Royal College of Dental Surgeons of Ontario

Report on Practice Models and Corporate Dentistry

September 18, 2025

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Executive Summary

Report Overview and Decision for Council

This Report sets out five options that the RCDSO has identified to address issues and harness opportunities related to dental practice models as part of the Practice Models and Corporate Dentistry (PMCD) Strategic Project.

Each option is presented as a distinct chapter of this Report. Each chapter includes an analysis of implementation considerations (e.g., regulatory tools, required resources, risks) and additional information for each option to support Council's decision on the proposal set out in the briefing note. The proposal is as follows:

- That the RCDSO proceed with all of the options identified in the Report, as they are interrelated and together represent a comprehensive and strategic response to the issues and opportunities related to dental practice models; and
- That this work will be undertaken in a phased approach to take into account interdependencies between the options and to ensure adequate resourcing for this work.

This Report does not assess the relative merits of different dental practice models, or comment on the issues and opportunities associated with various dental practice models for dentists.

Approach to Options Development

The options were developed using a **risk-based, evidence-informed approach** that considered academic literature and media; regulatory approaches used by various domestic and international regulatory authorities; relevant RCDSO data (e.g., complaints data and responses to the Annual Renewal Questionnaire); and survey-based consultation feedback from registrants, the public, and other interested parties.[1]

The College recognizes that each dental practice model offers opportunities and issues for patients. For this reason, the College adopted a **practice model-agnostic approach** to options development. This means that options were developed to address specific issues or harness specific opportunities for patients and were unbiased toward particular practice model types.

The options include a combination of **traditional regulatory tools** (e.g., Standard of Practice, educational resources) and **anticipatory regulation** to address known and unknown risks– anticipatory regulation involves using processes that build knowledge and capacity in key areas so that regulatory authorities can better anticipate issues and opportunities, and identify potential regulatory solutions.[2] Examples of anticipatory regulatory tools leveraged in this Report include regulatory sandboxes, and engagement with experts and other interested parties.

While the options in this Report are presented individually, they are complementary. **Multiple options could be implemented in a phased manner, as part of a strategic framework**, to address issues and harness opportunities related to dental practice models for patients.

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[1] See Appendices B to I of this report for highly abbreviated summaries of research and analysis. Appendices are linked on page 9.
[2] Armstrong, H. and Rae, J. (2017, November). A working model for anticipatory regulation: A working paper. Nesta. https://media.nesta.org.uk/documents/working_model_for_anticipatory_regulation_0.pdf

Options

Below is a summary of all five options that are being put forward for Council's approval.

Regulatory tools and implementation considerations for the options are summarized at a high-level in **Figure 1**, and the detailed text for each option can be found in the corresponding chapters of the report (i.e., Chapter 1 through Chapter 5).

Option 1: Update and develop new College requirements and recommendations for registrants to address unique issues for patients related to the business of dentistry. This option includes two components:

a. Updating existing College resources and developing new College guidance (e.g., a Standard of Practice) for registrants that clarify and address unique issues for patients related to the business of dentistry.

b. Gathering information to support a longer-term legislative/regulatory review that would aim to explore potential amendments to the Professional Misconduct Regulation under the *Dentistry Act, 1991*, and potential options for new legislation that would help to assure quality of care in an evolving dental practice landscape.

Option 2: Develop new requirements to ensure that a registrant holds primary responsibility for each dental clinic, and to ensure that registrant responsibilities for continuity of patient care are clear regardless of the practice model. This option includes two components:

a. Developing new College guidance (e.g., a Standard of Practice) for a 'lead' registrant in each clinic who has primary responsibility for the oversight and supervision of the clinic (i.e., for compliance with relevant legislation, regulation, and Standards related to practice management); and responsibility for providing current practice information to the RCDSO (e.g., the contact information for the lead registrant, whether the practice is affiliated with a third-party).

b. Develop new College guidance to ensure continuity of care (e.g., to ensure coordination of patient care between dentists where the patient is under the care of a practice, and does not have an individual dentist who is primarily responsible for their care).

Option 3: Enhance educational offerings for dental students in Ontario and RCDSO registrants that will help reinforce and illustrate their ethical and professional responsibilities regardless of the practice model. This option includes three components:

a. Developing new College resources (e.g., an RCDSO Connect session or ODA New Dentist Symposium session) focused on upholding ethical and professional responsibilities across various practice models;

b. Engaging with dental faculties in Ontario to implement strategies – e.g., course material, presentations – to reinforce for dental students their responsibility to protect the public interest respecting the practice of dentistry, regardless of their practice model.

c. Adding new scenarios to the College's Jurisprudence and Ethics Course and new resources and questions to the College's Practice Enhancement Tool concerning ethical and professional responsibilities and proliferating and emerging practice models – i.e., corporate dentistry, direct-to-consumer (DTC) dentistry.

Option 4: Develop a proposal for an 'Innovation Advisory Service' (IAS) pilot program.

