understand the importance of providing information to people in crisis, and to behave ethically.

— L.K.

Support for Infected Practitioners

The Well-Being Programs began offering support services to HIV-infected practitioners in 1994, and a separate handbook was published in 1995.[20] The support network is titled P.E.E.R.S. (Prevention, Education, Ethics, Resources and Support); the Council updates contact information annually.

Infection with a blood-borne pathogen — HIV, HCV or HBV, for example — poses challenges, and sometimes threats, to dentists. In the last 10 years there have been no documented cases of transmission of these diseases from dentists to patients,[21] yet fear and stigma have declined little, if at all. An activist public believes it has the right to know whether a healthcare provider is infected, and the courts have consistently sided with patient rights even to the point of using different standards to determine safety.[22]

Some infected practitioners have continued to practice. More have chosen to find an alternative to clinical dentistry and are now in administrative work or public health. Others, usually those whose diagnoses were made prior to the advent of protease inhibitors, went on disability.

Those dentists who work with infected colleagues now field more requests for help from dentists in crisis after an exposure, than from dentists who are actually diagnosed as having a blood-borne pathogen infection. Post-exposure prophylaxis is effective in preventing infection, but may have significant — sometimes-untenable — side effects and demands compliance with a complicated treatment regimen over a period of weeks.[23] The exposure itself is very anxiety provoking, raising personal and professional fears about the future and concern for family and sexual partners. Typical questions at this point may include:

- Can I practice while I'm waiting to find out if I'm infected? Do I need to use special precautions in the meantime?
- Do I have to tell my patients I've had an exposure incident? Do I have to tell my staff? Do I have to report myself to the board of dentistry? Will anyone else report me?
- Do I have to notify any of my insurance carriers? What happens if I do, and I don't become infected? What if I don't, and I do?
- Where can I go for answers? How can I be confident this information will be kept private?
- What are my legal rights as a provider?
- Who are the experts in my area when it comes to treating health professionals?

20 American Dental Association, *Resource Manual for Support of Dentists with HBV, HIV, TB and Other Infectious Diseases*. Chicago: American Dental Association, 1995.

21 Cleveland JL, Barker L, Gooch, BF, Beltrami EM, Cardo D and colleagues. Use of HIV postexposure prophylaxis by dental health care personnel: An overview and updated recommendations. *JADA* 133: 1619-1630, December 2002.

22 Sfikas PM. HIV and discrimination: A review of the Waddell case and its implications for health care professionals. *JADA* 133: 372-374, March 2002.

23 Op. cit. Cleveland et. al.

What can the dental society do to help its dentists in these situations? People in crisis of almost any kind need information. While the dental society itself will not be able to supply all the information, it can direct dentists to the agencies and people who can. Some key resources for dentists who have been exposed or infected include the following:

- **The American Dental Association:** ADA.org, especially the Dentist Well-Being Programs, the Council on Scientific Affairs, the Division of Legal Affairs, and the Council on Insurance. Callers do not have to reveal their identity to receive assistance.
- **The Centers for Disease Control and Prevention:** www.cdc.gov, especially the National Center for HIV, STD and TB Prevention, at www.cdc.gov/hiv/pubs/facts.htm. This site contains information related to prevention and management of occupational exposures, plus surveillance data about disease prevalence in the health care workforce.
- **The PEP-Line (800-933-3413). regional AETC (AIDS Education and Training Center):** www.aids-etc.org/.
- **The state health department.**
- **Peers who may be willing to share their own experiences.** Contact information is available through the Well-Being Programs office at the ADA. The staff of HIVDent, at www.hivdent.org/, may be able to assist as well.
- **Office of Sterilization and Asepsis Procedures:** www.osap.org.

Mental disorders can be surprisingly debilitating, even disabling. Because it's hard to 'see' the problem — though this is rapidly changing with the increasing sophistication of brain imaging technology — and because health professionals are so deeply socialized to present a 'professional' demeanor, suffering is often not obvious until it has reached an advanced stage. Personal cultural values about stoicism, beliefs that mental health disorders are really defects of character, and fear of stigma are all potentially factors in reluctance to seek adequate treatment.

– L.K.

Depression, Anxiety And Other Mental Health Disorders

Of the mental health diagnoses in adults, anxiety disorders are the most prevalent in the general population, and mood disorders the most disabling.[24] Anxiety and mood disorders are the most prevalent among professionals as well, and are the conditions most likely to come before a well-being program. The pre-requisites and rigors of professional training are such that few people with serious psychotic disorders (such as schizophrenia) would be able to become dentists, and it is unlikely that a well-being program would be asked to deal with this.

The mood disorders include major depressive disorder, dysthymic disorder, the bipolar disorders, and cyclothymic disorder.[25] The anxiety disorders include panic attacks, the phobias, obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder, and generalized anxiety disorder.[26]

It is well beyond the scope of this handbook to discuss these disorders, their diagnosis or treatment, in any depth. It may be useful, however, to discuss some of the ways they may cause practice impairment, and explore potential avenues for assistance.

Anxiety disorders, while sharing the common dynamic of fear, can be very different from each other — from specific phobias (of flying, for example) to panic attacks that seem to come out of the blue, from the focus on control of obsessive-compulsive disorder to the all-pervasive and uncontrollable worry of generalized anxiety disorder.[27]

Except for post-traumatic stress disorder, which is preceded by exposure to an event or events of extreme threat,[28] people with anxiety disorders have often experienced

24 Goldman H, ed., *Mental Health: A Report of the Surgeon General*, U.S. Government Printing Office, 1999. p. 226.
25 American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000. pp. 345-346.
26 Ibid., 429-430.
27 Goldman, op. cit. pp. 233-236.
28 American Psychiatric Association, op. cit., p. 471.

nervousness, worry, or excessive fear from very young ages. This fear and worry is disproportionate to the circumstances. Fear and worry extend into performance issues. The American Psychiatric Association's standard diagnostic manual notes that,

"Children with the disorder may be overly conforming, perfectionist, and unsure of themselves and tend to redo tasks because of excessive dissatisfaction with less-than-perfect performance. They are typically overzealous in seeking approval and require excessive reassurance about their performance and their other worries."[29]

Being able to talk with another dentist who has experienced depression can be of great assistance as well. It can help relieve feelings of shame and worthlessness, to see a colleague who is doing well despite the diagnosis. Accepting help, whether in the form of talk therapy or medication, or both, is difficult for proud and self-sufficient professionals to do, especially if they are men. Treatment for depression is often highly effective, however, and may result in significant benefit in every aspect of a dentist's life and practice.

— L.K.

Anxiety disorders result in a heightened state of physical arousal. These symptoms include muscle tension and aches or soreness, feeling shaky, trembling hands, excessive perspiration, increased pulse rate. Sometimes there may also be nausea or diarrhea, and panic attacks are often accompanied with intense fears of 'going crazy' or of dying.[30]

The symptoms of anxiety are very uncomfortable, and to compound that discomfort is the fear that 'someone will notice.' This can be particularly stressful in the dental office environment where personnel work in such close proximity to patients. Another dynamic of anxiety disorders is that the people who have them are vulnerable to worrying about the worry, or worrying about the symptoms, exacerbating what is already an uncomfortable situation. There is the danger of self-medication, especially when anxiolytics may be readily available, as they often are in a dental office.

Major depression and dysthymia share common symptoms, the difference being the extent and duration of symptoms. These disorders are characterized by depressed mood most of the time if not all the time; poor appetite or overeating; insomnia or hypersomnia; loss of energy; low self-esteem or feelings of worthlessness; difficulties with concentration and decision-making, and feelings of hopelessness. In major depression, hopelessness may extend into suicidal ideation or suicide attempts, and low energy is seen by others in slowed movements and inability to 'get moving.' Major depression is also characterized by the inability to experience pleasure; persons with dysthymia struggle with loss of interest in activities that were once found pleasurable. Almost paradoxically, some people with major depression become irritated and agitated. For a diagnosis of major depression, significant symptoms must have been present for at least two weeks; for dysthymia, symptoms must have been present most or all of the time for at least two years.[31]

Depression is more common in women than men,[32] and the reasons for this are likely to be multifactorial. It is widely believed that women are more open to seeking help and more attuned to emotional domains than men, as well as more often taking on or being given multiple responsibilities for the care of others. There is also reason to believe that the illness is both underdiagnosed and undertreated in men.[33] Men with depression may present themselves as suffering from stress, burnout, or overwork as these words do not carry the connotations of 'weakness' sometimes ascribed to depression.

These disorders can be very disruptive, the worst outcomes being desperation and, possibly, suicide. Even for people with the milder form of depressive illness, life can become a daily struggle with fatigue, procrastination, and 'quiet desperation.' Depression

29 Ibid., p. 473.
30 Ibid., pp.430, 473.
31 Ibid. pp. 356, 381.
32 Goldman, op. cit. p. 244.
33 Hirschfeld, R, et. al., The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. *Journal of the American Medical Association* 277(4), 333-340, 1997.

makes it hard to go to the office everyday. *Life* isn't fun anymore, much less the practice of dentistry. Upbeat conversations with patients and staff seem to take too much energy; keeping up the facade that everything is all right, when it isn't, is exhausting. Routine practice management tasks can begin to seem overwhelming and may be put off. What once were minor annoyances — a late patient, maybe, or a crown that doesn't set just right the first time — can evoke disproportionate responses of frustration or irritability.

Dentists may be tempted to self-prescribe sleeping medications, in an attempt to counter the sleep disturbance and fatigue of depression. If alcohol is used in an attempt to relieve depressive symptoms, it will eventually make things worse. Anecdotal accounts of dentists self-prescribing anxiolytics or antidepressants are not unusual; not only is this a violation of the dental practice acts, but a dentist who does this deprives him- or herself of an objective diagnosis and referral for appropriate treatment.

A physician who treats himself has a fool for a patient.

— Wm. Osler

If a dentist is experiencing symptoms of depression, a thorough medical exam is indicated; depression may be a symptom of an underlying medical disorder. A medical evaluation should also provide the venue for beginning to decrease the feelings of isolation that accompany depression and help to put symptoms in the context of brain chemistry, family history, and precipitating life events.

Included in the Appendix is a description of an attorney peer assistance program's facilitated groups for lawyers with depression. It is included because it could be a useful model for a similar group with dentists and other dental professionals.

Compulsive Disorders

What could a well-being staff person or volunteer do when a dental office manager calls to say the dentist is spending all between-patient time on eBay, and neglecting office management tasks? Or canceling patients to spend time at the casino? Or leaving pornography visible on his/her monitor for staff and patients to see? Or throwing the office into chaos by having affairs with several patients and staff at the same time? What if the dentist knows the hygienist is purging in the staff bathroom after lunch every day, getting thinner and complaining about being too fat?

These compulsive and impulsive disorders have some things in common — irresistible impulses to do repetitive behaviors, impaired insight and denial about the consequences of the behavior, mood swings associated with the behaviors, high comorbidity with other psychiatric disorders — substance dependence, mood and anxiety disorders, and antisocial personality disorders — and some research indications that similar neurotransmitter systems are involved.[34]

The behavioral dynamics of these disorders have many similarities to drug and alcohol addiction, and well-being staff or volunteers may find themselves being consulted even though they may have had little experience or training specific to the disorders.

What the dentist well-being program can do in this situation is assist the dentist or concerned others in finding appropriate professional assessment and referral. They can

34 McElroy SL, Soutullo, CA, Goldsmith, RJ, Brady, KT, "Co-Occurring Addictive and Other Impulse Control Disorders." From Graham AW et al, editors. *Principles of Addiction Medicine*, Third Edition. American Society of Addiction Medicine, Chevy Chase, MD, 2003, pp. 1347-1358.

offer the assurance that the dentist is not the only one who has experienced this kind of difficulty. They can be valuable consultants to treatment professionals in terms of dental practice issues, and assist in finding practice management resources. They can reinforce to the dentist the importance of following treatment recommendations and help to decrease the dentist's professional isolation by promoting involvement in dental society activities.

Neither this chapter, or indeed the handbook itself, can or should provide the definitive guide for each dentist well-being program. Each program will need its own written guidelines and procedures tailored to its unique goals, objectives, and structure. The common threads in all these efforts are professional self-accountability, compassion and concern for colleagues, and commitment to the highest quality of patient care.

Chapter 9

In some constituent societies, reporting has been informal, and limited to the executive director. This procedure was most often adopted out of concern for the confidentiality of recipients of well-being services. The drawback, of course, is that the broader leadership can lose awareness of the problems experienced by dentists within the state, and of the value of the society's well-being efforts. It may follow, then, that support for well-being activities can decline. Viewing this in another way, the dental society can unintentionally reinforce the stigma of addictive disorders and mental health problems when well-being activities are isolated from other dental society efforts.

— L.K.

Program Accountability and Evaluation

Regular reports of well-being activities provide a means for the leadership of the dental society to respond to the needs of its members, to include well-being needs in all levels of planning and to remain sensitive to the issues. Reports can be made while protecting the privacy of recipients of services by focusing on utilization rather than identity of individuals. Some items that may be reported include:

- Numbers of calls to the designated service line.
- Source of referrals (i.e., self, staff, family, patients, police, etc.).
- Types of request for assistance.
- Drugs of choice when substance abuse is the concern.
- Numbers of interventions on behalf of dentists.
- Numbers of dentists (and/or dental team members) in treatment.
- Numbers of dentists (and/or dental team members) on monitoring contracts.
- Numbers of dentists (and/or dental team members) completing the terms of their monitoring contracts.
- Relapse or recidivism rates.
- Numbers of dentists (and/or dental team members) discharged from the well-being program by referral to the licensing board.
- Relationship with the dental licensing board.
- Committee activities such as educational presentations.
- Liaison activities.
- Identification of any critical incidents.
- Continuing education of volunteers and/or staff.
- Expenses.
- Assessment of the program's strengths and weaknesses.

The chair of the well-being committee or responsible staff would be the appropriate personnel to collect and report this information.

Numbers are important indices in well-being programs, as in many other activities. They can provide data for assessment of a program's strengths and weaknesses, and guidance for program and resource development. They provide a mechanism for evaluating information from other sources — say, for example, that the state dental board handled fifteen cases where a dentist was reported for abusing substances, but the well-being program had only two referrals, there may be room for work. High numbers from one component and low numbers from another may reflect the effectiveness of educational or identification efforts. Numbers mean something.

Yet, everyone who has worked in or been touched by peer assistance efforts also knows that the numbers are only a shadow — of practices saved, families healing, dentists enjoying life again and communities benefiting by having a safe and healthy dentist.

What is my life like today as a sober recovering dentist? I enjoy dentistry and some days the worries and stress get to me, but I don't use alcohol or other drugs to escape. I continue to belong to support groups that give me an opportunity to talk about my daily frustrations. I've been given the gift of sobriety that I cannot keep for myself unless I continually give it away to others.

My thirteen-year old daughter and I were sitting at the kitchen table the other day. She was asking me a lot of personal questions as I was trying to eat my breakfast and read the newspaper. Finally, I put down the paper gently and asked her what all the questions were about, and she said, "Well, I have to do an interview with a person I admire — just answer a few more questions, please."

— Anonymous (and gratefully recovering), D.D.S.

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Additional Resources

American Dental Association

ADA.org

211 East Chicago Avenue
Chicago, IL 60611
312.440.2500 or Members-only Toll-Free Line (number on membership card)

Practice Management Resources and Guidelines

Closing A Dental Practice: A Guide for the Retiring Dentist or Surviving Spouse
General Guidelines for Developing Business Plans
General Guidelines for Written Employment Agreements Between Dentists and Employees
Guidelines for the Development of Mutual Aid Agreements in Dentistry

Contact: The Council on Dental Practice, ext. 2895. There is a fee for these publications, and some are bound together with other titles.

Dental Wellness Advisory Committee

Contact: The Council on Dental Practice, ext. 2622 or ext. 4647.

Alternative Dental Careers

Contact: The Council on Access, Prevention and Interprofessional Relations, Ext. 2861.

Financial Assistance (emergency grants, retraining loans, disaster relief)

Contact: The ADA Foundation, ext. 2547.

Council on Members Retirement Programs

(questions related to disability insurance or ADA insurance products)

Contact: 800.568.2001.

Division of Legal Affairs

Contact: ext. 2500.

AIDSinfo
www.aidsinfo.nih.gov
A service of the U.S. Department of Health and Human Services, AIDSinfo is a central resource for current information on federally and privately funded clinical trials for AIDS patients and others infected with HIV. As the main dissemination point for federally approved HIV treatment and prevention guidelines, AIDSinfo provides information about the current treatment regimens for HIV infection and AIDS-related illnesses.

AETCs (AIDS Education and Training Centers)
www.aids-etc.org
The AETC Program is the professional training arm of the Ryan White Comprehensive AIDS Resource Education Act. There are eleven regional training centers (listed below), and four national centers to deal with specialty needs.

- **Delta Region AETC** (LA, AR, MS)
  New Orleans, LA 504.903.0788
  www.deltaaetc.org
- **Florida/Caribbean AETC** (FL, PR, VI)
  Tampa, FL 813.974.4430
  seatec.emory.edu
- **Midwest AIDS Training and Education Center** (IL, IA, IN, MI, MN, MO, WI)
  Chicago, IL 312.996.1373
  www.matec.info
- **Mountain-Plains AETC**
  (CO, KS, NE, NM, ND, SD, UT, WY)
  Denver, CO 303.315.2516
  mpaetc.org
- **New England AETC**
  (CT, ME, MA, NH, RI, VT)
  Boston, MA 617.262.5657
  www.neaetc.org
- **New York/New Jersey AETC**
  New York, NY 212.305.8291
  www.nynjaetc.org
- **Northwest AETC** (AK, ID, MT, OR, WA)
  Seattle, WA 206.685.6844
  depts.washington.edu/nwaetc/
- **Pacific AETC** (AZ, CA, HI, NV)
  San Francisco, CA 415.597.8198
  paetc.org
- **Pennsylvania/MidAtlantic AETC**
  (PA, WV, MD, VA, DE)
  Pittsburgh, PA 412.624.1895
  www.pamaaetc.org
- **Southeast AETC** (AL, GA, NC, SC)
  Atlanta, GA 404.727.2929
  www.seatec.emory.edu
- **Texas/Oklahoma AETC**
  Dallas, TX 214.590.5529
  www.aidseducation.org

American Psychiatric Association
www.psych.org
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-3901
703.907.7300

American Psychological Association
www.apa.org
American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
800.374.2721 or 202.336.5500

American Society of Addiction Medicine
www.asam.org
4601 North Park Ave
Arcade Suite 101
Chevy Chase, MD 20815
301.656.3920

Centers for Disease Control and Prevention
www.cdc.gov (home page)
www.cdc.gov/hiv (HIV/AIDS information, including surveillance data on occupational exposure and prevention of occupational transmission)
www.cdc.gov/ncidod/diseases/hepatitis/index (Hepatitis information)

Drug Enforcement Administration
www.dea.gov/index.shtml

Federation of State Physician Health Programs
www.fsphp.org
Contact: Debbie Brennan at 781.434.7343
(The Federation of State Physician Health Programs (FSPHP) is a non-profit corporation. Its members are the state physician health programs, some of which provide assistance services to dentists and other health professionals, in addition to physicians.)

