Partnership Orthodontic Practice

ELBERT W. KING, D.D.S., M.S.

INTRODUCTION

A partnership or a multiple doctor practice, such as a group practice or professional corporation employing two or more doctors, has many advantages. Often it can provide a better service to the patient, more efficient utilization of equipment, more effective use of auxiliaries, usually a better return on time spent in the office where the members can share responsibilities giving each more freedom from the cares of managing a practice. The multiple doctor orthodontic practice makes possible the premise of accomplishing treatment smoothly and well for the patient, conveniently for the parents, and efficiently for the orthodontist. However, when some men begin to consider the disadvantages and listen to the tales of woe of some who have found a partnership or a group type of practice unsuccessful, they give up the idea. Probably though, they do not forget it. My purpose now is to discuss a particular type of multiple doctor practice, a partnership. This will include some of the business and other aspects of our partnership arrangement and, hopefully, should provide information as to why this has worked well for us and an insight into how it might work for you.

With the advent of corporate practice, you may ask: Why a partnership? Why have you not incorporated? We have not for reasons peculiarly our own which would be another discussion in itself. Yet we presently function very much like a corporation.

Presented before the biennial meeting of the Edward H. Angle Society of Orthodontics, Seattle, Washington, August 1971.

REVIEW OF THE LITERATURE

Partnership practice has had little mention in the literature and, of that, all has not been favorable for it. Recently, Dewey[1] in answer to a question published in *Dental Economics* indicated a reluctance to recommend partnership practice. He mentioned particularly the liability of all in a partnership for the actions of one. In our experience this is not a problem. He favored doctors sharing space, some personnel and expenses. This is, in fact, the way a group practice functions. In the same issue of *Dental Economics*, Silverman and Berke[2] discussed group practice. The larger of these usually include men representing several specialties as well as general practitioners. In effect, that is nothing more than a number of individual practices sharing certain common facilities. In some groups one member subordinates his practice for an administrative role and receives some of his compensation from the group in the form of a salary.

In another publication Winter[3] classified the possible types of partnership practice, ours being a "specialty partnership" according to her classification. She gave a formula for a man buying into a practice as a partner. This will be discussed shortly.

Regarding the business of a partnership, it is important, as Rutledge[4] has said, to determine beforehand the type of practice that is desired and then to plan accordingly. The same is certainly true for the specialty of orthodontics. Is the practice to be a low volume-high fee type, catering to a limited socioeconomic group? Will it be a broader-based type of practice with lower fees and higher volume? Whatever of the

above develops, how will the business phase of the practice develop? How will it be managed?

Historical

Most men starting practice, and probably most of us here, did not envision the type of practice that each has today. Certainly we in our office did not. In fact, both Dr. A and I, when we started, did not even know the questions enumerated above, let alone any answers associated with them. Rather our concern was that of providing the best possible orthodontic service. We wanted to care for the patients efficiently and to conduct the practice in a business-like manner. The latter we accomplished on the basis of trial and error, with some reference to books, periodical references and a few brief, too brief, consultations with some of our more respected, successful friends and colleagues. We improvised and made do with limited business knowledge and little experience. The community in which we practiced dictated a middle of the road type of fee structure in which we hoped to cater to all who wanted treatment.

The following historical comments seem appropriate for perspective on how our practice evolved. It started when Dr. A returned to Albuquerque, his home town, late in 1948. As the only formally educated orthodontist in the area, he was overwhelmed from the start. About a year later, during a brief stop-over in Albuquerque, Dr. A persuaded me to return and help out with the numbers of patients that he could not begin to accommodate. I joined him in the winter of 1950.

At that time Dr. A had a backlog of patients that would have taken him well over a year to start in treatment. Subsequently, we had, collectively, a long waiting list. Our one assistant was overburdened and overwhelmed by the work in the treatment rooms and that which accumulated on her desk. With only two other orthodontists in town and two more statewide, the pressure on us was great, for the public had little choice. The perimeter of our drawing area beyond Albuquerque extended approximately half-way to Denver, Salt Lake City, San Bernardino, Phoenix, Tucson, El Paso, Lubbock and Amarillo. We had a job to do and necessity forced us to examine our circumstances relative to accomplishing more and still pay strict attention to quality control. In that type of circumstance began the evolution of our present practice.

