DENTAL TRIBUNE

The World's Dental Newspaper · U.S. Edition

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Mid-career squeeze?
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'Salivary biomarkers for systemic disease is one of the final frontiers'

An interview with Dr. David Wong

In the past six years, saliva has risen to center stage for disease detection, monitoring and even health surveillance.

In cooperation with FDI Worldental Daily, Dental Tribune Asia Pacific spoke with UCLA's Dr. David Wong, director of the Dental Research Institute, at this year's World Dental Congress in Singapore about salivary diagnostic toolboxes and how they could be utilized for detecting systematic diseases.

In recent years, the role of saliva for the detection and monitoring of diseases has risen to center stage. Can you summarize the latest findings for us?

Seven years ago, the National Institute of Dental and Craniofacial Research [NIDCR], one of the 27 institutes at the U.S. National Institute of Health [NIH], made a visionary investment to turn salivary diagnostics into a clinical reality.

The outcomes of this scientific investment are what constitute the recent excitement and clinical potential for salivary diagnostics.

We now know there are multiple diagnostic alphabets in saliva to define the diagnostic coordinates of oral and systemic diseases. Point-of-care diagnostic technologies are soon to be in place to permit a drop of saliva to detect and monitor diseases at the dental practice.

How exactly does saliva work as a biomarker?

Biomarkers are defined as cellular, biochemical and molecular characteristics by which normal and/or abnormal processes can be recognized and/or monitored.

The salivary glands — major and minor — secrete approximately 1.5 liters of saliva into the oral cavity daily, carrying with it health/disease information, biomarker information.

The sources of these biomarkers can be disease sites or the sali-

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DTSC at the Greater N.Y. Dental Meeting

Dr. Dan McEowen presented at last year's Dental Tribune Study Club Symposia during the Greater N.Y. Dental Meeting, and he is scheduled to speak this year too.

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ADA's 150th Annual Session

By Fred Michmershuizen, Online Editor & Kristine Colker, Managing Editor Ortho Tribune & Show Dailies

When it comes to continuing education and innovative products, dental professionals who traveled to Hawaii for the ADA's 150th Annual Session were in the right place. The meeting, held Sept. 30 through Oct. 3 at the Hawaii Convention Center in Honolulu, had C.E. courses and technology for all practitioners, no matter what specialty area they practice in. The focus was on finding better and more efficient ways of providing care to patients.

Courses were divided into five separate tracks — dental assistant, preventive, team building, esthetic dentistry and new dentist. Of particular interest at this year's meeting was the popular Education in the Round series, in which live patient

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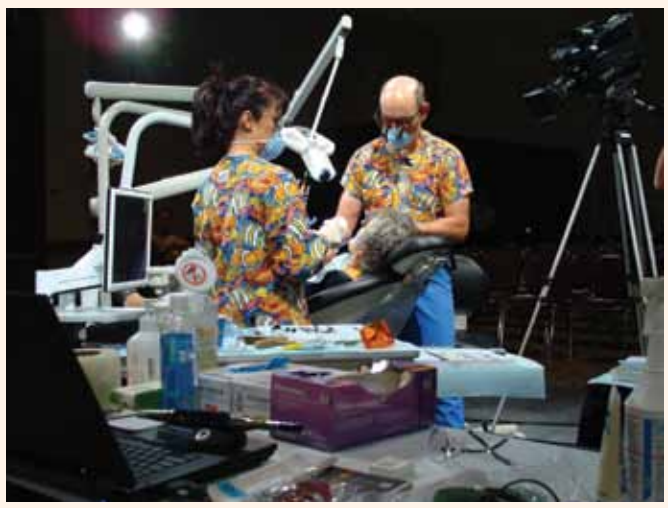
It was people everywhere in the front lobby of the Hawaii Convention Center during the ADA Annual Session. (Photo by Kristine Colker/Dental Tribune)



Dr. Lee Ann Brady and Dr. Peter Fay demonstrate impression technique for multiple implants during an Education in the Round session at the recent ADA meeting in Hawaii. (Photo by Fred Michmershuizen/ Dental Tribune)

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procedures were performed in a fully functional dental operatory.

