MEDICATION IN DENTISTRY

The Dentist and Prescription Drug Abuse

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ABSTRACT

Because dentists are authorized to prescribe narcotic drugs to their patients, they may be sought out by "drug seeking individuals" (DSI), disguised as patients, who are engaged in the illegal diversion of pharmaceutical-quality drugs to the street market.

Two common methods of gaining illegal access to pharmaceutical-quality narcotics for resale on the street are: forgery and verbal misrepresentation, and multiple doctoring. The diversion of such drugs can produce a very high rate of return for DSIs, with only a minimal risk of arrest and conviction.

This paper discusses the problem of DSIs, and how dentists can reduce the risk of becoming involved in the illegal diversion of narcotics. Prudent judgment and responsible prescribing by the dentist will increase the effectiveness of his or her practice, and help to abate a growing social problem.

SOMMAIRE

Parce qu'ils sont autorisés à prescrire des narcotiques à leurs patients, il se peut que les dentistes fassent l'objet de pressions de la part de personnes qui, déguisées en patients, recherchent des drogues de qualité pharmaceutique pour les revendre illégalement dans la rue.

Ces derniers utilisent ordinairement deux méthodes pour obtenir illégalement des narcotiques de qualité : la contrefaçon et le prétexte d'une part et la consultation multiple d'autre part. Les vendeurs peuvent tirer de très gros profits des médicaments ainsi détournés, tout en courant un risque minime de se faire arrêter et condamner.

L'article traite du problème de ces vendeurs de drogues et des moyens pour les dentistes de réduire le risque de se retrouver impliqués dans le détournement illégal des narcotiques. La prudence dans le jugement et le sens des responsabilités de la part du dentiste lors de la prescription des médicaments augmenteront l'efficacité de sa pratique et aideront à freiner un problème social qui va en s'aggravant.

Introduction

Dentists are authorized to prescribe narcotics and controlled drugs for therapeutic use. Although these medications are a welcome adjunct to treatment plans for the management of acute pain and anxiety, the authority to prescribe them may put dentists in a somewhat vulnerable position. Drug seeking individuals (DSI), disguised as patients, are known to visit dental offices as a means of obtaining pharmaceutical-quality drugs for diversion to the black-market.[1]

The diversion of controlled drugs, particularly narcotics, for non-medical use has been a serious concern for the last quarter century.[1,2] This problem started in the early 1970s, when international circumstances made the supply of street heroin unreliable. The so-called "drying up of the streets" forced drug addicts and traffickers to seek an alternate source of opiates and other mood-altering drugs. Unaware of the drop in supply, the medical, dental, and pharmaceutical professions became targets for con-artists, scam-artists and downright thieves.

Today, the diversion of pharmaceutical-quality narcotics from the drugstore to the street is a growing problem. There has already been an alarming number of convictions, under the Narcotics Control Act, involving the diversion of opiate drugs from the legal drug supply system to the illegal street market. This has led to a concerted effort on the part of all the health-care associations involved (i.e., medical, dental, pharmaceutical), as well as the pharmaceutical industry and Health Canada, through its drug surveillance branch, to address this problem. As a result of their efforts, convictions have levelled off, and even declined in some provinces, since the mid-'80s.[3]

Table 1 lists some of the common modes of procuring pharmaceutical drugs for illegal diversion. The most common methods by far, probably because of their simplicity, are forgery, verbal misrepresentation, and multiple doctoring,

which involves visiting several doctors, one after the other, in an effort to obtain multiple prescriptions for the desired narcotic.

The DSI procuring the narcotics is not necessarily a drug abuser, but is typically an entrepreneurial patient who is interested in cashing in on a lucrative and attractive business.[1,2] Drug diversion offers a very high rate of return with minimal risks. For example, the first drug targeted by DSIs was Dilaudid (4.0 mg), which continues to fetch a street price of up to 240 times the pharmacy price. This is equivalent to a rate of return of almost 20,000 per cent. **Table II** lists the 18 drugs that DSIs seek most often today.

