OF THE CALIFORNIA DENTAL ASSOCIATION

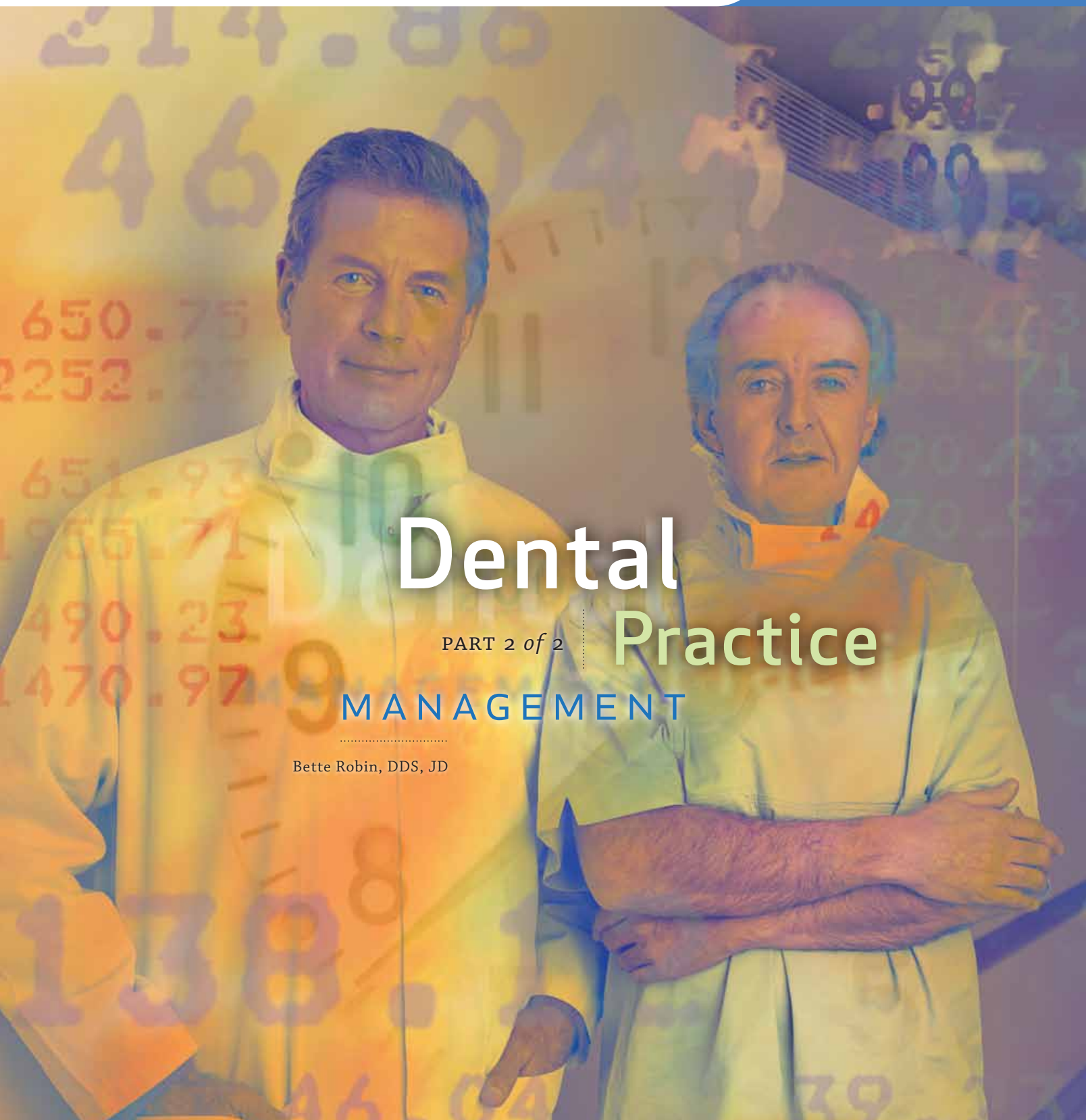
Journal

JULY 2008

The Lease

Transition Planning

Using a Sale Broker



Dental Practice MANAGEMENT

PART 2 *of* 2

Bette Robin, DDS, JD

OF THE CALIFORNIA DENTAL ASSOCIATION
Journal
CDA Journal
Volume 36, Number 7
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DEPARTMENTS

FEATURES

CDA JOURNAL, VOL 36, Nº7

The Business of Dentistry

ALAN L. FELSENFELD, DDS

I am a dentist. I run a small business. When most of us started dental school we did not believe that being a business manager was our ultimate goal. All of us desired to have a private general or specialty practice and treat our patients. Gradually it became clear that to do so would provide professional autonomy with freedom to practice as we pleased, but would also mean that we would be forced to enter the entrepreneurial world. In the midst of this transition to practice from school, the neophyte dentist is introduced to sometimes overwhelming demands.

The need to hire and, worse, terminate staff, pay bills, set charges and rates, negotiate with dental benefit plans or not, deal with regulatory agency demands, and repay education and practice acquisition loans are just a few of the myriad realities of owning or running a business. How does the young practitioner cope with these external influences on their practices when all they wanted to do was become a dentist and make a decent living? The most frequent complaint that our dental students have after graduation is that the schools did not teach them enough about the business aspects of dentistry.

Dental practices are small businesses by economic standards. But we are businesses with income, expenses, profits, or losses. Perhaps a small business from the perspective of any individual practice, we represent an industry with reasonably significant financial implications locally and nationally. According to an American Dental Association study in 2000, dentistry had a direct, indirect, or induced economic impact on society of more than $200 billion with direct employment of approximately 650,000 people and total employment to support the profession of more than 2 million individuals.[1]

Lest we forget, our business is taking care of our patients.

As a graduate student, I distinctly remember my professor coming into a small seminar asking for the definition of success for a business. We suggested the obvious answers as profit, growth, development, and product line expansion. After we completed our suggestions he commented that all of us were incorrect and that the ultimate criterion for the success of a business was survival. If a business maintains itself year after year, that is a successful enterprise. Restaurants are considered doing well if they make it to the five-year mark. Dental practices are successful businesses.

Lest we forget, our business is taking care of our patients. For this we are paid, and some would argue paid well, for our talents. Certainly the requisite skills, education, and struggle to get there coupled with the significant responsibility can support our fees. One only needs to consider the outrageous salaries that actors and professional athletes make to provide a perspective that leads to understanding of appropriate reimbursement for responsibility.

Somewhere in the quagmire of running a business it is easy to get lost in trying to increase production and profits. It is uncomfortable when I hear a dentist "diagnose" a crown or "sell" a treatment plan. As I walk around my neighborhood, I see many offices that suggest the dentists do general dentistry and cosmetic dentistry. Equally repugnant is the glut of practices that have Elite Dentistry, Gentle Dental Care, or similar marketing-based names other than the dentist on the door. I am waiting to see an office that does family and uncosmetic dentistry.

Equally appalling is when you let your fingers do the walking in the local Yellow Pages perusing all the advertisements of dentists who are trying to market their services by "free" exams, radiographs, and similar inducements. What has happened to the family dentist who provides good health care through dentistry? It appears the emphasis on making money in our practices has outprioritized the desire to provide quality health care to our patients for some of our colleagues.

Indeed, we are small business people. Unfortunately, some of us try to become big business people. If we wanted to sell widgets, we should have gone into the widget business. Most of us entered dentistry to care for our patients and enjoy the comforts of a profession that, even today, still allows us to control our

destiny and make a comfortable living. We should not lose sight of the fact that we are health care providers.

Certainly we should not lose sight of the fact that we must run an efficient business to survive, but our priorities need to be correct. You can go into the practice of dentistry and own a small business or you can go into the business of dentistry. The former is unfortunate; the latter deplorable. ■■■■

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Address comments, letters, and questions to the editor at alan.felsenfeld@cda.org.

CDA JOURNAL, VOL 36, Nº7

Origin of Esthetic Technique in Question

This is a letter of complaint. Recently, Simon and Magne published an article on esthetics in your journal ("Clinically based diagnostic wax-up for optimal esthetics: the diagnostic mock-up," *J Cal Dent Assoc* 36:355-62, 2008). The technique they described (as their own) I developed and published in the *Journal of the American Dental Association* in 2001.

As part of my graduate prosthodontic program at the University of Michigan, I was taught to carefully review the literature, particularly in describing potentially new techniques in order not to be accused of plagiarism.

Please forward this letter to your authors and request that they review the literature to see if they can find my article: van Zyl L, Geissberger M, Simulated shape design. *J Am Dent Assoc* 132(8):1105-9, 2001.

IAN VAN ZYL, BDS, DDS, MS
Middletown, Calif.

P.S. A sorry under "erratum" would be nice.

Author's response:

We appreciate the interest in our article "Clinically based diagnostic wax-up for optimal esthetics: the diagnostic mock-up."[1] It is a pleasure to see that this topic engages the readers and is continuously thought-provoking.