Dr. Samuel Low offered a demonstration of periodontal treatment, and Dr. Jon Suzuki demonstrated crown lengthening. Dr. Steve Ratcliff and Dr. Jorge Ramirez demonstrated implants for terminal dentition, and Dr. Lee Ann Brady and Dr. Peter Fay demonstrated impression technique for multiple implants. Dr. Terry Tanaka demonstrated TMD treatment, and Dr. Wynn Okuda demonstrated esthetic restorative treatment using composite resin.

At the ADA's Live Operatory Center (LOC), meeting attendees were able to receive free C.E. right on the exhibit hall floor. The focus was on the latest in high-tech innovation.

Meeting attendees interested in CAD/CAM technology were able to learn from clinicians offering step-by-step instruction on live patients using the CEREC system from Sirona and the E4D system from Henry Schein Dental. Questions from audience members helped keep the proceedings moving along at a nice pace.

Another presentation offered at the LOC, "150 High-Tech Products

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vary glands themselves can produce disease-informative surrogate biomarkers. The salivary gland system can be viewed as a local anatomical organ that is poised to monitor local and systemic diseases.

The good news is that the biofluid secreted, saliva, can be obtained non-invasively, painlessly and without embarrassment to the patient — no needles and no cringing.

Which salivary diagnostic toolboxes are at hand or currently in development and how could these be incorporated into the clinical practice?

Current salivary diagnostic toolboxes include the diagnostic alphabets — proteome, transcriptome, microRNA and microbial — and point-of-care diagnostic technologies. Integration into clinical practice requires identification of effective clinical application and approval by the Federal Drug Administration in the U.S.

With the exception of the salivary HIV-antibody test, no other salivary biomarker test has reached the FDA-level evaluation. We anticipate that our point-of-care device and biomarkers for oral cancer detection will be evaluated by the FDA in the next two years.

Do oral diseases have any impact on the diagnostic value of saliva?

A number of oral diseases have been evaluated for salivary diagnostic applications, including caries assessment, oral cancer and periodontal disease.

Proper control of oral diseases in the study population to control the effect of periodontal disease and inflammation, in particular, is important. DT

(This interview is published with permission from the FDI World Dental Federation, Switzerland.)

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Consumer group warns against zinc in denture cream

The Consumer Healthcare Products Association counters that zinc-containing denture adhesive products are safe

By Fred Michmershuizen, Online Editor

A consumer advocacy group has issued an "urgent national alert" to consumers against the use of denture creams containing zinc, but manufacturers of the denture adhesives insist their products are safe.

"Because of inadequate or nonexistent warnings, the zinc poisoning from denture creams has the potential to become a major public health disaster," reported U.S. Drug Watchdog, in a statement issued Oct 12.

According to the Washington, D.C.-based organization, "exposure to excess zinc can lead to unexplained weakness, numbness, loss of sensation or other nerve symptoms."

"Approximately 35 million Americans wear dentures, most of whom are elderly," a statement by U.S. Drug Watchdog said. "Severe zinc poisoning can lead to neuropathy, a condition that affects the nerves."

Meanwhile, manufacturers maintain that the products are harmless when used according to directions.

"Zinc-containing denture adhesive products are safe and effective when used according to the labeled directions," said Elizabeth Funderburk, spokesperson for the Consumer Healthcare Products Association (CHPA).

The CHPA is a Washington, D.C.-based, not-for-profit association representing the makers of over-the-counter medicines and nutritional supplements and the consumers who rely on these health care products.

"Zinc-containing denture adhesives made by CHPA member companies have explicit label directions to both explain in words — and demonstrate in pictures — the appropriate use of the creams," Funderburk said.

"In all cases, consumers are advised to use a small amount on well-fitting denture appliances. Too much product is being used if oozing occurs when dentures are put in place."

A statement from Procter & Gamble, manufacturer of Fixodent, reads, "All Fixodent products undergo rigorous scientific evaluations and safety testing. We continually monitor the safety of our products once in market.