Hazelden Publishing
www.hazeldenbookplace.org
Hazelden Foundation
P.O. Box 176
Center City, MN 55012
800.328.9000

HIVDent
www.hivdent.org

International Doctors in AA
www.idaa.org

Legal Action Center of New York
www.lac.org
New York:
153 Waverly Place
New York, NY 10014
800.223.4044
In New York State call 212.243.1313

Washington D.C.:
236 Massachusetts Avenue NE
Suite 505
Washington DC, 20002
202.544.5478

Locum Tenens
Locum Tenens is the term for temporary professional services. The constituent dental society will often be the best source of information for such services in a particular state. One such service specifically for dentists, and with national services, is Forest Irons Associates:
www.forestirons.com
800.433.2603

National Institute on Alcohol Abuse and Alcoholism
www.niaaa.nih.gov

National Institute on Drug Abuse
www.nida.nih.gov

New York State Department of Health AIDS Institute
www.hivguidelines.org

Twelve-step Programs
Contact information for local meetings can be found in local or online phone books. Local treatment centers and community mental health clinics will also have such information.

Alcoholics Anonymous
www.alcoholicsanonymous.org

Narcotics Anonymous
www.na.org

Cocaine Anonymous
www.ca.org

Gamblers Anonymous
www.gamblersanonymous.org

Sex Addicts Anonymous
www.sexaddictsanonymous.org.

Al-Anon
www.al-anon.org

University of Utah School on Alcoholism and Other Drug Dependencies
www.medicine.utah.edu/uas
Final Session of the summer training institute was held June 15-20, 2014. Any inquiries regarding the School please call: University of Utah Rehabilitation Psychology/Alcohol & Drug Abuse Clinic 801.581.6228

Treatment Programs

The following treatment programs have experience in treating licensed health professionals, and offer specialty services. All of them also offer multidisciplinary assessment programs. (Please note that their inclusion does not imply endorsement by the American Dental Association, nor is the exclusion of other programs a reflection on their quality or services.)

The Betty Ford Professionals' Program
39000 Bob Hope Drive
Rancho Mirage, CA 92270
Phone: 888.742.0053
www.bettyfordcenter.com

Bradford Health Services
2101 Magnolia Avenue South, Suite 518
Birmingham, AL 35205
Phone: 888.577.0012
www.bradfordhealthservices.com

COPAC
3949 Highway 43 North
Brandon, MS 39047
Phone: 800.446.9727
www.copacms.com

William J. Farley Center at Williamsburg
5477 Mooretown Road
Williamsburg, VA 23188
Phone: 800.582.6066
www.farleycenter.com

Hazelden Springbrook/Northwest
1901 Esther Street
Newberg, OR 97132
Phone: 503.554.4300
Toll Free: 866.866.4662
www.hazelden.com

Healthcare Connection of Tampa
825 Linebaugh Avenue
Tampa, FL 33612
Phone: 888.496.1294
www.healthcareconnectionoftampa.com

Illinois Institute of Addiction Recovery
2050 W. Iles, Street G
Springfield, IL 62704
Phone: 800.522.3784
www.addictionrecov.org

Menninger Clinic
5800 SW Sixth Avenue
Topeka, KS 66601
Phone: 800.351.9058
www.menningerclinic.com

Metro Atlanta Recovery Residences
2815 Clearview Place, Suite 100
Doraville, GA 30340
Phone: 800.732.5430
www.marrinc.org

Palmetto Addiction Recovery Center
86 Palmetto Road
Rayville, LA 71269
Phone: 800.203.6612
www.palmettocenter.com

Pine Grove Behavioral Health & Addiction Services
2255 Broadway Drive
Hattiesburg, MS 39402
Phone: 1.888.574.4673

The Professional Renewal Center
1421 Research Park Drive, #3B
Lawrence, KS 66049
Phone: 785.842.9772
www.prckansas.org

Ridgeview Institute
3995 S. Cobb Drive
Smyrna, GA 30080
Phone: 770.434.4567
www.ridgeviewinstitute.com

Rush Behavioral Health Center
610 S. Maple Avenue, Suite 5600
Oak Park, IL 60304
Phone: 312.563.3600 or
Toll Free: 1.888.560.5563
www.usnodrugs.com

Santé Center for Healing
914 Country Club Road
Argyle, TX 76226
Phone: 800.258.4250
www.santecenter.com

Talbott Recovery Campus
5448 Yorktowne Drive
Atlanta, GA 30349
Phone: 800.445.4232
www.talbottcampus.com

Urine Monitoring

The following companies provide toxicology and other monitoring services to a variety of professional health programs, and have had experience working with dentist well-being programs.

FirstLab
100 Highpoint Drive, Suite 102
Chalfont, PA 18914
215.396.5556
www.firstlab.com

Appendices

Disclaimer: The items included in the Appendix are informational in nature and not offered or intended to provide directives to individual dental societies. The non-American Dental Association resources identified in this publication are not necessarily endorsed by the ADA.

Appendix A ADA *Principles of Ethics and Code of Professional Conduct*

Section 2 — Principle: Nonmaleficence

Principle: Nonmaleficence ("do no harm"). The dentist has a duty to refrain from harming the patient.

This principle expresses the concept that professionals have a duty to protect the patient from harm. Under this principle, the dentist's primary obligations include keeping knowledge and skills current, knowing one's own limitations and when to refer to a specialist or other professional, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate.

Code of Professional Conduct

2.A. Education.

The privilege of dentists to be accorded professional status rests primarily in the knowledge, skill and experience with which they serve their patients and society. All dentists, therefore, have the obligation of keeping their knowledge and skill current.

2.B. Consultation And Referral

Dentists shall be obliged to seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills, knowledge, and experience. When patients visit or are referred to specialists or consulting dentists for consultation:

1. The specialists or consulting dentists upon completion of their care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist, or, if none, to the dentist of record for future care.
2. The specialists shall be obliged when there is no referring dentist and upon a completion of their treatment to inform patients when there is a need for further dental care.

ADVISORY OPINION
2.B.1. Second Opinions

A dentist who has a patient referred by a third party* for a "second opinion" regarding a diagnosis or treatment plan recommended by the patient's treating dentist should render the requested second opinion in accordance with this Code of Ethics. In the interest of the patient being afforded quality care, the dentist rendering the second opinion should not have a vested interest in the ensuing recommendation.

* A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims, and/or provide administrative services

2.C. Use of Auxiliary Personnel

Dentists shall be obliged to protect the health of their patients by only assigning to qualified auxiliaries those duties which can be legally delegated. Dentists shall be further obliged to prescribe and supervise the patient care provided by all auxiliary personnel working under their direction.

2.D. Personal Impairment

It is unethical for a dentist to practice while abusing controlled substances, alcohol or other chemical agents which impair the ability to practice. All dentists have an ethical obligation to

urge chemically impaired colleagues to seek treatment. Dentists with first-hand knowledge that a colleague is practicing dentistry when so impaired have an ethical responsibility to report such evidence to the professional assistance committee of a dental society.

ADVISORY OPINION

2.D.1. Ability To Practice

A dentist who contracts any disease or becomes impaired in any way that might endanger patients or dental staff shall, with consultation and advice from a qualified physician or other authority, limit the activities of practice to those areas that do not endanger patients or dental staff. A dentist who has been advised to limit the activities of his or her practice should monitor the aforementioned disease or impairment and make additional limitations to the activities of the dentist's practice, as indicated.

2.E. Postexposure, Bloodborne Pathogens

All dentists, regardless of their bloodborne pathogen status, have an ethical obligation to immediately inform any patient who may have been exposed to blood or other potentially infectious material in the dental office of the need for post exposureevaluation and follow-up and to immediately refer the patient to a qualified health care practitioner who can provide postexposure services. The dentist's ethical obligation in the event of an exposure incident extends to providing information concerning the dentist's own bloodborne pathogen status to the evaluating health care practitioner, if the dentist is the source individual, and to submitting to testing that will assist in the evaluation of the patient. If a staff member or other third person is the source individual, the dentist should encourage that person to cooperate as needed for the patient's evaluation.

2.F. Patient Abandonment

Once a dentist has undertaken a course of treatment, the dentist should not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Care should be taken that the patient's oral health is not jeopardized in the process.

2G. Personal Relationships with Patients

Dentists should avoid interpersonal that could impair their professional judgment or risk the possibility of exploiting the confidence placed in them by a patient.

Appendix B ADA Policies

Policy Statement on Bloodborne Pathogens, Infection Control and the Practice of Dentistry (1999:977, 983)

The dental office is a safe place to provide and receive dental care. Current and generally accepted epidemiological information supports the conclusion that there is no significant risk of contracting bloodborne diseases through the provision of dental treatment when appropriate infection control procedures are followed.

The dental profession in the United States has a long tradition of providing appropriate and compassionate care to the public, including individuals with special needs. The American Dental Association (ADA) believes that it has the responsibility to articulate a clear position on issues related to bloodborne pathogens and diseases and to formulate policy based on current and generally accepted scientific knowledge and accepted moral, ethical and legal imperatives.

This policy statement, addressing bloodborne pathogens, infection control and the practice of dentistry, will be reviewed on a regular basis and may be modified as scientific knowledge of bloodborne pathogen transmission and prevention in heath care settings evolves. The Association urges dentists, other dental workers who may participate or assist in dental procedures, and dental laboratories to follow all ADA policies that deal with bloodborne pathogens.

A key element of infection control is the concept of *universal precautions*, introduced by the Centers for Disease Control and Prevention (CDC) as a means to reduce the risk of bloodborne pathogen transmission (e.g., the Human Immunodeficiency Virus [HIV], Hepatitis B Virus [HBV] and others) in healthcare settings. The primary principle behind universal precautions centers on the premise that medical history and examination cannot reliably identify all patients infected with bloodborne pathogens. All patients, therefore, must be regarded as potentially infectious. As such, applying *universal precautions* requires that infection control procedures (e.g., HBV vaccination, routine handwashing, use of protective barriers and care in the use and disposal of needles and other sharp instruments) are used for every patient.

Most studies suggest that the prevalence of HCV infection among dentists is similar to that among the general population. Furthermore data historically indicate a higher HBV seroprevalence rate among dentists than the general population, however, declining overall seroprevalence rates and significantly lower rates among dentists under age 40 reaffirm the safety and efficacy of currently recommended infection control measures with respect to bloodborne pathogens. The dental profession, therefore, is strongly urged to continue to adhere to current infection control recommendations as set forth by the ADA and the CDC.

Since the implementation of universal precautions in the United States as a main element of infection control, and with the exception of the Florida case-cluster where HIV may have been transmitted from a dentist to six patients, there have been no documented cases of HIV transmission from dentist to patient, patient to dentist, or patient to patient as a result of dental treatment. Similarly, since 1987 and the implementation of universal precautions, there have been no documented outbreaks of HBV or HCV associated with the practice of dentistry.

Chemical Dependency And Well-Being Issues

ADA Policy Statement on Chemical Dependency (1986:519)

Resolved, that the following ADA Policy Statement on Chemical Dependency be adopted:

1. The ADA recognizes that chemical dependency is a disease entity that affects all of society.
2. The ADA is committed to assisting the chemically dependent member of the dental family toward recovery from the disease by education, information and referral. The establishment of constituent and component society chemical dependency programs is essential to this effort.
3. The ADA encourages those institutions responsible for dental education to allocate adequate curriculum on substance use, misuse and addiction.
4. In meeting the needs of the public and the profession, the ADA also encourages ongoing liaison between constituent society chemical dependency committees and their state boards of registration.
5. The ADA recognizes the need for research in the area of chemical dependency in dentistry.

ADA Policy Statement on Provision of Dental Care for Patients Who Are or Have Been Chemically Dependent (1989:556; 1991:619)

Resolved, that the following ADA Policy Statement on Provision of Dental Care for Patients Who Are or Have Been Chemically Dependent be adopted:

1. In the treatment of any dental disease, the general well-being of the patient must be a primary focus for comprehensive dental care. All disease states, either active or in remission, should be identified and considered in the overall dental treatment planning.
2. Chemical dependency (alcohol, nitrous oxide and other drug dependencies) is a primary, chronic and progressive disease that can affect every aspect of a patient's life.
3. The use of certain therapeutic agents in dental treatment may have effects on the health and relapse potential of the recovering chemically dependent patient.
4. It is the professional responsibility of the practicing dentists in the United States to be aware of chemical dependency as an illness and to address the issues of appropriate dental care in the chemically dependent population.
5. Confidentiality must be respected and maintained at all times.

Appendix C Definitions

Patient Issues

Infection Control: Patients infected with bloodborne pathogens can be safely treated in the private dental office. Current epidemiological evidence indicates that there is no significant risk of contracting bloodborne diseases through the provision of dental treatment when universal precautions are routinely followed. The practice of universal precautions is an effective means of reducing blood contacts that can result in bloodborne pathogen transmission, minimizing even further the already low risk of disease transmission in the dental office.

Vaccination: The Association urges dentists and other dental workers who may be at risk for infection to take advantage of the hepatitis B vaccine, and other vaccines as they become available, to protect themselves and patients from hepatitis B and other bloodborne infections.

Referral for Medical Evaluation: Dentists should be alert to signs and symptoms of bloodborne disease that may be identified during the provision of dental care. Patients with medical histories or conditions possibly indicative of infection should be referred to their physicians for diagnostic procedures, counseling and medical follow-up.

Patient Disclosure: The Association believes that all patients infected with a bloodborne pathogen(s) should disclose their bloodborne pathogen status as part of their medical history; dentists, like physicians, need to know every patient's medical history in order to make appropriate treatment decisions that are in the best interests of the patient.

Access to Care: The Association believes that individuals infected with a bloodborne pathogen(s) should be treated with compassion and dignity and should have access to dental treatment. Treatment considerations should be based on current and generally accepted scientific knowledge. A dentist should not refuse to provide oral health care that is within the dentist's current realm of competence solely because the patient is infected with a bloodborne pathogen.

Furthermore, the ADA's *Principles of Ethics and Code of Professional Conduct* states that a dentist has the general obligation to provide care to those in need. A decision not to provide treatment to an individual based solely on the fact that the individual is infected with a bloodborne pathogen is unethical.

Professional Judgment: The ADA supports the right and responsibility of each dentist to exercise his or her best professional judgment, based on current and generally accepted scientific knowledge and the ethics of the profession, in all situations regarding when and how to treat and whether to refer each patient.

Exposure Incidents: The Association recommends that dentists be familiar with current CDC postexposure protocols for the management of occupational exposures to bloodborne pathogens and that dentists institute office policies to ensure appropriate and efficient management of exposure incidents. The ADA recommends that the costs associated with postexposure prophylaxis and exposure sequelae be a benefit of Workers' Compensation insurance coverage.

Confidentiality: The Association urges dentists to maintain strict confidentiality of a patient's bloodborne pathogen status and medical condition. Under the Association's *Principles of Ethics and Code of Professional Conduct*, dentists are ethically obligated to safeguard the confidentiality of patient records and to maintain patient records in

a manner consistent with the protection of the welfare of the patient. This does not prevent dentists from sharing information about the patient's bloodborne pathogen status and medical condition with the patient's other health care providers when allowed by state or federal law. Dentists are encouraged to have an office protocol, in accordance with applicable laws, for the confidential handling of information about patients infected with a bloodborne pathogen(s).

Provider Issues

Practice Restrictions/Disclosure: The ADA affirms that dentists infected with bloodborne pathogens can safely provide dental care, and that bloodborne pathogen infection alone does not justify the limiting of professional duties or automatically mandate disclosure provided proper infection control procedures are implemented. Infected dental health care workers must practice in compliance with CDC or equivalent infection-control recommendations, as required by applicable law.

If the government mandates testing for bloodborne pathogen infection and disclosure for health care workers who test positive, the ADA Council on Government Affairs will investigate and pursue national legislative possibilities of a government-sponsored insurance program that would guarantee reasonable financial compensation to health care workers who may be discriminated against upon disclosure of their disease status.

Infection Control: Current epidemiological evidence indicates that there is no significant risk of contracting bloodborne diseases through the provision of dental treatment when universal precautions and recommended infection control procedures are routinely followed. Practicing universal precautions is an effective means of reducing blood contacts that can result in bloodborne pathogen transmission, minimizing even further the already low risk of disease transmission in the dental office.

However, because the foremost concern of the dental profession must continue to be protection of the patient, the Association strongly encourages all dental health care workers to undergo personal evaluation and assess their need to determine their bloodborne pathogen status. Furthermore, dental health care workers who believe they are at risk for bloodborne pathogen infection should regularly monitor their status. All dental health care workers testing positive for a bloodborne pathogen must practice only in strict compliance with the current infection-control recommendations of the CDC for infected providers or their equivalent, as required by applicable law; this includes submitting to, and adhering to any objective and appropriate restrictions imposed by expert review panels with competent jurisdiction, as outlined by the CDC.

The high ethical standards of the dental profession establish the welfare of the patient as the dentist's primary ethical obligation. The Association's Council on Ethics, Bylaws and Judicial Affairs has stated in an advisory opinion to the ADA *Principles of Ethics and Code of Professional Conduct* that a dentist who contracts any disease or becomes impaired in any way that might endanger patients or dental staff shall, with consultation and advice from a qualified physician or other authority, limit the activities of practice to those areas that do not endanger patients or other health care providers.