We are sorry to hear about Dr. van Zyl's disappointment that his article was not quoted by ours.[2] However, our records show that his article did not come up in a Medline search for the key words: wax-up, mock-up or porcelain veneers, which were the topics of our article. Most likely, the reason is that his article title, "Simulated shape design," is not a conventional dental term, nor does it resemble the subject of diagnostic wax-up or mock-up, and therefore did not come up in the database search. This example serves to illustrate the importance of using proper terminology in scientific literature. As authors and members of editorial boards of various dental journals, we advise writers to consult with journal guidelines and refer to the Glossary of Prosthodontic Terms when discussing prosthodontic terminology.[3] Please review the article titled "Terminology for implant prostheses" for further information on this important issue.[4]

We are certainly disappointed that Dr. van Zyl was under the impression that we claim to have developed the technique. Under no circumstances do we claim such a thing, nor did we contend it in the article. It is important to note that the purpose of our article was not self-promotional but rather educational; thus, its goal is to serve the readers by reviewing the literature in an unbiased way while quoting key publications on this topic. After reviewing Dr. van Zyl's article published in 2001, we discovered that he identifies himself as the "inventor and developer" of this technique. This is somewhat surprising considering the fact that he himself quotes the article "The diagnostic template" by Magne et al. from 1996 as a reference for the diagnostic mock-up technique.[5] Moreover, additional references on the precise step-by-step mock-up techniques used by Dr. van Zyl have been published prior to that by Magne et al. in 1999 and by Belser et al. in 1997.[6-7]

It is fascinating to observe how authors from different parts of the world evolve separately yet emerge with similar ideas, often with no awareness of each other's contribution to the subject. We all live in the same global village, influenced by each other's ideas, which lead some of us to form similar concepts independently of one another. Without question, this adds to the validity of the idea and serves to confirm the importance of publications that shed light on the same topic from different viewpoints. This could explain why even publications on this topic prior to Dr. van Zyl's article have refrained from similar assertions of invention and ownership of this technique. This could also clarify why Dr. Magne, who published on this technique extensively prior to Dr. van Zyl and could have claimed to be the "inventor" of this technique, chose not to do so.[5-7] It is out of the same spirit that Dr. Magne also chose to excuse Dr. van Zyl for his incorrect statements claiming to be the "inventor and developer" and his lack of proper credit to Magne's work.

We would like to thank Dr. van Zyl for bringing this information to our attention, and we encourage him to continue to publish and share his experience with the dental community.

With collegiality,

HAREL SIMON, DMD
PASCAL MAGNE, DMD, MSC, PHD
University of Southern California
School of Dentistry
Los Angeles

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Matt Mullin

Bisphosphonate Questions Answered

Treating patients who take bisphosphonates continues to raise questions not only in dentistry but in medicine as well.

Dentists may have questions about managing patients on bisphosphonates — a class of drugs used primarily for the prevention and treatment of osteoporosis that have been associated with a rare side effect called bisphosphonate-associated osteonecrosis of the jaw.

For those dentists with questions, the ADA developed "Dental Management of Patients Receiving Oral Bisphosphonate Therapy: Expert Panel Recommendations." The recommendations apply to patients taking oral bisphosphonates specifically and not intravenous bisphosphonate medications, where the risk for developing BON is higher.

Peter Jacobsen, PhD, DDS, vice chair of the ADA Council on Scientific Affairs and a member of the expert panel that developed the recommendations, advised

CONTINUES ON 481

Nine Stars USA Introduces Trashcans for Dentist Offices

Nine Stars USA recently launched its stylish, revolutionary line of hands-free, stainless steel infrared trashcans to the medical and dental community. Detecting motion within 10 inches and automatically opening the lid as users approach, the trashcans eliminate contact with dirt and potentially harmful bacteria.

New models include: DZT 42-1, an 11-gallon can measuring 14.5 inches wide and 27.5 inches tall; DZT 65-1, a 17-gallon can measuring 18.25 inches wide by 32.2 inches tall; and DZT 80.1, a 21-gallon can measuring 18.75 inches wide and 32.25 inches tall. For more information go to ninestars.com or call 866-9STARS-8.

Networking May Net New Patients to Your Practice

Establishing a rapport and showing interest in new acquaintances may be the key in attracting new patients to one's practice.

In an issue of the *Journal of the Michigan Dental Association*, Theodore Schuman, a business expert, presented 10 ways dentists can bring in new patients to those in associate and solo practices. Among the tips: Learn people skills; introduce yourself to everyone you meet; and get active in the community.

"Your personality can be a powerful advertising tool," he wrote.

Since existing patients refer 70 percent of a practice's new patients, asking for referrals is recommended. And while some dentists may feel uneasy asking for referrals, it doesn't have to be awkward. A comment such as "Mrs. Jones, you're an excellent patient. I wish I had a dozen patients like you," may even do the trick.

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"Treating gum disease during pregnancy has been shown to be safe and effective in improving women's oral health and minimizing potential risks."

ANANDA P. DASANAYAKE, BDS, MPH,PHD

New Evidence Shows Perio Disease Could Lead to Type 2 Diabetes

A dental research team from New York University has found evidence that expectant moms who have periodontal disease have increased chances of developing gestational diabetes mellitus compared to their counterparts with healthy gums.

Ananda P. Dasanayake, BDS, MPH, PhD, a professor of epidemiology and health promotion at the NYU's College of Dentistry, led the study that followed 256 women through their first six months of pregnancy at New York's Bellevue Hospital Center. Of that number, 22 women developed gestational diabetes and had notably higher levels of inflammation and periodontal bacteria than their colleagues who did not have periodontal disease.

It is believed the inflammation associated with perio disease is a factor in the onset of pregnancy-related diabetes because it may interfere with the proper functioning of insulin that regulates glucose metabolism.

"In addition to its potential role in preterm delivery, evidence that gum disease may also contribute to gestational diabetes suggests that women should see a dentist if they plan to get pregnant, and after becoming pregnant," said Dasanayake. "Treating gum disease during pregnancy has been shown to be safe and effective in improving women's oral health and minimizing potential risks."

Published in the April issue of the *Journal of Dental Research*, the research underscores the importance of good oral health for expectant mothers. A grant from the National Institute of Dental and Craniofacial Research supported the study.

"In the future," Dasanayake said, "we can expect to see more research on the link between these two conditions involving other high risk groups, such as Asian and Native American women."

Those who have had gestational diabetes are at a higher risk of later developing Type 2 diabetes. Asians, Hispanics and Native Americans are at the top of the list for greatest risk.

Early Intervention Makes Strides in Children With Speech Impairments

A parent-implemented program that stimulates the speech of children under the age of 3 who have cleft lips and palates has made some gains, according to a new study published in *The Cleft Palate — Craniofacial Journal*, a bimonthly publication of the American Cleft Palate-Craniofacial Association.

An estimated 1 in every 600 newborns, or 7,000 children a year, have a cleft lip and palate, CLP, the most frequent birth defects in the Unites States.

The participants in the study were 10 mother-child pairs in which the child had CLP and 10 other mother-child pairs of youngsters did not have clefts. The age range for children was 14 to 36 months. A bulk of the questions centered around whether parents could be trained to deliver an early intervention program for children with cleft palate as well as to what degree the effectiveness of the program.

The finding? Mothers could be trained to deliver a reliable intervention. A decrease in the use of glottal stops, increased speech accuracy, and more sound inventories were found in the children with clefts. While the speech gains did not surpass those made by the children who did not have clefts, the results have implications for service delivery models in cases where the services of speech-language pathologists are limited.

To read the entire study, go to: http://allenpress.com/pdf/10.1597-06-085.pdf.

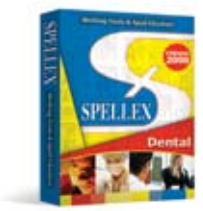
Cosmetic Dentistry Plumps up Otherwise Flat Dental Office Revenue

Cosmetic dentistry has emerged despite the relatively flat growth in the dental revenue, this according to a new survey from the American Academy of Cosmetic Dentistry in an issue of *Managed Dental Care*.

According to U.S. Census Bureau data, dental office revenue increased only 4.4 percent between 2005 and 2006, nearly almost 2 percentage points less than in 2004. Yearly revenue for the profession is at $87.4 billion, evenly divided between insurance payments and private pay. (Medicaid and other unspecified payers account for relatively little.)

But according to the article in *Managed Dental Care*, AACD research showed cosmetic dentistry revenues between 2005 and 2006 grew 15 percent, to $2.75 billion.

Spellex Releases 2008 Version of Premium Dental Spelling Software



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Spellex Premium Dental adds more than 30,000 terms to your spell checker. The dental spelling dictionary covers terms from all areas of general and hospital dentistry, including preventive dentistry, oral diagnosis, temporomandibular disorders, restorative, esthetic, and implant dentistry. Spellex Dental also includes oral pathology, radiography, orthodontics, endodontics, prosthodontics, pedodontics, and periodontics. Prices start at $69 for single users and $355 for 10 user licenses. To order or request product information or a free evaluation copy, go to spellex.com or call 800-442-9673.

It's All About Timing

Surgical timing has been a hot topic with various cleft centers all over the globe preferring early closure when the child is about 3 to 6 months old. One researcher, however, Damir Matic, MD, MSc, using data compiled over the past two decades is saying the optimal time to close the cleft at the alveolus in patients with either one- or two-sided clefts is at age 8 or 9 prior to canine tooth eruption.

"We close the lip at 3 months of age; we close the palate at 1-year old, but we don't touch the gum until they are 8 or 9, a time that corresponds to when the adult teeth start to appear," said Matic.

Matic, a scientist with Lawson Health Research Institute in London, Ontario, also is a craniofacial/plastic surgeon at London Health Sciences Centre and a professor in the department of surgery at the Schulich School of Medicine and Dentistry at The University of Western Ontario.

The study represents a significant breakthrough in cleft research involving an unprecedented sample size of 136 children. Matic and his team looked at a large group of children who had the cleft repair performed early and then compared that group to another large group of children who had the repair performed when they were older.

"Cleft is the most common facial anomaly and the second most common congenital anomaly among children," Matic said. "Our research is clinically based in terms of looking at how we can make our repairs better in light of our current knowledge and past discoveries. Based on our data, the downside of early closure is much worse than any potential benefits, and repairing the cleft prior to this time (7-9 years) will damage facial growth."