"We are not aware of any case where denture cream has been definitively linked to a health effect from zinc.

"Fixodent contains ingredients that are generally recognized as safe in the amounts used. All Fixodent products are made, packaged and labeled in accord with FDA manufacturing practices.

"Still, we are doing all we can to make sure our consumers know how to use Fixodent properly.

"Furthermore, we are monitoring and updating our Web site, our packaging and our communication to dental professionals when necessary.

"Our Web site has been updated, and our packaging will soon provide detailed information to our consumers."

A number of lawsuits have been filed against Procter & Gamble and GlaxoSmithKline, manufacturer of Super PoliGrip, on behalf of consumers who claim to have suffered negative health consequences due to zinc poisoning resulting from use of the products.

Consumer law firm Parker Waichman Alonso filed a federal lawsuit in the U.S. District Court of the Eastern District of Tennessee related to Super PoliGrip (Case #09-cv-22670).

Additional lawsuits have been filed against the manufacturers of Fixodent and Super PoliGrip on behalf of individuals who claim to have suffered neuropathy and other serious injuries from denture cream poisoning.

Fixodent and many other denture adhesives contain zinc.

Many of the lawsuits have been consolidated. On June 9, the U.S. Judicial Panel on Multidistrict Litigation consolidated 12 cases, including two Fixodent cases and 10 against SuperPoliGrip, into a multidistrict litigation (MDL) for coordinated pretrial litigation in the U.S. District Court for the Southern District of Florida, according to *AboutLawsuits.com*, a Web site offering information about personal injury litigation.

AboutLawsuits.com reported that the lawsuits involve similar allegations that manufacturers failed to warn that high amounts of zinc are contained in the denture adhesive creams, which can be absorbed by the body when a large amount of the product is used or if it is used over a long period of time.

Increased levels of zinc in the body can also deplete copper levels, causing a condition known as hypocupremia, which is known to increase the risk of significant neurological problems that can leave users with permanent and debilitating physical injuries.

Although the recommended daily allowance of zinc is 11 mg for men and 8 mg for women, with 40 mg being the maximum amount of zinc that can be safely tolerated, some denture creams have been found to expose users to levels as high as 330 mg per day, *AboutLawsuits.com* reported.

According to the CHPA, denture adhesives containing zinc are safe when used properly.

"First cleared for marketing in the United States by the FDA roughly 15 years ago, these products are very safe when used as directed, and adverse events are extremely rare," Funderburk said.

The statement from Procter & Gamble reads, "A small amount of zinc is used in Fixodent to help the denture stay in place securely so our consumers can eat, chew and talk more confidently.

"Zinc is a common ingredient in many over-the-counter products, a variety of foods and is a vital part of our daily diet. In fact, zinc supplements are commonly sold.

"Fixodent users may ingest a small amount of the product. However, we estimate the amount of zinc a consumer would ingest from daily usage of Fixodent is less than the amount of zinc in most daily multi-vitamins and comparable to six ounces of ground beef." DT

Dental signage for Halloween

A few weeks ago I wandered into a store called Big Lots! for the very first time and found this sign for sale among its Halloween decorations.

It's made of very thin metal with heavy plastic and uses replaceable, miniature, push-in type lights.

After laughing so hard I am certain the other customers thought I was mentally unstable, I picked it up for immediate purchase.

At a mere $15, it was a small price to pay for some dental humor that I suspect you, the readers of Dental Tribune, can also appreciate.

The picture you see is the sign hanging in my kitchen. I added the skeleton lights, which I think will be the only things I will remove from the wall after the holiday. *(Text & Photo/Robin Goodman, Group Editor)*

Suffering from the mid-career squeeze?

By Sally McKenzie, CMC

Mid-career, mid-life, mid-term. You've reached the middle, the halfway point. It can be a time of great prosperity and satisfaction or one of significant anxiety.

For some dentists it means they are hitting their stride and are right in the middle of the excitement, the challenge and the thrill of their chosen profession. They are at the top of their game, enjoying the fruits of their labors and looking forward to what the future holds.