Exposure Incidents: The Association's *Principles of Ethics and Code of Professional Conduct* requires that all dentists, regardless of their known bloodborne pathogen status, have an ethical obligation to immediately inform any patient they suspect may have been exposed to blood or other potentially infectious material in the dental office of the need for postexposure evaluation and follow-up and to refer the patient, as needed, to a qualified healthcare practitioner who can provide postexposure services. The dentist's

ethical obligation in the event of an exposure incident extends to providing information concerning the dentist's own bloodborne pathogen status to the evaluating health care practitioner, if the dentist is the source individual, and submitting to testing that will assist in the evaluation of the patient. If a staff member or other third person is the source individual, the dentist should encourage that person to cooperate as needed for the patient's evaluation. Dentists should document in the patient's record the actions they have taken in response to a patient's exposure to blood or other potentially infectious material. Care should be taken not to include in the patient record confidential medical information about the dentist or a staff member, to avoid unauthorized disclosure of this information with the patient record.

Insurance Coverage: If a dentist infected with a bloodborne pathogen discontinues the practice of dentistry because of a legal requirement to disclose his/her bloodborne pathogen status to patients, the Association believes the dentist to be totally disabled with respect to the practice of dentistry. The ADA will assist and support infected dentists in sustaining meaningful professional careers and will encourage insurance carriers to provide disability benefits for such dentists.

Education

Public Information and Education: Appropriate agencies of the Association should continue efforts to educate the public about both the efficacy of universal precautions and the absence of a significant epidemiological risk of contracting bloodborne diseases through the provision of dental treatment when recommended infection control procedures are routinely followed.

The healthcare and communications communities also should work together, in consultation with government agencies, to develop public service announcements and other educational messages regarding bloodborne diseases. Public education to increase awareness of how bloodborne diseases are transmitted should include information aimed at diminishing irrational fears about transmission of such diseases through dental treatment.

Professional Education: The *Principles of Ethics and Code of Professional Conduct* of the ADA states that the privilege of dentists to be accorded professional status rests primarily in the knowledge, skill and experience with which they serve their patients and society. All dentists, therefore, have the obligation of keeping their knowledge and skill current.

The Association recommends the development of national educational programs for the dental team that address infection control recommendations for preventing bloodborne pathogen transmission in health care settings as well as programs that address the management of the oral and systemic implications of bloodborne diseases. The Association further recommends that dental schools, dental auxiliary schools and advanced dental education programs incorporate these programs in curriculum content and clinical activities. The Association will further assist the profession in addressing bloodborne disease issues by assuring the widespread dissemination of current infection-control recommendations and information on bloodborne diseases to the dental community through Association publications, conferences and videotapes.

Legal and Legislative Issues

Antidiscrimination: The ADA supports clarifying or amending antidiscrimination laws and regulations, either legislatively or through the courts, in consideration of the rights of the patient to be free from acts of prejudice and the rights of others to be protected against an unreasonable risk of disease.

The Association also strongly supports state and federal legislation that protects a dentist from charges of discrimination if a dentist, in a sincere effort to protect a patient's health, elects to refrain from performing a dental procedure on a patient who fails to disclose medical information that, in the dentist's professional judgment and based on current and generally accepted scientific knowledge, may significantly impact the patient's treatment. The Association further strongly supports state and federal legislation that gives an infected patient's health care providers the right to share, when medically indicated, knowledge of the patient's bloodborne pathogen status and current medical condition without risking a violation of state or federal antidiscrimination laws and confidentiality laws.

Professional Judgment: The Association, where appropriate, will pursue legal and legislative means to effect changes to existing statutes, regulations, guidelines and interpretations which impose inappropriate restraint on the exercise of the dentist's professional judgment in the treatment of persons with disabilities and/or infectious diseases.

Classification of Bloodborne Pathogens: The ADA supports the classification of bloodborne pathogens as infectious and communicable disease agents and, as such, will take every appropriate opportunity to publicly support such classification.

National Policies: The Association supports initiatives to develop national policies on bloodborne disease/infection that can become the basis for coordinated efforts by the public and private sectors. The oral health aspects of bloodborne disease/infection and issues related to the practice of dentistry should be included in national policies.

Mandatory Testing: The ADA opposes any laws or regulations that require mandatory testing of dentists and other health care workers to determine their bloodborne pathogen status.

Enforcement of Infection Control Guidelines: Enforcement of CDC or equivalent infection-control guidelines should be assigned to state boards of dentistry.

Statement on Infection Control Standards of Care and Compliance: The ADA encourages and supports infection control standards of care, provided those standards are based on and justified by scientific research, and advocates and pursues fair systems of compliance as well as appropriate penalties for noncompliance.

Additional Definitions

Chemical Dependence is a term used interchangeably with substance dependence, addiction and alcoholism. It is a primary, progressive, chronic illness characterized by the continued use of a psychoactive substance despite significant, harmful consequences. Key symptoms include preoccupation with the substance and/or its use, compulsive use, tolerance, withdrawal symptoms, loss of control over the use, and the inability to sustain long-term abstinence.

Substance Abuse refers to the repeated use of psychoactive substances, resulting in negative outcomes (driving under the influence, for example) but without the development of tolerance, compulsive use, or withdrawal symptoms. Substance abuse precedes (but does not always lead to) the development of full-blown substance dependence.

Depression, as used in this handbook, refers to the constellation of mood disorders characterized by sustained depressed mood and loss of interest, along with other symptoms of variable severity. It is not used to describe what would usually be considered to be a normal reaction to a normal loss.

Anxiety disorders include panic attacks, the phobias, obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder, and generalized anxiety disorder. The predominant emotions in anxiety disorders are fear and worry, beyond what would normally be considered appropriate to the circumstances or situation.

Diversion programs, also referred to as alternative to discipline programs, are agencies which are authorized to refer and supervise licensees whose impaired practice is thought to stem from addictive disease, mental or behavioral disorder, or physical illness with the likelihood of being amenable to treatment. Individuals are 'diverted' from the regulatory system for the purpose of participation in a treatment program and monitoring of their recovery and safety to practice.

A **monitoring contract** is a formal, written agreement between a licensee and a diversion program or a peer assistance program, specifying expected behaviors and the consequences of failure to comply with the contract's provisions.

Appendix D Criteria For Substance Dependence*

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. **Tolerance, as Defined by Either of the Following:**

   (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect

   - Ordering patterns for stock medications may change; there may be increased utilization of nitrous oxide
   - Staff may be asked to phone in prescriptions (sometimes in other names) for the dentist's own use

   (b) Markedly diminished effect with continued use of the same amount of the substance

2. **Withdrawal, as Manifested by Either of the Following:**

   (a) The characteristic withdrawal syndrome for the substance

   - Office staff may notice morning lethargy, irritability, slight tremor
   - Office hours may be changed to accommodate drinking or drug use schedules to avoid acute withdrawal symptoms
   - Nausea/vomiting or diarrhea from opiate withdrawal may disrupt patient care
   - Fatigue and impaired concentration may result from stimulant abuse

   (b) The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

   - A dentist may consume enough alcohol in the morning to manage withdrawal symptoms of tremor, irritability or craving; the odor of alcohol may be noticeable to patients or staff because of close proximity during exams or procedures
   - Prescription medications (such as benzodiazepines) may be taken from office stock and used to alleviate withdrawal

3. **The Substance is Often Taken in Larger Amounts or Over a Longer Period than was Intended:**

   - Loss of control may be evident in intoxication at dental meetings or office functions (like a Christmas party)
   - References to intoxication may be made by the dentist, spouse or other close associates

4. **There is a Persistent Desire or Unsuccessful Efforts to Cut Down or Control Substance use:**

   - Watch for promises, usually broken, to family, staff or peers to stop drinking/using
   - Rules about drinking/using are often established and rigidly followed; should an office or patient emergency interfere with the 'cocktail hour' a dentist may react inappropriately

*Text in boldface type is from: *DSM-IV*, page 181 (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Washington, D.C.: American Psychiatric Association, 1994).

5. **A Great Deal of Time is Spent in Activities Necessary to Obtain the Substance (e.g., Visiting Multiple Doctors or Driving Long Distances), use the Substance (e.g., Chain-Smoking), or Recover From its Effects:**
   - Dentists abusing nitrous oxide may spend additional time in the office during weekends or off-hours, in order to use more
   - There may be increased use of "sick time" to recover from using/drinking binges
   - A dentist may become unreliable with the schedule, coming in late, taking long lunches or unscheduled breaks
6. **Important Social, Occupational, or Recreational Activities are Given up or Reduced Because of Substance use:**
   - Office hours may be cut back
   - A dentist may withdraw from professional activities (dental society activities, study clubs, continuing education), often placing blame on others for the withdrawal (e.g., not wanting to be involved in politics, others don't have anything to offer, etc.)
   - Practice management tasks and income production may suffer; it is not unusual for serious financial problems to develop
7. **The Substance Use is Continued Despite Knowledge of Having a Persistent or Recurrent Physical or Psychological Problem that is Likely to Have Been Caused or Exacerbated by the Substance (e.g., Current Cocaine use Despite Recognition of Cocaine-Induced Depression, or Continued Drinking Despite Recognition that an Ulcer was Made Worse by Alcohol Consumption):**
   - Dentists, like other licensed healthcare providers, know that inappropriate use of alcohol and drugs violates codes of ethics, practice acts and in some cases state and federal law — and that to do so has significant professional/legal ramifications
   - Other common problems include interpersonal conflicts with staff or patients, unpredictable behavior, mood swings, memory or judgment lapses, efforts to hide drug/alcohol use with resultant dishonesty, actual or potential fine-motor impairment (a critical area in dentistry)
   - Violation of personal and professional ethical standards is common

Bulleted text written by Linda Kittelson, M.S., R.N., C.S.A.D.C., manager, Dentist Well-Being Programs, Council on Dental Practice, American Dental Association. Major portions were included in: Kittelson, L, "Secrets and Lies: Alcohol and Drug Addiction in Dentistry." *California Dental Association Journal*, 26(10), October 1998, pp. 744-750.

Appendix E

Report of the Ad Hoc Committee on Physician Impairment Federation of State Medical Boards of the United States, Inc.

The Federation of State Medical Boards of the U.S., Inc., accepted this Report of the Ad Hoc Committee on Physician Impairment as policy in April 1995.

Section I. Introduction

In May 1993, Federation President Hormoz Rassekh, MD, established a special Ad Hoc Committee on Physician Impairment to evaluate current concepts regarding physician impairment and to develop medical board strategies for the regulation and management of such physicians.

After discussion of several forms of physician impairment, the committee elected to focus primarily on chemical dependency, because of its prevalence. In May 1994, Federation President Gerald J. B,champs, M.D., expanded the charge to include other impairments to be addressed immediately after guidelines are established for regulating and managing chemically dependent physicians. Other sections on psychiatric and physical impairments will be forthcoming, as well as an additional report on sexual boundary issues.

The ad hoc committee was composed of the following members: Barbara S. Schneidman, M.D., M.P.H., Chair; Roy J. Ellison, Jr., M.D.; Alexander F. Fleming, J.D.; Ruth Horowitz, Ph.D.; George J. Van Komen, M.D.; Maurice J. Martin, M.D.; Karen W. Perrine, J.D.; Julie F. Pottorff, J.D.; Hormoz Rassekh, M.D.; Nicholas E. Stratas, M.D.; Gerald L. Summer, M.D.; John J. Ulwelling; Andrew Watry. Rendel L. Levonian, M.D., was consultant, and Gerald J. B,champs, M.D., and Robert E. Porter, M.D., were ex-officio members.

Section II. Committee's Goals and Outcomes

The committee discussed at length the specific goals and outcomes they want to achieve. Subsequently, three goals were identified as follows:

1. Develop elements of a model impaired physician program (IPP) to be recommended to state medical boards along with guidelines to promote uniformity in rules/regulations regarding impaired physicians.
2. Enhance the protection of the public through communication with and education of citizens about physician impairment. Communication with the American Medical Association, state medical boards, state medical societies, Administrators in Medicine, as well as providing appropriate articles to the press, were also cited as avenues of disseminating information to the public.
3. Pursue federal and state legislative initiatives, when appropriate, to provide improved powers to state medical boards for the supervision of impaired physicians.

Section III. Development of Survey Instrument

In order to provide the committee with the information necessary to develop a model IPP, a survey instrument was developed by the committee and distributed to all state medical boards. This survey requested information on IPPs currently available to the state medical boards. Committee recommendations were derived from both previous board experience and the information received from the questionnaire. Out of 66 surveys mailed, 70 percent responded. The bulk of the responses received from the state medical boards are incorporated into the following report. Data from the survey is in the appendix.

Section IV. Definitions

1. Impairment-The inability of a licensee to practice medicine with reasonable skill and safety by reason of:
    a. mental illness; or
    b. physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or
    c. habitual or excessive use or abuse of:
    d. drugs defined in law as controlled substances,
    e. alcohol, or
    f. other substances that impair ability.
2. Impaired Physician Program (IPP) — A program approved by the state medical board and charged with the management of physicians who are in need of evaluation and/or treatment. Each state medical board should have available to it a program either under its own auspices or through a formalized contract with an independent entity whose program meets the standard set by the state medical board.

Section V. Model Program

The purpose of an IPP is to evaluate licensees with possible impairment and recommend appropriate management. The IPP should also monitor the progress of licensees in after-care programs, whether the referral is voluntary or board-mandated. In addition, programs should make periodic reports to appropriate individuals, committees, or organizations; develop intervention programs, intervenors' training programs, research programs; and serve as a resource for inquiries of physicians and the public.

An IPP should have the following elements:

1. **Administration:** Ability to adequately and appropriately manage and administer the program. Staff should include:
    a. **Physician Medical Director:** A medical director with appropriate background in chemical dependency and general understanding of mental illness. The IPP should provide for funding of a full-time physician medical director. The committee believes that a full-time physician medical director is better equipped with the clinical knowledge necessary to effectively evaluate the investigative information surrounding the impaired physician, both those who voluntarily refer and those who are board-mandated. The committee recognizes that smaller state medical boards may not have the available resources necessary to employ a full-time physician medical director. Therefore, the committee recommends that smaller state medical boards might wish to establish consortiums so that the employment of a full-time director may be feasible.
    b. **Executive Director:** An individual with the responsibility to oversee the administrative and operational aspects of the program. Some programs may wish to combine the functions of the physician medical director with the executive director.
    c. **Support Staff:** The program should include adequate clerical and other staff to support the physician medical director and executive director.

2. **Investigation:** Authority to investigate a report of possible impairment. The purpose of the investigation is to determine if the report can be substantiated and if intervention is warranted. Investigation should be conducted by professionals with training in the area being investigated.
3. **Intervention:** Authority to intervene if the investigation indicates a reasonable probability that the physician is impaired. The individuals conducting the intervention should be appropriately trained for the specific type of intervention, particularly in the areas of chemical dependency and mental illness.
4. **Evaluation/Assessment:** Authority to coordinate an evaluation to determine the nature and extent of the impairment. The committee recommends that, whenever possible, the evaluation of the physician be conducted by an independent evaluator to avoid the appearance of conflict of interest. Therefore, the program should have a number of resources that have been reviewed and found to be acceptable for referrals. The program should use the criteria set forth in Section VII to determine if a physician should be referred for an evaluation. In addition, the program should meet the criteria set forth in Section VIII, particularly in selecting an evaluator and obtaining evaluations.
5. **Treatment:** Ability to analyze information received from the evaluator and make recommendations for treatment, if necessary. The program should meet the criteria set forth in Section IX, particularly to determine if a facility or practitioner is acceptable for referrals.
6. **Discharge/Follow-Up Care:** Ability to develop and implement a discharge or monitoring plan that is designed to ensure that the impairment does not adversely effect the ability to practice with reasonable skill and safety and that the physician remains in recovery or is otherwise able to cope with his impairment. The program should also have the authority to ensure compliance with follow-up care and should meet the criteria set forth in Section X.
7. **Relapse Management:** Methods should be designed for the early recognition of relapse and should have the ability to respond timely and effectively. This response will include a report to the board, in most circumstances. For chemical dependency, the program should meet the criteria set forth in Section XI.
8. **Confidentiality:** The committee recognizes the need for confidentiality of program participation; however, it recommends to state medical boards the need for a non-board member, preferably an agency staff member, to be notified by the IPP medical director of a physician's participation, voluntary or not. Also, the committee affirms that the IPP medical director should, if warranted by a participant's noncompliance, communicate with the state medical board regarding this same physician. The committee recognizes that a method of confidentially protecting a program participant needs to be developed by the state medical board. The committee has determined that aggregate program data is considered public information and may be disclosed to all medical board members, but only a designated agency staff person should be apprised of the actual identity of the program participant.

The committee has identified and recommends to state medical boards the utilization of the following criteria in determining state medical board approval of an IPP. It is recommended that a formal contract be executed, setting forth the relationship between the two bodies, and that such contract be based on mutual trust.

1. Mutual interaction between the state medical board and the IPP. There must be a commitment between both parties in regard to open lines of communication.

2. The IPP must be aware of and understand the issues involved, relative to the licensure and disciplinary responsibilities of the board in its mission to protect the public.
3. The IPP does not deny services based on a physician's specialty, medical degree, or membership affiliations.
4. The IPP accepts all indigent physician patients and is available for all referrals by state medical boards.
5. The IPP must provide arrangements for emergency evaluations.
6. The IPP must have an aftercare contract consistent with physician rehabilitation and patient safety.

Section VI. Tracks for Referral to IPP

The ad hoc committee identified two pathways, or tracks, by which impaired physicians are referred to an IPP. Track "A" physicians are those who voluntarily enter the IPP without the state medical board's mandate and who do not expose patients to the possibility of patient harm. These physicians are usually considered self-referred, even though, most often, they are confronted by peers with the warning that disciplinary action may be taken if compliance is not forthcoming. Other violations of the medical practice act will be dealt with separately by the board. Track "B" physicians are mandated by the state medical board to participate in an IPP.

Section VII. Criteria for Referral

While all programs should have mechanisms that allow a physician to self-refer, it is recognized that most physicians will enter the IPP voluntarily or by board mandate. While it is appropriate for physicians to refer themselves to the program, there should be an evaluation of all suspected physicians and the following criteria should be used as the basis for referral. The committee recommends that when intervention or investigation uncovers one or more of the following criteria, a physician should be referred for evaluation/assessment.

1. There is information or documentation of excessive or habitual alcohol or other drug consumption.
2. There are sufficient indications of current alcohol or other drug use that may include positive body fluid analysis for mood-altering chemicals.
3. The physician's behavioral, affective, and/or thought disorder manifestations represent a threat to public safety.
4. Information or documentation of mental illness that is not being treated or that impairs the ability to practice.