Parts 1 and 2 of the study looked at bone production and facial growth in unilateral clefts. This study was presented in 2006 and 2007 to the American Cleft Palate Association, the largest society dedicated to cleft research in the world. Matic's research won best paper in the Junior Investigator Competition out of hundreds of submissions from all over the globe.

The third part of the study examined how the repair affects bone production and facial growth in patients with bilateral clefts. These findings were presented at the ACPA meeting in Philadelphia recently. Matic was involved in a panel discussion/debate regarding his research where he recommended the later closure, according to a press release. The overall majority of the participants voted with Matic, leading to a change in recommendation in the way cleft palates will be treated in hospitals around the world.

When ALD was administered, none of the implants were lost, and the quality of the bone density improved to 50 percent.

Study: Alendronate Enhances Success of Implantation

Estrogen deficiency negatively affects implant osseointegration in rats' maxillary bone, according to a new study published in the latest issue of the *Journal of Oral Implantology*. Additionally, results also yielded that alendronate, ALD, an aminobisphosphonate, may improve the quality and quantity of bone available for a successful implant.

Bisphosphonates, such as ALD, although controversial, are worthy of investigation for the enhancement of implant osseointegration, the structural and functional connection between living bone and an implant, in patients with low bone mass who are already taking bisphosphonates for osteoporosis, the study said, adding patients may receive additional benefits and be acceptable candidates for dental implants without needing to change their medication regimen and possibly as a result of their medication regimen.

The implants placed in rats with a deficiency in estrogen did not osseointegrate. The likelihood of losing the implants was 50 percent at two weeks; at four weeks 13 percent of the implant surface remained in contact with bone. The use of ALD helped to improve the bone-implant contact to 85 percent of the initial value. When ALD was administered, none of the implants were lost, and the quality of the bone density improved to 50 percent. Overall, ALD enhanced the osseointegration of implants.

To read the entire study, "Effect of Ovariectomy and Alendronate on Implant Osseointegration in Rat Maxillary Bone," go to http://www.allenpress.com/pdf/i1548-1336-34-2-76.pdf.

Automatic Receptionist for Dental by Troll Software

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Troll Software has announced its scheduling system for dental offices. Keep in touch with patients and let them confirm and reschedule their appointments back into the schedule with your permission. Troll

Software truly automates filling open spots in your schedule using e-mail, Web, and text messaging interfaces. Contact your practice management software vendor for more information, go to trollsoftware.com or call 877-876-5576.

UPCOMING MEETINGS

2008	
Sept. 6-9	94th annual meeting, American Academy of Periodontology, Seattle, Wash., perio.org/meetings.
Sept. 12-14	CDA Fall Scientific Session, San Francisco, 800-CDA-SMILE (232-7645), cda.org.
Sept. 24-27	FDI Annual World Dental Congress, Stockholm, congress@fdiworldental.org.
Oct. 16-19	American Dental Association 149th Annual Session, San Antonio, Texas, ada.org.
Oct. 25-29	American Public Health Association Oral Health Section's annual meeting and exposition, San Diego, www.apha.org/meetings.
2009	
May 14-17	CDA Spring Scientific Session, Anaheim, 800-CDA-SMILE (232-7645), cda.org.
Sept. 11-13	CDA Fall Scientific Session, San Francisco, 800-CDA-SMILE (232-7645), cda.org.
Oct. 1-4	American Dental Association 150th Annual Session, Honolulu, Hawaii, ada.org.

To have an event included on this list of nonprofit association continuing education meetings, please send the information to Upcoming Meetings, CDA Journal, 1201 K St., 16th Floor, Sacramento, CA 95814 or fax the information to 916-554-5962.

Honors


Charles J. Goodacre, DDS


A. Jeffrey Wood, DDS


Raymond Melrose, DDS, FACD

Charles J. Goodacre, DDS, dean of Loma Linda University School of Dentistry, has received the 2008 Gies Award from the ADEA, which recognized him for outstanding innovation by a dental educator.

A. Jeffrey Wood, DDS, San Francisco, Calif., professor and chair of the department of pediatric dentistry at the University of the Pacific Arthur A. Dugoni School of Dentistry, was named president of the California Society of Pediatric Dentistry.

Raymond Melrose, DDS, FACD, was awarded the St. George National Medal of Honor for his more than 30 years of outstanding contributions to the American Cancer Society. The award, the society's highest national honor, is given to a remarkable volunteer who has made a significant contribution to the achievement of the society's goals over an extended period of time.

Incorrect C.E. Price

Two prices were listed incorrectly for continuing education programs in the June issue of the *Journal*. The correct price is $119 for nonmembers for the following two programs from the California Academy of General Dentistry: "Pediatric Dentistry and Minor Orthodontic Treatment" on Sept. 21 by John N. Groper, DDS, and "Exquisite Complete and Implant Retained Overdentures Calibrated for the General Practitioner" on Dec. 7 by Joseph Massad, DDS.

BISPHOSPHONATES, continued from 477

dentists to read the recommendations and urged them to communicate with physicians when treating these patients.

"Knowledge about bisphosphonates and osteonecrosis is still evolving," said Jacobsen. "We still don't really know the incidence of osteonecrosis of the jaw in dental patients nor how to most effectively manage it. But research and treatment experience is moving quickly and the ADA is closely monitoring all publications on this topic to ensure our panel recommendations are current and accurate."

He added that cancer patients being treated with intravenous bisphosphonate drugs are "clearly at risk for developing BON" and "should have a dental evaluation ideally before, but certainly within the first several months of beginning IV therapy."

The incidence of BON in patients taking the oral form of bisphosphonates is much lower.

In January, an alert from the Food and Drug Administration warned of additional side effects from bisphosphonates, including the "possibility of severe and sometimes incapacitating bone, joint, and/or muscle (musculoskeletal) pain." The alert indicated "bisphosphonate use might be responsible for severe musculoskeletal pain in patients who present with these symptoms" and asked health care professionals "to consider temporary or permanent discontinuation of the drug(s)."

"Bisphosphonates have a history of coming up with unexpected things," said Robert Recker, MD, in a Jan. 28 article of the *American Medical News*. Recker, director of the Creighton University School of Medicine Osteoporosis Treatment Center, added he was frustrated that dentists have told patients to get off the drugs. "The truth is bisphosphonates are among the safest drugs we prescribe in osteoporosis," he said.

In a letter to the *AM News*, James Bramson, DDS, former ADA executive director, said the ADA recommendations do not suggest patients should stop taking these drugs prior to dental procedures, but instead that "dental treatment should not generally be modified solely on the basis of bisphosphonate therapy.

"The ADA recommendations stress that the incidence of bisphosphonate-associated osteonecrosis of the jaw is very low," Bramson wrote, and "patients may also benefit from having a dental exam prior to beginning oral bisphosphonate therapy."

Bramson concluded that the ADA recognizes that discontinuation of these drugs is a serious medical decision and that "the ADA recommends that dentists encourage patients to consult with their treating physician about any health risks associated with use of these drugs."

In 2006, the ADA Council on Scientific Affairs released recommendations encouraging dentists to talk with a patient's treating physician about any health risks and recommended that patients have a dental exam prior to beginning oral bisphosphonate therapy. In some cases, patients may want to schedule dental treatments before starting bisphosphonate therapy.

"The use of these drugs is a serious medical decision," said Jacobsen. "They provide a very real and measurable benefit by decreasing bone fractures in patients with osteoporosis. All drugs have side effects and any drug has a risk-to-benefit balance that needs to be considered."

Antibody Could Signal a New Way to Create a Healthier Mouth

A recently discovered antibody could be a beacon of healthier gums and teeth, said researchers at the University of Michigan School of Dentistry.

According to Charles Shelburne, an assistant research scientist, the antibody is to a protein called HtpG, the "bug" that makes it is *Porphyromonas gingivalis*, an important pathogen in periodontal disease.

"What has been seen in periodontal disease over the last 30 to 40 years is that patients with periodontal disease have higher levels of antibodies to the bacteria associated with periodontal disease, but what we know is that those antibodies aren't usually protective," said Dennis Lopatin, principal investigator and senior associate dean of the university's School of Dentistry. "It's like being vaccinated against the wrong strain of the flu. The healthy patient makes high levels of the antibodies but to the right part of the bug."

Researchers discovered that the HtpG antibodies were present in lower amounts in individuals with periodontal disease, and higher concentrations in those with healthier gums and teeth. And, not only were the HtpG antibodies present in higher amounts in people with healthier gums, those patients with the antibodies responded better to periodontal treatment. National Institute of Dental and Craniofacial Research funded the project.

"We're in a position now where we have a potential tool that gives insight as to how the patient will respond to treatment," Lopatin said. "In the United States we spend $8 billion to $12 billion a year caring for people with serious periodontal disease. From a public health standpoint, it's very important to identify those people who not only need therapy but will actually respond to a specific type of therapy."

In the end, this discovery may lead to interventional therapy, halting periodontal disease from starting or progressing, said Lopatin.

Soredex Scanora 3-D With HD Panoramic Takes Dentistry to the Next Level

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Instrumentarium Dental unveiled the new Soredex Scanora 3-D X-ray, true panoramic imaging technology that produces high quality images. Soredex Scanora 3-D combines a three field of view cone beam with high-definition panoramic imaging in a single system to produce anatomically correct images of teeth, bone and soft tissue, plus the highest quality panoramic images. Dental professionals will find the system especially effective for implant procedures, oral surgery, and TMJ analysis. For more information, call 800-558-6120 or go to soredexusa.com/scanora3dpr.

FDA OKs Drug to Reverse Local Anesthetics in Dental Settings

The Federal Drug Administration has issued an approval for the use of OraVerse in children and adults. The drug is the first of its kind to reverse local anesthesia used for dental procedures.