For others, mid-career feels more like being stuck in midstream, floundering somewhere in between the beginning and the end. It's too late to turn back, but there's not much promise in what lies ahead.

Behind them is the first 15–20 years of their dental career. They've invested a fortune in time and money in both dental and continuing education.

They should be reaping the rewards, but they're not. They are burdened by the monetary pressures. The lean months are growing more frequent, and it feels as if the financial tightrope they are tiptoeing across could snap at any time.

They are supposed to be the leaders of their practices, yet the personnel struggles, the revolving door, the sheer challenge of just keeping a group of people together, let alone building a team, is wearing them down.

Is it any wonder that they find themselves asking, "Is this all there is?" Where's the excitement, the enthusiasm, the career satisfaction?

Consider your position on this mid-career path. Are you enjoying the view from the pinnacle of success? Or are you frozen in place, stuck somewhere between merely average and truly excellent?

In addition, if you're not where you want and feel you should be, are you willing to take the necessary steps to change it?

Look at it this way: if the roof were leaking, you would have it repaired. If your car weren't running properly, you would take it to the mechanic.

It stands to reason that if the area of your life that has the greatest impact on your personal and professional happiness and satisfaction isn't delivering what you expected, you wouldn't hesitate to fix it. Right?

The question then becomes: Where to start?

You'll need to look at key systems, starting with the two critical areas that are most likely to be sending your practice, and consequently you, into a mid-term slump: patient retention and poor customer service.

Patient retention: 'The Deception of Perception'

We see this routinely in mid-career practices, everyone is busy. The schedule appears to be bursting at the seams.

Hygiene is typically booked out six months. A couple thousand patient records are on file. Therefore, the clinician is convinced that patient retention is perfectly fine.

"Busy" is as "busy" does, and busy is one of the great illusions of the dental practice, a perception that is not only deceiving but also costly. In fact, most dental teams are stunned to learn that 80 percent of dental practices are losing more patients than they are bringing in new.

However, upon hearing such statistics, the crew will simply turn and tell each other that they must be in that select 20 percent group because, well, you know, they are crazy with work. Just how crazy? Find out.

How many inactive patient records are taking up space in your files or stored away? Have you increased the number of hygiene days per week in the last year?

Is your hygienist's salary more than 33 percent of what she/he produces? Finally, have you converted 85 percent of your emergency patients to comprehensive exams?

If the number of inactive records is enough to open a second practice, you have patient retention problems.

If you have not increased hygiene days, you have patient retention concerns. If your hygienist's salary is more than a third of what she produces and if you haven't converted 85 percent of your emergency patients to loyal patients, you have more patients leaving your practice than you have new patients coming in.

While misery loves company, it doesn't require you to hang around this pity party indefinitely. Patient retention is an area in which you can take prompt steps to improve

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and see immediate results.

In most cases, patients have simply drifted away because the recall system, if it exists, is weak. Put recall to work and patients in the chair.

Patient recall task force

Generate a report from your computer of all patients past due for recall appointments in the last 12 months. Your objective is to reconnect with these patients using a defined strategy that will enable you to set goals and track the results of your efforts.

First, assign a member of the business team, typically the patient coordinator, to take the following steps:

1) Contact a certain number of past-due patients each day. The coordinator should use a specific script that she/he uses as a guide in making the calls.

In addition, she/he should check the patient records to identify a treatment concern noted in the patient's chart that could be mentioned during the phone call.

2) Everyone needs goals, and beyond just making calls, the coordinator should be expected to schedule a specific number of appointments, and follow-up with patients to ensure that a specific number of patients complete treatment.

3) The coordinator also assists the hygienist in meeting production objectives by scheduling the hygienist to achieve daily or monthly goals as well as managing a specific number of unscheduled time units in the hygiene schedule per day.

4) Finally, the patient coordinator monitors and reports on recall monthly at the staff meeting.

You will find many patients who are more than willing to schedule an appointment. They do so because you've demonstrated to them that you value this patient relationship and want them to return.

Be our 'guest,' not just our 'patient'

A few years ago, the Harvard Business Review reported that between 65 to 85 percent of people who leave one business for another do so even though they are satisfied.

