The Formation And Functioning Of Group Orthodontic Practice

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INTRODUCTION

Can you afford to be gone from your active practice for an extended vacation without neglecting the youngsters under your treatment? Is it conceivable that you could become ill for a considerable length of time and not jeopardize your practice? Have all possible accommodations been made for the patients to whom you are morally obligated in the event of your death? Suppose you live to that ripe old age of retirement; could you then afford it? Would the going value of the practice you may have spent the better part of your lifetime building realize a fair value upon disposal by yourself at retirement or by the representatives of your estate at your death; or would your practice, as is so common with most of us, be sold for the discounted value of the accounts receivable plus the value of the furniture and equipment, the latter being almost always nearly or fully depreciated? These questions confront all of us and, in this present day of high individual income, inheritance and estate taxes, the impact of an improper solution or no solution whatsoever may have a dire effect upon the beneficiaries of your estate. Blake[1] was certainly aware of this in his writing, "there are dentists who feels that a dental office with an extensive practice covering many years and earning a sizable income should represent a tangible asset after they are gone. Others know that, upon their death, other than the physical equipment and perhaps accounts receivable, the practice cannot be sold for it has no value. Many heirs have been shockingly disillusioned thereby."

Since orthodontics, in keeping with almost any field of medical or dental practice, encompasses so many personal relationships, it is, at best, difficult for the orthodontist to personally dispose of his practice; and its ultimate disposal, if left to a widow, more often than not presents insurmountable problems. In either event, it is necessary to obtain a qualified orthodontist who would not only be competent but conscientious as well in completing the unfinished cases.

Wouldn't it be a blessing if this weren't even a consideration with which to deal? In fact, wouldn't it be a panacea to orthodontists if all the above-mentioned eventualities could be dismissed entirely, knowing that your moral obligation to your patients, your future for your family, and your peace of mind have all become realities. While there is, of course, no hard and fast solution to all of those problems, I believe it is possible for many of us to solve a good portion of them through the practicing of orthodontics in groups. I base this statement upon four years of personal experience.

Stating his views regarding group orthodontic practice, Gibbens[4] states, "If orthodontic practice is to fulfill its responsibilities in full measure, then it must grow and develop from the limited one-man setup to a highly efficient, carefully coordinated unit capable of producing not only the highest quality of service but an increased availability of service in its respective community."

Garvin[3] editorializes his thoughts re-

garding group practice this way. "Dentistry has scarcely more than explored the potentialities of group practice, while medicine has made much progress in this direction. It has always seemed strange that there are so few partnerships among dental practioners. In dentistry, group practice is the ideal method of practice and the many advantages are worthy of careful study . . . . The star of group practice is rising rapidly."

In a recent publication by Foley, Crow and Halker[2] it was pointed out that, "We are practicing in an era of great technical progress. Dentistry has much to offer the public in health and happiness, but our production methods need to be modernized. Group practice offers both the patient and the dentist physical, financial and moral benefits."

In addition to the undeniable fact that more than one orthodontist is essential in forming such a functioning unit, important ingredients for a successful operation are compatibility, understanding, trust, confidence, devotion and, of course, similar basic concepts of orthodontic philosophies and treatment plans. Once these prerequisites have been accepted, the mechanics of a group practice can be undertaken. I shall be referring to our particular partnership entirely throughout, solely because of my firsthand experience with it, being cognizant, however, that other methods might prove as efficient.

Legal Documents

After seeking the advice of legal counsel and explaining our goals and/or objectives, which shall be taken up in detail later, it was suggested that the following legal instruments would be required: an Agreement of Sale, an Agreement of Partnership, and a Partnership Buy-and-Sell Agreement.

Agreement of Sale This instrument was drafted to equalize the existing practices and to adjust for and compensate the oldest partner who had the largest practice. A formula for arriving at this figure could, of course, vary among groups depending upon the circumstances. In our particular case, it was agreed that the fairest evaluation for all concerned could be attained by taking the following into consideration:

1) The relative value of equipment, supplies and furniture devoted to each of our separate practices. Since the amounts here involved were substantially equal, no problem was encountered.
2) The gross income realized by each of the three members during the previous year.
3) The amount of work under contract, but not yet completed, in each of the practices analyzed.