In several clinical studies, patients received a placebo or an OraVerse injection following their dental work under local anesthesia. Forty-one percent of OraVerse patients regained regular feeling in their lower lip and 59 percent reported normal sensation in their upper lip within an hour after taking the drug. In comparison, 7 percent of the placebo patients felt a return to normal lower lip sensation within the hour and 12 percent said they regained feeling in their upper lip in the same timeframe.

OraVerse is not recommended for children less than 33 pounds or under the age of 6.

A news release by Novalar, makers of OraVerse, said the most common side effect was pain at the injection site and there were no serious side effects noted in the clinical studies. While arrhythmia and tachycardia might occur when similar drugs such as OraVerse are administered intravenously, it is uncommon when the drug is injected into the gums, according to Novalar's press release.

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Why Your Lease Is an Important Asset

JASON P. WOOD, JD, AND PATRICK J. WOOD, JD

ABSTRACT The authors represent more than 3,500 dentists in California and have utilized their experience, knowledge and actual client examples to provide a thorough guide to protecting your future income and sale of your dental practice. This article is intended to provide an in-depth prospective of the value of the lease for your dental practice.

AUTHORS

Jason P. Wood, JD, is a member in the law firm of Wood and Delgado, which specializes in representing dentists.

Patrick J. Wood, JD, is a partner in the law firm of Wood and Delgado, which has offices in Irvine, San Francisco, and Temecula, Calif.

Most dentists think of attorneys either as patients or as people who may sue others. A problem in the dental industry is that there are far too few members of the legal profession who make their livelihood representing and protecting dentists in connection with their business affairs. Indeed, it seems the deck is stacked against dentists in California since the vast majority of attorneys are either bringing malpractice actions against them or representing the developers, landlords, and large corporations with whom dentists must do business.

Unfortunately, far too many dentists continue to believe they do not need advisers' knowledgeable in the dental industry to conduct their business affairs, and, as such, an increasing number of dentists fail to reach the pinnacle of their careers, being forced to deal with litigation, bad landlords, unprofitable dental practices, and other business problems that interfere with them focusing on the practice of dentistry.

This article focuses on how truly complicated a single facet of owning a dental practice is. The premises lease is often the most overlooked asset of a dentist and this mistake, can be detrimental not only to one's dental practice, but to an entire career of a dentist. This article will utilize case studies, changes in California law, and specific provisions in today's "form" leases, which are negatively impacting dentists throughout California. Whether one currently is looking for a new office location, purchasing a dental practice, or thinking about selling a practice, this article will provide insight on how to protect one's business.

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Leasing Brokers

Many dentists believe that a leasing broker acts as their attorney in connection with the lease. However, they are not attorneys and do not profess to be. They do not negotiate points of law or revise sections that may impact the value or transferability of the dental practice to another dentist. The leasing broker's main job is to find a suitable space, negotiate the rental rate, term, and possible tenant with whom a commercial broker interact; they generally will not understand the value of certain sections as they pertain to dentists.

Many dentists believe that by engaging a commercial leasing broker to negotiate their lease they are in fact protecting themselves from many of the issues the authors will be addressing in this article. However, if one reads the commercial leasing brokers indemnification section, one will see the broker clearly states they are not an attorney, and they encourage the dentist to seek legal counsel to review the lease. The broker understands every business is unique and therefore the lease can impact each business differently. Believe it or not, while rent, tenant improvement allowances, and the term of one's lease are clearly important to the success of the dental practice, they not are only provisions of a lease which can cut into the profitability and value of one's dental practice.

The Newer the Lease, the More Anti-tenant It Will Be

If a dentist has a lease that was drafted in 1975, chances are the rights and duties of the landlord and the tenant are fairly equal. However, as time progresses, members of the authors' profession spend more and more time drafting modifications to form leases to strengthen their clients' position, with their "client" being the landlord. Over the past 10 to 15 years, this trend has generated speed. One can now expect to have between 15 and 25 provisions in the newer leases that have the potential to negatively impact the value of the dental practice, possibly prohibit the dentist from selling it to another dentist, or cause one to have one's lease terminated upon selling it.[1]

ONE CAN NOW EXPECT to have between 15 and 25 provisions in the newer leases that have the potential to negatively impact the value of the dental practice.

California Courts: Tenant Friendly, but Will Protect the Law of Contract

For centuries there has been an ongoing battle between the "Law of Contract" and the courts' desire to protect the "uninformed." In California, the courts routinely draw lines in the sand in an effort to protect individuals from the repercussions of their signatures on the dotted line. One example of this is that California courts have ruled that covenants not to compete are unenforceable without the transfer of an ownership interest.[2] This is contrary to the majority of states that enforce covenants not to compete against associates even after the employment contract ends. Likewise, courts have stepped in to protect tenants from landlords who attempt to take advantage of the tenant when they go to assign the lease to another party.

In Ilkhchooyi vs. Best, the court prohibited a landlord from receiving "excess consideration" during the sale of the tenant's business.[3] In this case, a tenant was attempting to sell their business to a potential buyer. When the seller and buyer agreed upon a purchase price they were required under the lease to request an assignment from the landlord to transfer the lease to the buyer to complete the sale. The landlord then requested $30,000 as consideration for the assignment of the lease as part of the "excess consideration" clause. The deal fell apart and the tenant sued the landlord.[3] The court found it "unconscionable" to attribute the "excess consideration" to the allocation of goodwill of the business.[3]

In its findings, the court stated that the legislative intent of California Civil Code Section 1995.240 was to allow a landlord to capture the "bonus value" of the lease if the tenant was profiting from undermarket rents and was not intended to include allocations attributed to the business itself.[4,3] In part as response to this case, the Legislature codified the court's decision in California Civil Code Section 1950.8 that allows a tenant to sue a landlord for "treble damages" if a landlord attempts to receive "excess consideration" in connection with a tenant's business.[5]

Unfortunately, landlords in California quickly revised their leases to "get around" the Legislature and the court's decision while still receiving profit from a tenant's proposed sale. Section 1950.8 allows a landlord to receive excess consideration if "the amount of payment is stated in the written lease or rental agreement."[5] Therefore, landlords use phrases like "10 percent of the value of any consideration received by tenant in connection with or related to any assignment," "upon a requested assignment, tenant shall pay landlord $25,000 as consideration for landlord's granting of an assignment," "as a condition to entering into this lease, tenant agrees to pay landlord

$10,000 as consideration for a grant of an assignment of this lease," etc.

Landlords Secret Weapon: Recapture Clauses and Renewal Options Personal to Original Tenant

RECAPTURE CLAUSE

Many leases now have a "recapture" provision that allows the landlord to terminate a lease if the dentist asks for an assignment or a subletting of the office.[6] In other words, when the dentist finds a buyer for their practice they must notify the landlord that they wish to assign the lease to the buyer of the dental practice. As soon as the seller requests an assignment of the lease to a potential buyer, the provision "kicks in."[7] At that time, the landlord can either accept the assignment, deny the assignment, or terminate the lease.

Landlords have increasingly utilized this provision to extort various amounts of money from their tenants. While the numbers vary greatly, there is generally an increase for the "request" of compensation by the landlord with an increase in the purchase price of the dental practice. Please note, this section is often times used to get around the decision and Section 1950.8 of the California Civil Code discussed previously.

Personal Options

This section usually makes any option period to extend the lease personal to the dentist, making them useless to any potential buyer. Without at least seven to 10 years of a viable lease term (including option periods), many lenders will not lend money to a buyer to purchase your dental practice. This provision is contained in most new form leases since California courts have ruled that in order to prevent a renewal option transferring to a lease assignee, it must be specifically stated in the lease.[8,9]

Case Study

Below is one example the authors recently encountered showing how the above provisions have negatively impacted a client as a result of not modifying or removing these provisions when they entered into their lease. Due to attorney-client privilege the name of the client and the dental practice location is being withheld.

KNOWING WHAT ONE can possibly modify in a lease and what a landlord will not modify is just as important as negotiating the rent.

NEGOTIATED PURCHASE PRICE: $1,175,000

Lender Approval: Yes

The seller was a very successful dentist who had started his dental practice from scratch in a growing community. After steadily increasing production figures, the seller wished to move out of California after a decade of running his practice and had already found another dental practice to purchase. The broker involved in the transaction found a suitable buyer and the dental lender was willing to fund the entire purchase price … with one condition. The current lease term only had three years left on the lease but also had two five-year options remaining. The lender requested that these be assigned to the buyer. Unfortunately for the selling dentist, the remaining options were personal to the seller and there was a recapture clause in the lease that allowed the landlord (instead of granting or denying the assignment) to terminate the lease.

When the landlord saw how much the dentist was receiving from the sale of his dental practice, the landlord cited the recapture clause in the lease and threatened to terminate his lease if he was not paid a very large portion of the purchase price. The seller decried that the landlord was using extortion tactics to extract money from him and threatened to sue him and report the landlord to the authorities. In the authors' review of the lease it was clear: The landlord had the right to terminate the lease upon a requested assignment. After months of negotiation and threats of lawsuits the authors' client finally concluded that the landlord's position was absolute. He agreed to pay the landlord $100,000 if the sale went through.

However, the landlord did not stop there. As part of the condition to allow the sale to go through, the landlord arbitrarily increased the rent for the office $1 a square foot to what the landlord determined was fair market value. This caused the lender to reconsider the loan because the overhead percentage increased to a level to which they were not comfortable with loaning the money. In order for the sale to go through, the authors' client would have to reduce his purchase price an additional $50,000 to cover the increase in rent to the buyer for the next few years. Total loss: $150,000.