The number of convictions that are directly related to multiple doctoring continues to be low relative to the other two major types of medical-dental narcotic drug procurement (**Table III**). Even when a conviction is obtained, the resulting penalties are surprisingly minor. For example, in 1990 only 10 per cent of multiple doctoring convictions resulted in jail terms, of which 98 per cent were for less than six months. With such a high rate of return and minimal risk of serious punishment, it is not surprising that multiple doctoring and forgery have become attractive methods for the illegal diversion of narcotics. The other factor to consider is that drugstore-quality opiates are highly desired by users because of their quality, and because the stigma or guilt attached to their possession is minimal.

Dentists are natural targets for DSIs, because a significant part of their day-to-day practice involves the emergency management of pain and anxiety. This is particularly true during the patient's first appointment. In most cases, the dentist's decision to prescribe narcotics is clearly warranted. However, in a small percentage of cases, dentists may feel that they are being duped. A judgment call is made, but the benefit of the doubt is given to the patient, as it should be. A dentist's role in controlling the illegal diversion of narcotics to the street is to reduce this doubt, and decrease the likelihood of being duped or conned. **Table IV** lists the 10 narcotics prescribed by dentists that are most sought after by DSIs, their legal cost in the pharmacy, their street value (1991), and their rate of return.

Health Canada publishes a book entitled *The Physician and Psychoactive Drugs*. It lists 10 questions (**Table V**), and warns practitioners who answer yes to one or more of these question that they may be part of the illicit drug problem, and vulnerable to abuse by a DSI.[4]

There are many things that we, as dentists, can do to reduce the likelihood of being victims of DSI

Table I

Diversion Of Pharmaceutical Narcotics

Includes the following:
Theft in all forms (i.e. break and entry, armed robbery, grab theft, pilferage)
Forgery and verbal misrepresentation
Losses during transit
Multiple doctoring
Supplying of drugs by health professionals to known illicit users

Bureau of Drug Surveillance.

Table II

Common Pharmaceuticals Diverted To the Street Market

Drug Name	Generic Component
Codeine	(codeine)
Darvon	(propoxyphone)
Demerol	(meperidine)
Dilaudid	(hydromorphone)
Empracet 30	(codeine compound)
Fiorinal	(codeine-butalbital compound)
Hycodan	(hydrocodone)
Hycomine	(hydrocodone)
Lentine	(anilenidine)
Novahistex	(hydrocodone compound)
Percocet	(oxycodene compound)
Percodan	(oxycodene compound)
Ritalin	(methylphenidate)
Talwin	(pentazocine)
Tussionex	(hydrocodone compound)
Tylenol 3	(codeine compound)
Tylenol 4	(codeine compound)
Methadone	(methadone)

Data courtesy of RCMP Branch, criminal directorate, August 16, 1991.

Table III

Drug Offense Convictions in 1990

Offense	Percentage of Convictions
Possession	50
Trafficking	44
Multiple Doctoring	6
Importation	< 1

abuse, while not increasing the risk of unjustly withholding medication.

For example, forgery and verbal misrepresentation involve deceiving the pharmacist into dispensing narcotic drugs under the assumption of a doctor's order. Doctors' prescription pads are therefore very valuable tools in the illicit drug market, because they represent a "blank cheque" for a continuous supply of drugs. It is highly recommended that dentists guard their prescription pads carefully, and that they report any incidences of lost or stolen pads to the pharmacy, their licensing body, and the police. A single blank page from the pad can be photocopied into many legitimate-looking prescription scripts.[1,2,4,5] It is even possible for a determined criminal to "white-out" your instructions with liquid paper, and then repeatedly photocopy the resulting blank sheet. Dentists who have any doubt about a patient's integrity should consider placing a red line through the letterhead of the prescription sheet. This makes it difficult to "white out" the prescription without it affecting your letterhead, and may generate a telephone call from the pharmacist for confirmation. You will then have an opportunity to have a conversation with the pharmacist about the patient. Chances are that, in such a situation, the experienced DSI will not use your script for fear of generating attention.

Multiple doctoring is a criminal offense under Section 3.1 of the Narcotics Control Act (**Table VI**). The classic dental school case study involving a vagrant who goes to many dental emergency clinics asking specifically for Percocet or Percodan is well known. In the real world, however, DSI are highly educated and sophisticated professionals. They are well versed in oral pathology, and are experts at feigning the signs and symptoms of dental abscess, TMJ pain, or facial pain. Usually they claim to be too busy to be treated during their initial appointment, but promise to come back the next day. All they really want is a prescription for pills. They are also aware of what to say so that opiates are prescribed instead of comparably effective NSAIDS.

