Stress, burnout, substance abuse and impairment amongst members of the dental profession

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"Stress is the physiological, emotional and behavioural response of a person seeking to adapt and adjust to internal and external pressures or demands. It is basically a physical survival response leading to a fight or flight reaction".[1]

Dentistry is recognised as a very stressful occupation.[2] Dentists experience daily stress and have to deal with difficult situations on a daily basis. As a highly regarded, skilled professional, the expectations of patients and society places a dentist in a challenging and vulnerable position. Forrest [3, 4] hypothesized that the practice of dentistry is a rewarding but demanding profession. He claimed that dentists need to identify factors that cause stress and must take measures to eliminate or at least reduce the harmful effects of stress on their health and emotions. He claimed that the health of dentists might depend on how successfully they keep the rewards and demands of their profession in proper perspective.

Stress Inducing Factors

1) Work-related stressors are: [5]

- a high patient load;
- lack of sufficient control, especially over resources for effective service delivery, especially in community-based dentistry;
- lack of recognition and appropriate reward;
- lack of social support;
- quality of working life;
- occupational hazards: exposure to HIV, TB, HBV and now Covid 19, ocular problems, eye injuries, latex allergy and musculoskeletal pain.

2) Dentist - Patient Interaction

Attention-seeking behaviour, the discussion of personal problems, manipulative behaviour, non-compliance and chronic pain are examples of dentist-patient interactions that may be very stressful to the dentist.[6]

3) Personality traits of the clinician

The definition of personality[7] refers to individual differences in characteristic patterns of thinking, feeling and behaving. The study of personality focuses on two broad areas: One is understanding individual differences in particular personality characteristics, such as sociability or irritability. The other is understanding how the various parts of a person come together as a whole. Stress may thus be individualised. What is stressful for one dentist may not necessarily be stressful for the next. Denollet[8] alleges that people with Type D were associated with higher levels of perceived stress and increased levels of burnout.

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4) Perception of stress

Although the sources of stress are varied, the important factor is the individual's perception and reaction to the stressor. Most importantly, an individual must alter his perception of a stressor and improve the relevant coping skills. The source of a stressor may be internal or external frustrations, conflicting needs or goals and pressures. Identification of the stressor could enhance coping skills.[6] According to Moore and Brodsgard[9] dentists perceive the following as intense stressors: keeping to schedule; causing pain; workload too heavy; late and anxious patients.

How much stress a person can tolerate comfortably varies not only with the accumulative effect of the stressors, but also with such factors as personal health, level of energy or fatigue, family situations and age.[6] In South Africa[10] dentists' stress derives furthermore from rising costs, problems with medical schemes, external interference by government and insurance companies, repetitive nature of the work, feelings of isolation, risk of infection and litigation. The most satisfied and least stressed dentists are older, report higher income, attend more continued education and employ more dental auxiliaries than those who are less satisfied.

Professional Burnout

One of the possible consequences of chronic occupational stress is professional burnout.[11] Burnout is defined by three co-existing characteristics: Firstly, the person is exhausted, mentally and emotionally. Secondly, he develops a negative, indifferent or cynical attitude towards patients, co-workers – so called de-personalisation or dehumanisation. Finally, there is a tendency for persons to feel dissatisfied with their accomplishments and to evaluate themselves negatively. The effects of burnout, although work-related, will often have a negative impact on a person's personal relationships and well-being.[6, 12]

It is interesting to note that health professionals who burnout relatively early in their careers were more likely to stay in their chosen careers and adopt a more flexible approach to their work routines. This suggests that burnout does not necessarily have to result in far-reaching negative consequences.[13] Researchers who looked at three types of clinicians found that general dentists and oral surgeons had the highest levels and that orthodontists had the lowest levels of burnout.[14, 15]

Substance abuse

Although substance abuse may be divided into licit (i.e. alcohol, tobacco, cannabis and prescription drugs) and illicit substances, the intention of this article is to concentrate on alcohol and prescription drugs as substances of abuse.