After studying the above factors, it was decided that the oldest member should be compensated for the largest amount of work being brought into the partnership. A closing date was set for the single proprietorships. All cash, accounts receivable covering work completed to the date of the formulation of the partnership, as well as all debts and encumbrances of each party, remained the separate property of each member. The amount of good will for the oldest member was agreed upon and accepted as salable to the younger men. All assets were contributed to the newly formed partnership and capital accounts were equalized as good will payments were received by the oldest member.

Partnership Agreement This instrument deals with the capital to be provided to initiate the group practice, a statement as to profit and loss acceptances, equalization of the drawing accounts on a monthly basis, management, duties and restrictions, retirement, and death.

It was agreed by the three partners

that they should devote their full time to the affairs of the partnership excepting any active duty with the armed services in which any one or all might become so engaged. It was also understood that if and when illness or disability might occur to any of the individuals, he would be covered by full monthly compensation for a period of three months. If the disability continued beyond this period, the partner so affected would then draw one-half the monthly partnership drawing for an additional nine months, totaling a compensation of one year's duration. In the event that the partner couldn't return to the practice after the year, the remaining partners have the right to purchase the interest of the disabled partner. Terms state that the affected member is bound to comply.

The next consideration was temporary leaves for purposes of vacationing or attending orthodontic seminars or scientific meetings. Vacationing is to be credited at the rate of one month per year per member as he chooses, either all in one month, two two-week interludes, weekly or even on a daily basis. At any rate, it goes without saying that a meeting of the minds took place to the extent that only one member should be vacationing at any given time. As to the meetings, it was decided that as nearly as possible these would be attended on a rotational basis. However, as meetings were not deducted from vacation time, it was conceded that if one partner did attend more meetings, over a period of several years, it would be equalized among all concerned. Of course, local or regional meetings are attended by all members.

After many enjoyable years of active practice, one month of vacationing each year, and compensation for illness for extended periods, one still must face the realization of aging. Hence, it was a logical next step that we consider the how's and wherefore's of retirement. It could be so effected by any member by giving written notice to the other partners six months in advance of his intended retirement. This, in effect, is a buffer, whereby the remaining partners might accumulate the necessary capital to buy the retiring member's share or allow it to be sold to another orthodontist in order to maintain the workload already established. Details are likewise set up to the extent of semiretirement of any of the partners. In later years, as the efficiency of the older man diminishes and/or his drive disappears, he need not be content with hobbies to the exclusion of orthodontic practice entirely. Rather, he may continue to practice as little as he desires, for the patient load can be adjusted among the actively practicing members to account for the limited practicing. This truly substantiates the premise of Rilkin[5] and associates who state, "Dentists faced with . . . . . an overburdening practice may seek relief in several ways. A partnership would afford several advantages including increased income, lighter workload and increased freedom, introduction of new methods and techniques, savings effected through decreased cost of maintenance."

Though grim, realism forces everyone to face the inevitability of death. This partnership, not being able to forestall or overcome this obstacle, simply combated it by provisions to be applied at the appropriate time. In the event of death, the benefactors of the deceased will receive one-third of the interest of the partnership, which would be the amount of his capital account plus or minus any credit or debit in his drawing account, to include also, however, a fixed valuation of good will. The valuation of the partnership is revised yearly by the members concerned.

Partnership Buy-and-Sell Agreement

In essence, this legal pact deals with

the procedural outline to be maintained in the event of the necessity of same, due to the death of any of the partners. Upon the death of a partner, it is mandatory that his heirs or estate sell to the surviving partners the deceased partner's interests. The net value of the partnership is determined yearly by the partners themselves and this becomes binding for a one-year period on any survivors of the deceased partner and is so drafted to be binding on the state and federal government for inheritance and estate tax purposes. To help provide all or a portion of the funds necessary to finance the obligations arising under this agreement, life insurance was procured. The life insurance program was set up whereby each partner owned the policies on the lives of the other two partners. The amount of insurance was again affixed according to the value placed on the partnership. It is provided, of course, that in the event the insurance policies exceed the net value of the partnership, only that amount stipulated as the true net value shall be paid to the decedent's estate.