Section VIII. Evaluation/Assessment Program Criteria

Chemical Impairment

The committee recommends that an approved IPP employ the following criteria in selecting providers to whom referrals will be made for evaluations/assessments of physicians:

1. Providers performing evaluations/assessments should have demonstrable expertise in the recognition of the unique characteristics of health professionals involved in the disease of chemical dependency. To avoid the appearance of conflict of interest, a member of the health professional/impaired physician committee should have no vested interest in the provider offering the evaluation/assessment.

2. Admission for evaluation of chemical dependency should be contingent upon agreement of the patient to release to the health professional/IPP any records pertaining to the identity, diagnosis, prognosis, or treatment of such patient that are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research.
3. When assessment for chemical dependency requires residential or hospital inpatient care, it should be for an appropriate period of time to observe for withdrawal and to complete the evaluation, generally a minimum of three days.
4. The individual should undergo a complete medical evaluation, including appropriate laboratory and physical examinations. Laboratory examinations should include appropriate urine and blood drug screens and should be conducted by a physician with demonstrable knowledge of chemical dependency.
5. The psychiatric history and mental status examination should be performed by a psychiatrist knowledgeable in addictive disease.
6. A comprehensive psychological assessment should include neuropsychological testing performed by a qualified clinical psychologist. Testing shall give an indication of personality structure, including, but not limited to, assessment of memory and cognitive understanding. The assessment instrument(s) used should be specified in the psychologist's report.
7. Upon completion of the evaluation, release of all evaluation results will be made to the IPP.
8. All physicians who refuse recommended treatment will be subject to state medical board notification by the IPP medical director.

Mental Impairment

The committee recommends that IPPs approved by a state medical board employ the following criteria in selecting providers to perform evaluations/assessments of physicians referred by the IPP.

1. The providers performing evaluations/assessments should have demonstrable expertise in the recognition of the unique characteristics of health professionals involved in the disease of mental illness. To avoid the appearance of conflict of interest, a member of the health professional/impaired physician committee should have no vested interest in the provider offering the evaluation/assessment.
2. Evaluation of mental illness should be contingent upon agreement of the patient to release to the health professional/IPP any records pertaining to the identity, diagnosis, prognosis, or treatment of such patient that are maintained in connection with the performance of any program or activity relating to mental illness education, prevention, training, treatment, rehabilitation, or research.
3. When assessment for mental illness requires residential or hospital inpatient care, it should be for an appropriate period of time.
4. The individual should undergo a complete medical evaluation, including appropriate laboratory and physical examinations. Laboratory examinations should include appropriate urine and blood drug screens.
5. The psychiatric history and mental status examination should be performed by a knowledgeable psychiatrist.
6. A comprehensive psychological assessment may include neuropsychological testing performed by a qualified clinical psychologist. Testing shall give an indication of personality

structure, including, but not limited to, assessment of memory and cognitive understanding. The assessment instrument(s) used should be specified in the psychologist's report.

7. Upon completion of the evaluation, release of all evaluation results will be made to the IPP.
8. All physicians who refuse recommended treatment will be subject to state medical board notification by the IPP medical director.

Section IX. Treatment Program Criteria

Chemical Impairment

1. The provider of treatment should have demonstrable expertise in the recognition of the unique characteristics of health professionals involved in the disease of chemical dependency and have the ability to offer an inpatient treatment program of at least thirty (30) days. To avoid the appearance of a conflict of interest, a member of the health professional/impaired physician committee should have no vested interest in the provider offering treatment.
2. Admission for treatment of chemical dependency should be contingent upon agreement of the patient to release to the health professional/IPP any records pertaining to the investigation, identity, diagnosis, prognosis, or treatment of such patient that are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research.
3. Providers conducting the treatment must agree to release the results of the treatment to the IPP. Physicians undergoing treatment should agree to adhere to the recommendations of the treatment provider.
4. All physicians who leave treatment against medical advice will be subject to state medical board notification by the IPP.

Mental Impairment

1. The provider of treatment should have demonstrable expertise in the recognition of the unique characteristics of health professionals involved in the disease of mental illness and have the ability to offer an inpatient treatment program. To avoid the appearance of a conflict of interest, a member of the health professional/impaired physician committee should have no vested interest in the provider offering treatment.
2. Admission for treatment of mental illness should be contingent upon agreement of the patient to release to the health professional/IPP any records pertaining to the investigation, identity, diagnosis, prognosis, or treatment of such patient that are maintained in connection with the performance of any program or activity relating to mental illness education, prevention, training, treatment, rehabilitation, or research.
3. Providers conducting the treatment must agree to release the results of the treatment to the IPP. Physicians undergoing treatment should agree to adhere to the recommendations of the treatment provider.
4. All physicians who leave treatment against medical advice will be subject to state medical board notification by the IPP.

Section X. Follow-Up Care/Discharge Planning for Impaired Physician Program

Chemical Impairment

Two closely related models for follow-up/discharge planning are available: Track "A" for those who enter treatment through an IPP and Track "B" for those who enter treatment through board proceedings. Physicians who have engaged in conduct that the board determines constitutes a violation of the public trust should be routed through Track B.

1. **Length:** The IPP must have an aftercare contract consistent with physician rehabilitation and patient safety. While medical boards may be called upon to individualize aftercare contracts, the committee recommends that all physicians involved in an IPP should be supervised for a minimum of five years.
2. **Follow-up Criteria:**
    a. Monitoring physician familiar with the addiction process
    b. Personal primary-care physician. Self-treatment is prohibited.
    c. Supervisory physician with oversight of impaired physician while practicing medicine
    d. Attendance at AA, NA or other equivalent program
    e. Support group attendance, including a weekly meeting with peers
    f. Strong encouragement that a physician's personal and family support system be included in the recovery process
    g. Urine Screening:
        - Obtain witnessed urine screens by a same-sex observer
        - Use of an approved laboratory for screening urine samples
        - Establish a chain-of-custody for urine samples
        - Abused mood-altering chemicals
        - Screen at intervals appropriate to drug(s) of abuse
    h. Progress reports
    i. Psychiatrist or psychologist, if needed
3. **Portability:** All aftercare contracts must have the provision to allow IPPs to notify IPP/medical boards in other states of the physician's participation and current status.
4. **Reporting:** The IPP should report to the state medical board's designated representative on all cases of physician impairment. If the impaired physician enters treatment voluntarily, the IPP should submit "blinded reports" to the state medical board on a periodic basis, which report on the status of the impaired physician in regard to compliance with the provider's treatment recommendations. The periodic "blind reports" also should include a report on the monitoring of the workplace. IPPs reporting on those physicians who are board-mandated should report to the state medical board on a quarterly basis and include detailed reports on aftercare compliance.

Mental Impairment

1. **Follow-Up Criteria:**
    a. Monitoring psychiatrist
    b. Personal primary-care physician. Self-treatment is prohibited.
    c. Supervisory physician with oversight of impaired physician while practicing medicine
    d. Strong encouragement that a physician's personal and family support system be included in the treatment process
    e. Progress reports
2. **Portability:** All aftercare contracts must have the provision to allow IPPs to notify IPP/medical boards in other states of the physician's participation and current status.
3. **Reporting:** The IPP should report to the state medical board's designated representative on all cases of physician impairment. If the impaired physician enters treatment voluntarily, the IPP should submit "blinded reports" to the state medical board on a periodic basis, which reports on the status of the impaired physician in regard to compliance with the provider's treatment recommendations. The periodic "blind reports" should also include a report on the monitoring of the workplace. IPPs reporting on those physicians who are board-mandated should report to the state medical board on a quarterly basis and include detailed reports on aftercare compliance.

Section XI. Relapse Management

Chemical Impairment

The medical licensing board's response to relapse may vary, depending upon the physician's recovery program and the circumstances surrounding the relapse. It is important to remember that the occurrence of relapse may not be with the initial or primary drug of choice. Monitoring recovery groups and random urine drug screening provide opportunity for early detection of relapse.

1. The board recognizes three levels of relapse behavior that have the potential to impact public safety.
    Level 1: Behavior that might indicate relapse, without chemical use, should be reviewed by the physician medical director or designated representative who may make treatment recommendations that may include individual counseling or a return to a more intense monitoring protocol.
    Level 2: Relapse, with chemical use, that is not in the context of active medical practice may be reported to the medical board.
    Level 3: Relapse, with chemical use, in the context of active medical practice, which may include a positive blood or urine specimen, should be immediately reported to the state medical board.
2. The board underscores the need for prompt management of relapse to ensure public safety. There is a need to understand that the drug involved in the relapse may not be the primary drug of choice present in the initial chemical abuse process. Furthermore, it is important that management of a relapsed physician be within the realm of the IPP. If relapse is permitted to be managed outside the program, there may develop a loss of control in the recovery process that tends to produce isolation and recurrent relapse.

Relapse management should consist of the following:

a. Reevaluation should be conducted by the IPP medical director, with immediate investigation, intervention, and notification to the state medical board.

b. The recommendation should depend on the circumstances and the behavior surrounding relapse in consultation with the appropriate treatment provider.

c. An emergency suspension of the physician's license to practice medicine may be indicated if there is a danger to the public.

d. Noncompliance with the aftercare contract will result in a report to the board.

Mental Impairment

Relapse management should consist of the following:

1. Reevaluation by the IPP medical director, with immediate investigation, intervention, and notification to the state medical board.
2. The recommendation should depend on the circumstances and the behavior surrounding relapse in consultation with the appropriate treatment provider.
3. An emergency suspension of the physician's license to practice medicine may be indicated if there is a danger to the public.
4. Noncompliance with the aftercare contract will result in a report to the state medical board.

Section XII. Physical Impairment

The committee recognizes that many competent physicians have a physical disability prior to their medical education and training and have appropriately adapted their medical practice to accommodate their disability. The committee also recognizes that a practicing physician may experience the onset of a physical disability and should be presumed to self-limit or suspend his practice in accordance with his ability to safely practice medicine. However, for some physicians who are unwilling or unable to recognize limitations due to a physical impairment, the board must be able to intervene in order to protect the public. The committee recommends that state medical boards develop capabilities that would allow state medical boards to respond to such physicians with physical impairment. The committee recommends the following:

1. A board should develop the capabilities to have physicians with physical impairments evaluated or assessed by experts in the appropriate field.
2. If the assessment reveals a physical impairment, the board should be informed about the nature and prognosis of the impairment, including whether the condition is treatable.
3. The assessment should apprise the board of the impact of the impairment on the performance of the practice of medicine.
4. Any restrictions or limitations placed on the licensee should be narrowly tailored to reflect the impact of the impairment on the physician's ability to practice with reasonable skill and safety.
5. To the extent possible, resolution of these physical impairment issues should be through informal negotiation rather than formal proceedings.
6. The board should develop mechanisms to allow intervention to occur outside of the board.

Section XIII. Allied Health Practitioners

Impairment programs for allied health professionals should be available for referrals by medical boards. These impairment programs should meet the same criteria for approval as established by the medical board. If the state medical board has jurisdiction over allied health practitioners, appropriate impairment programs should be available

Section XIV. Appendix

The Survey of State Medical Boards Regarding Impaired Physician Programs Summary

On October 22, 1993, a survey instrument was mailed to all member medical boards, requesting information on impaired physician programs (IPPs) available to each board. In November 1993, Federation staff faxed reminders to those state medical boards who had not responded and as of December 30, 1993, 70 percent of all state medical boards had mailed in their responses.

Question 1: Does your board have a program available that allows the board to deal with impaired physicians? 89 percent of responding boards indicated they had an IPP available and 11 percent indicated they did not.

Question 2: Who runs the impaired physician program (IPP)? 48 percent of boards affirmatively responding to Question 1 reported that the state medical association ran the IPP. 28 percent reported the state medical board was responsible for the operation of the IPP. 20 percent indicated some form of joint relationship with another organization, and 8 percent reported that the IPP was operated by another private contractor.

Question 3: Does your program address other areas of impairment besides chemical impairment? If so, what areas? 85 percent of responding boards address other areas of impairment besides chemical dependency and 15 percent indicated they did not. The other areas of impairment that state medical boards address include psychological, physical impairment, and age-related cognitive deficits. 20 percent of those boards who address other areas of impairment indicated that sexual misconduct is also addressed by their board as an impairment.

Question 4: How is the IPP funded? 35 percent reported that the IPP was fully funded by the state medical board's budget. A large percentage of IPP budgets come from licensure fees, both initial and renewals. 28 percent reported that the state medical association is responsible for all costs associated with the IPP. 9 percent of the medical boards indicated that the IPP was jointly funded by monies received from either a state medical association or program participant in conjunction with monies from the state medical board, and 7 percent indicated that the program participant is wholly responsible for funding of the IPP. The remaining 21 percent of responding boards indicated that funding for the IPP is obtained from additional sources, such as insurance companies, federal grants, and hospitals.

Question 5: Does the impaired physician program employ a full-time physician medical director? If not, what percentage of time does the physician medical director devote to the impairment program? 33 percent reported employment of a full-time physician medical director. Of the remaining 67 percent, 18 percent indicated the medical director devotes at least 50 percent of his time to the IPP, 9 percent said 25 percent, 12 percent said 0-10 percent, and 18 percent did not know how much time the medical director devoted to the IPP.

Question 6: List the major elements of your impaired physician program and identify which of these elements are most effective. Identification of physician impairment was one of the most common elements identified. Evaluation, treatment, and aftercare monitoring were also identified as major elements for a successful and effective IPP. Other program elements that boards felt were effective included intervention, random urinalysis, the 12-step program, and trained staffing.

Question 7: If a physician comes before the state medical board, what criteria is used in order to recommend evaluation by the impairment program director? 87 percent of the responding boards indicated that suspicion of impairment alone was grounds for ordering a suspected impaired physician in for evaluation by the impairment program director or rehabilitation facility. Methods of identifying physicians suspected of being impaired include reports received from medical societies, hospitals, formal complaints, and relatives. Some states have identified specific criteria that must be met before ordering an evaluation. They include:

a. Is there documented diversion of drugs?

b. Is there documented consumption of drugs or alcohol?

c. Are there quality of care issues?

d. Is there any evidence to deem the physician a potential threat to public safety?

Question 8: Does your state's impairment physician program director have the sole authority to determine if impairment exists? 13 percent responding indicated that the program director has sole authority to determine if impairment exists, and 85 percent responded that determination of impairment was made by someone else besides the program director. Usually the board or a specific committee established to address physician impairment will make the decision to refer for further evaluation. In order to protect against conflict of interest, evaluators are required to provide only diagnosis and treatment recommendations. They will not provide the actual treatment and they must not have any personal, legal, or financial relationship to the individual being evaluated.

Question 9: What is the average length of monitoring and who manages follow-up care? 40 percent of responding boards indicated the average length of monitoring is 3-5 years, 35 percent said 5 years, and 4 percent reported that the length of monitoring is indefinite and is determined on a case-by-case basis. The remaining 21 percent reported monitoring varied from 1-7 years. Overall, most of the boards responding have monitoring contracts that average 3-5 years in length. The management of follow-up care is predominantly handled by the state medical boards and IPPs. If the board is not responsible for follow-up care, then the IPP medical director is. The responses received to this question indicate that there is a concerted effort between the IPPs, state medical associations, and medical boards to effectively monitor impaired physicians.

Question 10: Does your program have a monitoring contract? For how long? 78 percent of the responding boards use monitoring contracts, and the most common response to length was 5 years.

Question 11:

a. Who administers the urinalysis testing? 58 percent reported that independent laboratories administered the urinalysis testing, 20 percent use board investigators to handle urine screening, 15 percent indicated that the IPP is responsible for administering the urinalysis testing, and 7 percent did not answer.

b. Who observes the process (urinalysis testing)? Responses to this question were similar to those received in Question 11a. The main objective of observing this process is to make sure the samples received are not compromised. The "chain of custody" must be maintained.

c. Who pays for this monitoring (urinalysis testing)? 87 percent responded that the program participant is responsible for paying for the urinalysis screenings. If the participant cannot afford to pay for screenings, many times payment may come from alternative sources, ie, insurance companies, medical board, medical society.

d. Who is responsible for the monitoring during follow-up care? This question is similar to Question 9 in that it addresses managing follow-up care. Over 50 percent of the boards responding indicate that the IPP is responsible for monitoring follow-up care. The medical board and the IPP often work in conjunction with each other in monitoring impaired physicians.

Question 12: Who develops the criteria that identifies physician impairment? 39 percent of responding boards indicate that the state medical board was solely responsible for the development of criteria that identifies physician impairment, 25 percent responded that the medical board and IPP share the responsibility of developing the criteria, and 20 percent responded that the IPP director alone developed the criteria. Expert treatment professionals are being retained by state medical boards to assist in the development of their board's criteria.

Question 13: How are relapses managed? Most of the responding boards indicate that relapses would be dealt with expeditiously, on a case-by-case basis. Circumstances surrounding the reason for relapse, physician's chemical dependency history, and protection of the public are issues that are thoroughly examined before dealing with an impaired physician. The medical boards can order a reevaluation or take formal disciplinary action against a relapsing physician.

Question 14: Does the board have trigger mechanisms that will enable the state medical board to take formal disciplinary action if needed? If so, what are they? If a physician is noncompliant with the terms of his/her monitoring contract, the IPP contacts the state medical board. There are also mandatory reporting requirements for health care providers. Impairment can also be determined by questionable prescribing practices and various other practices that would trigger the board about suspected physician impairment.

Question 15: Do you treat out-of-state applicants for licensure with a history of impairment differently than you do your current licensee population? Please describe how you handle out-of-state applicants with a history of impairment. 61 percent of responding boards indicated that both out-of-state applicants and in-state licensees are treated the same, and 37 percent responded that out-of-state applicants are handled differently than current licensees. Most states require an updated assessment of the physician, as well as receipt of the
physician's treatment history in the other state. Depending upon how recent the impairment problem was prior to applying for a license will determine if the physician is granted a full and unrestricted license, restricted license, or denial of application. If license is restricted, the physician may also be required to participate in an IPP.

Question 16: What impact will the Americans with Disabilities Act (ADA) have on your program or ability to deal with impaired physicians? Explain. Most state medical boards are in the process of evaluating the ADA and are closely monitoring the New Jersey suit. 59 percent of responding boards said they are watching what is happening in New Jersey and noted how that case will set a precedent for future actions taken by the boards

regarding impairment. Most anticipate only minor impact as it relates to application questions. 20 percent feel that the ADA will put considerable strain on their ability to handle impaired physicians, and 15 percent feel that the ADA will have no impact on their program or their board's ability to deal with physician impairment.