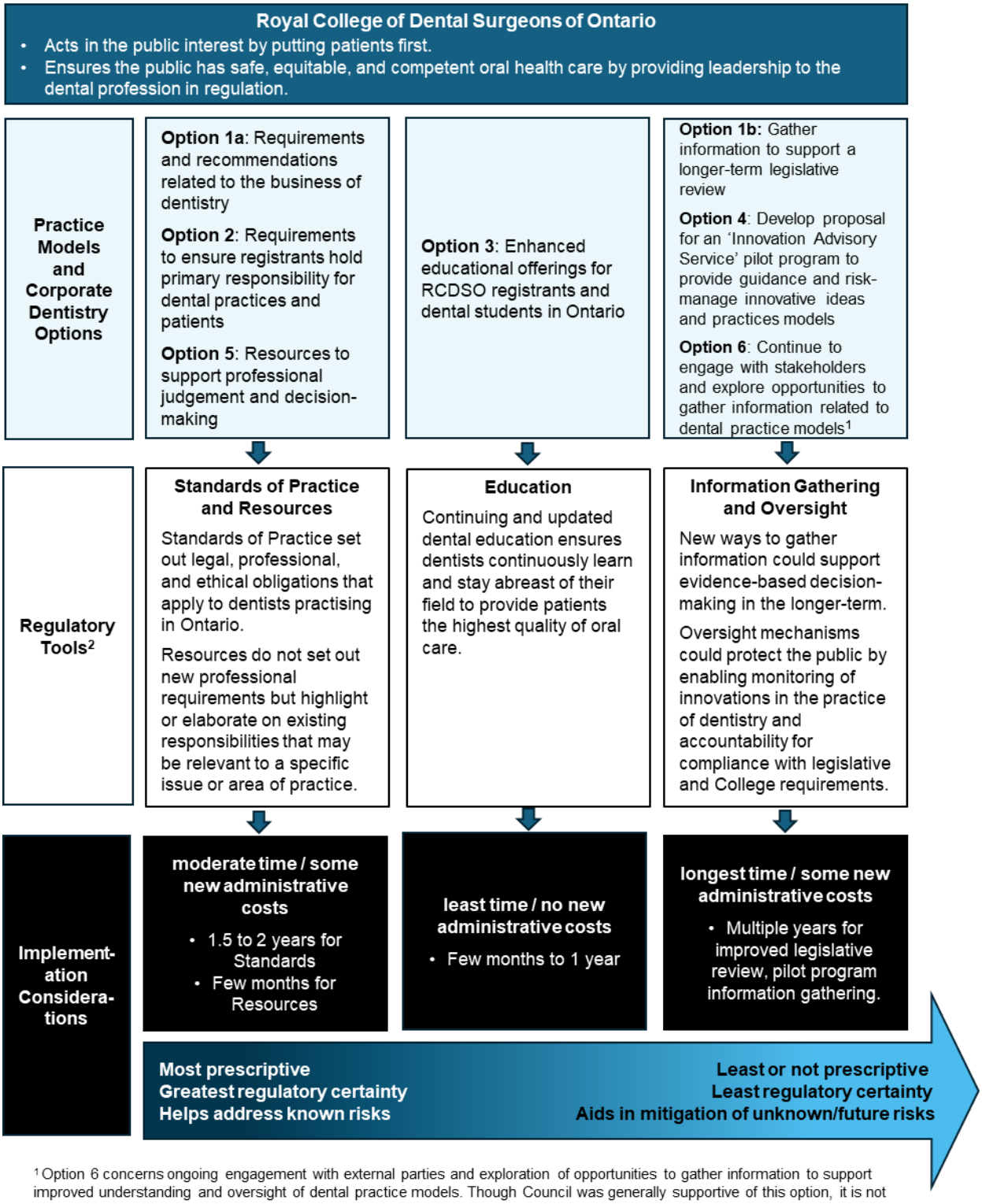
The RCDSO would develop a proposal for an 'Innovation Advisory Service' (IAS) pilot program **for Council's approval**. The program would be comparable to an innovation hub (described in Chapter 4) in that it would provide non-binding guidance to innovators regarding the current regulatory framework for dentists in Ontario and enable proactive risk-management of innovative ideas or practice models that have the potential to improve quality or delivery of services for patients.

Option 5: Develop resources to support patients' decision making and registrants' professional judgement related to dental practices or dental practice models. This option includes two components:

a. Developing new College resources and/or sharing pre-existing resources to help patients determine if the care provided by a particular dental practice is right for them (e.g., "five questions to ask your dentist about their practice").

b. Developing a resource that provides general guidance to support the professional judgement of registrants who are considering providing treatment through a DTC practice model.

Figure 1. Summary of Options and Implementation Considerations



[1] Option 6 concerns ongoing engagement with external parties and exploration of opportunities to gather information to support improved understanding and oversight of dental practice models. Though Council was generally supportive of this option, it is not being shared with Council for approval as it is operational and related to internal College processes.

[2] Note: the regulatory tools in this figure are those that have been leveraged in the options presented in this report. These tools do not represent the full suite of regulatory tools available to the RCDSO to carry out its mandate.

Next Steps

If Council approves the proposal, RCDSO staff will develop a plan to incrementally implement the approved all options to ensure a responsible and resource-wise approach.

Some recommendations may require additional resources and/or support from external partners. These considerations will be fleshed out in the PMCD Implementation Plan.

As work proceeds on the options in the Report, Council will be updated, and Council's direction will be sought at different stages.

Background

Dental Practice Models Context

Dentists work in various types of practice models. These include private practices, which are owned and operated by a single dentist (solo private dental practice) or multiple dentists (group private dental practice), corporately owned dental practices, and other types of clinical and non-clinical settings (for example, hospitals, educational institutions, and governments).

In recent years, models for dental practice ownership and operation have become more diverse, including a notable shift towards various corporate ownership models[3, 4] and the emergence of direct-to-consumer (DTC) dentistry.[5]

While corporate ownership models and DTC dentistry have the potential to improve access to care and provide patients with more choice, they also raise questions about how business objectives of dental practice owners (particularly non-dentist practice owners) interact with the obligation of dentists to prioritize the health and well-being of their patients, and with the core objectives of dental regulators to protect the public interest and ensure quality of care.

'Practice Models and Corporate Dentistry' (PMCD) was established as a Strategic Project under the Royal College of Dental Surgeons' 2023-25 Strategic Plan. The project was designed to advance the College's understanding of dental practice models, their implications for patient care, and to enable decision-making on options that support the effective regulation of dentists in all practice models, including corporate dentistry.

Regulatory Context

As of 2023, Ontario had the largest number of registered dentists (almost 11,000),[6] and the largest number of dental clinics (over 7,000),[7] of all Canadian provinces and territories.

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[3] Group Dentistry Now. (2020, May 27). Largest Majority Canadian-Owned Network Of Dental Practices Poised For More National Expansion. https://www.groupdentistrynow.com/dso-group-blog/largest-majority-canadian-owned-network-of-dental-practices-poised-for-more-national-expansion/

[4] 'Corporate dentistry' is as a dental practice model wherein a corporation, also known as a dental service organization or 'DSO', owns, aligns, or partners with multiple dental clinics and provides centralized operational support for the business and operational elements of the clinics. DSOs may be owned by dentists or non-dentists.

[5] 'Direct-to-consumer (DTC) dentistry' is a dental practice model that involves treatments which are largely self-administered with limited supervision from a dentist such as at-home whitening kits, mouthguards or aligners (to straighten teeth) made using a home impression kit.

[6] Royal College of Dental Surgeons of Ontario (2024). 2023 Annual Report. https://cdn.agilitycms.com/rcdso/annual-report-2024/content/index.html#/lessons/RWPcFStRtAK_9MhIKd4rwYgNy6fd6W_y

[7] Statistics Canada (2024, November 27). Businesses - Canadian Industry Statistics: Offices of dentists https://ised-isde.canada.ca/app/ixb/cis/businesses-entreprises/6212

As the regulator for dentists in Ontario, the Royal College of Dental Surgeons of Ontario (RCDSO) ensures the public has safe, equitable, and competent oral health care by providing leadership to the dental profession in regulation.

