JDIQ REVIEW

DENTAL TRIBUNE

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EMBEZZLEMENT MYTHS BUSTED

Dental fraud guru David Harris says that with dental office embezzlement, 'prevention controls' often aren't the panacea some claim they can be.

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2012 JDIQ MEETING PHOTO OVERVIEW

Photos highlight the lectures and exhibit hall at Canada's biggest dental meeting, Journées dentaires internationales du Québec.

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EXPERTS VET NEW WEBSITE'S C.E. COURSES

Just-launched one-stop dental community offers study clubs, exhibit hall, 'Networking Café' and courses from the profession's top speakers.

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Commentary

Dental specialists in Canada: A true need?

Costs of specialized treatment prompt access-to-care questions

By Eli Raviv, DMD, Certified Prosthodontist, and Kelvin Ian Afrashtehfar, DDS, FADI

Over the years, dental specialties have emerged in faculties of dentistry due to the advancements within specific areas of treatment, and they have been incorporated if not into each university, at least into virtually every province. In Canada the Commission on Dental Accreditation reviews and accredits the following nine dental specialties programs: dental public health; endodontics; oral and maxillofacial surgery; oral medicine and pathology; oral and maxillofacial radiology; orthodontics and dentofacial orthopedics; pediatric dentistry; periodontics; and prosthodontics.

Dental specialists have exceptional training (or, are highly skilled clinically); but with rights come responsibilities. Specialists also need to lead the way by becoming superordinate oral physicians. They must identify hundreds of systemic/genetic disorders that manifest in the oral and craniofacial area supporting the relationship between oral and systemic disease. Yet, conversely, in a survey answered by 200 governmental and professional agencies, more than 90 percent believed that dental health is isolated from general health.

The standard of care required of the health professional increases in correlation to how the practitioner holds himself or herself as a specialist — and the riskiness of the procedure.

The generalist, of course, is not deprived of responsibilities. When accepting a patient, a dentist assumes a duty of care that includes the obligation to refer the patient for further professional advice or treatment if it transpires that the task at hand is beyond the dentist's own skills. A patient is entitled to a referral for a second opinion at any time, and the dentist is under an obligation to accede to the request and to do so promptly.

In other words, when a generalist performs procedures that are mostly performed by dental specialists because of complexity or difficulty, the law holds all such practitioners to the standard of care expected of specialists providing similar procedures on a regular basis. Agreement on treatment recommendations appears to be somewhat higher among specialists than among general practitioners, indicating that graduate education may influence the decision-making process. Additionally, multidisciplinary treatment continues to produce extraordinary outcomes.

Therefore, referral to an experienced dental spe-

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Looking back at JDIQ

• The exhibit hall enjoys heavy traffic on the iconic red carpets at the 2012 Journées dentaires internationales du Québec.

Photo/Robert Selleck, Dental Tribune

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- New sinus-lift instrument uses gentle but effective hydraulic pressure
- Phillips Zoom WhiteSpeed: effective, protective teeth whitening

AD

Don't believe all you read on fraud

By David Harris

A recent Google search for dental embezzlement articles located approximately 30 articles, many written by some of the "stars" of dental consulting.

Most followed a common theme; they offer tips for fraud prevention that include control procedures, each designed to block a specific fraud technique.

While I agree that certain controls and techniques advocated by those authors are good ideas for reasons unrelated to fraud, I categorically disagree with the suggestion that more or different controls will prevent fraud. My attack on this conventional wisdom deserves explanation. While I am sure the authors had good intentions (and, by raising dentists' awareness about fraud clearly have performed a valuable service), I also think most have been caught by something called the Dunning-Kruger Effect, which happens when people who understand the basic elements of an issue become convinced they have a mastery of that issue. Many proponents of the "more controls prevent fraud" principle are either generalist consultants who advise on many areas, or dentists who are writing about their own (necessarily limited) fraud experience.

Fraud theorists have developed the "fraud triangle" that suggests three ingredients are required for fraud to happen: "pressure" (meaning motive), "opportunity" and "rationalization." Most pundits have correctly recognized the impossibility of controlling people's motivation or preventing rationalization, and therefore conclude that eliminating opportunity is how to prevent fraud. I agree with this analysis on a theoretical level; however, based on my own experience I conclude that many of the writers haven't considered that while their suggestions cause the removal of some opportunity, for this approach to succeed, all opportunity must be eliminated.

My company investigates embezzlement against dentists every day. Involvement with hundreds of embezzlements grants us a perspective that is impossible for the generalists and dabblers to acquire — we are given the chance on many occasions to watch how thieves behave.