Before long we added another assistant. We moved to larger quarters. We added a third assistant. With this began the first step in job classification, but we did not think of it in that way at that time. Actually, we used two employees as assistants, and one as a secretary-bookkeeper-receptionist. Soon we added two more people, a laboratory technician and a third assistant. Three years later, circumstances required another move to larger quarters. In another three years we expanded again. In 1960 Dr. C joined us. Our hope was that he would help ease the backlog that existed at that time. He did temporarily. Then he developed his own following of referral sources and patients. Three years later we again expanded our facilities. Through all of this, we were adding more people, a bookkeeper, a secretary, a full time receptionist, a hygienist, and the job classifications were expanding in number. So, too, were the complexities of management, paperwork, cost controls, accounting, and keeping track of many hundreds of patient and financial records.

By this time, 1966, the number of orthodontists in Albuquerque had tripled. The center of population had moved well east of us. We decided we should know more regarding the geo-

graphic distribution of our practice. Three of us obviously needed a fairly sizeable influx of patients to keep busy. The population shift in Albuquerque was continually northeastward. We were five miles to the west of the next nearest orthodontist and well west of the center of population.

A map with colored pins at the address of each active patient gave us the needed information. As we suspected, the geographic center of our drawing area was several miles east of our office, with many patients coming from well east of the easternmost of the other orthodontists. This circumstance led to an experimental opening of a second office four years ago. This was within a mile of the northeastern perimeter of Albuquerque's urban expansion. Our thought was that ultimately we might relocate farther east than our last location if circumstances so indicated.

The practice at the east office developed slowly but steadily, with only part-time staffing. In time it became apparent that we were committed to two locations. We had the facilities for four orthodontists with only three of us. Thus we invited Dr. D to join us which he did in July, 1969. A few months later we began to staff the east office full time. Three of us spend one day per week there and one of us two days. Now, with the four of us, we staff the two offices fully. That briefly covers history.

Professional Relations

What about the relationship of the men involved? When Dr. A and I started practice, we had a very loose but workable arrangement. We shared expenses equally. We really did not have a partnership, nor even an association. What existed was two separate practices within the same office with a sharing of expenses as in a group practice. This was a satisfactory arrangement in a new situation for both of us. The number of patients exceeded our ability to supply the demand of our service. Otherwise, we would have been in the position of competing with each other. We had nothing on paper regarding our relationship and, in our condition nothing was needed. We respected each other and regarded each other as being scrupulously honest. With this as a basis, such a relationship could only work well. Nevertheless, in retrospect, any association should have a written agreement. Such would help to prevent many potential misunderstandings.

The next phase in our practice was that of sharing expenses on a proportionate basis, i.e., we divided the expenses on the basis of our respective grosses. This meant that the amount each of us put into the office account each month varied with our respective gross incomes. While we were practicing in this way, I was advised by a prominent and well-known orthodontist, many years my senior, that this would not work. Well, it did for about ten years. The system did not necessitate a change; circumstances did, for we needed more help. Thus, as mentioned above, Dr. C joined us in 1960 as a preceptee. At this point we envisioned the formation of a three-man partnership on completion of his orthodontic education.

Prior to the completion of Dr. C's preceptorship, the three of us discussed the formation of the partnership and agreed that we should proceed. We sought legal and accounting advice. After several discussions with both accountant and attorney, our attorney prepared the agreement. It was based in part upon the procedure of partnerships in the legal profession and, of course, upon the needs of our particular type of practice and our collective requirements. It spelled out simply and

briefly our relationships, capital contributions, ownership, accounting, management, banking, division of profits, and selling arrangements should one of us be disabled, wish to withdraw or in case of death. To keep things up to date, our attorney recalls us annually for a partnership review. In the conference he covers many diverse subjects. Often this calls our attention to an overlooked detail of, for example, insurance coverage, employee relations, accounting or even personal relationships.

