Task Force on the Role of a Dentist in a Group Practice

Following the ACD Annual Meeting in October of 2021, President Richard E. Jones appointed several special task forces to research and develop recommendations to further the work of the College. One such task force was given the directive to study the business model, structure, and the role of the dentist in a Dental Service Organization (DSO). The members of this task force were the outgoing Regent from Regency 6, Doug Bogan, President Elect Robert Lamb, Vice President Terri Dolan, SPEA Liaison Erik Klintmalm, Former ADA President and Regent at Large Joe Crowley and Ethicist and ACD Fellow Phyllis Beemsterboer. This group was well versed in dealing with this topic having a recent graduate in a group practice, two seasoned dentists in a group practice, one retired dentist from a solo practice who has dealt with group practices on the ADA level, one seasoned dentist in a solo practice, a vice president of a large dental supplier with expertise in dental products and sales and lastly an ethicist from the academic realm.

Early on in our research and deliberation it was evident that the scope that we were tasked with was broader than just DSO's; so, it was expanded to include all group practices whether private or corporate. Some of the questions that were raised:

- What has led to the proliferation of DSO's as opposed to the traditional private single dentist practice?
- Why are young dentists attracted to DSO's?
- What is it about the structure that makes the profits appealing to a corporation whereas a private practice cannot attain that percentage of profit?
- What are the legal ramifications as it pertains to liability and to peer review?

One might ask why the big fuss about group practices? The findings by the Health Policy Institute found that overall, from 2005 to 2019 private practices decreased from 84.7% to 73.0%; that is an 11.7% drop. The statistics also showed a decline by sex and age groups across the board. DSO's and group practices are here to stay, and they are growing. The solo practice is still the dominate model; the question is how long will it remain that way? The group practice will be the face of the future of dentistry. To set the record straight, there are good DSO's and group practices, and there are not so good DSO's and group practices. One of the concerns is the potential to develop bad habits in an impressionable young dentist while pursuing the maximum possible profitability. The more that this practice model can be influenced concerning ethics in its infancy the better.

Citing Albert Guay, Matthew Warren, Rebecca Starkel, and Marko Vujicic in the Health Policy Institute Research Brief, six types of group practices were identified with the first two occupying the majority of group practices. These two are the ones that the task force was asked to deal with: Dentist Owned and Operated Group Practice (which we termed the Private

Group Practice or PGP) and the Dental Management Organization Affiliated Group Practice (DSO). In the later either a dentist entrepreneur ownership, a corporate ownership or a private equity ownership are the majority models. The PGP's and the DSO's have several advantages over the traditional solo private practice.

Those advantages are:

- space sharing with multiple dentists
- extended hours
- marketing
- group buying power for major equipment, supplies and sundries
- staff sharing
- a prime work force of recent graduating dentists who are anxious to start earning a salary to begin paying on their dental school debt.

The rent or mortgage payment remains the same whether the office is open from Monday to Thursday during the hours of 9 to 5 or six days a week with extended hours. Supplies will increase, however that is roughly 8% of the overhead. The increase in utilities would be meniscal. The only real expense is salaries for those increased hours or days. This only increases the level of profitability.

Another interesting article was in the August 2015 issue of JADA. Several points stood out that would impact the dentist in a group practice. When comparing the gender of the dentists in three practice models, private practices (PP's), small group practices and large group practices, the private practice had the lowest percentage of females. In looking at salaries the small group practice had the highest salaries with 38% reporting salaries of $300,000 or higher whereas the private practice had their highest average at $149,000 at 20% and the same salary at 28% for the large group practice. Also cited was the administrative time needed each week for the three practices. The private practice spent 7.11 hours, the small group practice spent 5.88 and the large group practice 4.37 hours. The last measure that needs cited from the article is overall satisfaction; the small group practice leads the way followed by the private practice and then the large group practice; apparently bigger is not always better.

Now that some parameters have been mentioned several more questions arise.

- How does a dentist function in a group practice?
- What are the dentist's rights?
- Is there a path to ownership?
- What legal ramifications are there in providing treatment?
- Is there "wiggle room" in providing treatment that someone else already planned?

Most dentists are familiar with the ADA's Principle of Ethics & Code of Professional Conduct which was developed when the vast majority of practices were solo private practices. As group practices are becoming a common place and growing faster than solo private practices, what

are the ethics involved for a dentist employed by a DSO or a PGP? At DentalEthics.org there is a great ethical dilemma in video format titled, The Young Dentist. This new graduate is beginning their career in a group practice. You would do well to view it at dentalethics.org.

In considering all that has been said until now the Task Force on the Role of a Dentist in a Group Practice developed the following 10 Rights:

1. The dentist is ethically bound to place the needs of the patient as primary, striving to create and maintain trust in the patient-dentist provider relationships.
2. The dentist is a professional with autonomy defining their role in the provision of dental care and diagnosis of dental disease.
3. The dentist must fully examine any patient that has presented for dental care and prepare an appropriate treatment plan.
4. The dentist should present to every patient all the appropriate treatment plan options, advantages, and disadvantages. The dentist must assure that each patient understands the rationale for each treatment option.
5. The dentist should address the cost of each treatment that is clinically acceptable and should not be pressured to propose more expensive options, encourage overtreatment, or engage in up-selling to generate more revenue.
6. The dentist should provide the dental treatment he/she planned for each patient under care. If the patient has been assigned to a new dentist, that dentist should re-examine the patient to assure agreement with the treatment plan.
7. The dentist must not perform any procedures outside of the scope of practice or for which they are untrained.
8. The dentist must know the rules, regulations, and laws in the jurisdiction in which they are practicing and are required to adhere to these guidelines.
9. The dentist should have their dental education degrees and dental license displayed where patients can observe.
10. The licensed dentist as leader with the dental team should be sure all allied individuals are educated, credentialed, and maintaining appropriate skills to assure the safety of the patients.

Most of these apply to any dental practice whether solo or group. The group practice is unique in that it is not uncommon for a patient to be examined and treatment planned by a dentist, and at some point, have another dentist perform a portion, if not all, of the treatment.

- What are the rights of that dentist if they disagree with the treatment plan?
- What are the legal ramifications if the treating dentist has not examined the patient?
- Where does this dentist stand in the event the case goes before a peer review committee?

These rights are not intended to hamper a group practice, but to bolster it. The old adage, "two heads are better than one", rings true in this case, and it can only benefit the patient. Collaboration is not a mechanism for dominance, but a teaching moment for the young dentist and for the seasoned dentist equally.

These 10 rights were introduced to the D3 students at the Indiana University School of Dentistry in April in conjunction with their deliberation on the fore mentioned dental ethics video, "The Young Dentist", and it was well received. Special thanks go to Drs. Odette Aguirre and Larry Garetto who aided in allowing this to be disseminated at the D3 Ethics Summit and provided some grammatical changes to bring it to its final form. Graduating from dental school and beginning a career is challenging, in itself, let alone making the decision to buy a practice, start a practice or join an existing practice as a rookie associate. These rights provide the new dentist information to negotiate in the event the selling dentist remains for a period of time as the Senior Associate or for negotiating when entering a group practice.

Now that we have identified these rights where does it go from here? It is the consensus of the Task Force that the document be used as a teaching tool in dental education and be introduced in the second year and be reinforced in the third- and fourth-year practice management courses. If all goes as planned this document will be beta tested at the White Coat Ceremony at the University of Louisville in August.

Terry L. Norris, DMD
Task Force Chair
July 2022