The people who steal from dentists share common characteristics — superficially they are usually long-service employees, exude efficiency and are liked by peers. Looking deeper, we see both a level of intelligence beyond what is required for their position and also a specialized intellect, which I would label "criminal intelligence" — the ability to perceive systems and rules, and to tailor behavior to work within (or around) the rules. Also, embezzlers are driven by powerful motivation, summarized as "need" or "greed." This combination of motivation plus "criminal intelligence" permits embezzlers to triumph over virtually any control system you might implement.

An uncomplicated solo practice has hundreds of possible fraud pathways. Considering each individually, you might be tempted to implement a control that would thwart that specific fraud. For example, the dentist personally making all bank deposits — a procedure advocated in many articles — blocks a specific fraud technique (someone helping themselves to cash or checks intended for deposit). However, making four bank deposits weekly takes considerable time for which the dentist should have better use. Second, this fraud is one rarely seen

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cialist — who has the clinical skills, the required equipment and the resources — is in the best interest of the patient and ought to be encouraged when suitable. Certain therapies performed by specialists are significantly more successful than when provided by generalists. For example, root canal treatments have a five-year success rate of 98.1 percentwhen performed by a specialist compared with 89.7 percent when performed by a generalist. For the oral implantology subspecialty, the outcomes of complex procedures diverge predominantly when requiring bone augmentation and management in the aesthetic zone.

When it comes to reviewing numbers, the ratio of growth in the specialties is overwhelmed by growth in general practitioners because some faculties of dentistry limit admission to only two specialists each year; others have only one. Canada has a markedly low ratio of prosthodontists to dentists (1:107) when compared with Nordic countries; but it has a very high number of denturists, or clinical dental technologists. In the United States, with 10 times the population of Canada, there was a projection at one point showing an estimated 294 million hours in unmet prosthodontic services.

A decade ago in Canada, female dentists made up 23 percent of generalists and 14 percent of specialists. The duration of specialty education conflicts with childbearing years and is a potential reason for the specialist gender gap.

Even with this lack of schooling opportunity to fulfill patient needs and meet dentists' demand for graduate education, some specialties have had to be closed because of financial or political issues — more limitation that ultimately must be addressed. To mention an example, a prestigious McGill prosthodontic program had to be closed more than 20 years ago, leaving the University of Montreal as the only option in Quebec to enter the specialty. Unfortunately, this last program, too, is being shut down for the next coming year. Quebec dental graduate education is left without any option to back up its prosthodontics backbone.

To cover the shortage of specialists in Canada, guidelines for the evaluation, education and registration of dental specialists trained from non-accredited institutions were developed, without sacrificing public protection or weakening self-regulation.

The fact that spending-power limits dental specialty care is true. We are in the presence of difficult financial times that limit patient access to needed treatment. Among patients making a first-time appointment with a specialist, countless numbers will drop out of treatment or go untreated altogether because of high costs, often connected to the expense of new technologies. Most of these treatments are not totally covered by the health insurance.

In response to these challenges, faculties of dentistry created one-year hospital- or university-based training residency programs — and the "advanced general dentist" was born. Results of these programs show that such dentists on average achieve a superior set of skills compared with general dentists and have shown a reduced need to make outside referrals.

Other answers need to be formulated by the individual institutions most influencing the careers of the specialty professionals being accredited. As oral health professionals we must do what is in the patient's best interest. We owe patients for the opportunity they give us to serve them. As a final commentary: The need for dental specialists in our country will not be diminished, but the challenges that limit patient access to their services must be addressed.

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KELVIN I. AFRASHTEHFAR, DDS, FADI, grew up in Mexico, where he graduated and received postgraduate certification in academic and research methodology. He received a fellowship nomination from the Academy of Dental Facial Esthetics (IADFE) for his achievements in the cosmetic industry and is a professor for the Mexican Dental Association (ADM). He is a member of the IADR and the International Academy of Science. At FDI World Congress in Mexico, he was awarded Fellow of the Academy of Dentistry International. He is an editorial board member for three international journals of implant dentistry. He appears in the Who's Who Worldwide Dentistry records. Afrashtehfar lectures and publishes on periodontal, restorative and public health matters. He collaborates in some prosthodontics departments in Quebec.

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sense and simplicity

◂ EMBEZZLEMENT, Page 2

in practice (presumably because it leaves an obvious discrepancy when bank deposits don't match daysheets). But this control procedure is visible to the thief, who, driven by the powerful forces I mentioned, will not simply surrender. Instead, the thief will develop an alternative way to steal that will circumvent the dentist's control efforts.