The mandate and objectives of the College are set out in the *Regulated Health Professions Act, 1991.* Objectives include, but are not limited to, the responsibility to develop, establish and maintain standards and programs: to assure the quality of the practice of the profession[8] and promote the ability of registrants to respond to changes in practice environments and other emerging issues,[9] such as those related to dental practice models. In achieving its objectives, the College has a duty to serve and protect the public interest.[10]

Notably, however, the regulatory authority of the College extends only to dentists who are registered with the College (or 'registrants'). The RCDSO does not have the authority to regulate non-registrants or the ownership structures through which registered dentists practice.[11] As some illustrative examples, the RCDSO does not have the authority to accredit dental practices or investigate their business operations,[12] or hold non-registrants (e.g., non-registrant clinic owners) accountable for their influence (if any) on the conduct and practice of registrants within their clinics. **Table 2** provides select topics related to RCDSO's regulatory authority, the regulatory framework for registrants, and its application to non-RCDSO registrants.

Notwithstanding constraints on the RCDSO's regulatory authority, given that changes in dental practice models may impact the safety and quality of patient care, an exploration of dental practice models, their impacts on quality of patient care, and regulatory decision-making on this topic fall directly within the scope of the RCDSO's mandate.

[8] pursuant to paragraph 3 (1) (3) of the Health Professions Procedural Code under *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18

[9] pursuant to paragraph 3 (1) (10) of the Health Professions Procedural Code under *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18

[10] pursuant to paragraph 3 (2) of the Health Professions Procedural Code under *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18

[11] Excluding the issuance of Certificates of Authorization for Health Professional Corporations incorporated under the *Business Corporations Act, 1990*.

[12] with the exception of facility permit authorizations and inspections of dental facilities where dentists: administer sedation and general anesthesia, and where dental CT scanners are installed and operated.

Objectives and Scope of Work

The objectives of the PMCD project are three-fold:

1. to better understand the types of dental practice models operating in Ontario;
2. to identify issues and opportunities related to various dental practice models, including corporate dentistry, for patients; and
3. to develop options to promote and assure quality of care and ensure effective regulation of dentists regardless of practice model type.

Table 1 provides an overview of the scope of work (that is, the research and analysis) that informed the options in this Report. Abbreviated summaries of research and analysis can be found in the appendices that are linked in Table 1:

Table 1. Scope of Work: Project Phases and Status

Phase and Status	Phase Summary	Appendices
Phase 1: Information Gathering **COMPLETE**	This phase involved gathering information through desktop research (e.g., jurisdictional and literature review) and consultation activities (including a consultation survey, and conversations with staff at the RCDSO and other regulatory colleges), to better understand: ○ the RCDSO's approach to its work including expectations/guidance related to practice models; ○ the types of practice models that exist in Ontario; ○ how practice models are regulated in other jurisdictions; and ○ issues and opportunities related to practice models for patients.	• Appendix B: RCDSO Research Summary • Appendix C: List of Practice Models • Appendix D: Jurisdictional Review Summary • Appendix E: Literature Review Summary • Appendix F: Consultation Summary
Phase 2: Analysis & Options Development **COMPLETE**	This phase involved reviewing previously gathered information, conducting additional research as needed, and analyzing RCDSO data (e.g., complaints, responses to the Annual Renewal Questionnaire) to develop options to address issues and harness opportunities that practice models, including corporate dentistry, present for patients.	• Appendix G: Data Analysis Summary • Appendix H: Issues Summary • Appendix I: Opportunities Summary
Phase 3: Decision-making & Implementation **IN PROGRESS**	This phase involves seeking Council's feedback and approval to implement options and establishing an Implementation Plan to guide timelines and next steps for the approved options.	• This Report and the associated briefing note.

Options

Chapter 1. Guidance related to the business of dentistry

Option 1: Update and develop new College requirements and recommendations for registrants to address unique issues for patients related to the business of dentistry. This option includes two components:

a. Updating existing College resources and developing new College guidance (e.g., a Standard of Practice) for registrants that clarify and address unique issues for patients related to the business of dentistry.

b. Gathering information to support a longer-term legislative/regulatory review that would aim to explore potential amendments to the Professional Misconduct Regulation under the *Dentistry Act, 1991*, and potential options for new legislation that would help to assure quality of care in an evolving dental practice landscape.

Rationale:

Findings from the Literature Review (Appendix E) and the consultation (Appendix F) concerning practice models and corporate dentistry suggest that requirements imposed on registrants by dental practices can have a direct impact on their practice of the profession.

- Organizational practices that prioritize business interests, such as maximizing profit or minimizing costs, can create conflicts of interest and/or lead to losses in clinical autonomy which can negatively impact quality of care (e.g., increase the risk of unnecessary treatments and lead to changes in treatment plans that are not made in patients' best interests). These negative impacts can manifest in various practice models.

Although the current regulatory framework for registrant dentists in Ontario (i.e., legislation, regulation and College guidance) addresses some issue related to practice arrangements for registrants it may not be as effective in the current dental practice landscape.

- The current regulatory framework for dentists in Ontario may not address all issues that can arise in dental practice arrangements. For example, the current regulatory framework does not specifically address earnings- or production-based targets in dentistry,[7] or independent contractor or employee agreements.[8]

The Jurisdictional Review (Appendix D) revealed that prescriptive requirements for non-registrants (e.g., dental service organizations, private equity) and registrants have been put forward in some jurisdictions to address issues for patient care associated with non-registrants' business interests and registrants' control in health professions.

- U.S. states of Texas, California, and Florida have proposed or established legislation that prohibits non-registrants from certain acts related to dentistry (e.g., directing or controlling the selection of treatments; controlling, owning, or otherwise determining the content of patient records; receiving payment for practice management services that does not reflect the fair market value of those services).
- Further, in Ontario, where a registrant optometrist engages in the practice of optometry as an independent contractor, they are required, by the Professional Misconduct Regulation under the *Optometry Act, 1991*, to include provisions in a written agreement that ensure they bear the financial risk, and have control of all aspects of their practice. In accordance with these requirements, the College of Optometrists of Ontario may request that its

registrants practising in an optical/corporation setting share their agreements with the College at any time for the purpose of verifying their status as independent contractors.[13]

Additional review of College data (i.e., complaints data; Appendix G) was undertaken based on feedback from Council at its March 2025 meeting. This review suggests that while examples of some issues related to practice models can be found in complaints data, others may be less common in complaints data.

