

Top Ten Reasons Why Many Associateships Fail to Result in Practice Purchase

While the “American Dream” continues to be owning your own home, the new “Dentist’s Dream” continues to be owning a practice. This concept is supported by the fact that approximately eighty percent of American dentists continue to operate as solo practitioners owning their own practice. The norm thirty years ago was to graduate from dental school, buy equipment, hang out a shingle with the practice name and start practicing. Today the road to ownership is a little different.

Due to extensive debt upon graduation, most new graduates today enter practice as associates. While many graduates immediately enter GPR’s or the Armed Services, upon completion of these obligations, the outcome is still the same. They enter private practice. As associates, they have the opportunity to improve their clinical skills, increase their speed and proficiency, and learn more about the business aspects of the profession they have entered. For most, they hope the newfound associateship will lead to an eventual ownership position. Instead, many find themselves building up the value of their host doctor’s practice, only to be forced to leave and relocate. This relocation is a result of enforcement of their non-compete agreement when the promised buy-in/buy-out didn’t occur.

Sometimes understanding why something fails and avoiding situations leading to failure is the best route to achieving the desired goal. This article looks at the most common reasons many associateships fail to result in ownership or partnership and provides a checklist designed to improve the chances of a successful outcome.

Reason One:

If the purchase price has not been determined prior to the commencement of employment, the parties find themselves on different ends of the spectrum as to what the practice is worth and what the buy-in price should be. The number one reason that after working in a practice for a one-to-three-year period of time the promised buy-in/buy-out does not occur is that the parties did not determine what the purchase price would be before the employment began.

The senior doctor expects that the practice will be valued at its current value. The recent graduate expects to receive credit for the increased production and profitability they have provided during the period of employment. Subsequently, they feel they are being asked to pay for their own sweat equity that has contributed to an increased practice value.

If the purchase price was established prior to the commencement of employment, three out of four associateships

lead to the intended equity position. Conversely, if the purchase price has not been determined, nine out of ten associateships lead to termination without achieving the ownership intended or promised.

Reason Two:

The second most common problem is that the details of the buy-in have not been agreed to in writing prior to or immediately after employment. The more items discussed and agreed to in writing beforehand, the better the chance of a successful equity ownership occurring as planned. The often used “if we like each other, we’ll work out the details later” never works.

The written instruments should be two specific documents, an Employment Agreement detailing the responsibilities of each party for employment, and a Letter of Intent detailing the proposed equity acquisition. The Letter of Intent should include the proposed date of sale, the proposed sale price, what will happen in the partnership if there are irreconcilable differences, will there be an obligation to buy the remaining portion of the practice, what will happen if the owner of the practice also owns the building, i.e., will it be a requirement or an option that the new doctor be allowed to purchase a position in the building as well, how will income be shared after the partnership is formed, how will patients be distributed after the new partnership is formed, how would additional future partners be handled, and a statement indicating that while the letter of intent is not binding on the parties, it does represent their agreement to the anticipated details of the proposed sale.

Reason Three:

The third most common reason an associateship fails relates to an insufficient existing patient base. Approximately one thousand to twelve hundred active patients are required for each practitioner in a dental practice. If the senior doctor does not intend to restrict or cut back on his/her number of available clinical treatment hours, then the conversion from a one-doctor to a two-doctor practice requires an active patient base of approximately fourteen hundred to eighteen hundred patients and a new patient flow of twenty-five or more new patients per month.

ACTIVE PATIENT ESTIMATION

Number of Hygiene Days Per Week¹

Times Average Number of Patients Seen Per Day Per Hygienist

Equals Total Number of Patients Seen Per Week

Times Twenty-Five (25) Weeks

Equals Total Number of Patients Per Six (6) Month Period

Times 1.5

Equals Estimated Number of Active Patients

¹If two hygienists work on the same day, this counts as two days.