Question 17: Do you believe the ADA will infringe upon the effectiveness of the board in dealing with disciplinary matters relating to impairment? Explain. Until further clarification is made regarding the ADA and how it will effect state medical boards, many of the responding boards felt uncertain as to whether the ADA will infringe or not.

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Appendix F ADA Golden Apple Awards Program

Recognizing Excellence – 12 Chances to Showcase Your Society's Achievements

The American Dental Association's (ADA) Golden Apple Awards Program is a unique opportunity for constituent and component dental societies to gain valuable recognition for their leaders, members and staff. With 12 categories, there are many opportunities for your dental society to showcase its outstanding programs and share ideas with other societies across the country.

Submit entries in all 12 categories or just one

I. Legislative Achievement

II. Excellence in Membership Recruitment and Retention Activity

III. Excellence in Dental Health Promotion to the Public

IV. Excellence in Member-Related Services/Benefits

V. Outstanding Achievement in the Promotion of Dental Ethics

VI. Achievement in Dental School/Student Involvement in Organized Dentistry

VII. Excellence in Science Fair Program Support and Promotion

VIII. Excellence in Dentist Well-Being Activities

IX. Open Category

X. Excellence in Access to Dental Care Programs

XI. The Green Apple — Excellence in Environmentally Sustainable Programs and Education

XII. Outstanding Achievement in the Promotion of Diversity and Inclusion

Visit ADA.org/goldenapple for more information.

Appendix G

Guiding Principles for Dentist Well-Being Programs (1996:693)

Resolved, that the American Dental Association supports efforts by constituent and component dental societies in the development and maintenance of effective programs to identify and assist those dentists and dental students affected by conditions which potentially impair their ability to practice dentistry, and be it further

Resolved, that constituent and/or component dental societies be urged to include these guiding principles in establishing or structuring peer assistance programs for dentists:

1. That statewide dentist peer assistance programs be established.
2. That appropriate protection be sought to ensure the confidentiality of those who seek and provide help through authorized programs.
3. That measures be sought to provide those who serve in dentist peer assistance programs immunity from civil liability, except for willful or wanton acts.
4. That strong, but not exclusive, ties with the recovering community be encouraged.
5. That strong working relationships be maintained between state, local and national programs.
6. That dentist peer assistance programs and dental licensure boards be encouraged to establish and maintain a system for referral and monitoring of dentists in need of assistance.
7. That educational activities be developed to inform the public, the judiciary, the dental society, dental students and the dental licensure boards of the assistance that is available.
8. That committee members become familiar with and review the Curriculum Guidelines for Education in Substance Abuse, Alcoholism, and Other Chemical Dependencies (1992) and provide liaison to dental schools to assist in implementation of this curriculum.
9. That continuing education programs on well-being issues be developed and offered to dentists and urge the acceptance of these offerings as a part of Continuing Education requirements, if they exist.
10. That periodic review of the peer assistance programs be conducted.

Appendix H Joint Commission on Accreditation of Healthcare Organizations

Medical Staff Standard

© 4. Peer recommendations are obtained from a practitioner in the same professional discipline professional discipline as the applicant with personal knowledge of the applicant's ability to practice.

LIP Health

Standard MS.4.80

The medical staff implements a process to identify and manage matters of individual health for licensed independent practitioners. This identification process is separate from actions taken for disciplinary purposes.

Rationale for MS.4.80

The organized medical staff and hospital leaders have an obligation to protect patients, its members, and other persons present in the hospital from harm. Therefore, the organized medical staff designs a process that provides education about LIP health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of LIPS who suffer from a potentially impairing condition.

The purpose of the process is help with the rehabilitation, rather than discipline, to aid a practitioner in retaining and regaining optimal professional functioning that is consistent with protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a practitioner is unable to safely perform the privileges he or she has been granted, the matter is forwarded for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

Elements of Performance for MS.4.80

Process design addresses the following issues:

1. Education of LIPs and other hospital staff about illness and impairment recognition issues specific to LIPs (at-risk criteria)
2. Self referral by an LIP
3. Referral by others and creation of confidentiality of informants
4. Referral of the affected LIP to appropriate professional internal and external resources for evaluation, diagnosis, and treatment of the condition or concern
5. Maintenance of confidentiality of the LIP seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the health and safety of a patient is threatened
6. Evaluation of the credibility of a complaint, allegation, or concern
7. Monitoring the affected LIP and the safety of patients until the rehabilitation or any disciplinary process is complete and periodically thereafter, if required
8. Reporting to the organized medical staff leadership instances in which an LIP is providing unsafe treatment

Note: *The Americans with Disabilities Act (ADA) bars certain discrimination based on physical or mental impairment. Toward preventing such discrimination, the act prohibits or man-dates various activities.*

Hospitals need to determine the applicability of the ADA to their medical staff. If applicable, the hospital should examine its privileging or credentialing procedures as to how and when it ascertains and confirms the ability of an applicant to perform the privileges requested.

Appendix I

Client Admonition List – Washington Physicians Health Program

720 Olive Way, Suite 717, Seattle, WA 98101
206.583.0127 • 800.552.7236 • Fax 206.583.0418

Client Admonition List

1. Do **NOT** consume so-called "non-alcoholic" beer or wine.
2. Do **NOT** consume non-beverage alcohol such as, mouthwash, liquid medication with an alcohol base, desserts, food cooked in alcohol, Primatene Mist, vanilla extract, etc.
3. Do **NOT** consume alcohol in any form, even for religious purposes.
4. Do **NOT** consume any OTC (over-the-counter) preparations, which possibly contain any cross-reacting substances such as Sudafed or other stimulants.
5. Do **NOT** consume poppy seeds found chiefly in salad dressings, bread, bagels, and pastries which must be opened or separated to examine inside.
6. Do **NOT** self-prescribe any drug, legend or scheduled (controlled).
7. Do **NOT** prescribe scheduled (controlled) drugs for relatives.
8. Do **NOT** prescribe any drugs for anyone without generating a patient record.
9. Keep any family member's medication(s) in a location distinctly separate from your medication(s) to avoid accidental contamination and/or ingestion.
10. Scrutinize all labels on any medications or other preparations you take before actually putting them in your mouth. Be sure to read all the labels in adequate light to ensure the correct identity of the medication and to ensure it does not contain addictive chemicals.
11. Beware of iatrogenic relapse. Inform any prescribing practitioner (M.D., D.O., D.P.M., D.D.S., D.M.D., A.R.N.P., etc.) that you are chemically dependent. Check with WPHP before taking any scheduled (controlled) drug, even if prescribed by another physician for a legitimate medical condition, unless an emergency exists, and then you are to notify us at the earliest opportunity.
12. Remove all alcoholic beverages and other non-beverage alcohol (as above) from your home, office, boat, and vehicles (this includes wine collections).
13. If a patient returns controlled substances to your office, these drugs should be inventoried, recorded, and disposed of by another individual.
14. At the time you give a urine specimen, note all substances you are currently taking including any prescribed medications, Over-The-Counter drugs, herbs, supplements, vitamins, or other chemicals.
15. Avoid the **"PERCEPTION:"** for example, sitting at a bar consuming soft drinks, exiting a liquor store carrying a package, drinking sparkling cider out of a champagne glass at a wedding, or being seen in a raucous party situation.
16. Avoid unexcused absences.
17. Avoid positive UA's (A MISSED UA = A POSITIVE UA).
18. Avoid missing payment of program and UA fees.
19. In the event of an adverse situation, cover yourself with a stat UA, preferably at our laboratory, but certainly at the nearest convenient facility.

20. Don't change malpractice carriers if possible.
21. **AVOID AT ALL COSTS A FRAUDULENT APPLICATION!** If questions regarding chemical dependency are worded ambiguously, or if there is any reasonable doubt about the intent of an inquiry, or if you are not absolutely certain of the proper and rigorously honest answer, consult with us before answering the question.
22. Don't "advertise" your addiction *or* your recovery.

I have read, fully comprehend, and agree to adhere to the above admonitions. I acknowledge receipt of a copy of this document.

Signed Client Date

Signed Spouse/SO Date

Used with permission of the Washington Physicians Health Program

Appendix J Mental Health Support Group

Note: This is the protocol used by the Florida Lawyers Assistance Program for support groups for attorneys who do not have chemical dependency, but who are involved with the program because of stress, depression or other mental health disorders. It was developed by Michael Cohen, executive director, Florida Lawyers Assistance, and used with permission.

FLA Facilitated Groups

Purpose of Groups

Initially, these groups were expected to provide a means of peer support in an affordable therapeutic group setting for those attorneys suffering from stress, depression and other mental health issues without chemical dependency. Earlier attempts to integrate these attorneys into FLA's traditional twelve-step groups were generally unsuccessful, and we began to conceive of establishing groups facilitated by a professional psychologist or mental health counselor. The need for such a resource has grown over the past few years as FLA has become established as, not only an assistance program for alcohol and drug dependent attorneys, but as a program for impaired attorneys with a variety of issues and conditions.

A secondary need is fulfilled in that attorneys who must be monitored by FLA can be monitored by the group facilitator rather than a private therapist. Heretofore, anyone under a monitoring contract with FLA was required to see a private therapist on a monthly (or greater) basis and have that professional file reports with FLA. The obvious disadvantage to this is the cost to the client and the potential risk to the therapeutic relationship. While many of these participants are treated by other professionals, the facilitator who sees them in an interactive group setting each week, while consulting with the private providers on an as-needed basis, is well qualified to report on the client's compliance and progress. Each facilitator will be provided a copy of each client's contract, where appropriate, and the necessary forms and instructions for filing the monthly reports with FLA.

What was not anticipated was the desire of a number of chemically dependent, or dual diagnosis clients to attend the group. As word was spread about the pilot group in Ft. Lauderdale, many of these individuals asked to be included and this first group was soon filled to capacity. The make-up of this group became approximately one-half recovering chemically dependent people and one-half non-chemically dependent individuals. In both groups, the majority have diagnosed, treated co-morbid disorders, but we have not made this a criteria. Additionally, we have approximately one-half of the group required to attend according to the terms of their contracts, most of which are court ordered, and one-half who attend on a voluntary basis. This will obviously vary from group to group, but demonstrates the need so many FLA clients have for therapy and support.

Signed Spouse/SO Date

Facilitator's Role

The facilitator's primary role is to maintain positive interaction within the group and assist individuals in breaking through their own mental defenses. Attorneys are generally highly intellectual and articulate, but are usually lacking in personal insight. Obviously, each facilitator has his or her own style in group work and we encourage the use of individual skills and assets in each group.

Monitoring of participants under contract is required of each facilitator. The necessary forms will be provided along with a copy of the appropriate contract. FLA requires that we have the reports in our office no later than the tenth of each month and the report should cover client's participation for the previous month. For Florida Bar disciplinary cases, only the front page of the report is transmitted to the Bar; for voluntary clients, no report is required, although in cases where the facilitator observes or otherwise becomes aware of behaviors that may indicate chemical relapse, failure to maintain medication, or other causes of concern, he or she should call either Michael Cohen or Judy Rushlow at FLA immediately to discuss an appropriate course of action.

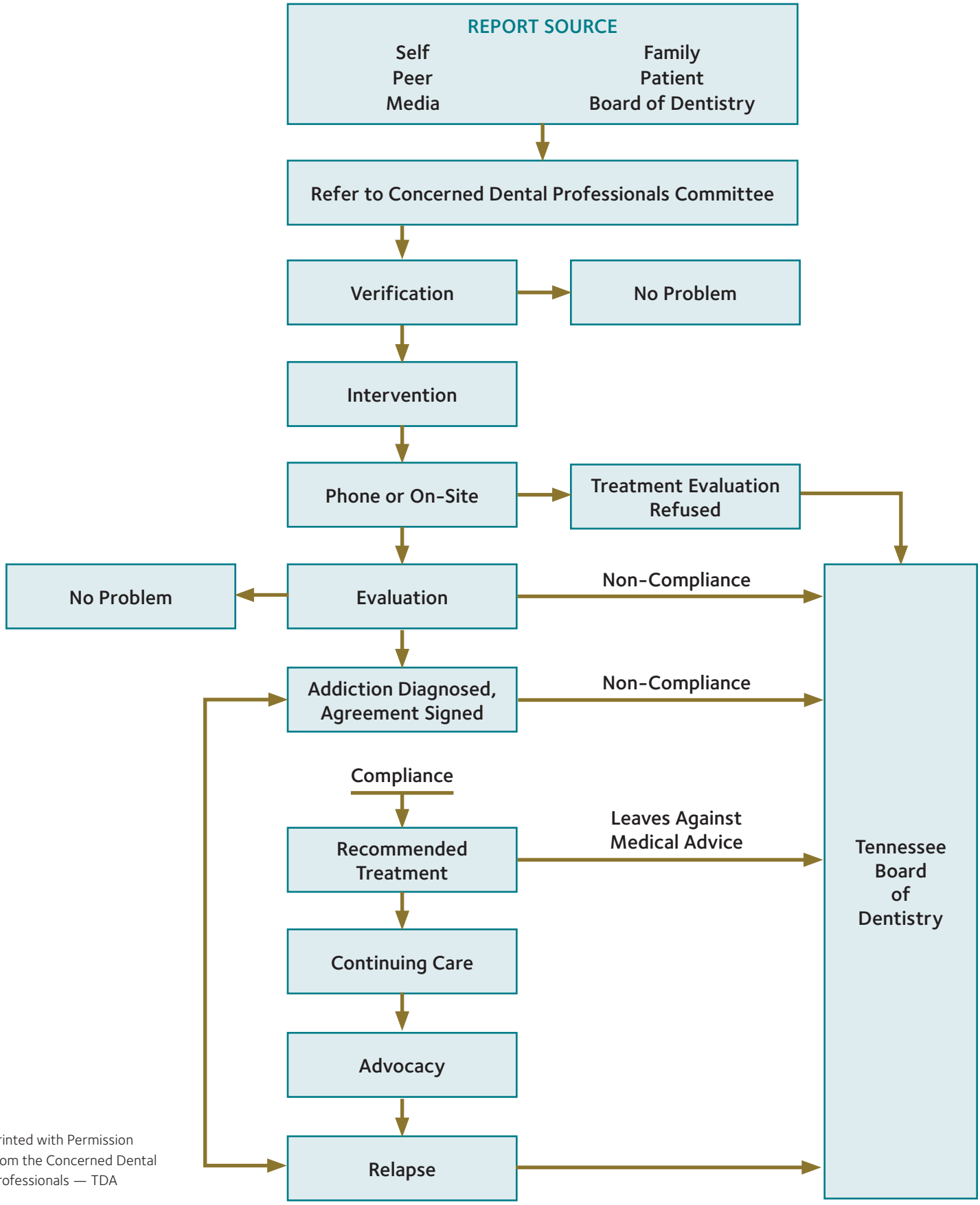
The facilitator should obtain the necessary releases and communicate directly to a client's psychiatrist or individual therapist to determine, at a minimum, if these providers consider the client appropriate for this type of setting. Utilizing this input, and at his or her own discretion, the facilitator should determine whether any individual may participate in the group. In the case of a monitoring client, the facilitator must discuss with FLA any recommendation to disallow participation so that other monitoring arrangements can be made.

The facilitator should be able to recognize the need for additional help in some individuals and direct them to psychological or psychiatric evaluation or treatment, re-evaluation of medication, substance abuse treatment, urinalysis testing, 12-step programs, or other services deemed necessary or beneficial. In the case of monitoring clients, these recommendations should be made to FLA via monitor report or other communication.

Signed Spouse/SO Date

Appendix K Sample Case Flow Chart

Concerned Dental Professionals Committee



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Appendix L Drug-Free Workplace

(This text can also be found in the 2011 edition of the Employee Office Manual, published by the ADA and used with permission.)

Alcohol abuse and the illegal use of drugs are national problems that affect all of us in one way or another. Drug and alcohol abuse affect individual users and their families, but also can affect the workplace. Impairment in the dental office has a particular set of risks and costs to the practice. Consider these points:

- An impaired worker can jeopardize the safety of the other workers.
- Depending on job responsibilities, patient safety can be compromised.
- Substance abuse can result in tardiness and unplanned absences, either if which is very disruptive to a dental office schedule.
- The practice is potentially at risk from damage to its reputation, litigation, or criminal activity.
- Your professional and DEA (Drug Enforcement Administration) licenses may be at risk if there is mishandling of controlled substances in your office, or prescription fraud in your name.

A majority of Americans use alcohol, most with no problems. According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), "moderate drinking" is defined as no more than 2 drinks/day (1 beer, 5 oz. Wine, 1.5 oz. Alcohol) or 14 drinks/week for men or 1 drink/day (7 drinks/week) for women. "Binge drinking" is defined as consumption of 5 or more drinks in one occasion. Many Americans use other substances (marijuana, cocaine, stimulants, etc.) even though they are illegal. Normal alcohol or drug use *should not* impair an individual's ability to work.

About 7.7 percent of the population will meet the criteria for a diagnosis of alcohol dependence (NIAAA); about 9-53 percent of drug users could be diagnosed as drug dependent, depending on the substance (DHHS/SAMHSA).

- Alcoholism and drug addiction can be diagnostically categorized together as "Substance Dependence Disorder" (Diagnostic and Statistical Manual of the American Psychiatric Association, 4th Edition). This is a *medical* disorder with *behavioral* symptoms in addition to physiological findings.
- Substance use disorders are treatable.
- In the general population, treatment for substance use disorders has about the same efficacy as for other chronic disorders such as diabetes and asthma; in health professionals, rates of recovery are much higher.

It is not unusual for people under stress (such as a divorce or major loss) to drink or use in an attempt to ease the uncomfortable symptoms that come with such situations. This is not an appropriate excuse for use on the job or impairment at work, and you should not make exceptions to your policy or allow yourself to be manipulated into overlooking a policy violation.

Any dentist is well advised to incorporate a Drug-Free Workplace Policy into standard office policies. Such a policy makes your expectations clear. It defines the protocol for crisis management. It provides documentation that you are in compliance with state Drug-Free Workplace laws if those apply — and some states (Alabama, for example) may provide tangible benefits in a discount on state Workers Compensation fees. The Department of

Labor offers a Small Business Workplace Kit, "Building Blocks for a Drug-Free Workplace" (http://www.workplace-dynamics.com/Drug-Free%20Toolkit.pdf). There are five components to a comprehensive Drug-Free Workplace Program:

- a Drug-Free Workplace Policy;
- supervisor (i.e., dentist) training;
- employee education;
- employee assistance; and
- drug testing.