Physical Plant

Having consummated the legal procedures whereby our three individual practices became one, the necessity for a physical plant became real. We secured the entire second floor of a small downtown building being renovated for medical and dental suites. It was constructed to our specifications and to the design we felt would be most functional to best utilize auxiliary personnel. Figure 1 depicts part of our reception room. The mural represents the legend of the Bridge of the Gods and Celilo Falls which are points of interest in our Pacific Northwest vacationland. Figure 2 represents one of the four identical operatories. Each operating room has two units composed of chair, pedestal receptacle, Angle-Wuerpel table, and

Fig. 1.

light. The hinged door beneath the sink conceals the soiled towels as they are placed through the door. Immediately above the sink is located a retractable viewbox large enough to place a cephalometric film for study or explanation to parents. When not in use it drops to the level of the countertop and the light switches off automatically. The portable engine is used in any of the operatories as needed. When not in use it is stored away from the chairs thereby allaying the fears of many junior patients due to its very presence. In Figure 3 is seen the tooth brush area. Both sides of the sink have identical pigeon holes which house the brushes of all our patients under treatment (note the reflection in the mirror

Fig. 2.

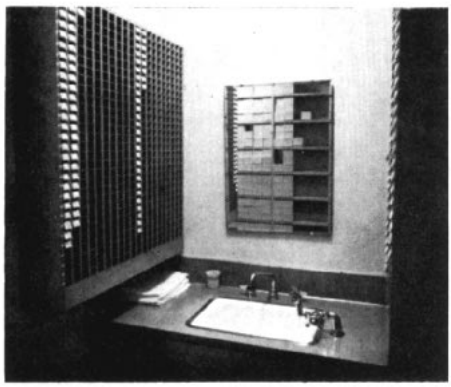

Fig. 3.

of the model boxes). This area serves a very functional and important part in our scheme of operation. Not depicted are the library where we hold consultations; the x-ray room where we have our own cephalostat holder, dental x-ray unit, the photographic set-up; the bookkeeping or reception area proper; the employee's lounge; or the areas where the models of the patients are stored. Per se, the area we occupy approaches 2400 square feet with every foot utilized to its capacity.

Handling of Patients

With a complete physical plant now ready, one practice for three men awaiting treatment, the next major consideration was the modus operandi. Just how should these patients be handled? Should each man have his own patients thereby resulting in individual practices once again with inequities in the patient load; or should it become a group project whereby every patient was treated by all the doctors? We chose the latter method and in less than one month we realized our course was the best one, both as to the service rendered and the acceptance it had with the patients and parents concerned.

For ease of understanding our procedures, let us follow one case from start to finish. The patient is referred to one of the doctors who makes the preliminary examination at the chair. If the patient is not ready for treatment, he is placed on our recall system for systematic periodic examinations. If full orthodontic treatment should be instigated at this time, another appointment is made for the patient to get all the records assembled that will be needed for a complete diagnosis and treatment plan. On this following appointment the patient is ushered into the room where the dental hygienist readies the patient for the impressions, calls the doctor to take the impression and gets a complete physical history. The x-ray technician then takes the cephalometric x-ray, the full mouth intraoral x-rays and the photographs. This procedure takes approximately one and one-half hours of which ten minutes is the doctor's time. The patient is dismissed and another appointment given for consultation with the parents and patient, once again with the same doctor.

After all models are trimmed and polished, the intraoral x-rays mounted, the cephalometric x-ray traced and measured using the Down's analysis, and the photographs developed, everything is in readiness for diagnosis and treatment planning. The three doctors study each and every record of the individual case, make individual diagnosis and treatment plans and then compare notes. If no difference is noted, another case with all its records is studied. This, I might add, is the exception. Usually, one of us thinks of a particular factor the others had not. It is then openly discussed among us. This provides a wonderful, built-in study club. Once the final decision is reached as to the treatment outline, it is dictated into the recording machine for placement on the individual's worksheet by the stenographer. Many times differences remain as to treatment pro-

cedures. In this event, the doctor originally consulted has the final say as to how this case shall be treated. Notations are made, however, about the various differences and periodically checked on as to the proper diagnosis, thereby furthering our study-club feature of diagnosis. Throughout treatment the patient's worksheet is constantly referred to, refreshing our minds as to the treatment plan and the objectives to be achieved.