- Where patients are directly affected by issues identified in the research (e.g., unnecessary treatment, overcharging, and continuity issues) we can find examples in complaints data and some corresponding decisions by the Inquiries, Complaints and Reports Committee (ICRC).
- However, issues that may not impact patients as obviously or directly – such as those concerning the clinical autonomy of dentists, financial conflicts of interest, or practice management issues – may be less common in complaints data.[14] This may be a result of patients not having a line of sight into these matters, and registrants or other staff in dental practices not feeling comfortable bringing issues related to these topics forward.

Intended outcomes

The proposed requirements under Option 1a would protect the public interest by addressing ethical challenges that can arise in dentistry as a result of business interests (such as the pursuit of profits or business efficiencies) which have the potential to conflict with ethical and professional obligations to provide care in the best interest of patients.

Information gathering proposed under Option 1b would protect the public interest by potentially supporting a review of the regulatory framework for dentistry in Ontario. The aim of the review would be to ensure that current legislation and regulation are effective in assuring quality of care in an evolving dental practice landscape.

Council's feedback

At its March 2025 meeting, Council raised questions about the College's ability to obtain information about dental practice arrangements and the College's ability to develop requirements that can remain flexible enough to meet the needs of patients in the evolving dental practice landscape. In partial response to these concerns, **Table 2** was developed to illustrate some of the limits of the RCDSO's regulatory authority with respect to non-RCDSO registrants including some aspects of Ontario's regulatory framework for registrants that do not apply to non-registrants who work in arrangements with registrants.

Council also noted that the RCDSO could capitalize on lessons learned from other jurisdictions, particularly in the U.S., where corporate dentistry is also a growing trend. College staff have implemented this feedback in two ways:

- Additional desktop research into a sample of U.S. states, where new legislation has been proposed or come into effect related to non-dentist involvement in dentistry, has been conducted and considered as part of this option (see references to research concerning California and Florida above and in Appendix D).
- In the longer-term, engagement with dental regulatory authorities in other jurisdictions can be integrated into the implementation of Option 6 which is not included in the Report, but

[13] College of Optometrists of Ontario. (2014, April 15). INDEPENDENT CONTRACTOR: REGULATORY STANDARDS INTERPRETED. https://collegeoptom.on.ca/resource/independent-contractor-regulatory-standards-interpreted/

[14] Based on a preliminary review of approximately 25 complaints from 2022 and 2023.

involves continued engagement with stakeholders and exploration of opportunities to gather information related to dental practice models. (As previously noted, Option 6 will be included in the PMCD implementation plan but is not being put forward for Council's approval given that it is operational in nature).

Table 2. Select topics related to RCDSO's regulatory authority, the regulatory framework for registrants in Ontario and its application to non-RCDSO registrants

Legend:
✓ – Prescribed or permitted by legislation/regulation
✗ – Prohibited by legislation/regulation
N/A – Not prohibited by legislation/regulation

Topic	Sub-topic	Registrants of the RCDSO	Non RCDSO-registrants	Enabling/ Disenabling legislation/ regulation (where applicable)
Regulation of the profession	May practice dentistry in Ontario	✓	✗	*Dentistry Act, 1991*
	Must meet professional and ethical standards established by the RCDSO and can be held accountable by the RCDSO	✓	N/A	*Dentistry Act, 1991* through the *Health Professions Procedural Code*
	May have their business practices or contractual arrangements investigated by the RCDSO, outside of the College's complaint and investigation process.	✗	N/A	N/A
Practice Arrangements	Registrant engages in the practice of dentistry by employment, association, partnership or otherwise with a non-registrant (other than as an employee or agent of government, agency of government, community health centre, university, or hospital).	✗	N/A	Professional Misconduct Regulation under the *Dentistry Act, 1991*
	Registrant fee splitting with a non-registrant of the profession (other than a registered dental hygienist).	✗	N/A	Professional Misconduct Regulation under the *Dentistry Act, 1991*
	Registrant enters into an arrangement respecting a lease or use of premises or equipment, under which any amount payable by or to a registrant, a related person or related corporation is related to the amount of fees charged by the registrant.	✗	N/A	Professional Misconduct Regulation under the *Dentistry Act, 1991*

Implementation Considerations

- **Regulatory Tools**: Under Option 1a, new requirements, clarified expectations and formalized RCDSO positions related to business interests would be codified in a Standard of Practice and other college resources. Guidance related to business interest in dentistry would address, among other topics, the ownership of dental clinics (e.g., records, goodwill), financial conflicts of interest (e.g., regarding maximizing profits, business efficiencies), and the maintenance of clinical autonomy (e.g., control over services provided) particularly for dentists practicing as independent contractors/employees.

  Under Option 1b, information gathering (e.g., as proposed in Options 2 and 6) and legal input would be needed before the College could make a recommendation, and Council could make a decision, on any potential legislative changes. Support from the Provincial Government would also be needed to make any legislative and/or regulatory changes.

  These changes would help to address the following issues and opportunities (see Appendix H and Appendix I for the full list of issues and opportunities, respectively):

  - Issue 1: Loss of clinical and non-clinical autonomy due to contractual requirements or practice policies/procedures that support business objectives (e.g., maximize profit, minimize costs) and may not be compatible with professional and/or ethical expectations of the profession.
  - Issue 2: Financial conflicts of interest that prevent, or could be seen to prevent, registrants from properly exercising their professional judgement (e.g., income sharing arrangements).
  - Issue 7: Lack of formal RCDSO positions on key topics, or "informal" positions that are out-of-date. For example, existing legislation, regulation, and College standards are silent on some topics related to practice ownership and practice arrangements, while some topics are only addressed informally by RCDSO Dispatch articles.

- **Risks**: Option 1a presents no legal risks. The RCDSO has a mandate to develop, establish and maintain: programs and standards of practice to assure the quality of the practice of the profession, and standards of professional ethics for its registrants.[15] Option 1b does not present legal risks; however, since it depends on information the College gathers through other options (i.e., Option 2 and Option 6) its implementation timeframe and outcomes are less clear. The concepts underlying Option 1a and Option 1b do not present real or perceived risks for patients.