Alcohol

Anecdotally, dentists have been singled out as the healthcare professionals most likely to be subjected to severe stress, burnout, failed marriages, depression, substance abuse and suicide.[16]

Stress and health problems among dentists were determined by Randkin and Harris.[4, 17] They reported that dentists are vulnerable to health problems due to the stress associated with their profession. Unfortunately, most of the literature on the stress that dentists experience is based on opinions rather than systematic research. However, they reported that most dentists use alcohol or drugs in moderation. Males are more likely to consume alcohol and both male and female dentists use alcohol more frequently than other drugs. Meyers[18] conducted an anonymous survey amongst dentists in the UK to assess overall stress, work stress and health. They found that alcohol use is associated with work-stress amongst dentists.[4]

It is estimated that approximately 10-15% of all healthcare professionals will abuse a substance at some time during their career, a rate in fact similar to that of the general population,[19, 20] although there are some indications that the profession could have an even higher prevalence.[20, 21] Alcohol may be the most commonly abused substance amongst dentists,[20,22,23] but other researchers have not been able to find evidence confirming higher alcohol consumption amongst medical students compared with students in other fields of study.[20, 24] Curtis reported that while 10-12 percent of the general American population becomes addicted to alcohol or drugs at some point during their lives, the prevalence for dentists and physicians is probably 12-19 percent.[21]

The factors underlying substance abuse amongst dentists are complex including work stress, personal vulnerability encompassing temperament, motivation, trait disposition, genetic disposition and 'coping mechanisms.' What remains unclear are the relative contributions of stress and personal vulnerabilities as mediators of Alcohol Use Disorder (AUD).[25] The results of the Winwood study[25] indicated that South Australian dentists suffered high levels of stress/burnout and hazardous levels of alcohol consumption (two to four times higher than the normative South Australian population) were reported, particularly amongst males and rural practitioners.

Of significance, Olivier[4] found that the majority of dentists

polled in his study, believe in the existence of the so-called "conspiracy of silence" where colleagues, friends and next-of-kin are reluctant to report dentists who have dependency problem. This "conspiracy of silence" leads to denial and enables the dentist to continue abusing alcohol.

Clarno[26] focussed on the gravity of the consequences of alcoholism and/or drug dependence within the dental profession. He was of the opinion that dentists suffering from these illnesses can be identified through a pattern of abnormal behaviour and personal, vocational, and social consequences that are progressive and potentially fatal. When denial by colleagues, family, friends, professionals, and office personnel is overcome, enabling no longer perpetuates the illness and help is forthcoming. The sophistication of today's alcoholism treatment provides us with the tools to initiate recovery. The dentist and his or her family has an excellent chance for recovery and everyone gains – the victim, the family, the dental profession, the dental patient, and society. Colleagues and next of kin must recognise their denial and enabling and accept the responsibility to help suffering colleagues. Dentists are just as susceptible to disease as other humans, and the tragedy of a wasted life because of alcoholism is inexcusable with our level of knowledge of alcoholism programs today.

Prescription drugs

According to the American Dental Association's Dentist Well-Being Committee (Dentist Health and Wellness),[21] alcohol is the drug of choice for 37 percent of dentists with substance abuse problems, while prescription drugs (particularly opiates and anti-anxiety agents such as the benzodiazepines) are used by 31 percent, nitrous oxide by 5 percent and street drugs (including cocaine) by 10 percent.

Dental students as well as organised dentistry should be made aware of the dangers of abuse of not only prescription drugs, but also of prescribing outside the dental scope of practice, and especially of self – prescribing.[20]

Many clinicians hold the view that the ability to prescribe drugs for themselves, friends or family is a convenient aspect of the job. They argue it can often save time, and perhaps even resources, to make a quick self-diagnosis and write up a prescription without the need to take time away from work to consult an independent GP or dentist.[27]

Although this practice is technically not illegal, it does raise serious ethical concerns and could ultimately result in a complaint to the HPCSA. The regulators worldwide advise against treating and diagnosing yourself or those close to you.