Over the past several years many men have asked us questions about our agreement, especially those contemplating an association or partnership. Interestingly, answers to the most asked questions do not appear in our agreement. Many of the queries were similar and fell into a few limited categories. They could be summarized as follows:

1. How do you adjust the monetary compensation for vacation time, sick leave, and meetings?
2. What if one man works faster than the other?
3. Who manages the office?
4. How do you divide the patients?

Most often we are asked the first and second questions about adjusting compensation for an extra hour more or less of work or the compensation for more or less production by one man. My answer to those questions often has been more short than informative: If you must worry about those details, forget it — a partnership is not for you.

However, to be specific regarding the financial adjustments for sick leave, vacations and meetings, we make none. As for differences in production, we make no adjustments for that either. We do take time off differently, produce differently and attend meetings differently. In that sentence, I suspect, is summarized the basis for more difficulties that arise in partnerships and associations than any other. We make no attempt to equalize for these differences and some others which do exist. If we adjusted for admitted inequities in production and time off, then how, for example, are we to compensate for a superbly written employee training manual by Dr. A or after hours' time spent by Dr. C modifying or adjusting a piece of equipment to some special need? Dr. D spends time in local society affairs and, as a hospital staff member, attends their meetings. Dr. C probably socializes with the other dentists more than Dr. A and I. Occasionally, I lecture or read a paper at meetings. Dr. D teaches from time to time. Each of us contributes in his own way to the name and prestige of the office. It would be difficult to equate such activities in terms of financial compensation. Our reasoning is that any attempt to make such adjustments can only lead to more and more adjustments, the specificity of which must ultimately result in nit picking. For example, I once read a partnership agreement that spelled out adjustments down to differences of fifteen minutes worked in a given month. Reflect a moment on all the other possible adjustments, such as coffee breaks, rest room trips, or even a nonpractice telephone call. What a waste should we attempt to watch each other that closely, let alone the actuality or equivalent of a time clock.

What many overlook in trying to equalize the above are the efficiencies of a group. We avoid many unnecessary duplications of space and equipment. For example, the same laboratory space serves four as well as one. We have the ability to employ more specialized people with higher degrees of competence. Each of us enjoys a better income and more time off than would be possible if we practiced separately. The added benefit of the group is

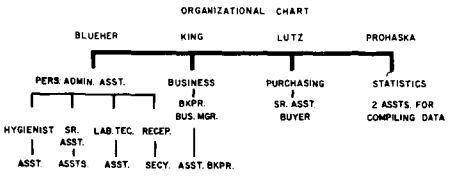

Fig. 1 Organizational chart of the practice.

greater to each of us than any inequities due to differences in time off or production. The cumulative advantages of participating in a partnership in terms of income and free time exceed the sum of what would be if each of us were in separate practices. Add to that the advantages of greater convenience, fewer management responsibilities, the sharing of on-call duties, the immeasurable benefit of immediate consultations on any difficult or unusual problem and the possible adjustments mentioned above pale by comparison.

Internal Management Organization

Each of us contributes to the practice in other ways that do not permit measurement in time or money but seem to suit our particular talents, temperaments and interests. So, in answer to the question, who manages the practice: it is by the partners, each serving in a specific role. An organizational chart appears in Figure 1. Dr. A manages personnel, a discussion of which is an entity apart from this paper. Among other things he sits as chairman of our salary review board. His management of personnel sometimes includes the role of father confessor which he does admirably, to which Dr. C or Dr. D might aspire, and in which role I would flop. Most of the actual management of personnel he delegates to our administrative assistant.

Dr. C supervises purchasing and all items pertaining to the physical plant. This, too, is a separate discussion. The actual buying is done by the senior assistant who answers to Dr. C. What we buy and how we buy it is up to the discretion of Dr. C and his assistant. For major purchases we decide upon the need for a particular item in a partnership meeting but leave the price and brand to Dr. C's decision.