- **Resources/Costs:** The development of new requirements via a Standard of Practice and resources are within the capacity of existing College staff. It would follow the existing Standards Review and Development Process and be guided by the College's Risk Assessment Framework and direction from the Quality Assurance Committee (QAC). The development of these documents would not generate new administrative costs for the College. A legislative review would require additional resources to support information gathering activities and to obtain legal input or advice.

- **Time to Implement:** The Standards Review and Development Process is a 1.5-to-2-year process. A new standard and supporting resources under Option 1a could be developed in

[15]pursuant to paragraph 3(1)(3) and paragraph 3(1)(5) of the Health Professions Procedural Code under *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18.

this timeframe as part of the PMCD implementation plan and if other standards-related work (currently being undertaken as part of the College Standards Strategic Project in the 2023-25 Strategic Plan) is deprioritized in the near term. As described under the 'Risks' for this Option 1b, the timeframe for implementing this options is less clear, but it is expected to be a multi-year process.

- **Anticipated Reactions:** Patients, patient-focused organizations, and registrants would likely appreciate the enhanced clarity and patient protection that are anticipated from Option 1a and 1b. Some registrants, and non-registrants who work in arrangements with registrants, may be concerned that Option 1a or 1b will result in an increase in regulatory burden, particularly if new legislation or regulations are proposed in the long-term.

Chapter 2. Guidance concerning responsibilities for dental practices and patients

Option 2: Develop new requirements to ensure that a registrant holds primary responsibility for each dental practice, and to ensure that registrant responsibilities for continuity of patient care are clear regardless of the practice model. This option includes two components:

a. Developing new College guidance (e.g., a Standard of Practice) for a 'lead' registrant in each clinic who has primary responsibility for the oversight and supervision of the clinic and responsibility for providing current practice information to the RCDSO.

b. Develop new College guidance (e.g., a Standard of Practice) to ensure continuity of care including coordination of patient care between dentists within a practice where the patient is under the care of the practice rather than an individual registrant.

Intended outcomes

The proposed guidance under Option 2a would help protect the public by identifying the accountabilities of registrants with respect to the practice in which they provide patient care and set new requirements that would add a level of oversight to the management of the practice. Option 2a would also introduce reporting requirements that would help the RCDSO oversee dental practices, including their operational structures.

The proposed guidance under Option 2b would help protect the public by setting expectations for dentists related to continuity of care (e.g., when treating patients of record who are under the care of a practice, and do not have an individual dentist who is primarily responsible for their care).

Rationale:

Findings from the Literature Review (Appendix E) suggest that continuity of care and poor practice management can have negative impacts on patient care.

- Systems for efficient practice management and follow-up enable registrants to provide comprehensive diagnosis and treatment. If a practice is disorganized, more attention may need to be allocated to dealing with managerial tasks, which can detract from clinical care. [16]
- Further, a loss of continuity of care may occur in dental practices that are disorganized or where patients are viewed as belonging to a practice, rather than an individual dentist.

Analysis of the RCDSO clinic ownership data (Appendix G) and feedback from Ontario dentists (Appendix F) raise questions about continuity of care and accountability for dental practices that are not directly managed by the registrants who own them.

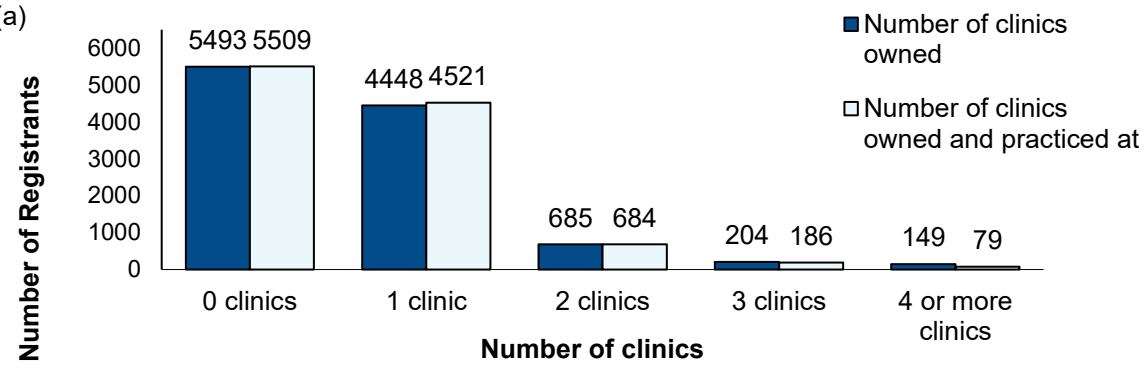
- Analysis of Annual Renewal Questionnaire (ARQ) responses suggests that as registrants own more practices, less of those practice owners practice at all of their clinics (see **Figure 2** below). This finding raises the question – in scenarios where the owner of a clinic does not practice dentistry at the clinic, how are the day-to-day clinic operations managed so as to ensure quality of care?
- Further, consultation feedback from dentists and other oral health care professionals identified the following issues based on their personal experience and perspectives: low practice oversight where owner(s) do not practise in their clinic; low accountability and continuity of care for patients in 'associate-led' practices; involvement of non-regulated clinic staff in clinical decision-making; high-turnover of registrants, and uncertainty among

[16] Levin. R. (2004). The correlation between dental practice management and clinical excellence. *The Journal of the American Dental Association 135*(3), 345-356. https://doi.org/10.14219/jada.archive.2004.0185

registrants regarding who holds certain leadership roles in the practice (e.g., the health information privacy lead).

Figure 2. How many clinics do you own and how many clinics do you own and practice dentistry at? Frequency comparison (Figure 2a) and percent difference (Figure 2b) between the number of registrants that own a given number of clinics and the number of registrants that own and practice at a given number of clinics.[17]

(a)



(b)	0 clinics	1 clinic	2 clinics	3 clinics	4 clinics
% difference between number of clinics owned, and number of clinics owned and practiced at	0.29% ↑	1.64% ↑	-0.15% ↓	-8.82% ↓	-46.98% ↓

Similar requirements to those proposed in Option 2a have been established for registrant dentists in Alberta, Saskatchewan and Newfoundland and Labrador, with some positive outcomes.