A **Drug-Free Workplace Policy** should clearly state why the policy is being implemented (for example, the practice is committed to the safety of its employees and its patients). It should include a clear description of prohibited behaviors, and a thorough explanation of the consequences of violating the policy.

You will want to draw up your own list of prohibited behaviors, but here are some suggestions:

- Staff are not to drink or use drugs on the job or in the office
- Staff are not to take controlled substances from office stock for their own use.
- No criminal activity will be tolerated in the office. This may include phoning in fraudulent prescriptions in the dentist's name, participating in scams with drug-seeking patients, ordering controlled substances from pharmaceutical companies without the dentist's knowledge, etc.
- Nitrous oxide is never to be used by staff.
- Staff are not to ask the dentist for a prescription for personal use.
- The dentist should not write a prescription for staff or their family members unless it is for a dental procedure or treatment, the individual is a patient of record, and there is appropriate documentation in the patient record.
- Staff should not engage any patients in discussions about illegal drug activity, such as where to obtain drugs, how to sell pharmaceuticals on the street, etc.
- Other components of the policy may include these provisions:
- Off-duty use of drugs, alcohol or any other substances which results in impaired work performance (such as absenteeism, tardiness, poor work performance, damage to the employer's reputation, or inferior quality of work), is prohibited and is cause for discipline (up to and including termination).
- Any employee with patient care responsibilities who is taking a prescribed or over-the-counter narcotic or drug with the potential to cause practice impairment must advise the dentist. The dentist will determine whether the employee can continue to work and may, in some instances, need to consult with the employee's physician regarding the potential for impairment.
- Employees are required to notify you if they are convicted of a drug offense.
- You may require drug testing of job applicants after an employment offer has been made. The employment offer may be contingent on passing the drug test. Test results must remain confidential.
- Subsequent drug testing may be done on either a regular basis (in which case several or all staff may be tested) or when there is 'reasonable suspicion' that an employee is in violation of the policy (only that individual is tested).

- "Reasonable suspicion" includes an employee admitting to drug use, the odor of alcohol or other substances (such as marijuana or solvents) on the person, drowsiness, excitability, belligerence, paranoia, hallucinations, staggering, inattentiveness, witnessed use of drugs, etc.
    - An employee who is reasonably suspected of being under the influence of alcohol or other drugs should be suspended without pay pending drug-testing or other investigation. *You should remember that if an employee is not safe to work, he/she is probably not safe to be driving and alternate transportation should be arranged.*
        - Employees who refuse to submit to testing should be disciplined.
            - Random drug testing is a standard component of a monitoring contract when an employee returns to work following treatment for substance dependence. The employer is not responsible for this testing, but, under the contract, should be informed of any positive results.

Violation of the policy will result in discipline. This may include referring the employee for drug-testing through an authorized laboratory and evaluation by a substance abuse professional, making continued employment conditional upon compliance with any recommendations made by the professional. In some cases, you may decide to make a report to the employee's licensing board (for licensed employees) and, potentially, to terminate the employee.

Because the issue of employee substance is legally complex, you should review your Drug-Free Workplace Policy with your attorney prior to implementing it.

Dentist/Supervisor Training may be available through dental society continuing education programs, your local Small Business Administration, or a local hospital. The well-being program of your state dental society or the staff of your state's professionals health program should be able to provide some assistance in setting up a program; many hospitals have some sort of Employee Assistance Program, whether in-house or contracted, and have experience with Drug-Free Workplace Programs. Online resources may be found at www.dol.gov.

- Areas in which you may need some training have to do with state and federal law, how to recognize and deal with employees who have job performance problems that may be related to alcohol and other drugs, crisis management, setting up an agreement with a laboratory, and how to evaluate potential referral resources.
- It is not your responsibility to diagnose a drug or alcohol problem, only to refer an affected staff member to the appropriate addiction medicine professionals.

Employee Education should be done systematically, on at least an annual basis, and all employees should be required to attend. Content should include:

- A review of your office's Drug-Free Workplace Policies, including the penalties for violation;
- the signs and symptoms of substance abuse or dependence, especially as they are manifested in the work environment;
- areas of vulnerability for healthcare workers, such as familiarity with drugs and their actions, access to controlled substances, the temptation to self-diagnose and self-prescribe, etc.; and
- resources for assistance.

Providing Employee Assistance is the fourth component of a Drug-Free Workplace Program. You will need to decide what you would be willing to do for an employee with a substance abuse problem, in terms of offering the opportunity to participate in a treatment program and returning to work with some kind of monitoring contract.

- It is not unusual for an employee with a substance abuse problem to have been viewed as an exemplary employee prior to the development of the problem.
- Rates of recovery from active addictive illness for healthcare professionals are very high, provided they receive appropriate treatment and comply with all continuing care recommendations.
- The kind of assistance extended to a troubled employee should depend as well on the kind of workplace impairment — for example, you may wish to treat an employee who is tardy to work because of a hangover differently than an employee who engages in criminal behavior in the office.

It is a good idea to seek some outside assistance if you discover an employee has a problem with drugs. Dentists and their staff members often develop close working relationships and know personal information about each other. This can impede your ability to be objective. Denial, deception and manipulation are among the hallmark behavioral symptoms of addictive illness, making it crucial that you have someone available who can provide a 'reality check' for you.

Most state dental societies have a dentist well-being program or knowledge of other resources that could provide you with this outside assistance.

- The staff and volunteers of these programs have experience with the issues of staff substance abuse, knowledge of applicable state and federal laws, and familiarity with local treatment resources.
- Information is also available through the Dentist Well-Being Programs at the ADA. See ADA.org for more information or call ext. 2662 or 2622.

Employee Assistance Programs (EAPs) are agencies that offer formal programs of short-term counseling and referrals to help employees address workplace performance problems that result from personal issues, including alcohol and drug abuse.

- Some EAPs work with consortia of small businesses.
- If the state dental society has a contract with an EAP for its own employees, it may be possible for member-dentists to buy into those services as well.
- If you are a member of a hospital staff, you should have access to assistance from the physician health committee.

Under the Americans with Disabilities Act, current use of illegal drugs is not a disability, but an individual will be treated as disabled under the Act if the individual: 1) Has successfully completed a drug rehabilitation program or has otherwise rehabilitated and is no longer using illegal drugs; 2) is participating in a drug rehabilitation program and is no longer using illegal drugs; or 3) is erroneously perceived as using illegal drugs, but is not engaged in such use. Of course, this portion of the Act will not apply to most private dental offices, so check on your state/local requirements.

Alcohol and Drug Testing is the last component of a Drug-Free Workplace policy as defined by the Department of Labor. Since laws on drug testing differ from state to state, you and your attorney should consider those. Information on each state's laws is available at http://www.testcountry.com/StateLaws/.

Pre-employment drug testing has become a standard and expected practice in many industries and workplaces. Testing for five drugs is required by many federal agencies — marijuana, opiates, amphetamines, cocaine and PCP. The panels for healthcare professionals are more comprehensive.

Employment related drug testing should be done only by labs that are able to (1) insure the integrity of the collection process, (2) document chain-of-custody for samples and (3) have all positive results review by a medical review officer. A medical review officer (MRO) is a specially trained and certified physician who decides whether an employee has passed the drug screen.

If you decide to utilize employee drug testing, you should first make yourself aware of your community's resources for such testing. Your local hospital will be able to assist you with this, or you can get information from your state's dentist well-being committee or physician health program. You will need to enter into an agreement with the laboratory you select so that, should a crisis arise where you need to send an employee for for-cause testing, the mechanisms to do so are already in place.

Prior to pre-employment drug testing, the prospective employee must sign a "Pre-employment Drug Testing Agreement" (see sample in Appendix). A sample of a more generic "Consent for Release of Confidential Information" is also included in the Appendix.

Sample Policy Description

(On Dental Office Letterhead)

This practice is committed to providing a drug-free workplace for our patients and employees. All employees are prohibited from being under the influence of alcohol or illegal drugs during working hours. The unlawful sale, possession or use of a controlled substance is strictly prohibited, and violators may be subject to immediate termination. All employees must notify the dentist of any drug conviction within five days after the conviction.

This practice recognizes drug dependency and alcoholism as health problems. As members of the health care team, we are committed to providing help to any chemically dependent employee who seeks it. We will assist the employee in meeting his or her responsibility to recover from substance abuse by treating him or her as any other employee with a health problem. The employee would be covered by health, sick leave, disability and other benefits according to office policy for medical problems. If any employee refuses or does not attempt to correct a substance abuse problem, the employee will be subject to disciplinary action up to and including dismissal, even for a first offense.

Pre-Employment Drug Testing Agreement

(On Dental Office Letterhead)

I hereby consent to submit to a urinalysis and/or other tests as shall be determined by *(Dental office name)* in the selection process of applicants for employment for the purpose of determining substance use.

I agree that *(Dental office name)* may refer me for collection of these specimens for the tests and forward the results to *(the designated Medical Review Officer)*, and from the Medical Review Officer to the employer. Positive results may be reported to the employer by the Medical Review Officer.

I understand that the current use of drugs shall prohibit me from being employed by *(Dental office name)*.

I further agree to hold harmless the laboratory and the Medical Review Officer from any liability arising in whole or in part from the collection of specimens, testing, and the use of the results from said tests in connection with *(Dental office name)* consideration of my application for employment.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced by anyone to sign this document.

Applicant's Printed Name

Applicant's Social Security Number

Applicant's Signature

Date

Witness' Printed Name

Witness' Signature

Date

Appendix M Consent for the Release of Confidential Information

I _____ authorize

(Name of patient)

_____

(Name or general designation of alcohol/drug program making disclosure)

to disclose to _____ the

(Name of the person or organization to which disclosure is to be made)

following information: _____

(Nature and amount of information to be disclosed, as limited as possible)

_____

_____

The purpose of the disclosure authorized in this consent is to:

_____

(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(Specification of the date, event, or condition upon which this consent expires)

_____

Dated **(Signature of patient)**

_____

(Signature of parent, guardian or authorized representative when required)

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Consent for the Release of Confidential Information (HIPAA)

I _____ **authorize**

(Name of patient)

_____

(Name or general designation of alcohol/drug program making disclosure)

to disclose to _____ the

(Name of the person or organization to which disclosure is to be made)

following information: _____

(Nature and amount of information to be disclosed, as limited as possible)

_____

_____

The purpose of the disclosure authorized in this consent is to:

_____

(Purpose of disclosure, as specific as possible)

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(Specification of the date, event, or condition upon which this consent expires)

I understand that generally _____

(Insert name of program)

may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____

Dated **(Signature of patient)**

_____

(Signature of parent, guardian or authorized representative when required)

These practice monitor documents are jointly authored by the Colorado Board of Dentistry, the Concerned Colorado Dentists Committee of the Colorado Dental Association, and Peer Assistances, Inc., and are used with permission.

North Carolina Caring Dental Professionals

CONFIDENTIAL

Call of Concern Data Sheet

Call received by Date Time

Caller's Name Caller's Phone Number

Caller's Relationship to Dentist/Hygienist

Identified Dentist's/Hygienist's Name Age

Dentist's/Hygienist's Office Address

Home: **Office:**

Dentist's/Hygienist's Phone Numbers

Caller's Perception of the Dentist's/Hygienist's Presenting Problem:

(Use reverse side for additional information or attach another sheet)

Caller's Name Caller's Phone Number

Perception of Caller's emotional state of mind about the situation, please describe:

(ex. angry, fearful, resentful, caring, concerned, ambivalent, etc.)

Is caller willing to participate in an intervention with the Dentist/Hygienist about their problem? YES ☐ NO ☐

Does the caller know others who can verify their concerns? YES ☐ NO ☐

Please list **Phone Numbers/Permission to Contact?**

1.

2.

3.

Director Notified:

Date Time Signature (CDP Volunteer)

(Use reverse side for Action Plan)

Printed with Permission from the North Carolina Caring Dental Professionals

Client Specific Information

Non-Board of Dentistry Referred

Number:

Name:

Address:

Office Phone: Home Phone:

Date of Birth: Male ☐ Female ☐

Years of Experience: License Status:

Specialty area of Practice: Drug of Choice:

Treatment modality *(in patient, out patient, none)*:

Type of problem *(chemical dependency, psychiatric, dual diagnosis)*:

Family history of chemical dependency: Yes ☐ No ☐
Impairment interferes with job performance: Yes ☐ No ☐
Impairment associated with diversion: Yes ☐ No ☐
Previous peer assistance program involvement: Yes ☐ No ☐
History of previous Board disciplinary action: Yes ☐ No ☐

Client Referral Source:

Name:

Address:

Phone: ( )

Employee: No ☐ Yes ☐ — Relationship:

Emergency Contact:

Name:

Address:

Phone: ( )

Checklist:

☐ Date of Admission Date:
☐ Client Rights Date:
☐ Contract Date:
☐ Disclosure Consent Form Date:
☐ Meeting Compliance Date:
☐ Evaluation Date:
☐ Treatment Recommendation Date:
☐ Treatment Discharge Summary Date:
☐ Continuing Care Plan Date:

Used with permission of the Tennessee Concerned Dental Professionals Committee

Clients' Rights

The Tennessee Dental Association's Concerned Dental Professionals Committee will not:

1. Request the client to make public statements which acknowledge gratitude to the TDA/CDPC;
2. Request the client to perform in public gatherings;
3. Will not use identifiable photographs of the client without written consent;
4. Recruit, recommend or otherwise invite a client to participate in or join any trade association.

The Client Has Been Informed of the Following:

1. All confidentiality laws and regulations;
2. Membership in any trade association or individual professional membership association shall in no way influence treatment and/or care rendered;
3. Clients will not have responsibility for the following:

   (a) the care of other clients;

   (b) the supervision of other clients; unless on-duty/on-site staff are present; and

   (c) access to confidential information;
4. The TDA/CDPC does not use human subjects in research;
5. No member of the Committee will ask to borrow money from a client.

Clients have been informed of the above rights and have signed a "Clients Rights Form" which is included in each individual client's file.

Used with permission of the Tennessee Concerned Dental Professionals Committee

CONFIDENTIAL

NC Caring Dental Professionals Program Participation Agreement — Dentist

I, _____, D.D.S., recognizing that I am recovering from the disease of alcoholism and/or chemical dependency, and desiring to enroll in the North Carolina Caring Dental Professionals Program during my recovery process, agree to adhere to the terms and conditions of the following treatment program. I recognize that in order to participate in the Caring Dental Professionals Program, I must reside and/or be licensed to practice Dentistry in North Carolina.

I SHALL:

1. Abstain from the use of all mood-altering substances, including alcohol, over-the-counter medications, herbal remedies, prescription medications and/or illegal substances unless approved by the CDP and/or an Addictionologist.
2. Agree to inform my primary care physician, dentist, and any other health care provider of the conditions of this agreement and request that they not prescribe any psychotropic drugs for me unless there is no reasonable medical alternative. Prior to my physician prescribing these drugs, I will then contact the Caring Dental Professionals Program.
3. I designate _____ M.D.

   Address _____

   Phone _____

   as my Continuing Care Personal Physician/Psychiatrist. I will communicate with my personal physician/psychiatrist no less than _____ times per year.
4. Agree to the following guidelines relative to my DEA privileges for scheduled drugs:

   _____

   _____

   _____

   _____

   If I retain my DEA privileges per the CDP Executive Director/Clinical Coordinator, I further agree to serially number and write in triplicate, all prescriptions for Schedule II, III, IV and V drugs. One copy of each such prescription will be given to me and one copy will be kept in a permanent file in the Dental Office. These prescription records may be checked at any time by the CDP Executive Director/Clinical Coordinator and/or Peer Assistant Volunteer.

   I also agree to cease using I.V. sedation (or other restrictions*) on patients in or out of the hospital during the period of this agreement if the retention of the DEA license is likely to interfere with recovery.
5. **Agree that I will not accept nor keep in my office, any sample drugs, which are Schedule II, III, IV or V during the period of this agreement.**

6. Under the above criteria, I may be requested to not stock any mood altering substances in my office for patient use. In the event that a patient requires medication for severe pain, I will contact Dr._____, phone_____, inform him/her of my restricted prescribing status, and request him/her to write a prescription for the patient.
7. Immediately report by telephone all "slips" from total abstinence to the Peer Liaison in charge of my case or the Executive Director/Clinical Coordinator of the Caring Dental Professionals Program. With any subsequent slip from sobriety, I agree to enter an appropriate assessment and/or treatment at the direction of the Caring Dental Professionals Executive Director/Clinical Coordinator. **Failure to immediately notify the CDP Executive Director/Clinical Coordinator may result in termination from the CDP Program and discontinuance of assistance and advocacy.**
8. Report to the Caring Dental Professionals Executive Director/Clinical Coordinator and the designated body fluid monitoring company, all use of prescription drugs and the name of the prescribing physician. I will obtain a copy of all, prescriptions written for me prior to the time I have them filled and request clearance from the Executive Director/Clinical Coordinator prior to *taking these* prescribed medications. **In case of an emergency or if I am unable to reach the CDP Staft; I will take the prescription as prescribed and notify the Executive Director the next business day.** These copies will also be provided to the Caring Dental Professionals Executive Director/Clinical Coordinator on a monthly basis.
9. Follow the Aftercare Plan of the Treatment Provider if such plan exists. In lieu of a Plan, an initial 90 day Aftercare Plan will be developed by the Caring Dental Professionals. Following the initial plan(s) I agree to attend a minimum of four (4) meetings per week of the AA and the NA programs and present verification of such to the Caring Dental Professionals Program at the last of *each month*. Verification is to be a signed slip from the secretary of each AA or NA meeting. I agree to attend a professionals' support group (Caduceus) at least 2 times per month and document my attendance on the AA/NA meeting attendance form. I will submit all reports the CDP office by the tenth of each month. Additional counseling requirements:

   _____

   _____
10. Submit to random urine and/or blood tests and, in some instances, hair analysis, at my own expense on a schedule determined by the Caring Dental Professionals Program. The laboratory analysis of these tests will be forwarded to the Caring Dental Professionals Program Executive Director/Clinical Coordinator.
11. Submit to any additional medical/psychiatric examinations at the direction of the Caring Dental Professionals Program at my own expense. The results of any examination will be forwarded to the Caring Dental Professionals Executive Director/Clinical Coordinator.
12. Notify the CDP of any changes in physical or mental health, address or employment. If I move from North Carolina to practice in another state, I authorize CDP to contact the Program Director of the comparable "Caring Dental Professionals Program" of the new state, and to inform them of my condition and the conditions of my Agreement with CDP and provide them with a copy of my CDP Continuing Care Agreement.
13. Obey all Federal, State and local laws governing the practice of dentistry in the State of North Carolina. Report by phone any arrest or conviction of any offense to the Caring Dental Professionals Executive Director/Clinical Coordinator immediately.