There is probably a control that would defeat any alternative fraud method selected, but this will simply prompt further adaptation. Since every control costs time, money or productivity, to implement procedures to block every known fraud modality would grind every dental office to a halt. I confess that, for most of my 20-year plus investigative career, I, too, believed in controls. My epiphany happened about five years ago when reviewing an investigation with one of my senior investigators. He had examined several years of transactions when he noticed something interesting: There was a point when the dentist (not realizing at the time that he was being embezzled) made some procedure changes in the office, including a new requirement that the dentist personally authorize all write-offs. The change eliminated the thief's favorite method of stealing: writing off balances she collected and pocketed.

What became clear to us was that, when the dentist decided that he needed to control write-offs, the embezzler varied her scheme and, within days, was happily stealing again. Subsequently, we have seen this pattern repeated frequently — a dentist, either with concerns about fraud or simply unhappy with some aspect of their practice, makes some change that impinges on the fraud methodology employed, which is followed by a quick adaptation by the thief.

There are other pieces of evidence supporting the uselessness of controls in prevention. Published statistics suggest that over half of dentists will be fraud victims in their careers. Surely, with so much information about control systems available to dentists, if those systems worked, the incidence of embezzlement should be much lower. I should also mention that the embezzlement probability has remained fairly constant over time, notwithstanding ongoing improvements in the security features in practice management software.

Also, the American Dental Association performed an extensive embezzlement survey in 2007. One question asked was how embezzlement was discovered. Less than 20 percent of fraud was uncovered by what I consider to be planned operation of the dentist's control system (including discovery by the dentist's accountants). More than 80 percent was discovered by accidental means, such as employees being fired for other reasons and their replacements finding fraud, or from patient complaints about billing irregularities, pointing again to the uselessness of fraud controls.

Please don't misunderstand — I'm not suggesting that controls are inherently bad, or that your office should abandon existing controls; many of which serve other important purposes. For example, checking your daysheet is worthwhile because it catches (potentially expensive) clerical errors. It probably won't find fraud because the thief will be aware of your attention to daysheets, and will employ tactics that bypass your daysheet. At this point I expect you want to know how I recommend dealing with the fraud epidemic afflicting dentists.

The solution is remarkably simple. Even with the plethora of fraud opportunities, fortunately the behavior of thieves is incredibly consistent. (And I should know, because I have observed many thieves). There are behavioral manifestations of stealing that are virtually universal, readily observable and difficult to hide. Dentists who understand how the behavior of thieves presents itself, and who can periodically consider employees in this light, have an excellent chance of uncovering frauds early.

For example, thieves want to implement their malevolent transactions when alone in the office, so they often frequent the office outside work hours. They also unreasonably resist changes in dental software, banking arrangements or involvement of outside consultants.

We developed a questionnaire designed to assist dentists in identifying telltale behaviors of embezzlers. It can be requested by emailing *fraudnews@prosperident.com*.

Monitoring employee behavior is the easiest, least expensive and most effective means of protecting yourself against embezzlement, and offers far more return on investment than futile anti-fraud controls; and it's something every practice owner should do.

DAVID HARRIS has had the pleasure of hearing many jail-cell doors slam shut on thieves he has caught. He is president of Prosperident, the only company in North America specialising in the detection and investigation of embezzlements committed against dentists. He is a member of the Academy of Dental Management Consultants and has been called the "The Dental Fraud Guru." Learn more by visiting *www.prosperident.com*, or contact Prosperident directly at *fraud@prosperident.com*, which is monitored both during and after business hours.

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2012 Journées dentaires internationales du Québec fills lecture rooms, exhibit hall

Marie-Eve Pare gets a Sylc therapeutic prophy powder treatment from Catherine Brock, RDH, in the Oral Science booth in the exhibit hall. The free treatments let dental professionals confirm for themselves that Sylc can cut cleaning time in half while immediately desensitizing, brightening and restoring natural dentin and enamel.
Photo/Fred Michmershuizen, Dental Tribune

Normand Bach, DMD, MSc, FRCD(C), presents 'Minor Appliances — Major Results.' Photos/Robert Selleck, Dental Tribune

The exhibit hall enjoys large crowds on the final afternoon of the three-day event.

David Gane, DDS, of Carestream Dental presents 'Understanding Cone Beam Computed Tomography' in a Dental Tribune Study Club class in the exhibit hall.