What does that mean for dentists? Many of your patients stay with your practice only until they find a reason to leave.

And most dental teams are often more than a little surprised by what

some of those reasons are:

- *The practice hours are not convenient.*
- *There's no place to park.*
- *The doctor hurts me.*
- *I don't understand the bills.*
- *They don't accept my insurance*
- *They changed a practice policy.*
- *They don't answer the phone.*
- *I can't leave a message.*
- *They charged me for a missed appointment.*
- *They are always trying to sell me something.*
- *The fees are too high.*
- *They can't keep staff.*
- *They told me I have to go to a specialist.*
- *They don't listen to me.*

What dental teams might consider insignificant issues or minor patient problems are costing practices a fortune in lost loyalty. Obviously, it doesn't take much to motivate patients to take their dental needs and wants elsewhere.

So how do you turn patients waiting for a reason to leave into long-term loyal partners? Take a close look at systems and service.

While surveys indicate 70 percent of customers/patients cite service as the No. 1 reason they defect, too often employees view managing patient service as a distraction from what they consider to be more important tasks, such as ensuring the schedule is full, collecting from insurance companies, confirming appointments, etc.

Ironically, the success of each of these goes hand-in-hand with providing excellent service.

First, find out what your patients think. Survey patients to assess if seemingly minor concerns raised by a few patients are a bigger problem than you may have realized.

Invest in a statistically valid survey instrument that is designed to ask questions that will elicit the most valuable and revealing information.

Next, engage in "action listening," which is different from "active listening." With action listening, the dental team commits to bring concerns and issues voiced by patients to the staff meetings for discussion and action.

For example, if patients are commenting that practice hours are inconvenient, the team develops a plan to address the issue, such as adjusting the practice hours for 60 days, marketing the change, and monitoring patient reaction and subsequent patient retention. The team can then assess if the change should be made permanent.

Look at practice systems and evaluate if they are best serving the patients, and thereby best serving the practice.

If the schedule is booked out weeks for the dentist and months for hygiene, if patients are routinely declining treatment, if collections are low and holes in the schedule are frequent, these are all system indicators that patient service is deficient.

While you're at it, pay attention to the obvious:

1) *Welcome each "guest."* Treat each patient as the most important person in your office from the moment she/he walks in the door until she/he leaves the parking lot.

2) *Have the answers.* Patients expect you to have immediate answers to basic questions. Track the common questions that patients ask. Take steps to ensure that every member of the team is prepared to answer them.

3) *Acknowledge patients immediately.* Under no circumstances should a patient be ignored when he or she is standing at the reception desk. It takes five seconds to look over at the patient and let her/him know you will be right with her/him.

If you pretend the patients are not there, you tell patients that they are an annoyance and unworthy of your time.

Providing excellent service means building a strong emotional connection with the patient — not just running on time and delivering good dentistry.

It means that every member of the team makes it clear that she/he cares about that specific patient, is willing to listen to the patient and shows genuine interest and concern for the patient. DT

About the author

Sally McKenzie is CEO of McKenzie Management, which provides succes proven management services to dentists nationwide.

In addition, the company offers a vast array of practice enrichment programs and team training.

McKenzie is also the editor of an e-Management newsletter and The Dentist's Network newsletter, sent complimentary to practices nationwide.

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The 'next big thing' in dentistry

By Louis Malcmacher, DDS, MAGD, FIADFE

I am asked all of the time what the next big thing is going to be in dentistry. What new technique or technology is going to change dental practice?

We certainly have made huge advancements in a number of areas, such as restorative therapy, implants and esthetics.

I believe the direction of the next great thing in dentistry is actually going to take place in the oral-systemic connection. Most dentists are familiar with this connection as being how oral health affects systemic health.

I'm going to look at the oral-systemic connection from a completely different angle: the oral-systemic esthetic perspective.

We all can do a magnificent job of making teeth look great and giving people a healthy and beautiful smile.

Esthetic dentistry has been an absolute boom over the last 30 years when it comes to such innovative techniques as teeth whitening and minimally invasive veneers, such as Aurum Ceramics' Cristal Veneers, Denmat's Lumineers and many others.

