Second Edition

Business Basics for Dentists

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WILEY Blackwell

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SECOND EDITION

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Preface

Surveys of new dental practitioners consistently rate practice management as the area where they were least prepared and found the most problems in practice. Dental schools do an excellent job of preparing graduates to handle dentistry's technical and patient treatment aspects. However, they do a less than excellent job preparing graduates to run a dental practice.

This problem comes from several sources. Most students do not enter dental school with a business background. They have taken scientific-based courses to prepare them for the rigorous dental curriculum and have not taken a business class in their predental curriculum. Many students have never had a dental-related job in the private sector. They depend on the professional mentoring of the faculty to prepare them for the world of dental practice.

Students are concerned with the immediate needs of learning dentistry, completing clinical requirements, and passing licensing exams – and that is where their efforts should go to their most immediate and pressing needs. They cannot run a successful dental practice until they graduate from dental school and earn a dental license.

National boards have tested students on fundamental scientific and clinical knowledge for years, not on how to operate a successful practice. Because many dental schools teach, in part, to prepare their students to pass these boards, curriculum time and faculty efforts are heavily weighted toward preparing students for this important milestone.

The economic environment of dental practice is changing rapidly, and educators have not kept up. In years past, if the new graduate knew dental techniques and treated their patients well, practice success was virtually assured. Today, new practitioners face a bewildering array of insurance plans, consumerism, corporate practices, large student debt payments, and regulatory requirements. In the face of this uncertain future, graduates want additional information to help them compete effectively in the new reality.

This book is primarily for dental students about to graduate, new graduates (in both private practice and other clinical settings), and recent graduates who have been out of school for five years or less. It is not written for well-established dentists who have practiced for 20 years, although they may find pearls to apply in their practices. Instead, the essential business information that new practitioners can apply in their practice situation to compete effectively is presented. It is not intended to be specific management advice for every management problem – readers should consult with accountants, management consultants, or mentors about specific problems – but if the issues can be understood, then the dentist will communicate more effectively with advisors and will understand and implement solutions and advice more effectively.

A dental practice is a small business that responds to business concepts and rules like any other small business. The only difference is that dentists sell dental services, not hardware, clothing, electronics, or automobiles. So it is essential to understand a business principle and then apply it to dental practices. In this way, a practitioner in New York City or Mayfield, Kentucky, can use the same business principle in different-looking practices.

The numbers given as examples or illustrations represent the United States as a whole. Some areas, especially large urban areas, have higher costs and fees than other small towns and rural areas. For example, typical wage rates for hygienists in large urban areas are currently $60 per hour; in many small to mid-sized towns, rates for hygienists are $35 per hour. Likewise, the fees charged are also generally higher in those urban areas. Therefore, the numbers shown may not represent a practice situation exactly, but the business concept behind the example is valid regardless of the practice area.

This book surveys the topics of operating a dental practice. As such, it is only an introduction to each of the topics. For example, although several pages are devoted to the methods of valuing a dental practice, experts have written entire manuals and even entire books on this subject alone. Other excellent texts, websites, and how-to manuals cover this book's topics. For example, the American Dental Association produces an excellent series of books that cover practice transitions, regulatory compliance, and many other management topics in a level of detail that cannot be put into one book. This book is only a starting place for studying management in the office.

This second edition has added more information about career planning. We have found that fewer graduates are directly entering private dental practice. As the practice world moves to more network practices, new graduates find more professional opportunities in those networks. Many use them as a stepping stone to an eventual private situation; others use them as a lifelong career option. Either way, the graduate still needs the information presented here to be a more effective employee.

We intend this book to be a text and a reference book. If the reader is a student, they may be required to read specific chapters to pass a test or course. A practitioner who has a problem with staff interactions in the office may pick up the book and read the chapter on how to motivate employees. Either way, the intention is to understand how business people think about problems and develop specific solutions to management problems. We hope that you find the information helpful in that regard.

JAMES L. HARRISON

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Career Planning

SECTION 1

Career development is becoming more critical for dental graduates in today's economic climate. Many students leave dental school with hundreds of thousands of dollars of student debt. Not only does the graduate need immediate income to make student loan payments, but the significant debt levels may also hinder their ability to secure loans at favorable rates. The increase in corporate and franchise practices provides immediate employment opportunities and increases competition in the local marketplace for start-up practices. Solo practitioners, who face increased competition as well, are often reluctant to take on an associate in the traditional role of owner and mentor. The complex dental insurance world makes practices less profitable than in the past, leading to further cash-flow problems for young practitioners.

Because of these economic constraints, graduates need to plan their career development. In the past, the simple answer was to "set up my practice." The plan may involve working in a corporate practice for several years to increase clinical and management skills or working in a public health setting to gain some student loan relief and build clinical skills. Most graduates still aim to practice ownership (solo or group), but now they must take an often-winding road to reach their goal. This section provides a way to plan a career in clinical dentistry. (In this book, we do not look at opportunities in industry or academia, only the various clinical practice opportunities.)

There are two general categories of income generation for new dentists. First, they can work for someone else (get a job). This option allows immediate income generation, but does not always provide long-term professional security. They can find employment with a private practicing owner-dentist as an associate dentist, with a Dental Management Service Organization (DMSO) as an employee dentist, or with the government through the public health or military systems. The second option is to own all or part of a practice. This option provides long-term security, but is often expensive and risky to establish. Here the graduate can buy an existing practice (buy-out), start a practice from scratch (cold start), or buy into an existing practice (buy-in) in a partnership arrangement. This section of the book examines each of these possibilities.

CONCERNS OF THE CAREER DEVELOPMENT PROCESS

The career planning process is concerned with three major concerns:

- **Establishing short- and long-term career goals**
  Everyone has a personal long-term career goal, and each of us takes a different path to reach those goals. Our short-term goals contribute to achieving our long-term career goals, and personal wants, needs, desires, and circumstances affect our career goals.

- **Understanding the difference between employment and ownership positions**
  Employment and practice ownership are two different concerns, and each has advantages and disadvantages that become decisive factors in career planning.