Dr. D handles the statistical information for the practice. In doing this he keeps a number of charts that provide us information regarding various aspects of the practice such as gross, net, certain percentages, the flow of patients into and out of the practice, and the source of our referrals.

I manage the financial aspects of the practice and obviously do the least work since I do not know how to keep books but, fortunately, the bookkeeper does. The day-to-day details of that phase of management are open to my discretion. Major decisions we air in our partnership meetings.

We consider these monthly partnership meetings a necessity for good management as well as important to keep open the lines of communication between the partners. At these meetings we review the minutes of our previous meeting and our profit and loss statement of the previous month. We always have a number of problems to discuss with decisions to be made. We take notes for dictating the minutes the next day. Our bookkeeper and administrative assistant attend these meetings in an advisory capacity.

Distribution of Patients

Regarding the distribution of the patients in our practice, this usually occurs in one of two ways. A parent requests a specific doctor, and this we arrange accordingly. More often than not, parents call the office for an appointment. The receptionist arranges this with the doctor with the first available time. Sometimes at the time of

consultation with parents regarding treatment, we will arrange the starting appointments and treatment with another of the partners if he can start the patient sooner.

Apparently, an unusual aspect of our practice as a multiple doctor arrangement relates to the continuity of doctor-patient relationship. We feel strongly that one of us should establish early a rapport with the patient and parents and continue this throughout treatment and observation. Experience over and over again revealed that a better acquaintanceship between the family and the doctor contributed to improved communications. This often led to better patient cooperation with faster and better treatment results. Furthermore, we derive pleasure and satisfaction from a closer rapport with the people that we serve. Admittedly, this approach is less efficient than the type of practice in which the patient takes so-called "potluck" on doctors at each visit. We say this with no criticism of the many who do otherwise. It is simply our chosen way with both its personal assets and economic liabilities.

Economics

Income from the practice and all professional income from whatever source belongs to the partnership. This includes income from the treatment of patients in the office, hospital calls, emergencies outside of office hours, honoraria, and consultative fees. The partnership pays all bills of the practice and of the partners whenever serving in a professional capacity and the salaries of all employees. All, including the partners, draw salaries on the fifteenth and thirtieth of the month. Dr. A, Dr. C and I own equal shares in the partnership and share equal salaries and bonuses. Dr. D owns a lesser share now, but in progressive increments he will own an equal share with us and share equally in the profits.

Usually we determine quarterly the amount that we shall draw semimonthly. This amount is calculated to be less than the anticipated net income for each month of the quarter. We do this to maintain adequate working capital in the partnership account at all times and a level salary for each of us. In adopting this salary procedure, we can anticipate a pay check in the same amount twice a month. The fluctuations in income that occur in individual practice no longer exist even though the production of one or the other of us may vary within the period covered. At the end of each quarter we usually receive an additional bonus distribution drawn down to our required minimum bank balance.

As an organization increases in size so should its income, its outgo and financial responsibilities. We require a continuous flow of new patients to sustain the practice. We need information on this and many other details of our practice. This involves a number of statistical records from which we construct graphs to follow our progress or lack of it. They cover gross, net, overhead, salaries as a per cent of gross, new patients, treatment starts, total treatment patients, etc.

The graphing of these data supplies meaningful information for the conduct of our group. For example, we might become concerned that in a given month the number of new patients might fall. The chart in Figure 2 tells us that in certain months of every year we see fewer new patients than in others. From year to year the performance is highly repetitive with some annual increments of growth. The recent economic slowdown is reflected in our statistical data on new patients. If the number of new patients should begin to fall off, these records could help us to anticipate and prepare for impending difficulties.