The HPCSA[28] has handled a number of cases where practitioners have been subject to fitness to practise proceedings for either self-prescribing or for prescribing to a family member or friend. Some more serious cases have also been referred to investigators over allegations of defrauding medical aids in relation to prescription charges. In one case, a doctor faced fitness to practise proceedings before the HPCSA after it was found he wrote out prescriptions in his patient's names for drugs that were for his own personal use.[29]

"Other than in emergencies," the HPCSA[30] says, "you should not prescribe drugs for yourself or for anyone with whom you have a close personal or emotional relationship."

This advice is echoed by the GMC[31] in ***Good Practice in Prescribing Medicines*** which emphasises the importance of objectivity in providing good care, saying: "independent medical care should be sought whenever you or someone with whom you have a close personal relationship requires prescription medicines." It advises doctors not to prescribe a controlled drug for themselves or anyone close to them except in emergency circumstances where a delay "would put the patient's life or health at risk".

There are many reasons for such tight controls on self-prescribing and prescribing to family/friends, most of which are connected to the loss of objectivity. The GDC[32] cautions: "Everyone needs objective clinical advice and treatment. Dentists who prescribe drugs for themselves or those close to them may not be able to remain objective and risk overlooking serious problems, encouraging or tolerating addiction, or interfering with care or treatment provided by other healthcare professionals."

Causing or fuelling addiction is a major factor in self-prescribing, as the GMC warns: "Controlled drugs can present particular problems, occasionally resulting in a loss of objectivity, leading to drug misuse and misconduct." The guidance adds that doctors who do prescribe these drugs "must be able to justify your actions and must record your relationship and the emergency circumstances that necessitated your prescribing a controlled drug for yourself or someone close to you."

A loss of objectivity leaves clinicians unable to provide optimal care which can result in serious problems being overlooked, missed/ diagnosis delayed or misdiagnosed.

While most clinicians should recognise that prescribing opiates or powerful painkillers is entirely unacceptable, it appears many still believe it is acceptable to diagnose and treat themselves or loved-ones for low-level illnesses such as

chest infections or acne.

It appears that the GMC and GDC take a very strict approach to clinicians who prescribe for themselves or those close to them. Recent GMC fitness to practise proceedings[33] have been raised against doctors for prescribing themselves or loved-ones with drugs such as benzodiazepines and opiates as well as with antibiotics and non-benzodiazepine hypnotics.

It is unfortunate that in South Africa, in spite of similar ethical guidelines and rules set by the HPCSA and the law, i.e. the three relevant Acts (Health Professions Act 56 of 1974, the Medicines and Related Substances Control Act 101 of 1965 and the National Health Act 61 of 2003) the law is not applied effectively to protect both the professional and the public.[20]

Impairment

An impaired dentist is unable to deliver optimal care to a patient. Colleagues who become aware of a dentist's dependency have a professional and ethical responsibility to intervene in a constructive manner.[35] Such interventions can involve discussing the issue with the afflicted colleague, calling upon family, friends or other support systems, offering help and finally reporting the dentist to the HPCSA Health Committee, established in terms of the Health Professions Act No. 56 of 1974 section 15(5)(F).