Recent graduates and the "new dentist in town" are the most susceptible to these con-artists. Whether from lack of experience, or fear of affecting the growth of their practice, these dentists will understandably be more easily swayed into doing what the DSI asks. Also, in many busy practices, conducting a medical follow-up of suspicious emergency cases re-

Table IV

Dentists' Drug List — Common Drugs Requested From Dentists For Diversion

Name of Drug	Generic Component	Pharmacy Price ($/tab)*	Street Price ($)**	Rate of Return (per cent)
Codeine 30 mg	codeine	0.08	2 - 17	2,400 - 21,100
Codeine 60 mg	codeine	0.20	7 - 35	3,400 - 17,400
Demerol	meperidine	0.10	10 - 15	9,900 - 14,900
Dilaudid 2 mg	hydromorphone	0.21	30 - 50	14,200 - 23,700
Dilaudid 4 mg	hydromorphone	0.35	30 - 70	8,500 - 20,000
Empracet 30	codeine	0.05	2 - 10	3,900 - 20,000
Hycodan	hydrocodone	4.30/100mL	100 - 200	2,200 - 4,500
Percocet	oxycodone	0.57	5 - 30	700 - 5,100
Percodan	oxycodone	0.70	5 - 25	600 - 3,400
Talwin 50 mg	pentazocine	0.38	10 - 30	2,500 - 7,800
Tylenol #3	acetaminophine codeine compound	0.03	2 - 10	6,500 - 33,200
Tylenol #4	acetaminophine codeine compound	0.14	2 - 10	1,300 - 7,000

* *Data courtesy of an Ontario pharmacist, 1995.*

** *Data courtesy of RCMP Branch, criminal directorate Aug. 16, 1991.*

quires too much time — i.e. calling a family doctor to confirm an allergy to NSAIDS, or calling the pharmacist to see if narcotics have been administered to the patient within the last 30 days. Nevertheless, taking this extra step is not only responsible doctoring, it also intimidates the DSI.

A quick and easy way to manage suspicious cases is to dispense only a single day's dose of medication, and then ask the patient to return the next day for a follow-up. Also, whenever you prescribe a narcotic, you should ask the patient if a pharmacist has dispensed a narcotic to him or her in the last 30 days — the informed DSI will be aware of Section 3.1 of the Narcotics Control Act, and will be intimidated by the question. This approach has the added advantage of protecting the dentist from accusations of irresponsibility if he or she is ever investigated by a drug surveillance inspector.

It is common practise for dentists to call in a prescription over the telephone. This is acceptable for "verbal prescription narcotics," including narcotics that are found in combination with two or more medicinal ingredients (e.g. Tylenol 3), which are not intended for parental administration, and do not contain diacetylmorphine (heroin), hydrocodone, methadone, oxycodene (Percocet, Percodan) or pentazocine (Talwin). Unfortunately, experienced DSIs are aware of standard phone-in procedures, and may impersonate a doctor in an attempt to seek narcotics directly from the pharmacist. It is difficult for the pharmacist to screen out these bogus calls from those of legitimate professionals. Ideally, dentists should have a close relationship with their neighborhood pharmacist, so that he or she will not only recognize their voice, but will also have an appreciation of their usual prescription methods. Also, it would be a good idea for all provinces to follow the lead of Quebec, by requiring dentists' license numbers to be disclosed to the dispensing pharmacist when narcotics or controlled drugs are prescribed.

Another potential area of abuse involves dentists who prescribe medication to friends without proper clinical assessment and documentation. This can result in the dentist regularly prescribing a narcotic for a condition that he or she is not trained to manage (e.g. backaches, migraine, headaches), with no supporting documentation. In addition, some of the dentist's friends may be abusing the prescribed narcotics, or secretly living another life that involves the illicit diversion of pharmaceutical narcotics to the street market.