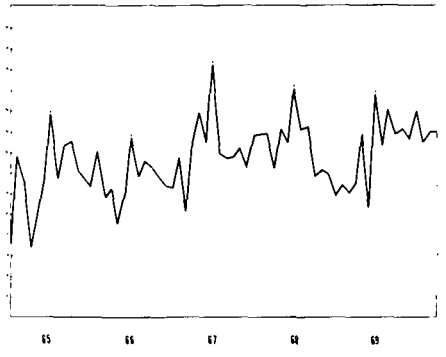

Fig. 2 Graphic representation of the number of new patients arriving into the practice month by month from 1965 through 1969. The high peaks in the graph indicated by dots, represent the month of August. The relatively lower points on the graph indicated by dots are for the month of April.

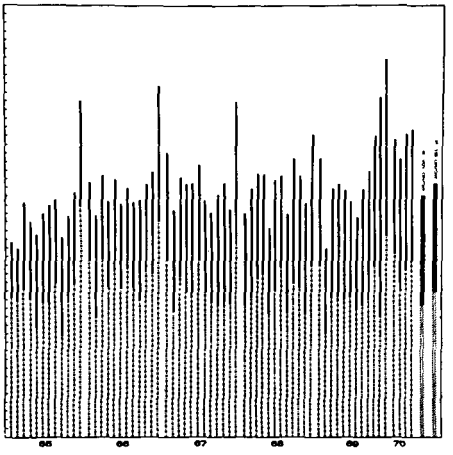

Fig. 3 A bar graph showing the income of the office for the years 1965 through the first four months of 1970. The absolute values have been purposely omitted. In each bar, the lower striated portion represents net income and the solid portion the overhead. The gross income of the practice was always high in December.

The two wider bars to the right in the illustration show a comparison between similar practices economically and ours. The data for the first of the two bars were derived from the American Dental Association 1968 Survey of Dental Practice IX. The second bar represents the same type of data from our practice for 1968. Most of the data from the ADA and our practice were similar except that our salary costs relative to gross were three to five percentage points higher. Laboratory costs were less by approximately the same amount.

The income from the practice fluctuates almost as much from month to month as the flow of new patients. For example, December income, as shown in Figure 3, always exceeds the monthly average by approximately twenty-five percent. January follows a close second. The month-to-month arrival of new patients into the office and the income of the office bear little relationship to each other. August and September usually record the annual highs for new patients in that order.

A comparison of our practice and practices with similar grosses according to the American Dental Association 1968 Survey of Dental Practice IX[6] shows both similarities and differences. For example, on a percentage basis our overhead is a couple of points lower at forty per cent, compared with the ADA statistic of approximately forty-five per cent. Our percentage of salaries to gross is higher, at about twenty per cent compared with seventeen per cent for the ADA survey. However, we include the salaries of our laboratory people in our figure and carry as a separate item only expenses for laboratory supplies. Thus our laboratory expense is significantly less and our salary figure would be increased. Rent, supplies, insurance and most other items are reasonably comparable.

Schulman, in 1970,[5] held that the most profitable type of orthodontic practice was the large, one-man practice. He noted that a participating partner rarely ever surpasses the net achieved by the busy single practitioner. He stated that one-man practices net sixty to seventy-five per cent of gross. Partnerships range from fifty to sixty-five per cent. Ours nets approximately sixty per cent. However, Shulman did not mention time spent in the office. Casual observation with-

out supporting data would lead me to suspect that men in partnerships spend less time in the office than solo practitioners. This circumstace would tend to make the overhead percentage somewhat higher because more duties are delegated and less time is spent in administrative duties.

Percentages can be deceiving. Many years ago Dr. A and I worked long hours with a very busy practice; our net was seventy-five per cent. A few years later our net was just over fifty per cent, but our take home pay was much greater. A third partner increased the percentage of net to fifty-five per cent. Recently, our fourth partner contributed further improvement to a net of approximately sixty per cent. Nevertheless, the true measure of effectiveness is the actual take home pay of the partners. For example, is it better to increase the gross of the office by a factor of ten per cent and have the net at a high seventy-five per cent or by twenty per cent and have the net at a low fifty per cent?