14. Submit a written report of my perception of my progress to the Caring Dental Professionals Executive Director/Clinical Coordinator on a monthly basis by the tenth of each month.
15. Meet with the Caring Dental Professionals Program designee and/or Peer Assistant on a monthly basis or (as otherwise deemed necessary by the Caring Dental Professionals Executive Director/Clinical Coordinator).
16. If I enroll as an anonymous participant I can anticipate remaining in that status unless the following occurs: 1) I constitute an imminent danger to the public or myself; 2) I refuse to cooperate with the Program, refuse to submit to treatment, or am still impaired after treatment, and exhibit professional incompetence; or 3) it reasonably appears that there are other grounds for disciplinary action.
17. Take **eight** units of Continuing Education in the subject of chemical dependency yearly and submit documentation of hours attended to the Caring Dental Professionals Executive Director/Clinical Coordinator. I further agree to attend any and all meetings, workshops and/or conferences offered by the CDP. Excused absences must be pre-approved by the Executive Director.
18. Comply with the Program Guidelines outlined herein and agree to accept the supervision to ensure my compliance with these terms and conditions.*

* Individual practice restrictions may be added to this agreement if deemed in the best interest of my recovery by the Caring Dental Professionals Executive Director/Clinical Coordinator in conjunction with the treatment counselor.

If I enroll as an anonymous participant, I can expect to remain in that status unless one or more of the following occurs: 1.) I constitute imminent danger to the public, myself or specified others; 2.) I refuse to *cooperate with the Caring* Dental Professionals, *refuse* to submit to assessment and/or treatment, or am still impaired and/or exhibit professional impairment; or 3.) it appears that there are other grounds for disciplinary action.

I agree to remain in Caring Dental Professionals Program as outlined in this Agreement for a period of three years (which may be shortened or lengthened by the Executive Director/Clinical Coordinator). I also agree to enter the Caring Dental Professionals Program Post Agreement Support Track for two years following successful completion of the initial Agreement. The Caring Dental Professionals Program, after affording me notice and an opportunity to be heard, may modify, change, alter, add to, or eliminate any provisions and conditions as necessary for my treatment program.

I agree to sign releases of information for the CDP with all treatment providers and to not rescind these at any time during this Agreement.

The Caring Dental Professionals Program will accommodate me with written verification of my participation in this treatment program if I so request. I acknowledge receipt of a copy of this document.

I **have** received a copy of the *North Carolina Caring Dental Professionals' Guidelines*.

Signature: _____ Date: _____

Participant

Approved: _____ Date: _____

Executive Director

Used with permission of the Tennessee Concerned Dental Professionals Committee

CONFIDENTIAL

NC Caring Dental Professionals Program Participation Agreement — Dental Hygiene

I, _____, R.D.H., recognizing that I am recovering from the disease of alcoholism and/or chemical dependency, and desiring to enroll in the North Carolina Caring Dental Professionals Program during my recovery process, agree to adhere to the terms and conditions of the following treatment program. I recognize that in order to participate in the Caring Dental Professionals Program, I must reside and/or be licensed to practice Dental Hygiene in North Carolina.

I SHALL:

1. Abstain from the use of all mood altering substances, including alcohol, over-the-counter medications, herbal remedies, prescription medications and/or illegal substances unless approved by the CDP and/or an Addictionologist.
2. Agree to inform my primary care physician, dentist, and any other health care provider of the conditions of this agreement and request that they not prescribe any psychotropic drugs for me unless there is no reasonable medical alternative. **Prior to my physician prescribing these drugs, I will then contact the Caring Dental Professionals Program.**
3. I designate _____ M.D.

   Address _____

   Phone _____

   as my Continuing Care Personal Physician/Psychiatrist. I will communicate with my personal physician no less than _____ times per month.
4. Immediately report by telephone all "slips" from total abstinence to the Peer Liaison in charge of my case or the Executive Director/Clinical Coordinator of the Caring Dental Professionals Program. With any subsequent slip from sobriety, I agree to enter an appropriate assessment and/or treatment at the direction of the Executive Director/Clinical Coordinator of the Caring Dental Professionals. **Failure to immediately notify the CDP Executive Director/Clinical Coordinator may result in termination from the CDP Program and discontinuance of assistance and advocacy.**
5. Report to the Caring Dental Professionals Executive Director/Clinical Coordinator and the designated body fluid monitoring company, all use of prescription drugs and the name of the prescribing physician. I will obtain a copy of all prescriptions written for me prior to the time I have them filled and request clearance from the Executive Director/Clinical Coordinator prior to taking these prescribed medications. **In case of an emergency or if I am unable to reach the CDP Staff, I will take the prescription as prescribed and notify the Executive Director the next business day.** These copies will also be provided to the Caring Dental Professionals Executive Director/Clinical Coordinator on a monthly basis.
6. Attend a minimum of 90 meetings in 90 days and four (4) AA/NA meetings thereafter for the duration of this three year portion of the Agreement for Advocacy and present verification of such to the Caring Dental Professionals Executive Director/Clinical Coordinator by the 10th day of the following month. Verification is to be a signed slip from the secretary of each AA or NA meeting. If a recovering professionals support

group meets within a one hour drive from you, attend these meeting a least 2 times per month and document on your AA/NA meeting attendance form and submit all reports the CDP office by the tenth of each month.

7. Submit to random urine and/or blood tests and, in some instances hair analysis, at my own expense on a schedule determined by the Caring Dental Professionals Program. The laboratory analysis of these tests will be *forwarded to* the Caring Dental Professionals Executive Director/Clinical Coordinator.
8. Submit to any additional **medical/psychiatric** examinations at the direction of the Caring Dental Professionals Program at my own expense. The results of any examination will be forwarded to the Caring Dental Professionals Executive Director/Clinical Coordinator.
9. Notify the CDP of any changes in **physical** or mental health, address or employment. If I move from North Carolina to practice in another state, I authorize CDP to contact the Program Director of the comparable "Caring Dental Professionals Program" of the new state, and to inform them of my condition and the conditions of my Agreement with CDP **and** provide them with a copy of my CDP Continuing Care Agreement.
10. Obey all Federal, State and local laws governing the practice of hygiene in the State of North Carolina. Report by phone any arrest or conviction of any offense to the Caring Dental Professionals Executive Director/Clinical Coordinator immediately.
11. Submit a written report of my perception of my progress to the Caring Dental Professionals Executive Director/Clinical Coordinator on a monthly basis by the tenth of each month.
12. Meet with the Caring Dental Professionals Program designee and/or Peer Assistant on a weekly/monthly basis or (as otherwise deemed necessary by the Caring Dental Professionals Executive Director/Clinical Coordinator).
13. If I enroll as an anonymous participant I can anticipate remaining in that status unless the following occurs: 1) I constitute an imminent danger to the public or myself; 2) I refuse to cooperate with the Program, refuse to submit to treatment, or am still impaired after treatment, and exhibit professional incompetence; or 3) it reasonably appears that there are other grounds for disciplinary action.
14. Take **eight** units of Continuing Education in the subject of chemical dependency yearly and submit documentation of hours attended to the Caring Dental Professionals Program. I further agree to attend any and all meetings, workshops and/or conferences offered by the CDP. Excused absences must be pre-approved by the Executive Director.
15. Comply with the Program Guidelines outlined herein and agree to accept the supervision to ensure my compliance with these terms and conditions.

* Individual practice restrictions may be added to this agreement if deemed in the best interest of my recovery by the Caring Dental Professionals Program in conjunction with the treatment counselor.

If I enroll as an anonymous participant, I can expect to remain in that status unless one or more of the following occurs: 1.) I constitute imminent danger to the public, myself or specified others; 2.) I refuse to cooperate with the Caring Dental Professionals, refuse to submit to assessment and/or treatment, or am still impaired and/or exhibit professional impairment; or 3.) it *appears* that there are other grounds for disciplinary action.

I agree to remain in Caring Dental Professionals Program as outlined in this Agreement for a period of three years (which may be shortened or lengthened by the Director). I also agree to enter the Caring Dental Professionals Program Post Agreement Support Track

for two years following successful completion of the initial Agreement. The Caring Dental Professionals Program, after affording me notice and an opportunity to be heard, may modify, change, alter, *add to*, or eliminate any provisions and conditions as necessary for my treatment program.

I agree to sign releases of information for the CDP with all treatment providers and to not rescind these at any time during this Agreement.

The Caring Dental Professionals Program will accommodate me with written verification of my participation in this treatment program if I so request. I acknowledge receipt of a copy of this document.

I **have** received a copy of the *North Carolina Caring Dental Professionals' Guidelines*.

Signature: _____ Date: _____

Participant

Witnessed: _____ Date: _____

CDP Clinical Coordinator

Approved: _____ Date: _____

Executive Director

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CONFIDENTIAL

NC Caring Dental Professionals Participation Agreement Sexual Misconduct/Psychosexual Disorders

I, _____, D.D.S./R.D.H., recognizing that I am recovering from a psychosexual disorder and desiring to enroll in the North Carolina Caring Dental Professionals during my recovery process, agree to adhere to the terms and conditions of the following treatment program. I recognize that in order to participate in the Caring Dental Professionals, I must reside and/or be licensed to practice dentistry/dental hygiene in North Carolina.

I WILL:

1. Abstain from the use of all mood altering substances, including alcohol, over-the-counter medications, herbal remedies, prescription medications and/or illegal substances unless approved by the CDP and/or an Addictionologist.
2. Agree to inform my primary care physician, dental professional, and any other health care provider of the conditions of this Agreement and request that they not prescribe any psychotropic drugs for me unless there is no reasonable medical alternative. **Prior to my physician prescribing these drugs, I will have them contact the Caring Dental Professionals.**
3. I designate _____ M.D.

   Address _____

   Phone _____

   as my Continuing Care Personal Physician/Psychiatrist. This physician/psychiatrist is experienced and informed about treatment of addictions and sexually transmitted diseases including HIV/AIDS. I will communicate with my personal physician/psychiatrist no less than _____ times per month.
4. Agree to the following guidelines relative to my DEA privileges for scheduled drugs:

   _____

   _____

   _____

   _____

   If I retain my DEA privileges per the CDP Executive Director/Clinical Coordinator, I further agree to serially number and write in triplicate, all prescriptions for Schedule II, III, IV and V drugs. One copy of each such prescription will be given to me and one copy will be kept in a permanent file in the Dental Office. These prescription records may be checked at any time by the CDP Executive Director/Clinical Coordinator and/or Peer Assistant Volunteer.

   I also agree to cease using I.V. sedation (or other restrictions*) on patients in or out of the hospital during the period of this Agreement if the retention of the DEA license is likely to interfere with recovery.

5. **Agree that I will not accept nor keep in my office, any sample drugs, which are Schedule II, III, IV or V during the period of this Agreement.**
6. Immediately report by telephone all "slips" from substances to the Peer Support Volunteer in charge of my case or to Executive Director/Clinical Coordinator of the Caring Dental Professionals. With any subsequent slip from sobriety, I agree to enter an appropriate assessment and/or treatment at the direction of the Caring Dental Professionals' Executive Director/Clinical Coordinator. **Failure to immediately notify the CDP Executive Director/Clinical Coordinator may result in termination from the CDP Program and discontinuance of assistance and advocacy.**
7. Report to the Caring Dental Professionals' Executive Director/Clinical Coordinator all use of prescription drugs and the name of the prescribing physician. I will obtain a copy of all prescriptions written for me prior to the time I have them filled and request clearance from the Executive Director/Clinical Coordinator prior to taking these prescribed medications. **In case of an emergency or if I am unable to reach the CDP Staff I will take the prescription as prescribed and notify the Executive Director the next business day.** These copies will also be provided to the Caring Dental Professionals Executive Director/Clinical Coordinator on a monthly basis.
8. Attend a minimum of **four** (4) meetings per week of the SA or other 12 step programs and present verification of such to the Caring Dental Professionals Executive Director/Clinical Coordinator by the 10th of each month. _____ AA/NA _____ S/A Meetings per week. Verification is to be a signed slip from the secretary of each meeting. If a recovering professionals' support group (Caduceus) meets within a one hour drive from you, attend these meetings at least two times per month and document on my SA meeting attendance form and submit all reports to the CDP office by the tenth of each month. Submit monthly copies of all staff monitoring forms.
9. If deemed appropriate by the Treatment Team and the Executive Director/Clinical Coordinator of Caring Dental Professionals, submit to random urine and/or blood tests and, in some instances, hair analysis, at my own expense on a schedule determined by the Caring Dental Professionals Executive Director/Clinical Coordinator. The laboratory analysis of these tests will be forwarded to the Caring Dental Professionals Executive Director/Clinical Coordinator.
10. Submit to any additional medical/psychiatric examinations at the direction of the Caring Dentist Executive Director/Clinical Coordinator at my own expense. The results of any examination will be forwarded to the Caring Dental Professionals Executive Director/Clinical Coordinator.
11. Notify the Caring Dental Professionals Executive Director/Clinical Coordinator of any changes in physical or mental health, address or employment. If I move from North Carolina to practice in another state, I authorize Caring Dental Professionals to contact the Program Director of the comparable "Caring Dental Professionals" of the new State, **and** to inform them of my condition and the conditions of my Agreement with Caring Dental Professionals and provide them with a copy of my *Caring Dental Professionals Continuing Care Agreement*.
12. Obey all Federal, State and local laws governing the practice of dentistry/dental hygiene in the State of North Carolina. Report by phone any arrest or conviction of any offense to the Caring Dental Professionals Executive Director/Clinical Coordinator immediately.
13. Submit a written report of my perception of my progress to the Caring Dental Professionals Executive Director/Clinical Coordinator on a monthly basis by the tenth of each month.

14. Meet with the Caring Dental Professionals' Peer Assistant or other Program designee on a weekly/monthly basis (as deemed necessary by the Caring Dental Professionals Executive Director/Clinical Coordinator).
15. Agree to continue my therapy with a therapist experienced in the treatment of psycho-sexual disorders after approval of the therapist by Caring Dental Professionals Executive Director/Clinical Coordinator.
16. Agree to monitoring of my practice boundaries including (but not limited to) observation by a staff member when working with patients, contracting a clinical associate if recommended and onsite monitoring by a Caring Dental Professional Peer Liaison.
17. Agree to the boundary restrictions in practice including but not limited to using an instrument cart or tray and not placing instruments on the patient's body and having staff present when working on a _____ patients.
    (type of patient)
18. Agree to monitoring of my prescribed medication with reports forwarded to Caring Dental Professionals Executive Director/Clinical Coordinator.
19. Agree to complete a professional education or vocational retraining if requested.
20. Will develop an office policy on sexual harassment and distribute to all employees. Will forward a copy of same to the NCCDP upon implementation.
21. Agree to explain practice boundaries to patients and others on a "need to know" basis.
22. Take **eight** units of continuing education in the subject of ethics in dental practice. I further agree to attend any and all meetings, workshops and/or conferences offered by the COP. Excused absences must be pre-approved by the Executive Director.
23. Comply with the Program Guidelines outlined herein and agree to accept the supervision to ensure my compliance with these terms and conditions.*

    * Individual practice restrictions may be added to this Agreement if deemed in the best interest of my recovery by the Caring Dental Professionals Executive Director/Clinical Coordinator in conjunction with the treatment counselor.

I agree to remain in Caring Dental Professionals as outlined in this Agreement for a period of three years (which may be shortened or lengthened by the Executive Director/Clinical Coordinator). I also agree to enter the Caring Dental Professionals' Post Agreement Support Track for two years following successful completion of the initial Agreement. The Caring Dental Professionals, alter affording me notice and an opportunity to be heard, may modify, change, alter, add to, or eliminate any provisions *and* conditions as necessary for my treatment program.

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CONFIDENTIAL

NC Caring Dental Professional Program Participation Agreement Mental/Psychological Disorders

I, _____ , D.D.S../R.D.H., recognizing that I am recovering from a diagnosed mental/psychological disorder and desiring to enroll in the North Carolina Caring Dental Professionals during my recovery process, agree to adhere to the terms and conditions of the following treatment program. I recognize that in order to participate in the Caring Dental Professionals, I must reside and/or be licensed to practice dentistry/dental hygiene in North Carolina.

I WILL:

1. Abstain from the use of all mood-altering substances, including alcohol, over-the-counter medications, herbal remedies, prescription medications and/or illegal substances unless approved by the CDP and/or an Addictionologist.
2. Agree to inform my primary care physician, dental professional, and any other health care provider of the conditions of this Agreement and request that they not prescribe any psychotropic drugs for me unless there is no reasonable medical alternative. **Prior to my physician prescribing these drugs, I will have them contact the Caring Dental Professionals.**
3. I designate _____

   Address _____

   Phone _____

   as my Continuing Care personal psychiatrist/physician. I will communicate with my personal psychiatrist/physician no less than _____ times per month.
4. Agree to the following guidelines relative to my DEA privileges for scheduled drugs:

   If I retain my DEA privileges per the CDP Executive Director/Clinical Coordinator, I further agree to serially number and write in triplicate, all prescriptions for Schedule II, III, IV and V drugs. One copy of each such prescription will be given to me and one copy will be kept in a permanent file in the Dental Office. These prescription records may be checked at any time by the CDP Executive Director/Clinical Coordinator and/or Peer Assistant Volunteer.