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- **Planning for career transitions**
  As professionals move through their careers, they must be sure that the transitions from one phase to the next are well planned. Otherwise, they may have made early decisions that either support or decrease the likelihood of making the next step in the plan a success.

OBJECTIVES OF THE CAREER DEVELOPMENT PROCESS

Given these three main concerns, we group the career development process's objectives into this section's major chapters. The issues that dentists should examine in their career planning process include the following:

- **Chapter 1: Career Planning**
  Everyone needs to examine their personal wants, needs, desires, and abilities when developing a comprehensive career plan. They also must make a realistic appraisal of opportunities and roadblocks that affect the process.

- **Chapter 2: Employment Opportunities**
  Many new graduates will enter directly into employment situations, whether in private practice (associateship), corporate, or government situations. To be successful, they must understand the nature of employment and the advantages of each type of employment position. They may use these situations as stepping stones to fulfillment of their long-term goal.

- **Chapter 3: Practice Ownership**
  An ownership position (either solo or in a group) has an entirely different purpose from an employment position. The owner is trying not only to make an income from the practice, but also to build personal wealth by increasing the value of the practice. These are generally "destination"-type opportunities, and most owners plan to be in their practice for their careers.

- **Chapter 4: Practice Transitions**
  Practice transitions involve changing employment or ownership positions, which may include starting a new practice, buying out an existing practice, or buying into an existing one. How a person goes about the process has important implications for financing and planning.

- **Chapter 5: Valuing Practices**
  If someone purchases all or part of a practice, they need to set a value so that they can borrow money to pay for the practice without placing a significant burden on the practice's cash flow. Therefore, the buyer needs to achieve a value that is consistent with business norms and will enable them to pay off the practice acquisition loan promptly.

- **Chapter 6: Securing Financing**
  When someone locates a practice to purchase and has a reasonable value associated with it, they need to find a lender who will lend them the money required for the purchase. Terms may differ for different lenders, and understanding these differences can help borrowers decide and negotiate an advantageous financing package.

Career Planning

CHAPTER 1

Don't confuse having a career with having a life.

Hillary Clinton

GOAL

This chapter aims to describe specific career planning decision points and processes.

LEARNING OBJECTIVES

After the completion of this chapter, the student will be able to:

- Describe the characteristics of dental practice as a career.
- Define professional options available to the new dental graduate.
- Describe career choice points that affect the career path.
- Describe personal and professional factors that affect the location decision.

KEY TERMS

career decision points career path

Dentists have many professional options to use their skills and training. Some involve ownership, while others are employee situations. In this book, we only discuss practice-related options. The opportunities include:

- Employment
  - Private sector
    - Private associateship (non-owner)
    - Corporate employee (non-owner)
    - Industrial research
    - Corporate support
  - Public sector
    - Military/Veterans Affairs
    - Public health patient care settings
    - Dental education
- Ownership
  - Private solo practice (owner)
  - Private group practice (owner)

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CHARACTERISTICS OF DENTAL PRACTICES

Dental practices are unlike many other service businesses. Most dentists are still in individual practices, with few colleagues with whom to confer. They must personally deliver the service, which involves hard physical work. They cannot delegate most procedures and must be personally present for the procedures that they do delegate. This means there is little managerial leverage, so the dentist cannot play golf while the office operates. There is no managerial progress. Someone cannot work their way up the management line to become a regional manager or vice president. Most new graduates come to the workplace with high educational debt and must include that in their practice debt finance plan. Dentists' earnings typically peak at 45–50 years of age. After that, the physical nature of the work causes them to decrease the number of patient visits. Often dentists then look to add associates or plan to sell their practices. The question is whether to sell at the peak of the income-generating potential (and therefore at the highest price) or to "milk the cow" and take income from the practice as they continue to slow down.

COMMON MYTHS ABOUT DENTISTRY

There are several misconceptions about dentistry that will influence career choices.

DENTISTRY IS EASY MONEY

Many people outside the profession view dentistry as an easy way to make a lot of money. Although dentistry is still one of the more lucrative professions, those in the profession know it is not easy to make money. Dentistry is physically demanding work. Dentists often work long hours in contorted positions to make patients comfortable. Back and neck problems, repetitive motion injuries, and eye strain are common problems of seasoned dental practitioners. Dentistry is also emotionally demanding work. Many patients fear dental procedures or have unrealistic expectations about their desired outcomes. Staff members may have personal problems or interpersonal disagreements that affect the work environment.

A DENTIST MAKES MORE MONEY OWNING A PRACTICE

Dentists *might* make more money if they own their practice. Practice ownership requires knowledge, skills, and abilities that not all dentists have. Additionally, owner–dentists need to spend time and emotional energy to operate the business side of effective practice. Not all dentists want to do this. Some are excellent clinicians but do not want the extra problems of ownership. They want to treat patients, not worry if the hygienist and assistant have interpersonal problems or fret about the changes in a local employer's dental insurance plan. These dentists are best off working for someone else, letting the owners worry about the management of the practice. They can make more money treating patients if they work with someone good at managing a practice or a network of practices. Someone who is excellent clinically, behaviorally, and managerially and loves all aspects of running a practice can make more money owning it.

BIGGER IS BETTER

Many dentists believe that a bigger practice is better. Personal wants, needs, and desires might lead someone to a smaller, more personal practice better suited to their temperament. A larger practice is not necessarily a more lucrative practice. Profits come from using the practice's resources to the maximum amount possible, regardless of size. A small practice can be as profitable as a large one. However, an extensive, well-run practice does have some advantages if the owner has the managerial expertise to make this larger and more complex business entity use all its resources effectively. A larger practice might show a higher profit if well run. A bigger practice may weather economic downturns more easily. When sold, larger, more profitable practices bring a higher price, although sometimes finding a buyer for these large practices is difficult.