Winter Clinic agenda includes dentistry's best

North America's largest one-day comprehensive dental meeting, Nov. 2, in Toronto features top speakers

The Toronto Academy of Dentistry 75th Annual Winter Clinic, scheduled for Friday, Nov. 2, brings together dental professionals and top speakers from across the globe to explore industry trends, clinical advancements and new products and services. Among the 2012 speakers are Elliot Mechanic, DDS; Bob Lowe, DDS; and, in the field of esthetic dentistry, Jordan Soll, DDS, presenting a live-patient demonstration using the Lava™ chairside oral scanner wand.

In the field of endodontics, speakers include Martin Trope, DMD, clinical professor in the department of endodontics at the University of Pennsylvania School of Dental Medicine. Trope's topic, "Modern Endodontics: From Theory to Practice," is sponsored by Brasseler Canada. Areas Thorpe covers include: approaches for vital versus necrotic cases; achieving minimal apical size; irrigation protocols including ultrasonic activation; root filling with bonded systems; and when to refer.

The academy is a resource to the dental profession in the Toronto area, enhancing careers of its members, from four component Toronto dental societies: North, East, Central and West.

(Source: Toronto Academy of Dentistry)

The Metro Toronto Convention Centre South Building is host site for the 75th Annual Toronto Academy of Dentistry Winter Clinic. Photo/Provided by Metro Toronto Convention Centre

Vancouver is host city to the Pacific Dental Conference. Photo/Provided by Pacific Dental Conference, ©Vancouver Aerial

Destination: Pacific Dental Conference

Vancouver, March 7–9

Experience the true flavour of the West Coast and earn C.E. credits at the same time. The PDC has an expert lineup of local, North American and international speakers. With more than 130 presenters, 150 open sessions and 36 hands-on courses covering a variety of topics, there is something for every member of your dental team. Explore the largest two-day dental trade show in Canada and have the year's first opportunity to see the newest equipment.

The spacious exhibit hall invites attendees to see innovative new techniques demonstrated on the live dentistry stage, and examine products and services from more than 300 exhibiting companies with representatives who are ready to engage attendees in discussions on creating practice solutions. At the conclusion of the conference, you can take a day to relax and revitalize by exploring some of the great tourist attractions in Vancouver. The ocean is just steps from the Vancouver Convention Centre, and the pristine snow-capped mountains offer up choice spring skiing conditions.

(Source: Pacific Dental Conference)

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Lessons learned

KEN HEBEL, BSC, DDS, MS, CERTIFIED PROSTHODONTIST, earned his undergraduate degree at the University of Western Ontario in 1979 and then completed a surgical internship program. He completed the prosthodontic graduate program at the Eastman Dental Center in 1983, along with his master's degree in anatomy. His career in implant dentistry started early, both in the surgical and prosthetic phases of implant therapy. He is a diplomat of the American Board of Oral Implantolgoy/Implant Dentistry, a diplomat of the International Congress of Oral Implantology and a fellow of the American Academy of Implant Dentistry. He is an assistant clinical professor in the Faculty of Dentistry at the University of Western Ontario and consultant to Nobel Biocare. He has provided hundreds of lectures worldwide and is one of the founders of the Hands On Training Institute, started in 1991, where he provides hands-on mini-residency training programs. He continues to maintain a private practice in London, Ontario, where he provides both advanced surgical and prosthetic phases of implant dentistry. Hebel can be reached via the training institute at *www.handsontraining.com* or *info@handsontraining.com* or by calling (888) 806-4442.

MyDentalPad, a comprehensive training resource for implant dentists, is digital-tablet based, but includes four full-colour, glossy, manuals so you need not be distracted by note taking. Photos/ Provided by Hands On Training Institute

Drawing on 25 years of experience teaching dentistry, Hands On Training Institute keeps improving 'sweet spot'

By Ken Hebel, BSc, DDS, MS, Certified Prosthodontist

If asked "What's your key lesson learned after teaching and practicing implant and restorative dentistry these past 25 years," my answer is: "Find the sweet spot in course content and delivery that gives dentists the confidence to go back to their offices and immediately implement what they learned." All the training in the world does dentists no good if they can't go back to their practice and immediately apply what they've learned to improve patient care and grow their practice. The obstacles to effective application are usually:

- A lack of confidence in their ability to apply what they were taught, caused by too much confusion about what they learned.
- The inability to recall what they were taught because of how the information was delivered to them.
- Or, the information was more theoretical than clinical.

At Hands On Training Institute, we knew we hit the sweet spot when more than 95 percent of our graduates were implementing implant dentistry into their practice almost as soon as they got their suitcases unpacked. Some faster than that. How did we build this kind of confidence and ability? Simply put, Reena Gajjar, DDS, and I continuously evolved our training from old-school techniques to embrace what we've distilled as five key observations based on teaching fundamentals.

