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SHORT COMMUNICATION

How will the corporate dentistry model change the specialty and practice of oral and maxillofacial surgery?

Dana C. Jackson

Department of Oral and Maxillofacial Surgery, Howard University Hospital, United States

ABSTRACT

Corporate dentistry is changing the traditional practice of oral and maxillofacial surgery. Dental Service Organizations (DSO) and Private Equity Firms are consolidating dental practices. DSOs allow dentists to focus on patient care while business experts manage the administrative aspects. The traditional practice models of ownership, independence, and the ability of oral and maxillofacial surgeons to control the direction of the practice are concerning as the DSOs capture more of the marketplace. The future direction of the specialty should be controlled by oral and maxillofacial surgeons who understand the individual and group practice model, allowing us to unite our individual practice patterns and resources for the greater good of the specialty. In addition, the impact on education and training, hospital practice, and maintaining our autonomy are important issues to address as we move forward. Moreover, it raises critical questions about the long-term implications of corporate dentistry on patient care, education, and professional autonomy within the OMFS specialty.

KEYWORDS

Professional autonomy; Dental care; Group practice; Patient care

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Introduction

The advent of corporate dentistry, which includes Dental Service Organization (DSO) and Private Equity Firms (PE), is changing the traditional practice of oral and maxillofacial surgery and the options available to surgeons. A DSO is a USA company that takes on all the related tasks to run a dental practice improving the efficiency and profitability of the business. The newer models are where a nondentist-owned DSO purchases practices and assumes operational but not clinical control of multiple practices, often partnering with private equity firms [1]. The practice management model is not unique to dentistry as Medical Service Organizations (MSO) have become more commonplace in recent years. All marketplace sectors are experiencing buyouts, including Ophthalmology, Dermatology, Urology, Pain Management, Orthopedics, Gastroenterology, and Dental Practices. DSOs are intricate organizations backed by private equity funding designed to grow and generate huge value and returns for their investors through the acquisition, growth, and selling of private practices.

The DSO is the holding company that joins practices together to make them more valuable. Private equity groups partner with DSOs to provide financing and allow multiple practice acquisitions. DSOs got their start in the 1990s benefiting the dental office by separating the clinical and nonclinical parts of dental practice. The idea was to have business experts deal with things like negotiating contracts with landlords, managing employees, and purchasing supplies, thereby freeing up dentists to focus on patient care. In 2017, Bloomberg reported that the overall market for dental services was around $73 billion, which made them attractive to private equity firms [2].

The idea was to allow dentists to focus on patient care while business experts manage the administrative aspects, such as:

1) Human resources, including recruitment and training of employees
2) Accounting, including billing and payroll
3) Marketing
4) Regulatory compliance
5) IT infrastructure
6) Technology and support

On April 2021, Brian Colao, Director of Dykema, a healthcare management firm, stated the current DSO marketplace is 30-32% consolidated and is expected to increase to 75-80% in the next 10 years [3,4]. Private equity firms are partnering with DSOs to buy practices at 100% of annual gross revenue. They then make changes to the practice to maximize its value with the expectation of selling at 300-400% of gross revenue [2]. According to Physicians Growth Partners LLC, private equity consolidation is new for oral surgery practices and has become more commonplace over the last 24 months and is a rapidly growing model [5].

The advantages advertised by the DSOs to the new oral surgeon include [6]:

1) Salary and benefit packages
2) Practice location flexibility
3) Access to cutting-edge dental technology and tools that are usually provided by the DSO
4) Mentoring programs
5) Malpractice insurance, along with health and dental insurance, paid vacation, continuing education, and retirement benefits ADG.org

For dentists fresh out of dental school, taking on the costs of practice ownership when they have a mountain of student loan debt isn't often feasible. Both corporate and large group

***Correspondence:** Dr. Dana C. Jackson, Resident, Department of Oral and Maxillofacial Surgery, Howard University Hospital, United States, e-mail: dana.jackson@howard.edu
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dentistry offer young dentists a steady paycheck from the get-go. As the cost of dental school continues to rise, these models will likely be the employment option many graduates seek out [1].