STUDENT DEBT MAKES IT IMPOSSIBLE FOR A DENTIST TO BORROW MONEY TO BUY A PRACTICE

Dental graduates are carrying higher levels of student debt than before. Changes in the student loan programs have made it more difficult to consolidate these loans at low interest rates. Tax law changes have limited the amount of student loan interest graduates can deduct. Nevertheless, dentistry is still one of the higher-income professions. Banks and other lenders who make start-up and buy-out loans to dentists understand these problems. They will work with dentists to develop loan packages if the practice can support the cash flow needed to pay all expenses, including student loans. Not all practices will be profitable enough at a price that can support the cash flow required to make all the payments, however. This can result from the practice price being set too high, high overhead in practice, or the financial

characteristics of the potential buyer. A graduate who does not have a high loan burden or who has a spouse who earns a significant income may show cash-flow needs that are much lower. This dentist may qualify to borrow for a practice purchase when someone else would not.

PUBLIC HEALTH IS FOR DENTISTS WHO CANNOT MAKE IT IN PRIVATE PRACTICE

It has become part of the professional culture that "good" dentistry is exquisitely done (expensive) reconstructive dentistry. True, dentists in the public care sector may not do much complex reconstructive dentistry because the organization's purpose is to provide more basic services to a larger clientele. This does not make dentistry or the dentist's application of their hard-earned skills of less quality or less critical. The public sector provides valuable services to a large segment of the population. Many dentists find satisfying and rewarding careers by devoting their skills to this style of practice.

A DENTIST DOES NOT HAVE TO TAKE INSURANCE PLANS IN PRACTICE

If a dentist is in a private ownership position, they make all the management decisions. Long-term, insurance-free practice is the goal of many practitioners. However, most do not get there. It takes a combination of location, clientele, management, clinical expertise, and time to develop a practice that does not participate in dental insurance plans. Someone may take plans in the short term with the aim to wean off them as they build a private clientele. As the economic environment and insurance industry change, more practices find the need to participate in insurance plans.

A DENTIST WILL BE IN THE SAME OFFICE THEIR ENTIRE CAREER

This used to be more accurate than it is today. In the past, the graduate would open or buy a practice and then build it over the years, and they would be in an ownership position immediately after graduation. New graduates today may work in several professional situations before arriving at their final practice setting. With the increasing number of employment opportunities, many dentists never reach an ownership situation, choosing to do clinical work in non-ownership positions for their entire careers. The old notion that private practice is the only good form of dentistry is dying out.

CAREER PATHS

Dentists now talk about career paths in which they have an ultimate, long-term goal but may take several steps to reach it. Short-term goals then support long-term goals. Each step in the short term should support the long-term intention. For example, the traditional path would be to finish dental school, go directly into a pediatric dentistry residency, and then open a practice. A new graduate who has high student debt may take a different career path. In this path, someone may graduate and join a public health practice that offers loan forgiveness. They can build speed and confidence while working with young patients in the clinical setting. They then attend residency and join a group pedodontic practice. Career paths are different for everyone depending on their circumstance. Graduates with an immediate family member who has a career in dentistry or other healthcare profession are at an advantage. They generally have a deeper understanding of a healthcare career and often have a built-in entry into a practice situation. Graduates with a history of working in private industry or government use that knowledge to their advantage.

Each person makes career path decisions based on their situation at the time of the decision. Specific decision points direct and influence decisions. These include the following.

THE DESIRE FOR INCOME

If someone desires a high income (as opposed to an adequate income), then a long-term plan should include a private practice ownership option. Specialist dentists' incomes are higher than generalists'. Short-term options might include associateships or military practice to build skills and knowledge while someone pays down debt and accumulates assets. If a high income does not drive a person's professional needs, other desires can be driving forces.

DEBT LOAD

If a dentist has a small or no student debt at graduation, then they are in the fortunate position of being able to take on debt for a practice purchase or personal needs. Heavy student debt may limit practice options to those showing excellent cash flow. Short term, a graduate might need to practice in an associateship or corporate practice for several years to pay down debt, or find a public health practice that includes loan payment or forgiveness.

THE DESIRE TO BE THE BOSS

Most dental students claim to want to "be their own boss," but when they face the reality of the debt load, managing the business, and the extra time necessary, many decide that the trade-offs are not worth it. Part of the old culture of the profession was that the ultimate form of professional effort was a private individual practice, and that notion has

changed. Currently, many corporate and public practices use the entirety of someone's professional skill, care, and expertise without practice ownership. If someone is fiercely independent and wants to make or break it on their skills, then private practice is the place.

THE DESIRE TO LIVE IN DIFFERENT LOCATIONS

Some people enjoy the idea of moving and living in different places. Others know where they want to settle and live the rest of their lives. If someone fits into the first group, then practice ownership is a problem. Practice ownership is a long-term commitment, and it takes many years to fully recover the investment (time and financial) that someone makes when establishing a practice. They may not find a willing buyer for a practice when they want to sell it or have licensing problems in a new location. Network practices, the military, and public health practices are all more conducive to moving to different areas and experiencing different cultures.

THE DESIRE FOR PERSONAL OR FAMILY TIME

Some people love dentistry and would do it 24 hours a day if they could. Others enjoy time away from the office for personal or family activities. Some like to take time every week, while others prefer to take periodic time off for travel or other similar activities. Where a person falls on this continuum is also essential in helping to decide career points. It is not easy to take much time off in an individual ownership position and maintain a high income. Patients want work done, staff members want to get paid, and income stops when the dentist is not there. They can set their hours and take time during the week, but taking many extended blocks is more of a problem. It is easier to take time in a group practice where others can cover for a dentist and share costs. The easiest way to take blocks of time is to work in an employment situation with guaranteed time off (such as military or public health). Often, people in this situation will work more hours during the week but will have the flexibility of blocks of vacation time.

OTHER DECISION POINTS

There are many other career decision points. If someone enjoys doing research, they obviously will be in a situation in industry or academia where they can do this activity, and where someone wants to live influences the path as well. If a dentist wants to live in a specific rural area, the only option may be private ownership. Some people prefer working in an organization with many other people; some prefer working alone.

LOCATION DECISIONS

Regardless of the specific career option, the dentist's first decision is where they want to live. Several factors contribute to this decision.