Lease Provisions to Modify

As mentioned previously, there are many provisions in a lease that can impact the value of one's dental practice. However, knowing what one can possibly modify in a lease and what a landlord will not modify is just as important as negotiating the rent. If one asks for the wrong things (i.e., trying to change a triple net lease to a gross lease), one typically will end up not receiving any of the requested

modifications. Following is a sampling of things one may wish to ask for when negotiating a new lease or assignment.

Dental Exclusive

If located in a smaller shopping center or strip mall, this provision could be crucial to one's business being successful. As mentioned previously, landlords have no provisions in their leases prohibiting them from leasing space to another dentist However, when a landlord is courting a new tenant for an empty space in their shopping center, this is an excellent time to demand to be the only dentist in the center; often times the landlord will grant this request.

Damage or Destruction to the Premises

The way this section of a lease is written appears to be innocuous. The section appears to be stating the obvious: The landlord has a duty to repair within a reasonable amount of time. However, a careful review this section reveals that in most leases there are many "outs" for the landlord so they do not have to rebuild in a timely fashion. In order to combat the landlord's "outs" in rebuilding, the authors suggest asking for time frames for repairs to commence and to be completed; failing that, the dentist has the right to terminate the lease. Generally, the authors' law firm requests 90 days to commence repairs and 180 days to complete repairs.

Release of Liability

If one is lucky enough to have their lease assigned to the buyer, the dentist will still be on the hook for the length of the lease, including any option periods left.[10] This could mean that one could have another 10 to 15 years of personal liability connected with the lease. The authors recommend that the dentist try to be removed from future liability after a valid assignment.

Length of Lease Term: Plan for Your Future

Do not accept a five-year lease for your dental practice. One is either going to spend $100 to $150 a square foot building out one's dental practice, or will be paying a substantial amount of money when one acquires the dental practice. Patients will be familiar with the location and if one is required to move, production will decrease in the short run since not all of one's patients will follow. Obtain as long of a lease term as possible without tying one to the location indefinitely. For instance, instead of requesting a 15-year term for a lease, ask for a five-year term with two five-year options. Furthermore, know when you want to sell the practice. This will prevent the following from happening.

OBTAIN AS LONG of a lease term as possible without tying one to the location indefinitely.

Case Study

NEGOTIATED PURCHASE PRICE: $650,000

Lender Approval: Conditioned Upon the Buyer Receiving an Additional Five-year Option

The seller had a strong HMO practice with an associate who produced the majority of the production in the office. The seller had utilized dentistry (and the revenue it created) to establish other successful businesses in another state. His other businesses had grown to a level where his involvement and presence at the dental practice was actually costing him more money than he was making from it due to the time away from his other businesses. He decided to sell and found his buyer quickly … his associate. Since the associate produced the majority of the work, the dental lender had no problems making a full value loan of $650,000 (plus working capital) to the buyer. The only condition, they needed an additional option to extend the term of the lease.

The seller had previously negotiated the lease with the landlord and had three-and-a-half years remaining on his current lease, with no options remaining. Unfortunately for the seller, the landlord, did not wish to "tie up" his property for a long period of time. He had previously been approached by the federal government to build a new building with the government as a tenant, lease it to them for 25 years, and then allow the landlord to have the building free. Even though this deal deteriorated, it left the thought of untold riches in the landlord's mind and he wished to keep the property open for any other future offers. Therefore, he was unwilling to grant the buyer an additional option "at this time," but would "entertain" the offer when the current lease expired. This of course did nothing for the transition since the lender required a longer-term lease to fund the buyer.

The seller was desperate and began offering tens of thousands of dollars to the landlord to grant the option. Even after $100,000, the landlord would not budge. The associate became restless and threatened to leave if the seller did not sell him the dental practice at a much-reduced price: $250,000, to cover the cost of a new build out if the landlord would not grant a future option to extend the lease. The seller accepted the associate's offer — at a loss of $400,000.

The above scenarios are a small sampling of the many issues dentists

face in entering into a lease for their dental practice. When counseling a dentist on the many unseen pitfalls in leases, they are usually astounded by the hidden issues, and they should be. As mentioned earlier, the "form" leases have been in the hands of attorneys for years, constantly being perfected and modified so that their clients, landlords, are protected as well as they can be.

While the lease is only one component of owning and operating a dental practice, many times it is one of the most important and the most overlooked. With simple changes to the lease, including the issues mentioned in this article, the lease could be a valuable asset to the dentist, possibly even increasing the value of the dental practice. ■■■■

TO REQUEST A PRINTED COPY OF THIS ARTICLE, PLEASE CONTACT Jason P. Wood, JD, 20 Pacifica, Suite 320, Irvine, Calif., 92618.

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5. California Civil Code Section 1950.8.
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Keys to Buying a Dental Practice and Successful Transition Planning

KATHLEEN JOHNSON

ABSTRACT So, you want to buy your own dental practice. Sounds great, but proceed with caution and follow the critical steps to success. Having spent the last 15-plus years in her management consulting business assisting dentists with selling, buying, and practice transitions, the author has outlined key steps to ensure a smooth transition from evaluating the practice to ownership.

AUTHOR

Kathleen Johnson is with Kathleen Johnson Consulting, Inc., in Anaheim Hills, Calif.

While purchasing or starting a scratch practice of one's own is a powerful dream and something that can easily become a reality, one needs to proceed with caution. Be aware of the fascination of the sense of independence intrinsic in this dream. The dream of owning one's own practice can quickly turn into a nightmare if one is not ready or chooses the wrong practice. The author recommends the new dentist work as an associate for several years following graduation as it can be very valuable in terms of sharpening skills and gaining knowledge of the challenges, benefits, and disadvantages of practice ownership.

Prior to a practice search, one needs to make some basic decisions. What type of practice would be the practice of one's dreams? A totally fee-for-service, or one that currently accepts PPOs, HMOs, and/or Denti-Cal?

Keys to Avoiding Stumbling Blocks

It is best to know about problems before investing time and significant money.

- Asking price and flexibility
- Will seller carry a note if the bank does not approve the full amount?
- Accounts receivable: amount, aging, collectibility, insurance; is AR for sale?
- Is insurance payment accepted as payment in full?
- Notes, collateral, subordination to bank
- Restrictive covenant not to compete by seller: distance and time
- Must be comfortable why dentist is leaving, especially if he or she is not of retirement age

- Be assured that all deposits are from dentistry performed in the practice you are purchasing and not from other sources (outside businesses, second dental practice, fraudulent insurance claims) tax returns legit.
- Be sure one is allowed to talk to current staff prior to closing to assure expected continuity.
- Talk to the landlord to assure transfer of lease.

Location. Locations should be prioritized based on where one will be comfortable living and practicing. What office setting is being sought? Is it a suite in a professional building, free-standing building, storefront in a shopping center or strip mall? Parking and visibility must also be a consideration.

Get in touch with a broker active in the market. Ask colleagues for referrals to brokers they have worked with and had positive experiences. With the Internet, a dentist can shop broker listings of practices or one can check listings of practices for sale in major dental periodicals and local dental association publications.

Review practice information. These reports will be provided by the broker or directly from a seller if a broker is not involved. When finding a practice that has caught one's interest and appears to be one with potential, you can set a date to visit the practice or attend the broker "open house."

Arrange for financing. Get in touch with brokers, consultants, accountants, and attorneys as they can usually make recommendations for suitable lenders to consider. Most lenders specializing in practice acquisition financing will fund 100 percent of the practice purchase price, plus all related working capital and transition costs needs. Be aware that lenders policies can vary widely in the length of the approval procedure, the interest rate, terms of the loan, and whether there are penalties for early prepayment of the loan. The author recommends one compare two to three lenders before making a final decision.

Obtain insurance. One will need to find a life and disability insurance agent experienced in working with dentists acquiring dental practices. Be sure to select an agent experienced in structuring and procuring disability coverage for the purpose of collateralizing a business loan. Most practice lenders will require this type of insurance as collateral for their loans. The most frequently used life insurance product for loan collateral is term life. The most frequently used disability products for this purpose are income disability, reducing term disability, and disability overhead.

IT IS BEST TO have an attorney to review the intent to purchase agreement, the buy-sell agreement, and the lease.

Get in touch with professionals. One should not do this alone. It is best to have an attorney to review the intent to purchase agreement, the buy-sell agreement, and the lease. Once an offer has been accepted, one should hire a dental consultant familiar with practice evaluations to assist you with evaluating the practice on site. If possible, one should arrange to be with the consultant during the evaluation. After the on-site evaluation, the author recommends having an accountant review the profit and loss statements and the tax returns for the last three years.

Office facility things that need to be considered are rent and the time, and terms of lease. Is it transferable? Are utilities included? Is there an option to buy the building? Are there zoning restrictions? What's the square footage? Number of treatment rooms? And are they modern? Expandable? Is the practice computerized? Digital X-rays? As for equipment: What are the units? Age? Condition?

If everything looks positive to this point, one is ready for the next step: Contact your consultant or adviser and arrange for an in-depth practice evaluation.

The first place to start when evaluating a practice is the information on the practice. The author reviews the reports on production, collections, adjustments, new patients, and patient visits by month for the current year, each month of the previous year, and totals for the previous two years. Collection vs. net production is critical as the practice may have a problem with collecting at the time of treatment. Adjustments by type are also looked at to determine if the practice is writing off patient's co-payments, giving huge discounts, etc.

Another critical area may be the production by category, (diagnostic, preventive, restorative, endo, perio, oral surgery, removable and fixed prosthodontics, orthodontics, and TMJ.) Are there procedures one does not do that will reduce production? And what procedures will one be introducing to the practice that will increase the production?

Uncompleted treatment. Is there treatment to do on the current patients or a potential need for extensive dentistry in the patient pool?