When the appointed time arrives for the consultation, the parents are ushered into the library, not the operatory, to discuss the case with the doctor. He explains in detail, as is routine in most orthodontic offices, the reasons for the records, what they show us, and then the eventual solution to the problem. During the course of this appointment it is pointed out that the other two doctors will likewise be working on the child for they helped diagnose the case and are just as familiar with it. It is pointed out that some of the advantages for the patient, once the case is started, are that the doctors can consult regarding the case whenever necessary, a doctor can take a vacation, become ill, or even pass away, and yet they have the assurance of their child's case continuing to a successful completion. Admittedly, when this treatment method was first instigated, there was some hesitancy on the part of some patients or parents because they wanted just one particular doctor, not the other two. After pointing out the advantages of having the services of three, if they still insisted on the one, notations were made to that effect and the one operator attended that case exclusively. It is still the routine in our office that if this intent is made known by the patient, the referring dentist, or the parent, it shall be carried out to their liking as far as possible. We have proved beyond question that better service is given if all three share the work on each case and have found that less than five per cent of our new cases demand this individual attention.

In quoting the fee, likewise, it is commented that this is what we three have decided is fair and equitable. Of course, all professional offices are asked about discounts due to business associations, service club affiliations, friendships, relatives, etc. With our partnership it is extremely easy to reply with the summation that I would consider giving a reduction for the treatment but, truly, the other men are as involved and therefore it is not fair or just to them. This usually concludes any further dissertation along these lines. I don't mean to infer that considerations are never given. Circumstances dictate many adjustments and changes are certainly made; however, only after all three doctors concur.

Once this consultation is concluded and arrangements made as to extraction letters, various notations to dentist, financial arrangements with the bookkeeper, etc., the appointments are made for the patient to begin the orthodontic treatment.

Our appointment book has an additional column next to the name column on which is recorded the intended operative procedures for the patient on that appointment. When the patient appears for the appointment, he immediately reports to the receptionist. Whenever any of the three doctors is ready for a patient, his assistant talks with the receptionist on the telephone intercommunication system. The receptionist informs the assistant that she is sending in (patient's name) to pinch and cements bands on such and such teeth, change the arch, construct a headgear or whatever has been ordered. Now, as the patient walks into the operatory, the doctor has already been told who is entering and is not fumbling for the name but rather has a cheerful, "Hello (patient's name)." He

has been told the order for today was, for example, to pinch and cement the maxillary first molars and take an impression for a biteplate.

After the bands have been cemented and properly isolated to prevent moisture from seeping into the fresh cement, the patient is referred to the hygienist who will do the scaling of the excess cement and again make ready for the impression of the biteplate. Until the hygienist is ready for the doctor, he is free to proceed with another patient. Before dismissing the patient to the hygienist, the assistant writes the patient's name on an appointment slip with a notation of what the doctor intends for the next visit and gives it to the patient. When the patient's work is done for the day, he is told to take the appointment slip to the receptionist who fills in the date and time on it and likewise places the patient's name and work order in her appointment book. The work order, of course, determines the amount of time the receptionist allots for the next appointment.

Our methodology for starting the majority of our full-banded treatment cases has become standardized enough that for the first three or four appointments the doctor seeing the patient does the work ordered. Incidentally, the work done on each patient is recorded on his worksheet at the day's end and, during the course of the day, the assistant keeps a list of all patients and work done by each doctor.

Once most of the bands have been placed the original work ordered by one man is not always done. If the patient comes to me with the order to change the upper arch, yet I feel the lower is the one I'd like to change, reference is made to the worksheet noting the last recording as to what was done and by which doctor. It simply means calling the operator concerned, having a discusson to determine what his intent was or explaining why I prefer doing this arch instead. This, and I cannot overemphasize enough, has been one of the most valuable teaching methods we've uncovered. Invariably, one of us would have forgotten some one little thing that was picked up by another. This stimulates one's thinking and, of course, steers the treatment in the right direction at the greatest possible speed. The code we use to determine which doctor recorded the work involves colored ink. Each doctor has a different color, so by noting the color of the last recorded work on the patient's worksheet, it informs us which one ordered this particular procedure with which you disagree. Again, a marvelous built-in study club. Never in any of our individual practices did we take anywhere near the number of study models and progress headplates as we now do. Whenever any question comes up as to whether or not enough anchorage has been established, whether or not to retract the anterior teeth more or not, etc., these progress records are ordered and taken—again with the aid of the technician. Then further study by all three doctors and revamping of treatment plan is ordered if indicated.

Once the case has reached the stage of retention, the bands are removed after having been checked by at least two of the doctors, one of them being the one originally contacted by the patient. Impressions are taken for models on which to construct the retainers and final records made. This includes models, full mouth and cephalometric x-rays and the photographs. Retention appointments are handled as were the full treatment appointments, by any one of the three men.