PROFESSIONAL FACTORS

The single most important professional factor is the dentist--to-population ratio. This ratio describes the number of dentists to treat a given population in the area. It is an indicator of the potential viability of a dental practice. It is usually expressed as a ratio such as "1 : 2300," which says that there is one dentist for every 2300 people in the service area. There may be a need to modify the ratio because it is a general number. The dentist should check that the ratio represents the area in which they are interested. (The numbers may be for the entire county or part of an urban area.) Moreover, the ratio includes both specialists and generalists. If the dentist is a generalist, they probably want to take the specialists in the area out of the equation. The ratio also includes a simple count of all licensed dentists. This includes retired, part-time, and non-practicing dentists. If the dentist can, they should play with the numbers to arrive at the number of full-time equivalent (FTE) generalists per population. (Someone who practices half-time represents 0.5 FTE dentists.)

Healthy ratios are generally between 1 : 1800 and 1 : 2500. The military has traditionally believed that one dentist can treat 800 soldiers (but the military has 100% utilization). Higher-income areas tolerate lower ratios as people buy more dental services. Rural areas traditionally have a lower utilization rate than urban areas. A ratio of 1 : 2500 or 1 : 3000 may be required in these areas to suggest enough patients. The dentist can get these ratios from the American Dental Association (ADA), which has several publications that summarize economic factors for dentists across the country. In smaller communities, the graduate can get a phone book and talk to people in the area. The dentist can probably develop an accurate ratio with information from the local chamber of commerce.

The number and type of other dentists in the area are deciding factors. The potential practitioner should feel comfortable with the professional community they will work within, the local dental society, and civic organizations. They should also be sure there are adequate specialists for referral

and consider staff availability. A new practitioner may need to train staff, or there may be training programs nearby.

PERSONAL FACTORS

Personal desires are probably the most important practice location decision. The dentist should decide where they want to live and move there. If they are not personally satisfied, then even excellent professional opportunities will not compensate for their lack of personal fulfillment. The dental practitioner should also consider their aspirations, career, and life plans. They should decide their preferred lifestyle. Each person has preferences for climate, culture, and recreational opportunities. Some want a rural lifestyle where hunting, fishing, and hiking opportunities abound. Others would not live anywhere that does not have an entire arts community and excellent country clubs. Everyone must reconcile their preferred practice pattern with their preferred personal style. They may want a crown and bridge–style practice but prefer a remote rural location. The two might not be compatible. Therefore, everyone must be realistic in their assessments.

The next most significant factor in dentists' general location decisions is spouse and family desires. Where someone wants to go is only part of the lifestyle decision, and if they are married the spouse is generally involved in the decision process. A professional or working spouse needs personal growth opportunities as much as the dentist does.

ECONOMIC FACTORS

Once someone has decided on one or several general areas to live in, they should then look at the area's economy. As a service provider, a dentist depends on other businesses to provide employment so that people have money and insurance to afford dental care.

The dentist should examine the economic base of the area. They should find out the sources of income for people in the area. Primary industries, such as mining, farming, and manufacturing, bring money into the local economy. (Each primary industrial dollar circulates eight times in a local economy before dissipating.) From there, the money flows to the secondary industries that support the primary industries, such as construction and retail stores. Tertiary industries, such as dentistry, provide services to the employees of other industries. The dentist should look for broad-based primary industries in the selected location. Several industries in a town provide a strong economy. The dentist should be prepared for a boom-and-bust economy if the area has a single primary industry (such as one large manufacturing plant or a mining-based economy). Everyone has money when the mines (or other primary industries) are busy. If the mines shut down, miners do not buy shoes or build houses, and construction workers and sales people do not go to the dentist. In contrast, a well-diversified primary industrial base can absorb an individual sector shutdown without leading to a general economic collapse.

Several indicators help to gauge the economic health of a community. Most patients consider dental care a deferrable expense rather than a medical necessity. As such, it is highly dependent on disposable income. (Disposable, or discretionary, income is what is left over after people have paid for necessities, such as food, housing, and clothing.) Higher disposable incomes generally mean a better dental economic location. Economic growth in an area means that people's incomes are growing and more people are moving into the area. These people will need a dentist. High-growth areas are also good locations. Some areas have a high turnover rate (people move frequently), while others are more stable. It is easier to establish a practice in an area with a high turnover than to break into a stable area where most people already have a dental provider. However, in the high turnover area, the practitioner will need to continually grow the practice as patients they previously attracted leave through the revolving door.

There are many places to find this information. A call to the local chamber of commerce is an excellent place to start. The chamber's job is to encourage commerce in the area. They already have much information about the potential town. Census data is helpful for comparisons. The problem with census data is that it is usually old by the time a person can get to it. Many states have state data banks that the dentist can call to find the information needed. Additionally, much of this information is readily available on the Internet.

PROFESSIONAL HISTORY

The dentist's professional history may limit their options or allow a particular option to be realistic.

DEBT LOAD

A person's debt load (especially student debt) influences whether an option is acceptable. Bankers have regulators and overseeing committees they must satisfy. If the dentist has so much debt that they are at risk of not being able to make the regular payments on some of their loans, the bank may not loan additional money for a practice.

PRODUCTION HISTORY

The practitioner must show that they can handle the volume of a practice that leads to adequate profit and cash flow. If someone is looking at a practice that needs to generate $900 000 annually to meet projections, the practitioner must show that they can do that much dentistry. Suppose they had previously been an associate generating $800 000 annually or in an Advanced Education in General Dentistry (AEGD) or military practice where they generated significant production. In that case, a lender could infer that they could reasonably handle the practice, but not so with a new graduate who was busy treating two patients daily.

PRACTICE CHARACTERISTICS

The characteristics of the practice the dentist is considering establishing or purchasing influence the viability of the option. If a practice has a large contingent of discounted insurance plan patients, the dentist will have to produce even higher amounts of dentistry to see adequate cash flow through the practice. Lower levels of discounted insurance participation lead to higher margins, but less dentistry is being done. In these practice opportunities, the dentist must have a marketing plan to generate the private-pay patients required for profitability.

CASH-FLOW PROJECTIONS

These factors all come together in the cash-flow projection. Suppose the practitioner can show through a realistic cash-flow projection that they can service the practice debt, generate an income to live on (including personal debt payments), and pay taxes. In that case, the practice option is viable, and if not, then it is not a viable option at this point.