- Dental regulators in Saskatchewan and Newfoundland & Labrador expect a primary dentist 'connected' to a practice, referred to as a 'Practice Director', to oversee and supervise the dental practice in the context of relevant provincial legislation, regulation, bylaws, and practice standards. [18, 19]
- The College of Dental Surgeons of Alberta (CDSA) has similar expectations of a 'Responsible Dentist' in a dental clinic but also requires the Responsible Dentist to provide

[17] Note that 'clinics' is used in this figure rather than 'practice' as clinics was the term used in the Annual Renewal Questionnaire data set.
[18] College of Dental Surgeons of Saskatchewan. (2024, February). Practice of Dentistry, Clinic Facilities Standard. https://saskdentists.com/wp-content/uploads/2025/04/04.08.2025-Practice-of-Dentistry-Clinic-Facilities-Standard.pdf
[19] Newfoundland and Labrador Dental Board. (2020, November). Standards of Practice for Dentistry in Newfoundland and Labrador. p 2-7. https://nldb.ca/Downloads/Standards-Practice-Dentistry-20240404.pdf

information about the practice to the Registrar including the names of each individual or entity providing management services and their roles and responsibilities.[20]

- Perspectives from staff at the dental regulators in Saskatchewan and Alberta suggest that while some of these requirements are more recent, they have been helpful in enabling more efficient investigations by providing a clear point of contact for the Colleges.[21]

Council's feedback

Council expressed support for Option 2a and Option 2b noting that they are essential for continuity of care and for strengthening accountability for patient care. If the proposal is approved by Council, new Standard(s) could be developed or an existing Standard could be modernized through the RCDSO's Standards Review and Development Process to include the proposed new guidance.

Implementation Considerations

- **Regulatory Tools**: As described above, under Option 2a, a Standard of Practice would be developed that requires a 'lead' registrant for each practice. The lead registrant would have primary responsibility for the oversight and supervision of the practice for compliance with relevant legislation and standards related to practice management (e.g., IPAC, training new staff), and responsibility for providing current practice information to the RCDSO (e.g., contact information of the lead registrant and the name of any affiliated third-party). Every registrant would continue to be responsible for the care they provide to patients and their existing responsibilities under legislation, regulation, and Standards of Practice.

  Under Option 2b, a Standard would be modernized or developed that would set guidance for registrants to ensure continuity of care for patients such as those who are under the care of a practice, rather than an individual dentist who is primarily responsible for their care.

  These changes would help to address the following issues and opportunities (see Appendix H and Appendix I for the full list of issues and opportunities, respectively):

  - Issue 3: Organizational inefficiencies in dental practices due to low clinic oversight and other practice management-related issues (described above).
  - Issue 4: Lack of accountability and responsibility for patient care (e.g., because patients are treated by a new registrant at each appointment).
  - Opportunity 2: Ensuring that a registrant has responsibility for overseeing and supervising the clinic for compliance with relevant legislation, regulation, and standards related to practice management can help to assure quality of care.
  - Opportunity 7: Improving the College's understanding and oversight over dental clinics and; consequently, issues that can arise at the practice-level.

- **Risks**: As previously noted, the RCDSO has a mandate to develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.[22] Unlike the practice of pharmacy in Ontario, however, there is no legislative framework that

[20] College of Dental Surgeons of Alberta. (2022, January). Standard of Practice: Practice Arrangements and Provision of Professional Services. https://www.cdsab.ca/wp-content/uploads/2021/12/CDSA-SoP-Practice-Arrangements-and-Provision-of-Professional-Services-1.pdf

[21] Staff from the College of Dental Surgeons of Alberta and the College of Dental Surgeons of Saskatchewan (personal communication, 2024).

[22] pursuant to paragraph 3(1)(3) and paragraph 3(1)(5) of the Health Professions Procedural Code under *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18.

sets out requirements for a lead registrant in a dental practice.[23] For this reason, the College would need to ensure that the responsibilities for a lead registrant, as proposed under Option 2a, do not overstep its regulatory authority (e.g., the RCDSO does not have the authority to prescribe standards for the accreditation of dental clinics). Option 2b presents no legal risks as a concept, as it relates to the College setting out guidance for registrants in relation to continuity of care.

- **Resources/Costs:** The development of new requirements via a Standard and any supplementary resources would follow the existing Standards Review and Development Process, and be guided by the College's Risk Assessment Framework and direction from QAC. The development of these documents would not generate new administrative costs for the College though some planned Standards work may need to be reprioritized. New staffing resources (e.g., in the Facility Inspection Program area) would be needed to support the development and implementation of new practice information tracking processes and record management.

- **Time to Implement:** It is estimated that a new Standard and supporting resources under Option 2a and 2b could be developed within 1 to 1.5 years, as part of the PMCD implementation plan, should other standards related work (currently being undertaken as part of the College Standards Strategic Project as part of the 2023-25 Strategic Plan) be reprioritized in the near term. The timeframe to develop and implement a process to track clinic information would depend on the scope of information that is gathered but an estimated 24 to 36 months would be needed to adjust internal processes.
- **Anticipated Reactions:** Registrants may have concerns about potential administrative burden concerning Option 2a; however, administrative burden should be minimal for dental practices that are already in compliance with existing legislative and College requirements concerning practice management, and for registrants who already have chief responsibility for their practice (i.e., private practice owners).

[23] As an example, under the *Drug and Pharmacies Regulations Act, 1990*, designated managers have the same liability as pharmacy owners with respect to any offences under the act. The *Dentistry Act, 1991*, does not establish the same liability for RCDSO registrants.

Chapter 3: Enhanced educational offerings for registrants and dental students

Option 3: Enhance educational offerings for RCDSO registrants and dental students in Ontario that will help reinforce and illustrate their ethical and professional responsibilities regardless of the practice model. This option includes three components:

d. Developing new College resources (e.g., an RCDSO Connect session or ODA New Dentist Symposium session) focused on upholding ethical and professional responsibilities across various practice models;

e. Engaging with dental faculties in Ontario to implement strategies – e.g., course material, presentations – to reinforce for dental students their responsibility to protect the public interest respecting the practice of dentistry, regardless of their practice model.

f. Adding new scenarios to the College's Jurisprudence and Ethics Course and new resources and questions to the College's Practice Enhancement Tool concerning ethical and professional responsibilities and proliferating and emerging practice models – i.e., corporate dentistry, DTC dentistry.