The tooth brushing area, as was earlier stated, houses all brushes for the patients under treatment. These are given to the patient once the first archwire has been tied to place. They are instructed by the assistant as to the method of tooth brushing we prefer

while they are wearing the appliances. A pigeon hole is assigned to them and a brush placed within a plastic container is given to them. The routine has become established so that after the patient has informed the receptionist of his presence, he immediately goes to the tooth brush area and "gets them clean." Then he seats himself in the reception room and awaits his turn. If the teeth are unclean when he is seen by the doctor, a follow-up is made on this youngster's oral hygiene. We can determine if the patient understood the method explained, whether or not he is conscientious, etc. It certainly reduces the probability of food remaining attached to the appliances throughout treatment. Beyond question we are sure the teeth are properly brushed at least once every two or three weeks.

Personnel

The team that has made this orthodontic case progress as smoothly as possible is made up of three orthodontists, their dental assistants, the hygienist, x-ray technician, two laboratory technicians, a receptionist, and a clerk/bookkeeper. One other person is employed who is a "jack-of-all-trades." She is available throughout the office and can double in any of the capacities of the other employees. Anyone not available for the day's work has only to report by phone and the "floater" steps in. I might add that this person is a definite asset in the office. Gibbens[2] concurs by pointing out that "efficient auxiliary personnel are necessary adjuncts to the effective conduct of an orthodontic practice." This factor has also been recognized by the American College of Dentists whose Committee on Socio-Economics[6] has itemized as a problem for future attention and planning: "Improved dental practice administration methods should be promoted whereby dentists would make more use of auxiliary personnel."

The most recent addition to our staff has been a male office manager, who has been assigned the duty of correlating and maintaining a smooth organization functioning to capacity. Of course, this includes supervision of the personnel, the physical plant, supplies, etc. With our many employees, the personnel problems are by no means small tasks. In other words, he assumes the headaches of the business management of the practice—the doctors perform the orthodontics.

Certainly, any operation involving this many different people has many problems arising from time to time. As they do present themselves they are tackled, many times by the trial-and-error method, until a workable solution for our particular practice has been reached.

Disadvantages

In addition to these ever-present problems, let us reflect a moment on some of the distant disadvantages of a group practice:

1) Liability—not only does this include professional or on-premises but likewise extends to the personal life of each member. Automobile liability, property damage, etc. become a common concern.
2) Less personal contact with the individual patient. It could happen that you would see one particular patient only once in six months.
3) Especially easy to overexpand the patient load. With three men drawing for one practice, care must be exercised in the number of cases undertaken.
4) More off-duty hours consumed with staff meetings; conferences of the three doctors both with themselves and with the business manager.
5) Yielding to the majority regard-

ing policies of office management you may not especially like.

Summary and Conclusion

To counterbalance these disadvantages, let me recall in summary some of the advantages, much more weighty than the disadvantages to us in our group practice.

1) Vacations, illness, retirement, death are accounted for.
2) Increased income.*
3) Built-in study club, three heads instead of one.
4) Consultation on all cases.
5) More efficiency with aid of auxiliary personnel. A larger volume can be enjoyed without jeopardizing treatment.
6) Good will has become real — a tangible, salable asset.
7) Ability to keep abreast of any new orthodontic findings for all meetings can be attended by at least one of the three members.
8) Buying power:
   A) Quantity lots regarding supplies.
   B) Larger office space than could be afforded on an individual basis.
   C) Better utilization of auxiliary help.
9) Easy addition of another orthodontist to staff with this type practice.
10) Practice constantly growing. Good will doesn't dwindle with age and/or drive.

In concluson, a group orthodontic practice has a very important role to play in our modern-day society. It offers many challenges which take firm courage of your convictions to overcome, but it also offers the exhilarating reward of complete personal satisfaction. Working in unison as a team has led us to our common goal — professional service to our community, security for ourselves and our families, and peace of mind!

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*The 1954 Survey of Dental Practice conducted by the Bureau of Economic Research and Statistics of the American Dental Association reported that the solo practitioner had a mean net income of $10,725. The dentist who shared part of the costs of practice through various arrangements reported $11,039. The dentist who practiced in a complete partnership reported $14,876.

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