CAREER PLANNING PATHWAYS

Given these decision factors, we provide the career pathway flowchart in Figure 1.1 as a helpful way to think about career paths. We discuss each option in more detail in later chapters of this section.

The first and most crucial task for any dental student is to finish dental school. Until a person does this, no other career decision has any meaning. That is not to say that they should wait until graduation to begin making these plans. Some dental students cannot see that there is a life after dental school with no fixed curriculum, where everyone makes the same choices. For these reasons, we discuss making decisions after graduation, but not waiting until after graduation to make the decisions.

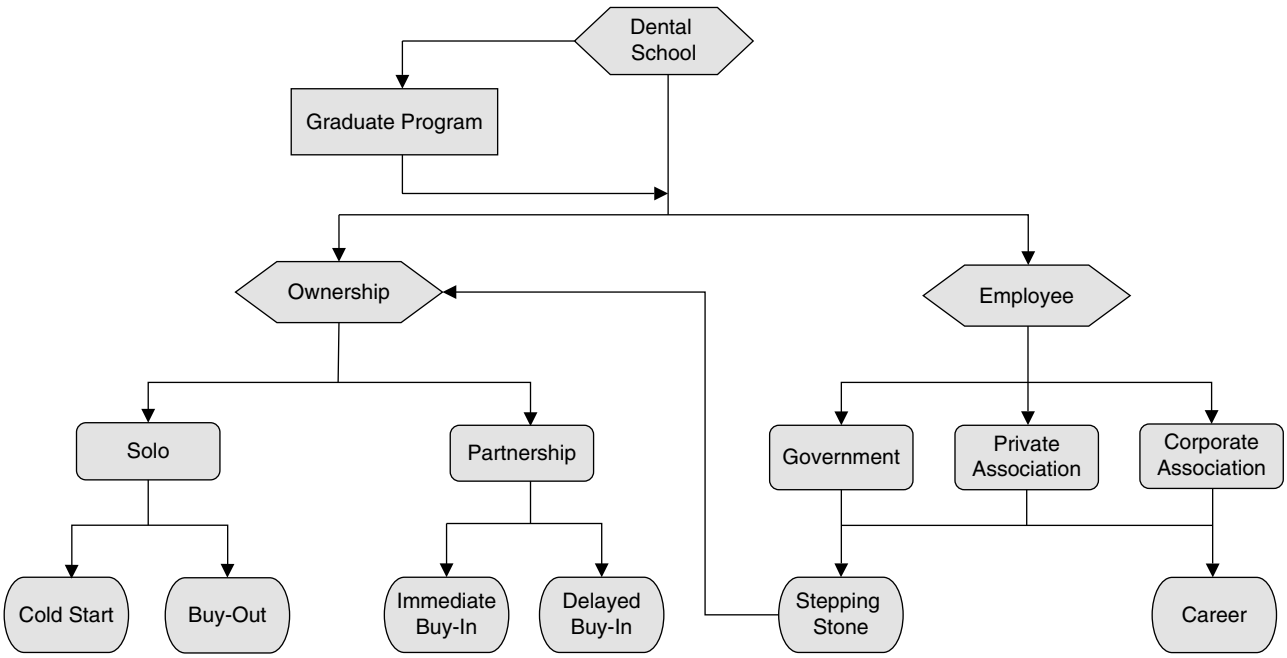

FIGURE 1.1 Career pathway flowchart for dental graduates.

GRADUATE TRAINING

The initial decision point after graduation is whether to pursue graduate training or move directly to a practice option. Graduate training may take the form of additional general training or specialty training. Regardless, this only delays the career decision for several years.

Advanced Training in General Dentistry

There are two options for general dentistry training after dental school: AEGD and general practice residencies (GPRs). AEGD programs focus primarily on dental treatment. They generally occur in a dental school environment and are the halfway point between dental students and practicing dentists. If someone feels they need time to become a more competent technical dentist before going into practice, an AEGD may benefit them. AEGDs usually do not require participants to be on call, and the dentist will not get the same level of medical/hospital experience as they might in a GPR. GPR programs are frequently held in medical facilities. These programs concentrate on dentistry as it relates to whole-body medicine. As such, participating dentists are included in medical rotations, sometimes functioning almost as overflow physicians at some time in the program. Like being a physician, most require participants to have on-call shifts. Because GPRs do not focus exclusively on dentistry, participants gain a wide variety of exposure and experiences. These experiences are beneficial for those considering oral surgery and emergency care specialties.

Specialty Training

A dental specialty is an area of dentistry that the ADA has formally recognized through its National Commission on Recognition of Dental Specialties. Currently, there are 12 dental specialties recognized by the National Commission. This commission sets standards for recognition and policy guidelines for its Boards and Organizations. They all require the completion of an advanced education program. These are:

- Dental Public Health
- Endodontics
- Oral and Maxillofacial Pathology
- Oral and Maxillofacial Radiology
- Oral and Maxillofacial Surgery
- Orthodontics and Dentofacial Orthopedics
- Pediatric Dentistry
- Periodontics
- Prosthodontics
- Dental Anesthesiology
- Oral Medicine
- Orofacial Pain

The graduate needs to research the specialty they are considering. Dental specialties have associations where professionals can meet, network, and discuss their work. If someone is interested in a dental specialty, there are few better places to look than the corresponding professional association. They should spend time shadowing and talking to mentors about the specialty to ensure it fits their desires and interests. This can also give insight into the daily life of a specialist. Internships/externships are usually done in an academic or hospital setting. This offers insight into a typical day in residency and often goes more in depth into the different treatments and procedures.

Graduates should consider the economic effect the delay will have on starting their careers. Most specialty programs do not pay residents, and most practitioners must pay tuition to attend. (Hospital-based residencies, such as a GPR or oral and maxillofacial surgery, generally pay a modest stipend.) So, income will be lost for two to four years while the graduate completes the program. However, this may be offset by the higher income levels many specialty practitioners earn.