Many senior doctors count their number of active patients by counting the number of patient charts on a wall. However, if these charts have not been purged within the last two years, this will give an inaccurate count. The best way to estimate the active number of patients involves utilizing the hygiene recall count as shown above.

If there is an insufficient number of patients and/or an insufficient new patient flow, frequently after about a six-month period of time, the senior doctor realizes that all expenses relating to the new doctor are coming directly out of his/her bottom line. The practice begins to experience severe financial pressure, and the associateship ends.

Therefore, if an insufficient existing patient base exists, the new patient flow becomes even more important. How and where will new patients come from? It should be noted that if the senior doctor is nearing retirement and the intent is that within one to two years the senior doctor will turn over total ownership of the practice, and he/she intends to cut back shortly after the beginning of employment, this problem is not as critical.

Many times we see that the senior doctor views bringing in an associate doctor as the answer to increasing busyness within the practice. A practice with insufficient new patient flow that experiences the addition of a new practitioner results in two doctors competing for the same insufficient patient base. This competition results not in the intended solution but rather becomes the cause of employment termination.

Reason Four:

The fourth reason associateships end prior to ownership transfer relates to incompatibility in the clinical skills between

practitioners. While this certainly includes the possibility that one practitioner’s skill level is below standard, it also includes different philosophy of practice issues. For example, a new practitioner who does not believe in the use of amalgam restorations and accepts employment in a practice that does not believe in composite restorations may have a problem. A senior doctor’s practice, which consists primarily of amalgam, extractions, partial and complete dentures will not be compatible with a younger practitioner who desires a reconstructive and cosmetic practice. While on the surface it would appear that having different skill levels and philosophies would be desired, in reality, the patient base available to the younger practitioner in this type of practice generally does not lend itself to the type of dentistry the younger practitioner desires to perform.

Reason Five:

The failure to identify when the buy-in or buy-out is to occur and to execute it within the agreed to time frame is the fifth reason for failure to achieve an ownership status. While the Letter of Intent may have stated that the buy-in was to occur in one to two years, certain behaviors and signs during the continuing employment relationship might give an indication that the senior doctor is having difficulty honoring the intended buyout. It is also possible that the associate does not feel ready or comfortable consummating the transaction within the original outlined time frame. If this position is assumed on the part of only one party, the buy-in may not occur as one party loses patience over the delay.

Reason Six:

The next reason leading to problems standing in the way of a successful transition from associate to owner relates to an insufficient access to the patient base by the associate. This restricted access can take several different forms. If it was never the senior doctor’s intent to turn over existing patients, but rather to give the associate new patients or patients obtained only by the associate’s own efforts, the productive capability of the associate will be greatly compromised.

If the intended result is a partnership between the doctors, then one of the most important things that the associate is buying is an “equal access” to the existing and new patient base. Dental equipment can be purchased over night and an office space set up within a matter of four to six weeks. However, it takes years to develop the patient base.

It is this patient base which comprises the goodwill value of the practice. Goodwill value typically constitutes seventy to eighty percent of the value of a practice. If the senior doctor fails to recognize the need to turn over existing patients to the associate, then the associate will be frustrated by his/her efforts to produce dentistry, earn his/her salary, and improve skills. While it is normal for the senior doctor to be concerned about

turning over existing patients with whom he/she has developed a trusting relationship to an unknown and untried new graduate, it must occur if this relationship is to blossom into ownership.

Unfortunately, senior doctors frequently give instructions to the staff to specifically steer patients away from the new doctor. A similar situation occurs when the new doctor diagnoses dentistry of a highly profitable nature, such as bridgework or crowns, only to find that it is scheduled with the senior doctor. Worse, instances have occurred where it was originally scheduled with the new doctor, only to be changed to the senior doctor's schedule.

The best method of introducing a new doctor into the practice consists of an introduction through the hygiene program. Each patient is informed by the hygienist that the senior doctor has requested that the new doctor see as many of the existing patients as possible to familiarize the patient with the new doctor. The recall examination is a very non-threatening manner of introduction.