Intended Outcomes:

The proposed educational enhancements would help protect the public by reinforcing and illustrating dentists' ethical and professional responsibilities across all practice models, including emerging dental practice models where the application of these responsibilities in practice may be less understood.

Rationale:

Academic literature suggests that strengthening registrants' ethical reasoning may help mitigate the possibility of financially-driven treatment decisions based on registrant-specific factors or internal motivations. [24]

- A 2020 survey-based study of 1075 Ontario dentists by Ghoneim et al., (2021) found that registrants who were younger than 40 years old, American trained, and who perceived their practice loans as large, were more aggressive in their treatment decisions.[25] The survey also found that dentists perceived professional role (PPR) – defined as the belief that they are healthcare professionals versus businesspersons – had a significant relationship to the aggressiveness of treatment decisions. Those who saw themselves as businesspersons were more likely to make aggressive treatment decisions. [26]
- While these characteristics are not specific to a particular practice model, dentists with these characteristics may be more biased towards working in particular types of practice models, or more likely to be influenced into making aggressive treatment decisions when working in models with profit-driven objectives.

The Literature Review (Appendix E) suggests there may be an opportunity to improve practice management courses in dental education programs to help equip dental students with skills needed to uphold key principles of dental professionalism in all practice models, not just private practice models.[27]

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[24] Ghoneim, A., Yu, B., Lawrence, H., Glogauer, M., Shankardass. K., and Quiñonez, C. (2021). What influences the clinical decision-making of dentists? A cross-sectional study. *PLOS ONE 16*(6): e0253183. https://doi.org/10.1371/journal.pone.0233652
[25] Ibid
[26] Ibid
[27] See page 147 in the September 2024 Council meeting materials

- Studies from Australia, the U.S., and Canada recommend dentists receive more education in dental school concerning dentistry as a business so that they are better equipped to withstand commercial influences on their practice.[28, 29]
- A study by Badger et al., (2015) previously noted that the majority of U.S. dental practice management education concern traditional private practice models and may not prepare students for changing dental practice landscape including the legal structures and dentist's rights and responsibilities in emerging practice models.[30]
- Additionally, inquiries with staff at the Faculty of Dentistry at the University of Toronto and the Schulich School of Medicine and Dentistry reveal that both faculties have practice management or practice administration courses that introduce the basics of corporate practice models and direct-to-consumer dentistry, however, it may be possible to further engage students on this topic, particularly in the context of their ethical responsibilities as registrants of the profession.

Council's feedback

Council expressed support for this option, recommending that Options 3a and 3b be coordinated and comprise the main focus of this work. If the proposal is approved by Council, Options 3a and 3b will be coordinated and prioritized as part of the PMCD Implementation Plan.

Implementation Considerations

- **Regulatory Tools:** Under Option 3, various educational resources and strategies (e.g., Jurisprudence and Ethics Course enhancements, presentations) would be pursued to provide greater certainty and clarity to registrants regarding the application of existing ethical and professional responsibilities to emerging practice models.

  These changes would help to address the following issues and opportunities (see Appendix H and Appendix I for the full list of issues and opportunities, respectively):

  - Issue 1: Loss of clinical and non-clinical autonomy due to contractual requirements or practice policies/procedures that support business objectives (e.g., maximize profit, minimize costs) which may not be compatible with professional and/or ethical expectations of the profession.
  - Issue 2: Financial conflicts of interest that prevent, or could be seen to prevent, registrants from properly exercising their professional judgement (e.g., income sharing arrangements).
  - Opportunity 3: Education concerning practice models can better support registrants to uphold their ethical and professional responsibilities regardless of the practice model.
- **Risks:** There are no legal risks associated with this recommendation. The RCDSO has a mandate to develop, establish and maintain standards of knowledge, skill, and programs to

[28] Holden, A.C.L., Adam, L., and Thomson, W.M. (2020). Dentists' Perspectives on Commercial Practices in Private Dentistry. *JDR Clinical & Translational Research 7(*1), 29-40.
[29] Badger, G.R., Fryer, C.E.S., Giannini, P.J., Townsend, J.A., and Huja, S. (2015). Helping Dental Students Make Informed Decisions About Private Practice Employment Options in a Changing Landscape. *Journal of Dental Education 79*: (12) 1396-1401.
[30] Ibid

promote continuing evaluation, competence and improvement among the members.[31] There are also no real or perceived risks to patients or registrants.

- **Resources/Costs:** Proposed enhancements to the RCDSO's QA program are within the capacity of existing College staff and QAC and would follow existing processes. The development of new educational resources will not generate new administrative costs for the College.

- **Time to Implement:** This recommendation is estimated to take a few months to a year to implement. The implementation timeframe would depend on the outcomes of engagement with dental faculties in Ontario (i.e., Option 3b), and timing for the implementation of other options (e.g. Option 1 and Option 2) as it may be prudent for QA program enhancements to follow the development of guidance related to dental practice models that is set out in new Standards of Practice. Additionally, new material may need to be approved by QAC and receive permission from the university (e.g., for a Category 1 continuing education course).

- **Anticipated Reactions:** Reactions from registrants are expected to be neutral or positive, given that the College has received questions from some registrants about how to uphold ethical and professional responsibilities when working in certain dental practice models. Reactions from the public are also expected to be neutral or positive. Reactions from non-registrants involved in emerging practice models are not expected to be negative as resources will be clarifying the application of existing (rather than new) ethical and professional expectations to emerging practice models.

- **Other Considerations:** Longer-term, the RCDSO may consider other opportunities to promote education for registrants related to business interests and dental practice models, including identifying relevant courses across the three continuing education course categories (Category 1, Category 2 and Category 3).

[31] The Quality Assurance (QA) Program, mandated by the *Regulated Health Professions Act, 1991* and guided by the Quality Assurance Regulation 27/10 under the *Dentistry Act*, is administered by the Quality Assurance Committee of the RCDSO to ensure the ongoing competence of dentists practicing in Ontario.

Chapter 4. Proposal for an 'Innovation Advisory Service' pilot program

Option 4: Develop a proposal for a time-limited, RCDSO 'Innovation Advisory Service' (IAS) pilot program for Council's approval. The pilot program would be comparable to an 'innovation hub' (described below) in that it would be an avenue through which the College could provide non-binding guidance to innovators and enable proactive risk-management of innovative ideas or practice models that have the potential to improve quality or delivery of services for patients.