Patient population. What is the number of active patients? Active patients are critical in a practice purchase as goodwill is figured in the purchase price. A definition

of an active patient is one who has been seen at least one time over an 18-month period. Figuring this can be tricky as one cannot usually trust the number of patient listed in the computer as active.

Most dental offices are not consistent with updating their patient status. One cannot usually trust the number of charts on the shelves as inactive patient charts are not always removed. What one can trust is hygiene visits per month. The dentist needs to estimate the number of active patients, the estimated percentages of three-, four-, and six-month continued care visits. That would give the number of hygiene visits due per month.

One should review the patient demographics: economic status, insurance dependence, residence/ZIP code analysis, proximity to office, and patient ages, and look at the new patient flow: number per month and referral sources.

Dentist's philosophy. The dentist needs to select randomly 10 percent of the total number of active patient charts. Review the X-rays and diagnosis, type of work, treatment notes, and redos, as well as look at some lab cases.

- Review the continued care (recall) system. Is there one? What type?
- Carefully review the current fee structure.

Staffing. Staffing can be a crucial element of transfer. Is the staff aware of the sale? If not, when does the seller plan to inform them?

- Evaluate salaries, hourly rate, hours worked, length of employment, benefits and if anyone is due for an increase.

Transfer of ownership. Does the seller wish to stay on? If so, for how long and in what role. If he or she wants to stay on as an associate, is there enough work for both of you? What about compensation? Will the seller write the letter of introduction?

Evaluation and Numbers

Philosophy: If practice income minus (overhead + debt service) provides a livable income one can consider a deal. If numbers don't add up: BIG PROBLEM. In California, the asking price can be as high as a full year's gross income.

Personal variables: What is valuable for one person may not be for another? Are you looking for a bargain or a career opportunity, even if you overpay? This is a decision one needs to take care with and not allow emotions to get in the way.

A PRACTICE PURCHASE means that every day brings new faces, names, and situations to one's schedule.

Careful transitioning of one's new practice can be a huge key to success or disaster. That is why the author highly recommends the dentist meet the staff prior to the close of escrow. He or she should interview each staff member to discuss their position and give them information on your background. They need to know who the dentist is so they can transfer that information onto the patients with confidence.

Since the seller needs to terminate the staff positions at the close of escrow, it is important they know you intend to keep them and that you do not plan to make any drastic changes walking in the door.

The practice one is purchasing may have a staff that is highly paid and receives a huge benefit package. The buyer's first thought may be to not hire them and find a new staff when getting started, but that would be a huge mistake as the patients rely on the current staff and would not be familiar with anyone in the practice.

Keys to Success

Prior to seeing the first patient, one should set a time for a practice transition meeting with all staff present. The agenda should include:

- Meet Dr. _____, understand his/her professional and clinical philosophy.
- Each staff member should take a few moments to share his or her feelings about the practice change.
- Provide information about any changes.
- Discuss how patients may react to the news.
- Discuss how to answer the phones.
- How to schedule Dr. _____ .
- Hygiene visits and meeting the new doctor

For a new owner, reviewing a patient's chart and finding personal comments about that patient is like discovering a pot of gold. Personal comments offer a chance to jumpstart the relationship and develop it further. If the seller did not note that type of information, the buyer should start by keeping a separate "personal comments" form in the chart or computer notes. Ask about patient interests and family life.

Review personal comments prior to every visit and then follow-up with the patient. One's clinical skills are very important, but showing interest in patients touches them, builds credibility and likeability, and that's what counts with patient retention.

A practice purchase means that every day brings new faces, names, and situations to one's schedule. Consider taking a proactive approach through the most important daily communication forum — the huddle. This allows the team to

gather and share information with the dentist that will help each person provide the most personalized care possible.

The hygienist must make every visit count by building relationships and educating patients about their health. Remove the typical "You look great; see you in six months" routine. Those words do not create value and urgency and do not give the patient a strong reason to return. At the end of the visit, the hygienist should reinforce the reason for returning sooner and be assumptive about preappointing the next visit.

Other sources for finding a practice: CDA classified ads, colleagues, lending institutions, dental supply companies and the *Dental Shopper*.

Congratulations on your purchase! The author hopes these keys provide the groundwork upon which your practice flourishes for years to come. ■■■■

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The Benefits of Using a Qualified Practice Sale Broker

BETTE ROBIN, DDS, JD

ABSTRACT A qualified practice sale broker can be useful for facilitating the process of transitioning a dental practice from one dentist to another. This article addresses many of the various factors involved in the sales process and the issues that often arise that can be avoided by being well-informed and/or working with a professional such as a practice sales broker.

AUTHOR

Bette Robin, DDS, JD, earned her dental degree from Loma Linda University and her law degree from Southwestern University School of Law. She also holds a certificate in mediation/arbitration from Pepperdine School of Law.

The first step toward finding a qualified practice sales broker is to determine what is important and exactly what outcomes one would like from the process. Some important criteria one may consider include the following items:

Professional credentials. There is nothing more important than education, knowledge, and credentials when selecting a broker. Therefore, investigate the credentials and educational background of the potential broker and chose someone who is qualified, well-educated, and experienced.

Single representation. A practice sale broker should only represent one side of the transaction, either the buyer or the seller. There are numerous legal cases setting forth this principle many of them stating simply that brokers best serve only one master.

Referrals from other dentists. Referrals from other dentists satisfied with their practice sale broker are a great way to estimate the effectiveness and experience of a broker you are considering hiring and must be one of the considerations given the highest weight by a doctor selecting a broker.

Geographic area of focus. Choose a broker who is familiar with the area where your practice is located. This is important because the broker can better appraise the worth of property in the area and has a better chance of knowing people and having connections in the area, which could lead to the more rapid sale of one's practice. A dentist should generally use a practice sale broker whose sole area of focus is their general geographic vicinity.

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Deciding Major Issues

This section addresses some of the most important issues that arise in the transition process. Anticipating and being informed about these issues is important to a smooth and successful transition.

Six major topics are addressed here that include the process of determining an appropriate sales price, creating desirable transaction terms, tackling the negotiation process, analyzing the appropriate type of sale, considering the tax consequences of the sale, and securing a fast sale and closing. Each section is accompanied by tips that are followed by anecdotes of the consequences of being uninformed.

DETERMINING AN APPROPRIATE SALES PRICE

Retiring dentists tend to undervalue their dental practices, which is usually one of their most valuable assets. This may be because a retiring dentist's equipment may be older and fully depreciated, because a doctor does not appropriately understand the value of his or her many years of long work, or for a variety of other reasons. Therefore, an experienced broker can be useful in determining an appropriate sales price because he or she has seen hundreds of transactions and knows how to factor in the numerous variables that go into determining value. This allows a retiring dentist to maximize his or her profit, and usually allows the buyer to obtain 100 percent financing on his or her purchase.

Tip No. 1: Know Your Worth

CASE STUDY

A dentist had been in a partnership with his best friend from dental school for more than 35 years. They had a good working relationship, and when his friend died, the dentist bought out his deceased partner's share of the business from the estate, according to the terms and conditions of their buy-out agreement. The valuation formula was low, but still reasonable for a partnership buy-out. The surviving dentist increased his workdays from two to four days per week, and this schedule continued for several years after his partner passed away. He began to receive inquiries about a potential sale from new graduates, and using the formula from the partnership buy-out agreement, the dentist started to negotiate a sale with two recent graduates. Fortunately, the doctor enlisted the assistance of a practice sale broker to appraise the practice. He soon learned that he had undervalued the practice by approximately 50 percent. Even with that knowledge, however, the doctor still did not really believe his business was worth "that much." The practice was listed and closed within 30 days for more than double what the doctor originally thought his business was worth and the dentist was glad he retained an experienced professional.

RETIRING DENTISTS

tend to undervalue their dental practices, which is usually one of their most valuable assets.

CREATING DESIRABLE TRANSACTION TERMS

There are many transaction terms to consider in a dental practice sale and the terms outlines can make a significant overall difference. The best practice transition contracts spell out precisely both parties' understanding and agreement. Tax consequences, covenants, retreatment issues, and trade secret definitions are just a few of the issues that can be precisely determined by a professional broker. A reputable broker with appropriate credentials is very knowledgeable about specific contractual language, the terms and conditions of sale, and is able to properly advise the selling dentist.

Tip No. 2: Get it in Writing

CASE LAW EXAMPLE

Failure to establish specific and detailed transaction terms often leads to the need for legal resolution. The case of James E. Gernert, MD, et al. vs. Duane Hartleip, MD, et al. (L.A. Superior Central, BC 126513) provides an interesting example as to what happens when there is a lack of specificity in practice sale contracts. Dr. Hartleip sold his urology practice to Dr. Gernert in preparation for retirement. The deal turned ugly after the transaction closed. Dr. Gernert alleged that Dr. Hartleip breached the covenant not to compete, stole patients, defamed him, and unfairly competed against him in a nearby area. Dr. Gernert further alleged that Dr. Hartleip had promised to retire. However, the sales contract failed to mention most of the issues the parties found themselves facing.

On the face of the contract, Dr. Hartleip allegedly complied with all of the terms and conditions, however, according to Dr. Gernert, none of the promises were kept and the "spirit" of the contract was breached. The court rendered a defense verdict in favor of Dr. Hartleip, with an allowance for attorney's fees. The court essentially found that the written words of the document prevailed and no verbal evidence was admitted for consideration. The court found that particularly between two educated parties of equal bargaining power, a "deal was a deal" and the contract.

TACKLING THE NEGOTIATION PROCESS

A thorough understanding of the main transaction points and the importance of bargaining are necessary to achieve the best transaction. An experienced broker with appropriate credentials can competently negotiate the various aspects of the transaction, factoring in specific items, and knowing when and what to give and take. The covenants set forth in the agreement are particularly important, whether there is merely a covenant not to compete, or additionally a covenant not to solicit, a covenant not to treat, and a covenant not to hire employees, requires sophisticated negotiation skills and may make or break the transaction.