The new doctor, upon entering the examination room, repeats the same story, "Mrs. Smith, Dr. Senior has requested that I check as many of the hygiene patients as possible so that you are familiar with me and I with you. This way, in the event that I am the doctor on call and you should have an emergency problem, you will not hesitate to call me to obtain the needed relief. After all, we will already be familiar with each other." This method of introduction has proven to be highly successful.

When the patient is excused and returned to the front desk, if the new doctor has diagnosed needed dentistry, the patient is given a choice of an appointment with either doctor. Which doctor the patient ultimately sees for treatment is left up to the patient, not the doctors or staff. Fifty percent of the patients will take an appointment with the next available doctor or the appointment most convenient for the patient, regardless of who the doctor will be. Approximately twenty-five percent of the patients will state that they really liked the new doctor and they'd like to be seen by Dr. New. The other twenty-five percent of the patients will state that the new doctor was really nice but that they only see the senior doctor. This choice is noted in the patient's file. In the future, the determination is already made as to which doctor the patient prefers.

After a few months of the new doctor seeing as many of the recall patients as possible, the new doctor's schedule will begin to fill quickly. It will eventually reach a point where the senior doctor will note that his/her schedule is starting to slow down. It is at this point that the doctors will begin sharing the recall exam responsibilities.

Reason Seven:

Reason Seven relates to the senior doctor's unwillingness or

inability to "let go" and turn treatment responsibility over to the new doctor. There may be a variety of reasons for this to occur, but the senior doctor must carefully examine himself/herself to determine if they indeed are ready and willing to accept a release of their practice. In the case of a senior doctor who is close to retirement, this may be a very emotional and taxing decision. Until the senior doctor has identified pursuits after retirement from practice which he/she has a greater interest in than the practice of dentistry, the senior doctor will be unable to turn over practice responsibilities to another doctor. Many doctors feel that their only interest in life is their dental practice. For these doctors, it is especially difficult.

The new doctor who is considering an associateship should spend a few minutes investigating the senior doctor's outside interests and activities. Is the senior doctor a hunter or a traveler or a golfer, does the doctor indicate he/she is having trouble spending enough time at the office because of outside activities, or has the doctor indicated his/her spouse has expressed a desire for them to cut back because of activities they would like to be engaged in? These can be viewed as good signs indicating that the senior doctor will have no problem "letting go." Conversely, the senior doctor who is proud of the number of hours he/she maintains at the office or who has no other interests in life, should raise serious concern on the part of the new doctor as to whether or not this doctor is willing to let go.

Reason Eight:

This reason centers around different business and/or practice philosophies. Unfortunately, a lot of this particular problem deals with integrity issues as well. It is very important for the new doctor to attempt to ascertain the attitudes and philosophies relating to business demonstrated by the senior doctor. A senior doctor who is willing to share his/her practice numbers, profit and loss statements, and tax returns with the new doctor generally indicates a doctor who is open and honest. This doctor does not have anything to hide and is proud of his/her accomplishments. A doctor who is unwilling to share numbers, unwilling to share personal financial information and who appears to be very distrustful is probably going to be the same type of doctor for the foreseeable future. There is a major difference between being concerned about privacy and having something to hide.

One important question to ask a doctor who has been in practice for more than twenty years is the status of that doctor's retirement plans. Do they have a well-funded pension/profit-sharing plan, or are they still getting by day-to-day, week-to-week and month-to-month financially? If the senior doctor is having financial stresses after twenty years of practice and if this is intended to be a partnership of more than a three-to-five year duration, financially the partnership will probably not

occur. A doctor who has a well-funded pension/profit sharing plan and is proud of his/her personal financial accomplishments would indicate a strong probability that the practice will be financially strong enough to launch the new doctor into a similar state.