EMPLOYEE OR OWNER POSITION

The next central decision point is whether to become an immediate owner of a practice or to work as an employee, long or short term. This may be a decision that is made for the graduate. As already described, there may not be a purchase opportunity, or the graduate may not be in a financial or experience position to own a practice. Many graduates use employment (government, private, or corporate) as a stepping stone, building clinical and managerial skills while paying down debt and building financial assets. After several years, they may be in a better financial position and purchase a whole or part interest in a practice. Others may use the employment situation as a career option. When someone is in an ownership position, they may loop back to an employee situation by selling their practice, often to a corporate entity, and working for that corporation.

Employment Opportunities

CHAPTER 2

A *man's got to know his limitations*.

Harry Callahan, *Magnum Force*

GOAL

The goal of this chapter is to describe common issues in employment situations for dentists.

LEARNING OBJECTIVES

At the completion of this chapter, the student will be able to:

- Describe standard methods of compensation for dentists.
- Describe standard associate-owner arrangements in dentistry.
- Differentiate between an employee and an independent contractor.
- Describe the advantages and disadvantages of working as an associate in private practice.
- Describe the advantages and disadvantages of working for a corporate practice.

KEY TERMS

arbitration
associateship
associateship contract
BSA (business service agreement)
buy or sell provision
career benefits
claims-made policy
commission
DGP (dental group practice)
direct pay
dispute resolution
DMSO (dental management service organization)
draw against future earnings
employee benefits
employee dentist
employee insurances
employee status
employment contract
government employment
incidents of ownership
independent contractor
mediation
military
non-competition agreement
non-disclosure agreement
non-solicitation provision
paid time off
percentage of collections
percentage of production
public health
restrictive covenant
salary
tail coverage
termination for cause
total compensation
variable commission
wage

Business Basics for Dentists, Second Edition. James L. Harrison, David O. Willis, and Charles K. Thieman.

Many new dental graduates take employment positions initially out of dental school. This may be to hone clinical skills, pay down debt or build assets, improve practice management knowledge, or because they do not want the involvement of practice ownership. Regardless of the reason, the critical point about employment is that the dentist is there to make money for the employer, whether a private practitioner, network practice, or governmental organization. If the dentist does not make money for the employer, they will not be there long. The dentist should understand that employee positions are not about them but about the organization. The dentist is valuable so long as they contribute to what the organization does.

GOVERNMENT EMPLOYMENT

MILITARY

One option for employment is to become a dentist in the Armed Forces. The US Army, Navy, and Air Force all recruit dentists to serve as commissioned officers in their Dental Corps. Both active duty and reserve components recruit dentists with a US dental degree and a license to practice dentistry. Students may also be eligible for special programs covering tuition and providing a monthly wage while in dental school. Graduates will serve in the military as dentists for a set time, depending on the program.

Dental Corps members are responsible for the dental health of military personnel and their family members. Many dentists are stationed stateside in the medical clinics of military bases, and others are assigned tours of duty at US military bases worldwide. Responsibilities may include the emergency medical treatment of service members in deployed places near combat or participating in humanitarian missions in the United States and overseas.

As a military member, a dentist will be eligible for all the benefits and privileges that any other service member enjoys (Box 2.1). Military dentists work at modern dental facilities, use modern technology, spend quality time with patients, and maintain a flexible schedule. Additional bonuses and retention incentives are available to dentists.

The Health Professions Scholarship Program (HPSP) is a program that a dental student can apply for that will pay for three years at an American Dental Association–accredited program (DMD/DDS). This scholarship covers tuition, books, equipment, supplies, and a monthly stipend (income). Since the military pays for schooling, it requires a minimum four-year commitment to military service upon graduation.

BOX 2.1 CURRENT EMPLOYEE BENEFITS OF MILITARY DENTISTS

- Medical, dental, and life insurance
- Substantial retirement plans
- Housing allowances
- 30 days paid vacation each year
- Signing bonus
- Health professions loan repayment
- Special pay incentives
- Advanced training opportunities
- Dental officer retention bonus

The military reserve Dental Corps employs dentists in the armed services. Some reservists are former active-duty service members, and others have only served in the reserve Corps. There are several scholarship and loan forgiveness programs for Corps participants. Reservists can maintain active employment in the civilian world, using the reserves as part-time employment. The reserve dentist should remember that they can be called to active duty at any time and with very short notice. This might be a problem, especially for a dentist who owns a solo private practice.

PUBLIC HEALTH

The uniformed dental officers of the United States Public Health Service Commissioned Corps serve in the Indian Health Service, the United States Coast Guard, the Federal Bureau of Prisons, and the National Health Service Corps. The Commissioned Corps is governed by the Surgeon General and falls under the Department of Health and Human Services rather than the Department of Defense. Even though the Commissioned Corps is not an armed service, officers may be called to assist in public health response to man-made and natural disasters. Officers enjoy the same benefits as their military counterparts.

The Health Resources and Service Administration (HRSA) operates Federally Qualified Health Centers in many areas of the United States. These are community-based healthcare providers that offer primary care services in underserved areas, both urban and rural. Examples of Federally Qualified Health Centers include Community

Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing. There are strict guidelines they must follow to qualify as a health center. Many include dentistry in their services and have loan repayment and scholarship programs for participants through the National Health Service Corps (NHSC).

Some state and local governments provide dental services for their citizens. They often target these programs at specific high-need groups, such as homeless populations or underserved geographic areas. There is tremendous variation in the expectations and compensation in these programs. Some of these employment opportunities for dentists are full-time, while others rely on part-time area practitioners. Some offer full benefit packages; others use independent contact dentists. Many new practitioners use these opportunities to supplement their income as they build a practice.

PRIVATE PRACTICE/ASSOCIATE ARRANGEMENTS

An associateship occurs when one dentist (generally a junior dentist) works for another dentist (generally the senior dentist) who owns the practice. The essential characteristic of this arrangement is that the practitioners are not equal. One controls the workplace or the work of the other. The owner–dentist may take any form of business (proprietorship, partnership, LLC, or corporation). The non-owner dentist may have one of two types of status. They may be an employee of the practice or have an independent practice within the owner–dentist's practice (independent contractor arrangement).