Adding a Partner

When a practitioner or partnership decides to add a partner, how does a new man buy into the practice? Winter[3] in her discussion described one formula as follows: To arrive at the value of the practice: evaluate the physical assets of the office, leasehold improvements, supplies, etc., and add to that one-half of the average net for the last three years. For example, if the physical assets amounted to $20,000 and the average net was $25,000 then the $20,000 plus one half of the $25,000 would equal $32,500. A one-half interest in the practice would amount to $16,250.

On the advice of counsel and the accountant our approach has been different. It is as follows: First, a prospective partner works on a salary for one to three years, then he becomes a partner in graduated increments until his share is equal to that of the others in the office. To determine his contribution we inventory all of the physical assets of the office and add to that the accounts receivable less a five per cent depreciation factor. This gives us the net worth of the office. If three partners own the practice and a fourth joins, it would work out in this way. Let us assume that the physical assets of the office amount to $100,000. The depreciated accounts receivable are $50,000. The net worth therefore is $150,000. According to the agreed upon plan the new man will contribute twelve per cent to the capitalization of the office for a twelve per cent share in the partnership. He will then receive twelve per cent of the proceeds of the practice in salary and bonuses. In succeeding years he will add four, three, three, and three per cent to the capitalization for a twenty-five per cent interest. At each successive increment he will receive a salary in proportion to his percentage interest. To arrive at the contribution figure we divide the net worth of $150,000 by eighty-eight, which is the percentage amount remaining after turning over twelve per cent to the new member. That gives us the value of one per cent. We then multiply that one per cent by twelve to arrive at the contribution he will make to the capital account of the office.

No figure is included for good will. Rather the new partner actually produces more than he draws at first with his minority interest and in this way he compensates the original partners for the intangibles of the practice.

Why increase the capitalization of the practice instead of buying an interest? Taxes. All partners can then withdraw their proportionate share of the excess capital in the capital account tax free. This represents a return of

capital, not income. The day of tax reckoning will not come until a partner sells his interest.

Social Relationships

Each of us has his own circle of friends with some overlap. From time to time, but relatively infrequently, we and our respective spouses are together socially. We are all good friends and I suspect we are so because the primary and principal relationship between us is the professional business of the partnership.

Our respective wives come to the office on relatively rare occasions. They do not participate in any of the business of the office — only the proceeds.

Our social relationships are not even mentioned in our partnership agreement. However, I suspect that the very aloofness from the offices of our respective wives is a great contribution by them to the success of our partnership.

Conclusion

Over the past years we feel that our experience justifies partnership practice for us. We have enjoyed an adequate income with sufficient time for continuing education, meetings and vacations. We have had the advantage of close association with others in our specialty for the exchange of ideas and consultation in regard to patients. Four of us share responsibilities that one alone would have in solo practice but, because there are four, we can collectively do more than one in the area of management. We have enjoyed these advantages with more freedom from the cares of managing a practice. We would hold the opinion that partnership, group or corporate practice is the wave of the future for all of dentistry. On the basis of our experience we can recommend it to others as a very pleasant and rewarding way to practice.

801 Encino Place, N.E.
Albuquerque, New Mexico
87102

Bibliography

1. Dewey, Lawrence C.: Practice Administration Clinic. Dental Economics, June 1971, page 34.
2. Silverman, Sherman A., and Berke, Frederick A.: The Anatomy of a Group Practice. Dental Economics, June 1971, pages 20-24.
3. Winter, Lois: Pick the Partnership that Fits. Dental Management, March 1971, pages 71-78.
4. Rutledge, C. E., and Winsor, E. H.: The Dental Business Office. Philadelphia, 1956, Lea and Febiger.
5. Schulman, Martin L.: Knowing Your Practice. Journal of Clinical Orthodontics, 4:516-522, 1970.
6. 1968 Survey of Dental Practice IX. Some Characteristics of Dental Practice According to Level of Gross Receipts of ADA. September 1969, pages 689-692.