Once the teeth look good, what about the peri-oral areas around the mouth? If the teeth look good but we ignore the rest of the face, then we have really limited what we have done in esthetic dentistry.

It is time to give serious consideration to extending the oral-systemic connection to the esthetic realms of the face, which dentists are more familiar with than any other health-care practitioner.

Botox is used for smoothing facial wrinkles by eliminating dynamic wrinkles caused by muscles in motion. Dermal fillers are commonly used to add volume to the face in the nasolabial folds, lip augmentations, oral commissures and marionette lines.

As we age, collagen is lost in these facial areas and these lines start to deepen.

These dermal fillers are injected right under the skin to plump up these areas so that these lines are much less noticeable. The face looks more youthful and esthetic, and Botox and dermal fillers are the perfect complement to any esthetic dentistry.

I have been trained and have had experience with Botox and dermal fillers for a while, and these are very easy procedures to accomplish once dentists have been properly trained.

As dentists, we give injections all the time. This is just learning how to give another kind of injection that is outside the mouth, but is in the same area of the face that we inject all the time.

We also have a distinct advantage over dermatologists, plastic surgeons, medical estheticians and nurses who commonly provide these procedures in that we can deliver profound anesthesia in these areas before accomplishing these filler procedures.

I will never forget that during my training, my patients were completely comfortable during dermal filler and lip augmentation therapy because of my ability to deliver proper anesthesia to these areas.

The patients treated by other health practitioners were quite uncomfortable and indeed this is one of the biggest patient complaints about dermal fillers.

Many state boards are allowing general dentists to provide botulinum toxin and dermal fillers to patients. Is there a market for these services?

In 2008, close to $5 billion was spent on botulinum toxin and dermal filler therapy in the United States. Think about this — that was money spent on non-surgical elective esthetic procedures that could have been spent on esthetic dentistry, and the patient made a choice.

Interestingly, these procedures become more popular in an uncertain economy because patients want to do something to look better that is more affordable than surgical esthetic options.

Botox and dermal fillers are the perfect complement to your esthetic dental practice.

Like anything else you do, this requires some training and the learning curve is incredibly short because you already know how to give comfortable injections and are familiar with facial anatomy.

I often give training sessions in botulinum toxin and dermal fillers and dentists are amazed how easy these procedures are compared to everything else we do.

Finding practice models is easy: start asking family and friends, who will fight to have you practice on them.

If you want further proof, ask women in your practice if they have had or would like Botox and dermal filler therapy.

You will be overwhelmed at the positive response.

What's the next big thing in dentistry? It may come as we start expanding beyond the teeth and gums into the oral and maxillofacial areas, which is within every dentist's skill set.

All you need is knowledge and practice. Then, you will be able to deliver these new services to your patients and truly complement your esthetic dental practice. DT

About the author

Dr. Louis Malcmacher is a practicing general dentist and an internationally recognized lecturer, author and dental consultant known for his comprehensive and entertaining style.

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Protecting yourself from employee theft, fraud and embezzlement (part 2)

By Eugene W. Heller, DDS

Other preventative areas

Each office should use a time clock, and the dentist must initial manual entries. Petty cash should be counted and balanced daily. The amount of receipts plus cash on hand should equal the same balance every day.

The outside of the envelope containing the petty cash should be used to monitor the daily balance.

Each day, the date, the receipt total, the cash total and the sum of receipts and cash should be listed along with the initials of the person reconciling the petty cash.

When the age of computerization came to dentistry, one of the selling points was that computers would make it more difficult to embezzle. Nothing could be further from the truth.

Whether computer-related, computer-enabled or computer-camouflaged, the use of computers has made embezzlement easier than ever unless the proper safeguards are instituted.

Preventing theft by computer requires a thorough understanding by the dentist of the security features built into the office's software. This information must be carefully reviewed with the software vendor's support team to ascertain that access to various features of the system is correctly restricted.

No system should allow the deletion or erasing of accounts or charges by staff or allow deletion/disabling of the entire system.