Many associateships are part-time. The owner–dentist knows they have more patients than they can see, but they do not have enough patients to keep two dentists fully busy. In these cases, the new dentist often works in a second associateship or salaried position when they are not at the primary office. They must ensure they do not violate restrictive covenants or other agreements in the primary office.

There are several common scenarios of owner–dentists seeking associates. Regardless of the specific scenario, the best associateships are where the owner can provide an adequate patient pool to keep the employee busy.

- **The owner–dentist has many "extra" patients and office capacity (space and staff)**
  This scenario is the best for both parties. The owner–dentist can refer new patients to the associate. The office has unused capacity, so the associate adds few additional costs.
- **The owner–dentist has one or more unused operatory for the associate**
  The key to this scenario succeeding is an adequate patient base for the owner to share with the new associate. That means the owner–dentist must be as busy as they want, with excess patient flow.
- **The owner–dentist is not busy and wants the associate to help share costs**
  This common situation leads to many problems, often resulting in the two practitioners competing against each other for the patient base. If the owner–dentist is not busy, they need to increase their patient base through marketing or other methods rather than trying to decrease costs through engaging an associate.
- **The associate can use the office when the owner is not there**
  This scenario works for the new dentist to build a patient base, and it works well if the new dentist wants to continue to work the "off" hours (evenings and weekends). Once the new dentist establishes a patient base, then they look for a new office (or establish an office) to work more reasonable hours. The owner–dentist often provides space and materials, and the associate generally provides staff.
- **The owner has a second office for the new dentist to work in**
  The owner may have established or purchased an office in a nearby location or town. They want someone to work the practice, often with potential buy-in opportunities. There is not much mentoring in these situations; each dentist (owner and employee) is busy working in their respective offices. These are usually good opportunities to do a large volume of dentistry under the management tutelage of a senior dentist.
- **The owner provides primary care or managed care patients for the associate**
  In some associateships, the owner–dentist gives the associate all the excess discounted insurance patients or assigns the associate to do all the primary care, with the owner doing the advanced (and costly) complex restorative care. The only way these scenarios work is if the owner pays a salary to the associate. If the associate's compensation is based on production or collections, they may find insufficient profit in these situations to adequately fund the associate's lifestyle.

OWNERSHIP

A true associateship arrangement involves a senior owner–dentist and an employee dentist. This can take one of two forms.

Employer/Employee

One form of associateship is the pure employer–employee relationship, in which the associate is a professional employee of the practice (proprietorship, partnership, LLC, or corporate). As an employee, the associate participates in office benefit plans like other employees. The practice withholds income taxes and matches Social Security taxes the same as other employees. The owner is in clear control of the situation. A restrictive covenant (covenant not to compete) is common in employee situations. (Note: the effectiveness of these restrictive covenants varies by state.)

Independent Contractor

The second type of relationship is called an "independent contractor." In this arrangement, the associate dentist contracts independently for the owner–dentist. Several advantages exist for the owner–dentist in this arrangement. Because the associate is independently employed, they are a proprietorship and file their own Schedule C. The owner does not pay matching Federal Income Contributions Act (FICA) tax and pays no unemployment tax on the associate. The owner does not withhold income taxes. Instead, the associate estimates and files quarterly like any other proprietorship. The associate does not participate in any office retirement plan or benefit plans offered to other employees. The downside for the owner–dentist is that a restrictive covenant is virtually non-enforceable in an independent contractor arrangement. By definition, if the associate is *independent,* they can work for any dentist (or for themselves) where and when they see fit. If the associate leaves the practice, they are ethically and legally obligated to inform patients so that the patients can receive continued care. Otherwise, this may put the associate in the position of being forced to abandon the patient. (The owner can have a non-solicitation clause for employees and patients not under the care of the associate.)

Many owner–dentists want to have the best of both situations. They want to avoid the tax consequences of the additional employee, but they also want the advantage of a restrictive covenant; they need to choose one or the other. The Internal Revenue Service (IRS) has several guidelines for determining whether a relationship is an employee–employer or independent contractor relationship. Box 2.2 shows that most dental associateships are employer–employee relationships, and the only true independent contractor relationships are space- and time-sharing arrangements.

BOX 2.2 CHARACTERISTICS OF AN INDEPENDENT CONTRACTOR

- Worker personally delivers the service
- There is a continued (ongoing) relationship
- Worker must work on employer's premises
- Worker uses employer's equipment or materials
- Owner controls employees (hiring, firing, and paying)
- Worker cannot work at other locations
- Worker cannot suffer a loss

COSTS

Most associateship arrangements result in increased costs for the owner. The owner must hire additional clinical assisting staff for the employee practitioner. The number of front office staff often needs to expand significantly if they offset hours so that the junior dentist is in the office for hours when the owner is not. Office space may even need to increase. The new dentist is usually not as productive as the owner–dentist, leading to decreased relative revenues. Often the owner–dentist spends time with the new dentist that they formerly spent seeing patients, decreasing income further. For all these reasons, associateships typically lead to decreased income for the owner–dentist for the first year. By the second year, however, the younger dentist's production should increase and cash flow should improve enough that the owner–dentist can see some profit from the arrangement.

The practice typically pays costs for the associate with a couple of exceptions. (This varies by geographic area.) Before applying the percentage, the owner generally deducts the lab bill and extraordinary costs (such as implant parts) from the production (or collection) amount. This results in sharing these costs on a percentage equal to the percentage income split. (Box 2.3 gives an example of lab bill allocation.) Direct professional costs (such as malpractice insurance and continuing education expenses) are paid by either owner or associate, and the owner usually pays other costs (supplies, staff, etc.).

BOX 2.3 EXAMPLE ASSOCIATESHIP FINANCIAL ARRANGEMENT

	Associate pays (1)		Owner pays (2)		Split, off the top (3)	
	Associate	Owner	Associate	Owner	Associate	Owner
Fee		$1000		$1000		$1000
Lab (3)						$200
						$800
Split	$350	$650	$350	$650	$280	$520
Overhead costs		$300		$300		$300
Lab (1, 2)	$200			$200		
Net	$150	$350	$350	$150	$280	$220

Assumptions: $1000 procedure, $200 lab bill, 65/35 split, and $300 overhead costs.
There are three scenarios:

1. Associate pays the lab bill after the split.
2. Owner pays the lab bill after the split.
3. The lab bill is subtracted from the gross ("off the top") before the split.

