Corporate Dentistry

The fact that the American College of Prosthodontists is addressing the subject of corporate dentistry underscores the importance of the changes now affecting providers of dental health care in the United States. Health professionals in general are in the midst of major practice transformations, exemplified by demographic shifts, changing educational competencies, degree requirements, and practice settings.[1]

Conceptually, there is no clear distinction between the term private practice and corporate dentistry, given that many solo private practice prosthodontists are professionally incorporated (PC) and that all states except three (Arizona, Wisconsin, and Utah) require dentists to own dental offices. The term 'corporate dentistry' is sometimes used synonymously with 'managed group practices,' and the management organization may be referred to as a dental management organization (DMO) or a dental service organization (DSO). For a practicing prosthodontist, career options in this environment might include:

- Private practice ownership
- Associate in a Private Practice
- Associate in a traditional group practice
- Practice within a DMO/DSO group practice
- Academic positions and faculty practice

The Academy of General Dentistry has defined corporate dentistry as: "A variety of practice modalities in which management services, at a minimum, are provided in a manner that is organizationally distinct from the scope of activities performed by a dentist within only his or her practice."[2]

Fewer than 25 years ago, more than 90% of dentists were owners. That proportion has now declined to less than 85%, as increasing numbers of dentists work in a DMO/DSO practice model or are employees in other types of practices, including public health settings.[3] The trend toward larger, consolidated multi-site practices is expected to continue, driven by changes in practice patterns of new dentists, a drive for efficiency, and increased competition for patients.[4] Approximately 8000 dentists are currently working in very large/corporate/DMO-DSO-affiliated group practices. Twenty-four percent of new dental graduates now go to work for DMO/DSO-affiliated practices. While the delivery model for dentistry is changing, it is unclear how fast and how prevalent the non-solo model will be or how prevalent non-ownership will be.[5-6] Factors affecting the choice of practice can include:[7]

- Educational debt
- Gender
- Race

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- Ethnicity
- Having a parent who is a dentist
- Trends in dental insurance benefits
- The economy
- Midlevel providers
- Changes in oral health status
- The Health Care Reform Act
- New dental schools
- Dentists practicing longer
- Fewer associate opportunities in private practice

The average debt for dental school graduates has increased over time, primarily due to increases in the cost of attending dental school.[5] The percentage of female U.S. dental school graduates increased from 39.5% in 2003 to 47.2% in 2013.[8] Future growth in the U.S. population will continue to come disproportionately from racial and ethnic minorities and immigrants. Already, non-Hispanic white births are less than 50% of all births in the U.S.[9] These reasons and others may make a growing segment of dentists now more likely to prefer salaried positions as employees in DMO/DSO-affiliated group practices rather than the more traditional entrepreneurial setting.

Given the above evidence, the fact remains that DMO/DSO-affiliated group practices are here to stay and will play an increasing role in private practice decisions of dentists in the future. Levin has stated that "these businesses [DMO/DSO-affiliated group practices] pose stiff competition for traditional solo practices by promoting a lower priced alternative and accepting more insurance. They have the potential to transform a geographic market virtually overnight".[10]

The question then might be re-framed of one not so much focused on the classification of practice (solo-private, group, DMO/DSO-affiliated group practice) but rather on the practitioners (prosthodontists) themselves. Garcia wrote eloquently in an ADA guest editorial 'The Restructuring of Dental Practice,' that regardless of the practice setting, "a dentist's professional and ethical obligations are always to place a patient's best interests above the dentist's self-interests. And corporations per se are not the problem. The vast majority of dentists already practice under some form of corporate structure, such as a professional corporation or a limited liability company." Regardless of who accepts the responsibility for business decisions, dentists hold the responsibility for their clinical decisions and ethical conduct. Garcia goes on to say, "When all is said and done, what matters most is our patients' oral and overall health. Thus, regardless of the particular type of setting in which they practice, all dentists need to hold utmost the quality and outcomes of the care that they provide."[11]

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The most significant distinction between the two forms of practice essentially comes down to a willingness to accept a corporate culture and thrive in an environment that may be divergent from the traditional small business model of a typical prosthodontic setting. Management and some employee decisions may be made at a different level, and a partial or complete loss of independent control over some aspects of the practice can occur. This does not imply that there will be any change or degradation of the quality of care. In fact, it may dramatically improve in many circumstances. It simply becomes a matter of which environment best suits the personality and expectations of the individual practitioner as these corporate opportunities become more available.

To that end, it is the position of the American College of Prosthodontists to support all members, regardless of their style of practice, to always serve our patients' and the public's best interest with the highest ethical and quality standards.

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Approved ACP Board of Directors: Oct. 20, 2015

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