Tip No. 3: Negotiate and Document

CASE LAW EXAMPLE

The case of Wallace, MD, vs. Cooperman, MD, decided in Los Angeles Superior Court on Dec. 11, 1995, illustrated the importance of adequately negotiating and documenting a practice sales transaction. Dr. Wallace purchased Dr. Cooperman's ophthalmology practice in 1989. Dr. Wallace subsequently sued Dr. Cooperman stating the practice was misrepresented as being more profitable that it was in reality.

Dr. Cooperman contended that Dr. Wallace's lack of success was due to increased competition from HMOs, that Dr. Wallace failed to advertise the practice and develop relationships with referring doctors, and that Dr. Wallace's personality had alienated the patients. After a lengthy jury trial, the court agreed with Dr. Cooperman. The parties should have completely negotiated and put in writing all the terms and conditions of their agreement. Therefore, complications like these can be eliminated and provide both the seller and buyer with peace of mind with the help of the services of a professional broker who has experienced negotiation skills and expertise in formulating contracts.

DETERMINE THE APPROPRIATE TYPE OF SALE

Practice transitions come in various forms. For example, it may involve a phased transition, a partnership leading to full buy-in, a straight sale, or a combination of these things. An experienced broker can be useful for evaluating a doctor's needs and desires and determining the best type of transition for that particular doctor.

THE TAX CONSEQUENCES of a sales transaction are extremely important to a selling and purchasing dentist.

Tip No. 4: Specialization is Key

CASE STUDY

A doctor retained a transition firm based outside of California to handle his transition. He paid a relatively large upfront cost for an appraisal and then another upfront cost for a "standard" contract. The doctor found himself a potential buyer, that person started employment as an associate, which led to a partnership and then a full buy-out. The doctor soon found out the firm was not versed in California law, that the covenant not to compete sections were not in accordance with California law, and there were numerous problems with the contract.

He then decided to hire an experienced broker and found out that his practice was undervalued for the California market by about $175,000 and that the document created by the transition firm he had hired, which he paid thousand of dollars for was basically worthless. It was an expensive lesson to learn but the sale was eventually consummated on terms and at a price the doctor was very happy with once he had the assistance of a professional broker who specializes in such transactions.

CONSIDERATION OF TAX CONSEQUENCES OF THE SALE

The tax consequences of a sales transaction are extremely important to a selling and purchasing dentist. The allocation of the sales price determines the actual net for the seller and tax depreciation and amortization schedule for the buyer. Generally, the amount of the sales price allocated to goodwill is taxed to the seller at the capital gains rate and the rest of the sales price is taxed at the seller's ordinary income rate, generally at least double that capital gains rate.

Although the buyer can fully amortize and depreciate an asset purchase, the allocation schedule determines the speed at which those deductions can occur. Other tax consequences also must be considered, including a doctor's plan to purchase another practice and utilize a 1031 exchange, or a doctor's ability to sell stock rather than assets of his practice.

Tip No. 5: Pay Attention to Taxable Entities

CASE STUDY

A doctor spent most of his career in an outlying area developing a successful dental practice. After his children moved out of the house, the doctor and

his wife decided to relocate to a beach city and find a small practice to work a couple days a week and ease happily into retirement. The doctor successfully entered escrow with his longstanding practice and made an offer to purchase his dream beach practice. The doctor's representatives failed to mention the benefits the doctor would derive from a 1031 exchange. Three-hundred thousand dollars was allocated to that equipment and that amount was taxable ordinary income to the doctor. The doctor could have exchanged with the amount allocated to equipment for his Southern California purchase and avoided that current tax burden if he had been properly represented.

SECURING A SPEEDING SALE AND CLOSING

Time is an important factor in selling a dental practice, especially in the event of a death, disability, or illness. An experienced broker has an extensive and detailed database of buyers. This database is generally obtained by a broker's contact and participation with dental schools, dental meetings, through speaking, which gives the broker access to new graduates and buyers.

Tip No. 6: Watch Out for the Details

CASE STUDY

A dentist developed a very successful practice over the past 30 years. Collections exceeded $1.5 million per year and the practice was broad-based and attracted about 35 new patients per month. The doctor was nearing retirement age and he began to receive unsolicited phone calls and mailings from practice sale brokers and recent graduates. He was a savvy businessman and decided that since he had numerous potential offerees, he would handle the transaction himself with the assistance from a local attorney. The transaction went relatively smoothly, although it took about six months. About a year after the closing and after attending a convention and talking to several of his friends, the doctor realized he had included his accounts receivable in the sales price, which had steadily crept up after his decision to sell. This one item cost the doctor approximately $200,000.

Celebrate Your Transition

Transitioning a dental practice is a multifaceted and intricate process, so having the right knowledge and information is crucial. The use of a qualified practice sales broker with the appropriate credentials and knowledge can help ensure a smooth transaction and lend peace of mind that all goals were met and bases were covered in the process. ■■■■

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Should We Be Concerned About the Future of Dental Insurance?

H. BARRY WALDMAN, DDS, MPH, PHD, AND STEVEN S. PERLMAN, DDS, MSCD

ABSTRACT Paying for dental services is a complex interaction of insurance, government, and out-of-pocket expenditures. The increasing demands to control health costs, in response to the competitive nature of national and global economics, raise the specter that the escalating need for services (e.g., for an increasing geriatric population) could affect adversely third-party support for dental services. A call for a proactive stance is made. A review of the related factors considers the basis for this concern.

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"Of each dollar spent for dental services, (in 2004 and 2005) the private sector pays 94 cents and the public sector 6 cents, primarily through federal and state Medicaid reimbursements. Patients pay 44 cents out of pocket and private benefits cover 50 cents."[1,2]

The costs of dental services are felt to a far greater extent than the costs of other health services. In 2005, out-of-pocket spending accounted for more than 44.2 percent of dental costs compared to 15.0 percent for all personal health expenditures, 3.3 percent for hospital care, and 10 percent for physician services.[2] Nevertheless, virtually half (49.8 percent) of dental costs are covered by private health insurance arrangements (a greater share of coverage of costs than for all other major health services). The deficit in coverage lies in the extremely limited input by government agencies for dental services.

Since 1980 (with projections through 2011) federal, state, and local governments' proportion of spending for overall personal health expenditures ranged from 39 percent to 44 percent; 40 percent in 2005.[2] During this period, government spending represented between approximately:

- 53 percent and 60 percent of all hospital costs;
- 30 percent and 35 percent for physician services;
- 11 percent and 23 percent for prescription drug costs; and
- 49 percent and 64 percent for nursing home costs.

By contrast, government spending for dental services ranged from 2.9 percent in 1990 to 6 percent of the $86.6 billion spent in 2005, with a projection that it would reach 7.3 percent in 2011 (**TABLE 1**).

TABLE 1

Percent of Government Spending for Personal Health Services, Selected Years 1980-2011[1-3]

	All Services	Hospitals	Physicians	Prescription Drugs	Nursing Homes	Dentists
1980	40.3%	54.3%	30.5%	13.9%	54.2%	4.9%
1990	39.0	53.2	30.6	11.6	49.2	2.9
2000	43.4	59.0	33.2	21.8	60.6	4.6
2004	44.4	56.3	34.6	27.5	60.8	6.0
2005	44.9	56.7	35.2	27.2	62.3	6.0
Projection						
2011	44.4	59.8	34.9	23.1	64.0	7.3

Lack of Health Insurance

"... the Census Bureau reported that the number of uninsured in 2006 had increased by 2.2 million Americans, largely because of a decline in employer sponsored insurance."[4]

In 2006, 2.1 million of the additional individuals without health insurance were nonelderly, including 1.4 million adults and 710,000 children. Almost 70 percent of the uninsured children were in families with incomes at 200 percent or more of the federal poverty level. Reversing years of steady declines, the number of uninsured children grew by 1 million over the past two years.

As debate continued on reauthorization of the State Children's Health Insurance Program, 48 percent of the increase in uninsured children from 2005 to 2006 was among families with incomes between 200 percent and 399 percent of the federal poverty level (roughly $40,000 to $80,000 for a family of four in 2006). Among children, the share with employer-sponsored insurance declined by 1.2 percent. The decline of employer-sponsored coverage for children was reported at all income levels. But there was no change in the share of Medicaid or SCHIP coverage to offset the employer-sponsored decline since most children in this income group are not eligible for public coverage under current rules.[4]

"In 2006, there was an actual decline in the number of people in poverty. Even in this economic environment, the number of uninsured increased substantially."[4]

The number of children without health insurance increased to 8.7 million, 11.7 percent of the child population. The number of uninsured adults increased by 1.4 million, bringing the total to 37 million, 20.4 percent of the adult population. In 2006, a total of 47 million Americans lacked health insurance.[5] In contrast to children, public coverage generally is not available to adults, even at low-income levels. As a result, nearly half of the growth of uninsured adults was among those with incomes below 200 percent of poverty.[4]

Spending for Health Care

In 2005, per capita national health expenditure was $6,697 (ranging, in 2004, from less than $4,000 in Utah to almost $6,700 in Massachusetts[6]). A total of $1.988 billion was spent nationally in 2005 for health services, 16 percent of the gross national product.[4] By the year 2016, the Centers of Medicare and Medicaid Services project that health spending will be nearly one-fifth of the GDP (19.6 percent). The aging of the population with its associated complexity of health needs will have an added "... impact on cost growth in the years to come."[7]

Per capita expenditures in 2004 "... was about 13 percent higher than in the next highest spending country, and about 90 percent higher than in many other countries that we would consider global competitors."[7]