Reason Nine:

Unfortunately, personality conflicts are a frequent reason for associateships failing to lead to buy-ins or buy-outs. While all prior areas may be working well, if two doctors have conflicting personalities, there will be immediate stress and friction within the practice. This conflict between the doctors will quickly spill over into the staff, and the patients will sense hostility within the office.

While a variety of different personality tests and assessments have been developed over the years, a few common-sense rules can easily determine whether a potential for conflict exists. Obviously, two short-tempered individuals will not get along. An outgoing leader will get along well with a quiet follower. Two very quiet, introverted personalities probably will not mesh. A trusting person will not get along with a distrustful person.

The assessment for personality conflicts will be an ongoing assessment during the initial interview process. If there appears to be significant concerns about personalities, and the doctors will be in a partnership arrangement that is expected to exceed three to five years, the warning signs should be carefully evaluated at the onset of a proposed relationship. If a long-term relationship is intended, it may be prudent to seek professional personality assessments.

Reason Ten:

The final reason that associateships fail to lead to buy-ins or buy-outs has, in fact, nothing to do with the doctors or the practice. There have been countless situations where the doctors got along wonderfully, but they turned their relationship over to their individual attorneys, who proceeded to cause problems in the relationship. It is extremely important that both doctors realize the boundaries that must be set relative to their attorney's involvement in finalizing the buy-in and buy-out arrangements.

At this point in your relationship, your attorneys should be your advisors, not your decision makers. The negotiations relative to this proposed buy-in or buy-out were conducted at the onset of your relationship and have been detailed in your Letter of Intent. Your individual attorneys are hired to make sure that the "i's" are dotted and "t's" are crossed in a proper document. They are not being hired to re-negotiate the transaction. If they are allowed to do so, the longer they can continue arguing with each other, the higher the legal bill and the less chance that this transaction will consummate into an ownership change.

Without attempting to beat up the legal profession, we must realize that attorneys are adversarial by nature and training. They have been taught to fight hard to get the best deal for their individual client. Unfortunately, many attorneys have no concept of fairness and equitable arrangements. If the attorneys' personalities and styles are allowed to spill over into the doctor's relationship, the relationship will probably end short of the intended result.

The most successful transitions involve the use of a neutral third party mediator who provides suggested sample documents for the transaction. These consultants usually have worked with many attorneys in the past and have boilerplate templates of what the transaction should be like. They, in turn, can provide a neutral outline of the agreements. These agreements are subsequently submitted to both parties' individual attorneys for review to make sure they are technically and legally correct.

Each attorney is requested to submit the proposed changes in writing to the doctors. The attorneys are instructed not to contact or discuss the agreements with the other party's attorney but to only direct their comments back to their specific clients. Using this method can significantly reduce the legal fees involved. Generally legal fees are in the range of \$500 to \$1,000 per doctor using this method. Requiring the attorneys to submit their recommended changes in writing cuts down considerably on trivial requests for changes.

The parties will usually have received an early warning regarding the potential attorney problems at the beginning of the relationship. Problems occurring while producing the Employment Agreement and the Letter of Intent will be a pretty clear indication that significant problems can be anticipated at the conclusion of the employment period and the preparation of Partnership Agreements.

Summary

While this article has been aimed primarily at a one-doctor practice evolving to a two-doctor practice, the issues apply equally to larger group practices. These discussions also apply when the situation involves a one-to-two-year associateship with the senior doctor retiring at the end of the associateship. Other situations may involve a three-to-five-year partnership ending with the new doctor purchasing the remaining equity position of the senior doctor at the end of five years. The senior doctor may retire or continue on as the new doctor's associate on a part-time basis. They also apply to long-term partnerships defined as five or more years.

Unfortunately, nothing can guarantee that a successful outcome will occur. However, by identifying the potential pitfalls and reasons that may cause failure at the beginning of the relationship, one can greatly improve the chances of success.