Narcotics are commonly stored in dental clinics. This, unfortunately, places dental clinics at risk for break-ins and thefts. All narcotics and controlled drugs should therefore be stored under lock and key.[4] In addition, the loss or theft of narcotics and controlled drugs, as well as cases involving forged prescriptions, must be reported to Health Canada's bureau of drug surveillance.[5]

By law, practitioners are required to keep records describing all of the narcotics and controlled drugs that they have dispensed to patients in excess of a three-day supply. These records must be kept for two years.[4] At the same time, however, a dental office may store up to 100 tablets of Tylenol 3, which could be dispensed to more than 30 or 50 patients in amounts equal to or less than a three-day supply, without contravening the rules. It is therefore prudent to keep records of all the narcotics dispensed in a dental office. This will eliminate misunderstanding, and ensure that the dentist is above suspicion if and when a drug surveillance inspector makes a surprise visit to his or her office.

The potential for DSI's to reap financial gain through the diversion of legitimate pharmaceutical drugs for illegitimate use puts dentists at risk of becoming inadvertently involved in this criminal process. Since the recognition of

Table V

Questions Dentists Should Ask Themselves:

Do you prescribe on demand?
Do you accept the diagnosis made by a patient?
Do you comply with drug selection suggested or requested by a patient?
Do you prescribe small quantities of medication to "get them out of the office?"
Do you prescribe any medication without first performing all necessary examinations to ensure that the patient is in actual medical need of such medication?
Do you prescribe before making every effort to ensure that the patient is not obtaining medication from other sources while under your care?
Do you leave your blank prescription pads or supplies of narcotics and controlled drugs in a place accessible to unauthorized individuals?
Do you practise in isolation without maintaining a close professional relationship with pharmacists and other practitioners in your area to facilitate the early identification of drug abuse problems?
Do you react in a negative manner when contacted by a pharmacist to confirm a prescription or to discuss any other matter related to one of your prescriptions?
Do you permit your nurse/receptionist to authorize prescription renewals or relay such information to pharmacists on your behalf?

If you answer yes to one or more of the above questions then you may be part of the problem.

The Physician and Psychoactive Drugs (Health Canada) 1992.

Table VI

Narcotics Control Act, Section 3.1(1)

No person shall, at any time, seek or obtain a narcotic or a prescription for a narcotic from a practitioner unless that person discloses to the practitioner particulars of every narcotic or prescription for a narcotic issued to that person by a different practitioner within the preceding 30 days.

Bureau of Drug Surveillance.

the problem during the '70s, and the education of the profession during the '80s and '90s, much has been done to curb it. Nevertheless, it still exists, and the nature of the offense still makes all patients specifically seeking opiates suspect.

Prudent judgment and responsible doctoring will increase the efficiency and effectiveness of any dental practice. No one wants to have a reputation of being the "easy" doctor to get pills from, yet we don't want to deny medication when it is indicated, either — if you are still in doubt once you've considered all the factors, it's best to medicate.

For more information on this type of drug abuse and how it affects our profession, see the *Prescription Triangle* (1991).[6] This video is available from the Drug Addiction Foundation Library or the CDA library. ■

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References

1. Carlisle, J. *The Physician and Prescription Drug Abuse. Members Dialogue.* Jan. 1994. The College of Physicians and Surgeons of Ontario. p. 13-15.

2. Goldman, H.B. Desperately Seeking Drugs: A Clinical and Risk Management Approach. *NARC Officer* Nov.-Dec.:15-20, 1993.

3. Health and Welfare Canada 1990 *Narcotic, Controlled and Restricted Drug Statistics - Analysis Report.* Ministry of Supply and Service Canada, 1991.

4. Health and Welfare Canada: *The Physician and Psychoactive Drugs.* Ministry of Supply and Services Canada, 1991.

5. *Compendium of Pharmaceuticals and Specialties.* 29th edition. The Canadian Pharmaceutical Association, 1994.

6. Addiction Research Foundation. *The Prescription Triangle* (video). The Addiction Research Foundation, 33 Russel St., Toronto, Ontario M5S 2S1.

DID YOU KNOW?

Bone-Building Beverages

Data from Agriculture Canada indicate that soft drink consumption has increased by 49 per cent since 1974. In contrast, milk consumption has decreased by 9.5 per cent. Daily milk consumption -- at about 250 mL -- is almost identical to soft drink consumption.

If milk continues to be replaced by soft drinks in the diets of teenagers, particularly girls, bones might not reach their genetical potential for growth, during the times when calcium needs are at their highest levels.