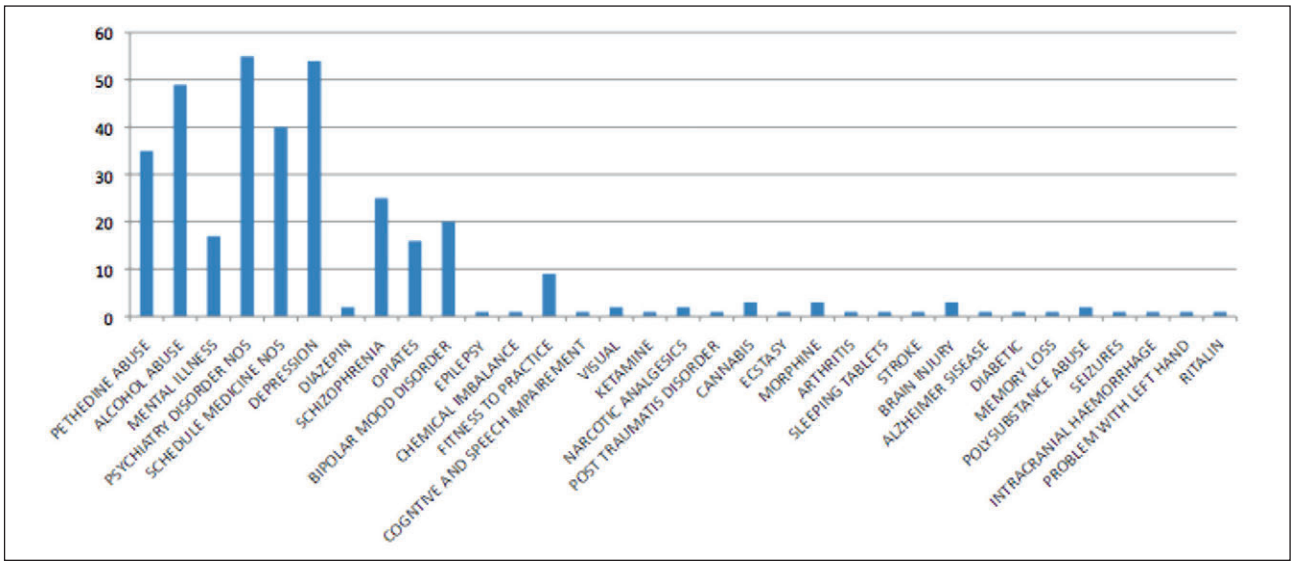
The committee regulates/advises impaired practitioners suffering from mental or physical conditions or the abuse of or dependence on chemical substances, affecting the competence, attitude, judgement or performance of a student or a practitioner.

The committee was established to manage compliance of the practitioners while protecting the public. The committee is non-punitive, meaning that its advice is provided to assist and not to punish.[34]

Conclusion

The dental profession is now, because of the Covid-19 crisis under more stress than ever. There are no indications that the additional financial and emotional pressures of the pandemic will be relieved soon. This will place vulnerable professionals at even a greater risk of stress related impairments. It is important for all dental personnel to be made aware of the risk factors leading to drug and alcohol addiction. It is important that co-workers, colleagues and next-of-kin recognise and understand when a dentist is under stress. It is the imperative that dentists identify support systems and it is perhaps opportune that the professional associations concentrate on creating support structures for the respective professions to help prevent substance abuse and to provide the necessary support for effective rehabilitation. As previous authors[51] have plead: "A national strategy between professional bodies and academic institutions in this regard is perhaps overdue and should be attended to as a matter of urgency."

List of stress-related impairments suffered by health professionals – April 2015 to March 2016 [34]