The major reason new graduates chose the corporate route is the increase in student loan debt, which averages $400,000 – 500,000 for many residents [7]. The offers made by the DSOs are competitive and enticing compared to those from oral surgery group practices and educational institutions. I have seen offers come across my desk ranging from $400,000 – 750,000 as a base salary with the option of additional income based on production. This raises issues regarding traditional options when choosing a career in oral and maxillofacial surgery. Many DSOs are primarily office-based, focusing on dentoalveolar surgery, implants and bone grafting. There is limited opportunity to manage head and neck infections and pathology. The surgeon often travels to multiple offices with general dentists and other dental providers on-site in a group practice format. The office may or may not be fully equipped and plumbed for oral and maxillofacial surgery specialty care. Intravenous sedation, deep sedation and general anesthesia procedures are variable based on office design and staffing. Most do not offer the option of hospital privileges for the management of trauma, infections, orthognathic, and reconstructive surgery. TMJ surgery and cosmetic surgery procedures are not often offered as part of the contract. The primary incentive for these offices is maximizing the enterprise value.

The advantages for the practicing surgeon include [8]:

1) Practice growth strategy
2) Reduction in medical supply costs through volume discounts
3) Insurance payer contract negotiation
4) Staff recruitment and training
5) Provider recruitment
6) Service line expansion
7) Mergers and Acquisitions

The practice's owner may retain full control and the DSO only supports the business' management aspects. The DSO can also provide assistance in selling the practice with various options, including partial ownership while continuing to work as an employee or direct purchase [1]. Many surgeons have opted to sell their practices for a retirement "nest egg" as opposed to recruiting a young oral surgeon to gradually buy the practice or sell it directly to an oral and maxillofacial surgery group.

As a program director, my residents frequently ask for my advice on job opportunities upon completing their residency. Traditionally, graduates have the choice of solo practice, group practice, academia as a faculty member at a dental school or hospital, or a fellowship to receive additional training in the specialty. Ownership and control of a practice were real incentives to directly purchasing or a "buying- in" to a private practice. Educational opportunities included teaching, research along with practice options. Most graduates would join our parent organization, the American Association of Oral and Maxillofacial Surgeons (AAOMS), Oral and Maxillofacial Surgeons National Insurance Company (OMSNIC), as well as membership in our component and constituent oral surgery societies. AAOMS membership requires hospital privileges to manage and treat more complex patients with major surgery needs, including trauma, infections, pathology, orthognathic and reconstructive surgery. In recent years, surgery centers have become more commonplace. OMNSNIC is the primary malpractice insurance for oral and maxillofacial surgeons nationwide.

The following questions have yet to be answered:

1. What happens to the "full scope" oral and maxillofacial surgery practice if many of our surgeons choose to participate in this model?
2. What is the incentive to maintain hospital privileges and the ability to treat patients with the training that is specific to our specialty (e.g. orthognathic and reconstructive surgery, oral-facial infections, TMJ surgery, pathology and cosmetic surgery) if these offices do not support this format?
3. What impact will this have on the future of our specialty, including training and educational requirements? Will the shift in practice trends towards office-based oral and maxillofacial surgery impact the required Commission on Dental Accreditation (CODA) educational standards for the specialty? What will be the impact of recruitment and retention of qualified faculty, considering many institutions struggle to compete with the salaries offered by the private sector?
4. What is the impact on the membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS), Oral and Maxillofacial Surgeons Political Action Committee (OMSPAC) OMSNIC, component, and constituent society membership if new surgeons do not see the value in joining our traditional organizations? If our numbers continue to decline, will we have the same organizational influence and structure to help shape policy nationally, including the protection of our anesthesia model, prescription drug abuse, and other OMSPAC initiatives?
5. What is the long-term impact of decreasing individual or group ownership with the private equity firms purchasing oral surgery practices? The opportunity for the oral surgeon to "buy in" becomes less as fewer surgeon owned solo and group practices are available in the marketplace. If the consolidation of dental practices continues to increase from 30% to 70%, approaching a monopoly, will the salary structure and practice model change for the benefit of the private practice surgeon and for the specialty?
6. What will be the impact on patient care, if any, with profits being the primary driving force for maintaining the practice? How is the quality of care and patient satisfaction affected?

Conclusions

The traditional practice models of ownership, independence, and the ability of oral and maxillofacial surgeons to control the direction of the practice are concerning as the DSOs capture more of the marketplace. The future direction of the specialty should be controlled by oral and maxillofacial surgeons who understand the individual and group practice model, allowing us to unite our individual practice patterns and resources for the greater good of the specialty. In addition, the impact on education and training, hospital practice, and maintaining our autonomy are important issues to address as we move forward.

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This is a rapidly changing environment without a clearly defined ending. It would be in our best interests to bring our collective minds together to develop strategies that will address the changing landscape and support our specialty for the future.

Disclosure statement

No potential conflict of interest was reported by the author.

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