1) *Hands-on training.* Dentists wanting to learn implant training are clinicians. Teach them from a clinician's viewpoint using good, quality information that's relevant to their everyday practice. Implement hands-on modules to build practical skills and confidence.
2) *Content structure.* Course content must be structured in a well-organized format that is easy to understand. Making it easy is the hard part.
3) *Content delivery.* The way the information is delivered is critical to how the participant learns.
4) *Take-home resources.* Long-term content retention in a course is relatively low. Provide comprehensive materials that the dentist can take back to his/her practice as a valuable reference and a continued learning experience.
5) *One Instructor.* Having one instructor, rather than multiple instructors, allows for consistency in instruction and philosophy and provides a solid foundation that dentists can later build on.

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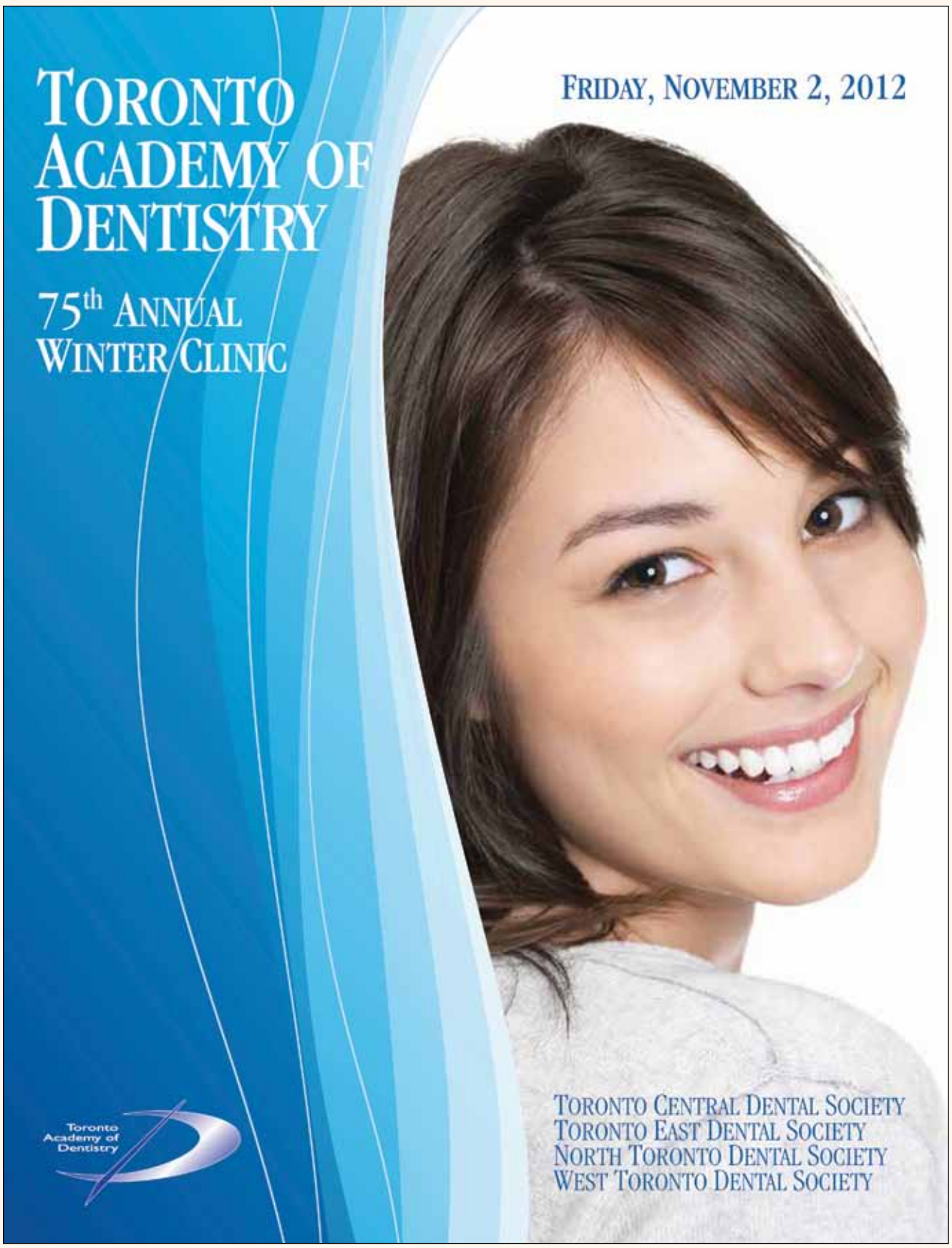
AD



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