References

1. Van der Merwe (2004). "Stress Solutions: Understand and manage your stress for a balanced, energized life." 1st ed. Tafelberg Publishers, Cape Town
2. Rada RE, Johnson-Leong C. Stress, burnout, anxiety and depression among dentists. J Am Dent Assoc. 2004;135(6):788-794. doi:10.14219/jada.archive.2004.0279
3. Forrest WR (1978). "Stresses and self-destructive behaviours of dentists." Dental Clinics of North America: 22: 361-371.
4. Olivier JH (2008) "A Profile on Alcohol Consumption among South African Dentists – A Dentist's Perspective." Submitted for the partial fulfilment of the requirements for the degree PhD (General Human Sciences). University of Pretoria:1.
5. Basson RA (2012). "Management and Prevention of Burnout in the Dental Practitioner." Dentistry: 3: 168.
6. Bodner S (2008). "Stress management in the difficult patient encounter." Dent Clin Am: 52: 579.
7. Adapted from the Encyclopedia of Psychology. Accessed 21/06/2020.
8. Denollet J (2005). "DS 14: Standard assessment of negative affectivity, social inhibition, and TYPE D personality." Psychosom Med: 67: 89.
9. Moore R, Brodsgard I (2001)"Dentists' Perceived stress and its relation to perceptions about anxious patients." Community Dent Oral Epidemiol 29: 73.
10. Olivier JH (2008) "A Profile on Alcohol Consumption among South African Dentists – A Dentist's Perspective." Submitted for the partial fulfilment of the requirements for the degree PhD (General Human Sciences). University of Pretoria.
11. Gorter RC et al (1999) "Measuring work stress among Dutch dentists." Int Dent J 49: 144.
12. Felton JS (1998) "Burnout as a clinical entity: Its importance in healthcare workers." Occup Med (Lond). 48:237.
13. Cherniss C (1992) "Long-term consequences of burnout: An exploratory study." J Org Behav. 13: 1.
14. Humphris G (1998) "A review of burnout in dentists." Dent Update 25: 392.
15. Kaney S (1999) "Sources of stress for orthodontic practitioners." Br J Orthod. 26: 75.
16. La Porta (2010) "Occupational stress in oral and maxillofacial surgeons: Tendencies, traits and triggers." Oral Maxillofac Surg Clin North Am. 22: 495.
17. Rankin JA, Harris MB (1990) "Stress and health problems in dentists." J Dent Prac Admin. 7: 2.
28. Meyers HL, Meyers LB (2004)"It's difficult being a dentist; Stress and health in the general dental practitioner." BDJ: 197: 89.
19. Baldisser MR. (2007) "Impaired healthcare professional." Crit Care Med 35: S106.
20. Marnewick JC, van Zyl AW (2014) "Substance abuse among oral healthcare workers." SADJ. 69: 148.
21. Curtis EK. (2011) "When dentists do drugs: A prescription for prevention." Today's FDA. 23: 28.
22. Kenna GA, Wood MD (1991) "The prevalence of alcohol, cigarette and illicit drug use and problems among dentists." J Am Dent Assoc. 81: 177.
23. Baldwin JN et al (2006) "Assessment of alcohol and other drug use behaviours in health professions students." Subst Abus. 27:27.
24. McAuliffe WE et al (1991) "Alcohol use and abuse in random samples of physicians and medical students." Am J public Health. 81: 177.
25. Winwood PC et al (2003) "the role of occupational stress in the maladaptive use of alcohol by dentists: A study of South Australian general dental practitioners." Aust Dent J. 48: 102.
26. Clarno JC. The impaired dentist. Recognition and treatment of the alcoholic and drug-dependent professional. Dent Clin North Am. 1986;30(4 Suppl):S45-S53.
27. https://www.mddus.com/resources/resource-library/risk-alerts/2012/march/caution-over-self-prescribing# Accessed 28/06/20.
28. https://www.hpcsa-blogs.co.za/assistance-for-impaired-professionals/ Accessed 30/06/20.
29. Personal experience of author while MLC for MPS
30. https://www.hpcsa.co.za/Uploads/Professional_Practice/Ethics_Booklet.pdf Accessed 30/06/20.
31. https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices#:~:text=Good%20practice%20in%20prescribing%20and,drugs%20serve%20your%20patient's%20need. Accessed 30/06/20.
32. https://www.gdc-uk.org/docs/default-source/guidance-documents/guidance-on-prescribing-medicines.pdf?sfvrsn=2e82e39c_2 Accessed 30/06/20.
33. https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/making-a-recommendation-about-a-doctors-revalidation/gmc-fitness-to-practise-proceedings. Accessed 1/07/20.
34. https://www.hpcsa-blogs.co.za/assistance-for-impaired-professionals/ Accessed 2/07/20.
35. Fung EYK, Lange BM. (2011) "Impact of drug abuse/dependence on dentists." General Dentistry: Sept: 356.

This article was published online in International Dentistry - African Edition in 2020