The statement generator should never be turned off. Any patient complaints relative to payments and balances must be carefully investigated.

Computer reports are designed to assist in avoiding theft problems. But to work, someone (i.e., the dentist) must review them. These will only take a few minutes to review, but this must be done.

Adjustment, refund and write-off reports should be read by the dentist daily. The dentist should scan posting reports daily. The dentist can quickly spot incorrect charges posted for procedures he/she has just performed.

The accounts receivable (A/R) aging report should be checked monthly and discussed monthly with the financial coordinator. The financial coordinator should be prepared to respond to each account over 90 days old with why, what has been done and when payment is expected.

In addition to demonstrating that the dentist is monitoring things, this also greatly assists in making certain that collection procedures are being followed, thereby keeping accounts receivable under control.

Dealing with embezzlement

Dealing with embezzlement, fraud and theft involves four steps. Discovery is the first step. It is the dentist's responsibility to diligently observe what is going on in his/her office relative to the handling of money.

If theft is suspected or discovered, the next step is investigation. Before making any accusations, the dentist must make certain that the evidence supports the alleged crime.

This means reviewing entries, reports, patient account records, etc., to gather the hard evidence necessary to confront the thief.

Prosecution is the next step. This is sometimes harder for the dentist than the realization that his/her trust has been betrayed. However, it is a necessary step. If not, the theft will continue, either from you or another dentist. This means calling the police.

Reasons dentists do not prosecute

Why do some dentists elect to forgo prosecution? Topping the list is the fear of a slander suit. Avoiding this allegation is the purpose of the investigation stage.

If you have the evidence, you are not guilty of nor can you be accused of slander. Involving the police once you are certain you have become a victim will aid in protection against these false allegations.

In addition, many dentists fear to prosecute because of fear of the IRS. After all, they have unreported income. If one fails to report and prosecute the theft, the IRS takes the position that income has been fraudulently under-reported.

If one reports the loss to the authorities, the IRS views this as proof that a loss by theft has occurred and therefore the under-reported income is offset by the theft loss and no charges by the IRS will be levied.

Non-reporting of employee theft can also be the fear of blackmail. Some of the dentists suffering losses from theft are themselves involved in insurance fraud, unreported income and/or income tax evasion. They know the offending staff member is aware of this and, out of fear of retaliation, they elect to terminate the employee but not prosecute.

Recovery

The last of the four steps of dealing with employee theft is recovery. Total recovery is usually not possible.

Even if successfully prosecuted involving a judgment requiring repayment, most staff members involved in theft no longer have the money nor do they possess the ability to repay, even if spread over a lifetime.

Actual judgments issued such as $50 per month until the amount embezzled has been repaid would require 100 years of monthly payments to recover a $60,000 loss (that does not even include interest).

The best chance of partial recovery comes from the office insurance policy. Limits of $10,000 to $25,000 are common. The policy will pay the actual amount of loss or the policy limit, whichever is lower.

However, most policies require the reporting of the loss to police and prosecution if advised by the local district attorney.

Conclusion

Most theft, fraud and embezzlement is avoidable if minimal safeguards are instituted.

However, the dentist must take an active role. Dentists who blindly trust their employees are the easiest targets and may suffer the greatest losses.

Many new dentists who acquire their dental practice by purchasing an existing practice face the same problem relative to implementing safeguards as older dentists in practice for many years face.

How can you solve this dilemma? Blame it on your accountant.

Tell your staff that your accountant has recommended certain changes be made in how things are done because this represents better compliance with GAAP (generally accepted accounting principles).

In this manner, these changes will barely be questioned, except perhaps by a staff person who is guilty of theft. DT

About the author

Dr. Eugene W. Heller is a 1976 graduate of the Marquette University School of Dentistry. He has been involved in transition consulting since 1985 and left private practice in 1990 to pursue practice management and practice transition consulting on a full-time basis. He has lectured extensively to both state dental associations and numerous dental schools. Heller is presently the national director of Transition Services for Henry Schein Professional Practice Transitions. For further information, please call (800) 730-8883 or send an e-mail to *ppt@henryschein.com*.

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