WHO SHOULD HAVE ACCESS TO THE CONTROLLED SUBSTANCES IN YOUR OFFICE?

Your editor has heard numerous stories over the years of employees stealing from their employers' practices. Some have involved the taking of a few hundred dollars from petty cash, but other, more sophisticated employees have cleverly manipulated the accounts receivable to redirect the payment of tens of thousands of dollars into their own personal accounts. Despite having a watchful eye on the practice and a good accountant, dentists often have lost huge amounts of money before the "trusted employee" was finally caught. Although only rarely is there any money left to be recovered in these instances, the dental practices usually have survived without any permanent consequences. The practitioner-victims, however, do become much more alert and often redesign their business practices to help prevent similar thefts in the future. They only wish that they had been more proactive in looking for the often subtle hints of developing problems.

Public disclosure of prescription fraud involving the dental office is another area of practice where the adverse publicity in the community can be embarrassing but likely will be only temporary. Theft of prescription blanks that might be left lying around casually in a busy office can result in the writing of illegal prescriptions for controlled substances with a forged doctor's signature. Drug abusing employees or their friends and family members may benefit from this easy and relatively inexpensive access to high-quality prescription pharmaceuticals. Not only can drug abuse from stolen prescription pads cause serious harm or result in an overdose death, it also can lead to the dentist being charged as an accessory to a crime, if it can be demonstrated that he or she should have been more diligent in limiting access to the prescription pads. Prescription pads should never be used like scrap paper for making notations. Access to prescription blanks should be as limited to most office staff as access to the banking checkbooks.

In a similar vein, when state laws permit busy practitioners to have non-professionally licensed office staff call in prescriptions to the pharmacy for their legitimate patients, drug abusing staff members can easily call in illegal prescriptions for themselves, friends, or family members without the doctor's knowledge. Pharmacists who are familiar with the dental auxiliary's voice and style have no reason to doubt the legitimacy of any of the calls. Some drug abuser-employees use the drugs themselves; others sell them at in-

flated "street prices" to be able to buy the street drugs of their choice. It is my opinion that despite the extra time it takes to personally call into the pharmacy all new prescriptions and refills, this is the sole duty and responsibility of the licensed practitioner. As an added safety benefit, the dentist should be less likely than their unlicensed auxiliaries to make critical phone transcription errors.

Open access to controlled substances in the dental office is an area of vulnerability for drug abuse. Certainly the drug-abusing dentist who purchases, stores, and dispenses the drugs can easily divert them for his or her own use by merely administering to each patient less drug than is recorded in the drug records and saving the remainder of the recorded dose for personal use. Drug abuse is a widely accepted risk among practitioners who must have access to these drugs to adequately treat patients, and, unfortunately, this abuse eventually will devastate the dental practice. However, an equally dangerous threat to the absolute survival of an office practice and the dentist's financial security involves the consequences of an unlicensed employee with a drug problem who has open access to the controlled substances. A recent example, according to an Associated Press news article, involved a Colorado ambulatory surgery center's surgical technician who had hepatitis C. She had easy access to fentanyl syringes, which were placed openly in the operator prior to each patient's entry. While alone in the room to set up instruments for the next case, she would steal the next patient's fentanyl syringe and quickly replace it with the one with which she had previously injected herself and that she had then refilled with saline. Thus each patient to whom the practitioner thought he was giving fentanyl actually was receiving saline contaminated with the hepatitis C virus. Although the technician eventually was caught and jailed, more than 6000 angry and distraught patients had to be tested for hepatitis C, and the facility was bombarded with questions as to how and why they could let this happen? So far, according to the article, ten cases of hepatitis C have been linked to this disaster. Not only were many innocent patients exposed to this incurable disease, but undoubtedly multiple lawsuits will follow that could bankrupt the facility and make the practitioner uninsurable in the future if the state licensing board does not first revoke his license for lack of proper employee supervision and drug security violations. Additionally, the public relations nightmare resulting from newspaper, television, and Internet publicity of the details of the potential epidemic could be the final blow to the ultimate survival of a previously successful practice.

How can the cautious practitioner avoid a similar disaster? No perfect solution has been put forth, but several suggestions for decreasing the risks should be considered. As was mentioned in previous editorials, most practitioners are comfortable with whatever practice system they have developed, or, in some instances, with the system that somehow developed by happenstance. Although change is difficult and usually meets with resistance, the thoughtful practitioner who can step back and observe his or her practice for potentially fatal weaknesses will be much less likely to succumb to a disaster. One of those areas for consideration involves decreasing the access of office staff to controlled substances. The wise practitioner does not permit auxiliaries to fill syringes with controlled substances, as this should be the sole responsibility of the dentist. Also, auxiliaries might mistakenly mix up the labels for drugs that they draw into syringes. If a drug ordering mistake occurs, dental auxiliaries may not realize the difference between a new shipment of multiple-dose vials of ketamine labeled 100 mg/mL and the usual 10 mg/mL concentration that the office normally receives from the wholesaler. All that they may notice is that ketamine is in a new package. Other drugs that come in various concentrations such as midazolam (5 mg/mL and 1 mg/mL) and meperidine (100 mg/mL and 50 mg/mL) can mistakenly be drawn into mislabeled syringes and administered to patients, possibly causing significant harm. Drugs with look-alike labels and sound-alike names such as meto-

prolol, a beta antagonist, and metaproterenol, a beta agonist, can be mistakenly ordered, delivered, drawn into syringes, and administered when nonprofessionals handle these drugs. Physicians, dentists, nurses, and pharmacists, not auxiliaries who are given on-the-job training, are trained and licensed to properly handle medications.

Another way to limit employee access to controlled substances is for the dentist to never leave filled syringes or drug vials unattended in the operatory; rather, dentists should consider carrying them from room to room in a "fanny pack" or locking them in a small cabinet in each operatory until the injection is ready to be made. Accredited hospitals already have strict rules to help prevent drug theft, but private unaccredited offices without mandatory controls are highly vulnerable to drug theft and deception.

Who should have access to controlled substances in the dental office? The answer is simple: only licensed professionals and as few of them as is reasonable. That trusted chairside auxiliary who has worked in the office for 5 years could be the person to ruin your practice if he or she is a drug abuser. The cautious practitioner must be always be alert to the sometimes subtle signs of employee drug abuse and theft and must take appropriate measures to make the office drug systems theft-proof.

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