ADVANTAGES

There are many advantages to associateships for both the owner and junior dentist. The associateship can act as a trial period before a partnership or buy-in. This gives both sides a chance to decide if they are compatible enough to establish a long-term professional relationship. The junior dentist invests a minimum amount of money. These people often have high educational debt loads and probably cannot borrow enough money for a practice purchase or start-up. If they require expansion, the owner–dentist has the financial resources to afford it. There should be few ego conflicts since there is a delineated hierarchy. Associateships should be excellent learning opportunities. The senior dentist can learn new techniques and materials from the new graduate. The associate learns practice management, patient interaction skills, and clinical efficiency in practice. Due to economies of scale, the now larger practice may afford equipment and personnel that would not be profitable or feasible in a smaller practice. If the associateship leads to buy-in or buy-out, the owner sells, and the associate buys the practice at the peak of its income-generating potential.

DISADVANTAGES

Associateships have no incidents of ownership for the associate. It is a job, pure and simple, not a co-ownership arrangement. Associates often believe they have "helped build the practice," increasing its value through their efforts. They believe the owner should give them some consideration in compensation or a buy-in valuation. On the other side, owners contend that they have paid a good wage for the associate's work. The associate has no more claim on the increased value of the practice than does a hygienist or assistant. This conundrum has led to more than one associate buy-in offer failing to complete. The answer lies in communication and openness from the beginning.

Associateships face many of the same difficulties as other group practices. With more than one dentist in the office, staff can become disoriented, unsure who to go to for what problem. There are more management problems for the owner because the practice is now larger. These occur in accounting, staffing, and scheduling issues. Often owners see a drop in income for the first year of an associateship. This is due to increased expenses, the extra time required to help the associate (fewer patients seen), and a possible decrease in the patient pool as they share the patient pool with the associate.

Most associateships (80–90%) end without forming a partnership. When they end, many associates find that a restrictive covenant they signed as part of the employment agreement excludes them from a particular area. An associate should be sure that if they cannot live by the restrictive covenant, they do not sign it. (This may mean that they do not begin the associateship.) This problem is especially acute in associateships that have lasted for several years.

When there is no real buy-in, the restrictive covenant forces the associate to uproot from the area, though they have established ties in the community and want to stay.

WORKING FOR CORPORATE NETWORK PRACTICES

Rather than have one practice with 50 dental practitioners, networks of practices may have 50 locations, each with one practitioner. In these, the owners attempt to gain the savings of large groups but retain the intimate nature of the individual practice. There are two common forms of organization. One is a dental group practice (DGP), where non-dentists own the practices. The other is a dental management service organization (DMSO), in which the parent company owns most of the practice's assets and provides support services under a strict contract. State laws regarding ownership of professional practices play a large part in which form is common in each state.

Corporate networks claim to be more efficient than individual practitioners. Much of this comes from their size, which allows them to negotiate volume discounts that the small, individual practitioner cannot. The networks negotiate lower costs (volume discounts) for dental supplies and office products. They often establish a corporate laboratory or negotiate volume discounts with existing dental labs. Their knowledgeable background ensures they negotiate favorable leases and find better locations for new practices. They develop competitive staff compensation packages that are market driven but not too generous. The parent company can also negotiate higher reimbursement from third-party carriers (insurers). If they control a large share of the dental marketplace, they may threaten to leave the insurer's network of providers if they do not increase reimbursements for their practices.

OWNERSHIP

A common form of ownership is a DGP in which the parent organization owns the individual practices directly. Here, the dentist is an employee of the parent corporation. The parent corporation (DGP) compensates the individual dentist for the dentistry that they do. Supply and demand determine the pay scale. The DGP pays what it must pay to get enough skilled dental providers. Often the parent will provide significant employee benefits as part of the total compensation package. Some DGPs allow more senior dentists to buy an ownership interest in the parent through employee stock ownership programs (ESOPs) or other forms of ownership involvement. They often offer these through a retirement plan or bonus options. Some DGPs have a co-ownership arrangement with the individual practitioner. The parent organization may own a controlling portion (say 51%) of the practice and the practitioner may own the remainder. When the practitioner leaves or retires, there is a ready buyer for the practice.

A DMSO is an arrangement common in states requiring dentists to own dental practices. Here, the parent company owns most of the tangible assets of the practice (e.g. dental equipment and the building). Depending on state law, the dentist continues to own the intangible assets. The DMSO then has a contract (business service agreement, BSA) with the dentist or professional corporation to provide management and other services for the dental practice. These services often include purchasing or leasing office space and equipment, scheduling, billing patients, filing insurance claims, hiring employees, marketing the practice, and managing bank accounts for the practice. The Professional Corporation (PC) owns the patient records and provides all professionally licensed services (i.e. patient care as defined in the practice of dentistry in each individual state). The PCs often must be owned by a licensed dentist or a dentist licensed in that state. The contracts often have strict buy-out and restrictive covenants that make it difficult and expensive for the dentist to leave the practice and compete directly with the former DMSO. These arrangements vary by state depending on the individual state's laws.

The ownership structures can get quite complex, and several investors can own the DMSO. The investors can be internal, usually founding owners. They might be investors from the outside – generally from private equity groups. The investor with the greatest percentage of equity or stock ownership owns the majority control of the DMSO. The minority investors have input into the company's operation, but the controlling interest determines the final say/control. Most private equity investments in DSOs are majority ownership, although some DSOs are funded by private equity investment taking a minority position. Many evolving DMSOs are founder owned. However, growth and the need for capital to fund it lead to outside investment and the help of a private equity relationship.

COMPENSATION

Dentists often earn a percentage of production or collections in corporate network arrangements. If production is the basis of compensation, then net production (production minus adjustments) is often used, especially in areas where a large portion of the dental market includes managed care (reduced payment) plans. Supply and demand in the area determine the specific percentage. The parent company often offers employee benefits (such as health insurance,

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