   I also agree to cease using I.V. sedation (or other restrictions*) on patients in or out of the hospital during the period of this Agreement if the retention of the DEA license is likely to interfere with recovery.
5. **Agree that I will not accept nor keep in my office; any sample drugs, which are Schedule II_3 III, IV or V during the period of this Agreement.**
6. Immediately report by telephone all "slips" from total abstinence and/or emotional relapses to the Peer Support Volunteer in charge of my case or to Executive Director/Clinical Coordinator of the Caring Dental Professionals. With any subsequent slip from sobriety/emotional stability, I agree to enter an appropriate assessment and/or treatment at the direction of the Caring Dental Professionals' Executive Director/Clinical

Coordinator. **Failure to immediately notify the CDP Executive Director/Clinical Coordinator may result in termination from the CDP Program and discontinuance of assistance and advocacy.**

7. Report to the Caring Dental Professionals Executive Director/Clinical Coordinator all use of prescription drugs and the name of the prescribing physician. I will obtain a copy of all prescriptions written for me prior to the time I have them filled and request clearance from the Executive Director/Clinical Coordinator prior to taking these prescribed medications. **In case of an emergency or if I am unable to reach the CDP Staff will take the prescription as prescribed and notify the Executive Director the next business day**. These copies will also be provided to the Caring Dental Professionals Committee on a monthly basis.
8. Submit to random urine and/or blood tests and, in some instances, hair analysis, at my own expense on a schedule determined by the Caring Dental Professionals. The laboratory analysis of these tests will be forwarded to the Caring Dental Professionals Executive Director/Clinical Coordinator.
9. Submit to any additional medical/psychiatric examinations at the direction of the Caring Dental Professionals Executive Director/Clinical Coordinator at my own expense. The results of any examination will be forwarded to the Caring Dental Professionals Executive Director/Clinical Coordinator_
10. Notify the Caring Dental Professionals Executive Director/Clinical Coordinator of any changes in physical or mental health, address or employment If I move from North Carolina to practice in another state, I authorize Caring Dental Professionals to contact the *Program* Director of the comparable "Caring Dental Professionals" of the new State, and to inform them of my condition and the conditions of my Agreement with CDP and provide them with a copy of my Caring Dental Professionals' *Continuing Care Agreement*.
11. Obey all Federal, State and local laws governing the practice of dentistry and/or dental hygiene in the State of North Carolina. Report by phone any arrest or conviction of any offense to the Caring Dental Professionals Executive Director/Clinical Coordinator immediately.
12. Submit a written report of my perception of my progress to the Caring Dental Professionals on a monthly basis by the tenth of each month.
13. Meet with the Caring Dental Professionals' Peer Assistant or other Program designee on a weekly/monthly basis (as deemed necessary by the Caring Dental Professionals Executive Director/Clinical Coordinator).
14. Agree to continue my therapy with a therapist and/or psychiatrist experienced in the treatment of mentallpsychological disorders after approval of the therapist by Caring Dental Professionals Executive Director/Clinical Coordinator.
15. Agree to monitoring of my prescribed medication with reports forwarded to Caring Dental Professionals Executive Director/Clinical Coordinator.
16. Take **six** units of continuing education offered through the Caring Dental Professionals Executive Director/Clinical Coordinator. I further agree to attend any and all meetings, workshops and/or conferences offered by the CDP. Excused absences must be pre-approved by the Executive Director.
17. Comply with the Program Guidelines outlined herein and agree to accept the supervision to ensure my compliance with these terms and conditions.*

* Individual practice restrictions may be added to this Agreement if deemed in the best interest of my recovery by the Caring Dental Professionals in conjunction with the treatment counselor.

If I enroll as an anonymous participant I can anticipate remaining in that status unless the following occurs: 1) I constitute an imminent danger to the public or myself; 2) I refuse to cooperate with the Program, refuse to submit to treatment, or am still impaired after treatment, and exhibit professional incompetence; or 3) it reasonably appears that there are other grounds for disciplinary action.

I agree to remain in Caring Dental Professionals as outlined in this Agreement for a period of three years (which may be shortened or lengthened by the Executive Director/Clinical Coordinator). I also agree to enter the Caring Dental Professionals' Post Agreement Support Track for two years following successful completion of the initial Agreement. The Caring Dental Professionals, after affording me notice and an opportunity to be heard, may modify, change, alter, add to, or eliminate any provisions and conditions as necessary for my treatment program.

I agree to sign releases of information for the CDP and with all treatment providers and to not rescind these at any time during this Agreement.

The Caring Dental Professionals will accommodate me with written verification of my participation in this treatment program if I so request. I acknowledge receipt of a copy of this document.

I **have** received a copy of the *North Carolina Caring Dental Professionals' Guidelines*.

Signature: _____ Date: _____
Participant

Approved: _____ Date: _____

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Missouri Dental Well-Being Program

Contract for Advocacy

Name: Date:

Social Security Number: Code Number:

Circle one: Mandatory **OR** Voluntary

Primary Care physician:

Address:

Phone Number:
Home Office

Answering Service/Beeper:

I have informed this professional about my participation in the Dental Well-Being Program. Should I be prescribed any mood-altering medications including *any scheduled medication* (class II through class V) including antihistamines, I understand that my primary care physician or other specialist *must* provide documentation to the Missouri Well-Being Administrator verifying diagnosis, indications, prescription dose and duration. Should drug screen analysis prove positive for medication, and my primary care physician has provided no documentation, I will be considered to be non-compliant with this agreement until such documentation is received. Typical medications not requiring documentation could include ASA, acetaminophen, antacids and ibuprofen. Initials:

1. I understand that I am financially responsible for all drug screens and any other professional services rendered on my behalf during the entire period of treatment and recovery. Initials:
2. I understand that if the Missouri Dental Board has mandated me to the Dental Well-being Committee, quarterly reports on my progress will be reported to the Missouri Dental Board and other appropriate agencies as defined in the disciplinary order. Initials:
3. I understand that if I have voluntarily entered the Missouri Dental Well-Being Program, quarterly reports on my progress will be reported anonymously to the Dental Board using only my assigned code number. Initials:
4. I understand I will be billed a monthly administrative fee of $ charged by the Well-Being Program while I am participating in the program. I understand that I am reflect increased costs during my participation in the Well-Being Program. Initials:
5. I understand that I am committing to a contract of at least five years to include treatment and recovery phases. Initials:
6. Should I relocate to another state, I authorize the Missouri Dental Well-Being Program to disclose information regarding my affiliation with the Missouri Well-Being Committee to the applicable impaired professional program in the state to which I am relocating so that there may be continuous monitoring and documentation of my treatment and recovery. Initials:

7. I acknowledge that if, at any time, whether I am a mandated participant or not, the Well-Being committee has evidence or reasonable concern that I am impaired in my practice, have relapsed, or if I am not compliant with this agreement, or fail to comply with therapeutic recommendations from the treatment center, monitoring group or the committee administrator, I will be reported to the Missouri Dental Board. Initials: _____

8. Should it be discovered that I have violated the Missouri Dental Board disciplinary orders or the Dental Practice Act after the date of the disciplinary order or after the date I have voluntarily entered the Well-Being Program, the violation will be reported to the Missouri Dental Board within ten (10) days of discovery. Initials: _____

9. I agree to abstain from the use of medications, alcohol and any other mood-altering substances including over-the-counter medications unless ordered by my primary care physician and when appropriate in consultation with the administrator of the Well-Being Committee. If my physician prescribes **any scheduled medication** (class II through V), I agree to bring this to the attention of the Committee administrator before using such medication unless there had been a true emergency necessitating its immediate use. Initials: _____

10. I agree not to self-medicate, including over-the-counter medications that may contain potentially addictive ingredients. Typical over-the-counter medications that would be acceptable without prior approval are ASA, acetaminophen, antacids and ibuprofen. Initials: _____

11. I understand that the treatment facility evaluators will be required to provide the Well-Being Committee with a written report determining whether or not I suffer from an impairment, identify that impairment, set out recommendations for treatment of the impairment and address whether my practice of dentistry or dental hygiene should be restricted in any way due to the impairment. Initials: _____

12. I agree to notify the Administrator of the Well-Being Committee immediately in the event of a relapse. Initials: _____

13. I agree to participate in a witnessed urine, blood and for saliva testing to screen for any use of alcohol and/or drugs by myself. The Well-Being Committee may request such testing and/or its designated monitors. Results of this testing will be sent directly to the committee administrator. Such results will be used to monitor and assess my progress in recovery. Initials: _____

14. I agree to attend a monitoring group assigned by the Well-Being Committee on at least a monthly basis when and where provided. Initials: _____

    Group Location: _____

    Contact Person: _____

    Telephone: _____

    Frequency: _____

    Monitoring groups are mandatory. A planned absence requires approval by the Committee Administrator. Absences may necessitate individual make-up sessions with the group facilitator. Poor attendance will constitute non-compliance and result in the Well-Being Committee not being able to provide documentation as to your compliant participation or status of recovery. Initials: _____

15. I understand that should the program administrator become concerned about my participation in recovery that I may be required to meet with the Well-Being Committee to review my recovery program. Initials: _____

16. I agree to provide a copy of the mandating contract between myself and the Missouri Dental Board, the Bureau of Narcotics and Dangerous Drugs, or any other outside agency or authority.

17. I agree to attend a self-help group such as AA, NA, CA or other 12 step programs as directed by the Missouri Dental Board or the Well-Being Committee times per week.

    My dry date is: _____

    Home Group Number/Location: _____

    Initials: _____

18. I agree to provide the appropriate release forms for urine/blood screen results, treatment center records, therapist reports and other written and verbal information requested for use by the Missouri Well-Being Committee. Initials: _____

19. I have informed a key employee or colleague about my participation in the Missouri Dental Well-Being Program. They have my consent to provide information regarding my compliance with the Well-Being Committee requirements when requested by the committee or the Administrator.

    This person's name is: _____

    Address: _____

    Home Phone: _____ Work Phone: _____

    I agree to inform the Missouri Well-Being Committee Administrator should this key employee or colleague be otherwise unavailable and to provide for a replacement within 30 days or less. Initials: _____

20. I understand that the Well-Being Committee Program agrees to assume an advocacy role with the Missouri Dental Board, Bureau of Narcotics and Dangerous Drugs any other outside referring authority for me provided that I agree to and meet all conditions of all of the above terms. The duration of this agreement will be for a minimum of five (5) years with renewal subject to review by the Missouri Well-Being Committee Program six months prior to the expiration date. Initials: _____

21. I understand that I am not required to be a member of the Missouri Dental Association, the Missouri Dental Hygienists' Association or any other professional organization to participate in the Well-Being Program. Initials: _____

Impairment: An illness, substance abuse or physical or mental condition suffered by a dentist or dental hygienist that is reasonably related to the practice of dentistry or dental hygiene.

In consideration of my being allowed to participate in the Well-Being Committee program, I expressly acknowledge that neither the contractor, the Missouri Dental Association, the Missouri Dental Hygienists Association, the Well-Being Committee, or the Missouri Dental Board, nor any of their employees, board members, agents or independent contractors will be responsible for or provide any professional services to me, and I

expressly release the contractor, the Missouri Dental Association, the Missouri Dental Hygienists Association, the Well-Being Committee, the Missouri Dental Board and all of their employees, board members, agents and independent contractors from any and all claims, whether now existing or hereafter arising from my participation in the Well-Being Committee Program or any services provided to me there under, including but not limited to claims that I might hereafter assert that the contractor, the Missouri Dental Association, the Missouri Dental Hygienists Association, the Well-Being Committee, or Missouri Dental Board, any of the agents or independent contractors, board members or employees were negligent or that any of said persons or entities committed any acts of omission or commission that I claim are or were negligent or that I claim were acts of professional malpractice, it being the intent hereof that I will be forever barred from asserting any such claims hereafter.

In the event I hereafter assert any such claim, I agree that such assertion will disqualify me from further participation in the Well-Being Committee and that the Committee will be absolutely entitled to discharge me from said program, and will immediately notify the Missouri Dental Board.

Sign: .....

Print name: .....

Date: .....

Witness:

Name: .....

Title: .....

Date: .....

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Colorado State Board of Dental Examiners

Initial Practice Monitor Report

Licensee: Telephone Number:

Address:
Street City ZIP

Monitor: Telephone Number:

Address:
Street City ZIP

This report should be submitted with the first Practice Monitor Report submitted by the monitor.

Orientation

	Yes	No
The licensee and I reviewed together the Final Agency Order (FAO), Stipulation and Order, or the Dentist Rehabilitation Contract. We also reviewed the Report of Investigation if the licensee is on a FAO or Stipulation.		
The licensee and I developed together the dimensions of the monitor program and identified individual responsibilities to my satisfaction.		
The licensee and I scheduled regular monitoring appointments at the frequency required.		
The licensee. and I agreed upon a fee for service and signed the Fee for Service Agreement.		
I conducted an initial evaluation of the licensee's performance and areas of competency and weakness.		
The licensee and I agreed upon problem areas including those identified in the FAO, Stipulation, or Rehabilitation Contract and developed a plan to monitor the areas.		

I certify that I have received and read a copy of the Final Agency Order, Stipulation and Order, or Rehabilitation Contract and I fully understand what is required for monitoring the licensee.

Signature of Monitor Date

Signature of Licensee Date

Attach this form to the front of the Practice Monitor Report and submit both reports.

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Colorado State Board of Dental Examiners

1560 Broadway, Suite 1310
Denver, CO 80202
303.894.7757

Practice Monitor/Evaluator/Reviewer/Etc., or Any Other Title Determined Appropriate by the Board Report

Licensee _____ Telephone Number _____

Address _____
Street City ZIP

Monitor _____ Telephone Number _____

Address _____
Street City ZIP

Time period of report from _____ Through _____

Date(s) of Review _____ Number of Records Reviewed _____
(Minimum of 10 records required, if not stated in Stipulation)

This report is for: *(check)*

☐ Record Keeping ☐ Prescribing Practices ☐ Dental Procedures ☐ Fiscal Activities

Physical Facility

S=Satisfactory or above, NI=Needs improvement, U=Unacceptable, N/A=Not applicable	S	NI	U	N/A
1. General appearance, cleanliness, and orderliness of reception and business areas, operatories, sterilization area, and lab				
2. Presence of adequate/appropriate sterilization equipment, such as autoclave, dry heat, or vaporclave and is biologically monitored on a weekly basis.				
3. Presence of effective.tuberculocidal surface disinfectant				
4. Presence of current X-Ray inspection certification sticker				
5. Evidence of attempts to comply with OSHA (gloves, masks, MSDS book, etc.)				
6. Presence of basic emergency kit.				

Observations & Comments. Please print or type. All **Needs Improvement** or **Unsatisfactory** responses require a detailed explanation.

Staff Management

S=Satisfactory or above, NI=Needs improvement, U=Unacceptable, N/A=Not applicable	S	NI	U	N/A
1. Is the staff aware of the licensee's situation? (Purpose of question is to avoid inadvertent disclosure)				
2. Does the staff work together to ensure a smoothly run practice?				
3. Does the staff appear to support the practitioner?				
4. Does the licensee or any staff member keep odd hours? Chronic tardiness or absence? Early arrivals or late departures? Frequent bathroom breaks?				
5. Is any staff member asked to pick up prescriptions for patients? _				
6. Does the licensee or any staff member exhibit mood swings, slurred speech, excitability, hand tremor, sweating, or nitrous mask imprint?				
7. Are there unusually frequent nitrous deliveries or leaks?				
8. Are the licensee and staff trained in CPR and currently certified?				

Observations & Comments. Please print or type. All **Needs Improvement** or **Unsatisfactory** responses require a detailed explanation.

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Fiscal Activity

S=Satisfactory or above, NI=Needs improvement, U=Unacceptable, N/A=Not applicable	S	NI	U	N/A
1. Are billings, payments, petty cash, accounts receivable, insurance claims handled properly?				
2. Do supply accounts show payments to pharmacies for office samples?				
3. Do statements from mail order dental supply houses show controlled substances are ordered?				

Observations & Comments. Please print or type. **All Needs Improvement** or **Unsatisfactory** responses require a detailed explanation.

Dental Procedures

S=Satisfactory or above, NI=Needs improvement, U=Unacceptable, N/A=Not applicable	S	NI	U	N/A
Appropriate sterilization and disinfection techniques				
1. Are handpieces and instruments heat sterilized between patients?				
2. Is an adequate surface disinfectant technique used between patients?				
3. Are the operatories properly set-up (draped)?				

S=Satisfactory or above, Nl=Needs improvement, U=Unacceptable, N/A=Not applicable	S	NI	U	N/A
Radiographic or clinical check of techniques and quality				
1. Diagnosis and treatment planning				
2. Crown/bridge quality				
3. Direct restorations				
4. Endodontic treatment				
5. Extraction/other surgery				
6. Orthodontics				

Other evidence of improper care, treatments, diagnosis or substandard practice? If yes, please describe. Please print or type. **All Needs Improvement** or **Unsatisfactory** responses require a detailed explanation.

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Prescribing Practices

S=Satisfactory or above, Nl=Needs improvement, U=Unacceptable, N/A=Not applicable	S	NI	U	N/A
1. Is there appropriate handling of emergency phone requests for pain medication?				
2. Is there evidence of prescribing medications without seeing the patient?				
3. Is there evidence of prescribing for self, family or staff?				
4. Does the practitioner ever fill or pick up patient's prescriptions?				
5. Are prescriptions for controlled and uncontrolled substances noted in patient records?				
6. Are treatment dosages, quantities, and regimes appropriate?				
7. Are prescriptions written so they are difficult to alter?				
8. Are prescription pads secure and out of sight?				
9. Is there adequate documentation of nitrous oxide orderin , recei t, and storage?				
10. If DEA privileges are intact is DEA registration current?				
11. If DEA privileges are suspended, is there evidence that controlled substances are kept in office or prescribed?				
12. If DEA privileges are intact, and the contract does not prohibit the dentist from keeping other controlled substances inventory on site check Controlled Substance Prescription Log for medications administered and/or dispensed from inventory.				

Observations & Comments. Please print or type. All **Needs Improvement** or **Unsatisfactory** responses require a detailed explanation.

Record-keeping

S=Satisfactory or above, NI=Needs improvement, U=Unacceptable, N/A=Not applicable	S	NI	U	N/A
1. Do the record entries reviewed follow a consistent and logical order. in all or most charts reviewed?				
Do the records include:				
2. An adequate description of the patient's presenting or subsequent complaints, including duration, of aggravating factors and significant changes?				
3. Examination results?				
4. The dental diagnosis?				
5. A description of the treatments rendered?				
6. A complete and current medical history with detailed history of problems identified?				
7. Appropriate follow-up to problems identified in #6?				
8. Appropriate radiographs?				
9. Prescriptions?				
10. Informed consent forms appropriately and properly completed?				
11. Post op instructions, recall or other follow-up?				

Observations & Comments. Please print or type. All **Needs Improvement** or **Unsatisfactory** responses require a detailed explanation.

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All **Needs Improvement** or **Unsatisfactory** responses require a detailed explanation. Please print or type any information that was not included in the comment spaces, using an additional sheet of paper if necessary. You must identify patients and records by initials only. Identify here the files reviewed by the patient's initials.

Signature of Monitor Date

Signature of Licensee Date

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