Health Insurance

"The average premium for family (overall health insurance) coverage in 2007 is $12,106, and workers on average now pay $3,281 out of their paychecks to cover their share of the cost of a family premium."[8]

Health insurance premiums consistently have outpaced inflation and the growth of workers' earnings. As a result, workers have to spend more of their income each year on health care to maintain coverage, either through increased contribution for premiums or reduced benefits, or indirectly as when employers forgo wage increases to offset increases in premiums.[8]

It is anticipated that premium growth will continue to exceed per capita disposable personal income through 2014. "This may further strain the current system of employer-sponsored health insurance coverage."[9] Rather than increasing employees' share of insurance premiums, employers continue to seek cost savings by increasing the use of coinsurance, adding deductibles, and eliminating coverage for specific treatments or prescription drugs. "These actions might slow premium growth for employees, but they ultimately increase the burden on individuals as their direct out-of-pocket costs increase."[2]

"Rising medical bills may prompt some employers to develop strategies to manage the costs associated with the provision of coverage as they attempt to strike a balance between attracting and retaining talented employees and minimizing labor costs."[10]

Spending for Dental Care

During the past 35 years, total current and constant dollar (removing the effects of inflation) spending for dental services has increased steadily; constant dollar spending has more than doubled. Total personal care costs, however, increased at a greater rate. As a result, the dental service share of expenditures for health services decreased from 7.4 percent to 5.2 percent, with a projection that it will decrease to 4.3 percent by 2011 (TABLE 2).

Since 1990, there has been limited change in constant dollar per capita spending for dental services (TABLE 3). As a result, the increase in constant dollar national expenditures for dental services would, to some degree, be a reflection of the ongoing increases in the general population.

TABLE 2

Expenditures for Dental Care as a Component of Total Personal Health Care Costs: Selected Years 1970-2011[2,3,11]

Year	Expenditures (in billions)			Percent of Total Personal Health Care Cost
	Current Dollars	CPI (1982-84=100)	Constant Dollars	
1970	$4.7	39.2	$11.9	7.4%
1980	13.3	78.9	16.8	6.2
1993	38.9	188.1	20.7	5.0
2000	62.0	258.5	23.9	5.4
2005	86.6	324.0	26.7	5.2
Projection				
2011	104.6	na	na	4.3

TABLE 3

Current and Constant Dollar Per Capita Expenditures for Dental Services: Selected Years 1990-2004[11,12]

Year	Expenditures (in billions)		
	Current Dollars	CPI (1982-84=100)	Constant Dollars
1990	$120	155.8	$77
1995	156	206.8	75
2000	205	258.5	79
2001	219	269.0	81
2002	235	281.0	83
2003	244	292.5	83
2004	256	306.9	83

Should We Be Concerned About the Future of Dental Insurance?

Whether it is manufacturing an automobile, building a new bridge or ship, employing service workers, educating the next generation of youngsters, or insuring the needs of retired employees, the cost of health services (including dental care) is an increasing reality and a major factor in our highly competitive national and global economies.

Now add some additional developments that could (will?) strain further the economics of health costs during the practice careers of increasing numbers of dentists:

- Twenty percent of the population will be age 65 and older. In six states — Florida, Maine, Wyoming, New Mexico, Montana, and North Dakota — more than 25 percent of the population will be 65 years and older.[13] "Adults aged 65 and older have the highest health care spending, averaging $8,647 per person in 2004."[7]
- Increasing numbers of individuals with a wide range of disabilities, many of whom in the past succumbed to their conditions, are living longer, and 1) require increased health and supportive services, and 2) reside in our communities. In 2006, 15.1 percent of U.S. residents, age 5 years and over (more than 41 million individuals) had one or more disabilities including sensory, physical, mental, and self-care disabilities.[14]

In such an increasing competitive environment to provide for burgeoning health care costs, will private insurance arrangements continue to provide for 49.8 percent of dental costs, or will other components of health services be emphasized further in union-employer contract negotiations? Will government agencies continue to maintain only 6 to 7 percent coverage for dental costs?

At present, the economics of dental practice continue to be favorable. The average net income for an independent private practitioner who owned all or part of his or her practice in 2004 was $185,940 for a general practitioner,

and $315,160 for a specialist.[15] Whether this positive economic picture can be sustained in the event of a downturn in dental insurance coverage, that would in turn require increases in out-of-pocket spending by the public, is the question to consider as the profession prepares for the challenges posed by employer and government agency efforts to control health care costs.

While it may run counter to current efforts to showcase cosmetic dentistry, emphasizing the relationships between oral health and an individual's general medical status would be better suited to make the case for continued third-party support for dental services. Similarly, emphasizing the need to provide care for the growing population of the elderly and individuals with special health care needs would garner needed support for third-party coverage of dental care.

Directions

In the past, the dental profession remained in the shadows of the American Medical Association during the debates over the enactment of Medicare/Medicare legislation in the 1960s and general proposals for national health insurance in the 1970s and 1980s. Similarly, during the contentious political conflict over the legalization of denturism in the state of Oregon in the late 1970s and 1980s, the dental profession attempted to respond to the full-denture needs to the population only after it appeared that the voters would approve the initiative. But it was too late, the legalization of denturism was approved by two-thirds of the voters.[16] Presently, the dental profession continues to remain in the shadows of the medical profession over the explosion of litigations, the associated sky-rocketing of malpractice premiums (somehow assuming there is limited need for concern), and governmental efforts to reduce hospital and physician reimbursements under the Medicare/Medicaid programs.

We may remain in the position of *responders* to government and other third-party intrusions into dental practice. We could, however, *participate* in current and future debates over health care reform and promote those efforts that improve the shrinking availability of health benefit dollars, preserve the tax deductibility of dental services, and develop programs to ensure dental cost coverage among the tens of millions of individuals who currently lack adequate insurance and, who as a result, are far less likely to seek needed oral health services.

Or are we prepared to just wait and see whether labor management negotiators will remember to support dental services in future health insurance packages? ■■■■

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Peat and Re-peat

To the untrained eye, sheep, like penguins, look pretty much the same.

Robert E. Horseman, DDS

ILLUSTRATION BY CHARLIE O. HAYWARD

"Now we have the technology that can make a cloned child," writes Steve Connor, science editor of *The Independent*.

We should proceed cautiously here, more so than was exercised creating the child in the first place. Recognizing the wide diversity of members of, say, the Osmond Family and the Manson Family, not everybody should get to vote.

Remember Dolly, the Ewe de Benchmarke clone of a few years ago? The technology involved in Dolly's cloning is said to be vastly more complicated than this new procedure that is so simple and efficient, scientists are worried some maverick attempts to perform it would be too real to ignore.

Robert Lanza, chief scientific officer of Advanced Cell Technology, an American biotechnology company, warns, "It's unethical and unsafe. If this was applied to humans, it would be enormously important and troublesome."

Dr. Lanza probably is referring to the parents of teenaged children who would jump at the chance to do a little discreet gene manipulation if they thought it wouldn't make things worse. Apparently it is another of these things like performing your own rhinoplasty, we are forever being warned about to "Never try this at home."

To date, fears that the successful cloning of Dolly would result in the world being overrun by look-alike sheep have not materialized, although it would be hard to tell. To the untrained eye, sheep, like penguins, look pretty much the same. Nevertheless, Lanza says, "We now have a working technology whereby anyone, young or old, fertile or infertile, straight or gay, can pass on their genes to a child by using just a few skin cells." Not

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discussed yet is the inevitable problem of convincing the cloned individual he is not the original.

If you, as a layman, have trouble absorbing these biotechnical revelations, rest assured they work. Presumably, those selected skin cells should not be saturated with tattoo ink, in which case the clone might resemble a Jackson Pollock canvas.

The cloning research is not being done on live people, but, as usual, on mice. Put a mouse alongside a man, like in a police lineup and you fail to see any physical connection that would warrant the substitution. Men are taller, for one thing. But you are not a scientist, a group that has learned by experience that a mouse will put up with indignities a man and PETA will not tolerate. Mice have been reprogrammed and genetically tweaked until almost anything is possible except a normal, cheese-eating existence.

As long as mousetraps still work and crazed rogue mice are not running up pant legs or down blouses, we are content to leave the experiments to the lab techs and concentrate on the promises and waffling of political candidates. A federal grant for research labs is small potatoes compared to the $500 million or so required for presidential campaign expenses. The results for both are frequently disappointing.

Set aside for the moment the religious and ethical elements of producing "designer children." It is our obligation as dental professionals to ponder not only how many implants can be billed to a working man's salary and how many veneers it would take to create a virtual clone of Julia Roberts, but how much research money is being directed to improving human dentition.

Say you are a parent of a child in her third year of orthodontic treatment so she can look like Hillary Swank and make a bundle displaying all 32 teeth in TV commercials. What if you could have had a hand in designing this kid without the peg laterals, the impacted third molars and the 2 centimeter overjet? Imagine choosing a shade for her anteriors so white, she would never bug you for a makeover before she was even into puberty? Never mind the hair, eyes, lips, and all the other attributes real or enhanced requisite for the young to survive in today's milieu, this is important stuff and we need to keep an eye on these genetic programmers.

Dr. Lanza concludes with "... for instance, if we had a few skin cells from Albert Einstein, or anyone else in the world, you could have a child that is, say, 10 percent or 70 percent Albert Einstein by just injecting a few of their cells into an embryo."

Maybe Einstein is not the best example, because harvesting some of his skin cells could be a problem as they have been largely unavailable since his death in 1955. Besides, we already have too many kids with funny hair.

Assuming God really wants everyone to be happy except for, perhaps, mice, if you are considering becoming in a family way, you might want to postpone it for 15 or 20 years until your options become clearer. ■■■■