Intended Outcomes: Registrants and members of the public could engage with the College to receive advice (not approval) regarding how the regulatory framework for dentists in Ontario applies to their innovative idea (e.g., a technology) and/or practice model. This would encourage innovators to share new initiatives with the College to help enable compliance with existing legislation and College requirements, and help the College protect the public interest by enabling more proactive, risk-based decision-making.

Rationale:

The Jurisdictional Review (Appendix D) identified 'regulatory sandboxes' and 'innovation hubs' as useful tools to enable effective regulation of new technologies and business models in the energy, law, and veterinary medicine sectors, to name a few.

- An **innovation hub** is a program that provides a point of contact within the regulator for innovators to raise inquiries and seek non-binding guidance on the application of regulatory requirements to their ideas. It does not provide temporary exemptions from requirements set by the regulator.[32]
- Conversely, a **regulatory sandbox** is a program that may provide temporary exemptions from its regulatory requirements (e.g., Standards of Practice) to enable piloting of innovative solutions that have the potential to improve the quality or delivery of services. Innovation hubs generally have lower resource requirements than innovation sandboxes and require less regulatory risk-management.

Separately, a better understanding of innovative concepts and practice models may enable regulatory decision-making that enables patient protection and limits negative impacts of regulation on competition for patients (such as increased prices or the maintenance of unaffordable prices).[33]

- Although competition is often viewed as playing a limited role in Canada's health system,[34] it plays an important role ensuring patients have access to the broadest range of services that meet their needs at the most competitive prices. Recent work by the Competition Bureau suggests this to be true. In the past year, the Competition Bureau has investigated and/or analyzed anti-competitive business practices of pharmacy retailers,[35] competition in the

[32] See page 10 in Scassa, T., Kumru, E.N., & the Office of the Information Privacy Commissioner of Ontario. (December, 2024). Exploring the Potential for a Privacy Regulatory Sandbox for Ontario. https://www.ipc.on.ca/en/media/5116/download?attachment

[33] C.D. Howe Institute. (2020, July). Commentary No. 575: Licence to Capture: The Cost Consequences to Consumers of Occupational Regulation in Canada. Commentary_20575_0-2.pdf

[34] Competition Burean (2007, October). Generic Drug Sector Study. https://competition-bureau.canada.ca/en/generic-drug-sector-study

[35] Competition Bureau. (2025, April 11). Competition Bureau advances an investigation into Express Scripts Canada's business practices in the pharmacy sector. https://www.canada.ca/en/competition-bureau/news/2025/03/competition-bureau-advances-an-investigation-into-express-scripts-canadas-business-practices-in-the-pharmacy-sector.html

veterinary drug sector,[36] and preferred provider networks[37] in the employer-sponsored drug insurance sector.[38]

- Additionally, the Competition Bureau has long maintained the position that restrictions imposed by self-regulated professions, such as those related to business structures, "may have anticompetitive effects… which could result in consumers paying higher prices for services, and firms reducing the supply of services they provide and being less likely to develop innovative services." For this reason, the Competition Bureau encourages self-regulated professions to evaluate regulatory responses for their impact on competition and with 'net public benefit' in mind.[39]

Council's feedback:

There was some concern among Council members that this option might not produce substantive benefit. This concern is partially addressed by the 'time-limited' nature of the pilot program – this means that the pilot program would be concluded and reviewed for its effectiveness after an initial period (e.g., 12-18 months) to determine if achieved its objectives and if it should be extended, shut-down, or otherwise changed. Additionally, a fulsome proposal that sets out more detail about the pilot program would be prepared and shared with Council for its approval, to enable an informed-decision regarding whether the RCDSO should implement the program. If Council approves this option, a fulsome proposal for an IAS pilot program would be shared with Council for its approval at a future meeting.

Implementation Considerations:

- **Regulatory Tools:** As described above, Option 4 proposes a program that is similar to an innovation hub. The IAS pilot program would be a time-limited program that would leverage the expertise and processes of the Practice Advisory Service (PAS) department, and other College departments, as necessary, to drive greater engagement with proponents who would like to implement an innovative idea or practice model. The program would help to (1) protect the public from innovations that may otherwise contravene the existing regulatory framework for dentists and (2) enable proactive regulation of innovations that may not be contemplated by the existing regulatory framework, or otherwise brought to the College for discussion.

  Table 3 demonstrates the similarities between the current PAS and the proposed IAS pilot program, as well as the program design elements of the IAS that would be more suitable for achieving the intended outcomes.

  This pilot program would help to address the following issues and opportunities (see Appendix H and Appendix I for the full list of issues and opportunities, respectively):

  - Issue 3: May support innovative ideas that have the potential to address organizational inefficiencies in dental practices (described in Chapter 2).

[36] Competition Bureau. 2024, October 30). Pets, vets and meds: The case for more competition. https://competition-bureau.canada.ca/en/how-we-foster-competition/education-and-outreach/pets-vets-and-meds-case-more-competition#sec04

[37] 'Preferred provider networks' are a feature of employer-sponsored benefit plans that requires or expects patients to fill prescriptions at particular pharmacies in order to receive either discounts or reimbursement.

[38] Competition Bureau. (2024, October 22). Competition Bureau submission to the Ontario Ministry of Finance consultation on the preferred provider networks in the employer-sponsored drug insurance sector. https://competition-bureau.canada.ca/en/how-we-foster-competition/education-and-outreach/competition-bureau-submission-ontario-ministry-finance-consultation-preferred-provider-networks#sec01

[39] Competition Bureau. (last updated 2022, January 20). Self-regulated Professions—Balancing Competition and Regulation. Government of Canada. https://competition-bureau.canada.ca/self-regulated-professions-balancing-competition-and-regulation

- Opportunity 3: May support practice elements that have potential to improve physical access to oral health care for patients.
- Opportunity 6: Overall, this option may help support innovative concepts or models that have the potential to improve the quality or delivery of services for patients.

- **Risks**: This option poses a liability risk to the College due to the potential for to misinterpret the College's advice as endorsement or approval of innovative ideas, rather than advice. However, this risk can be mitigated with clear communication regarding the pilot program's purpose and service offering. Furthermore, it is an objective of the College to develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues. [40] This option provides the College with a progressive and proactive opportunity to achieve this objective.

- **Resources/Costs:** The service provided through the IAS pilot program would largely fall within the expertise of PAS; however, inquiries related to practice models are some of the most challenging for the College to address and require more extensive investigation where they relate to matters or concepts that PAS staff don't regularly advise on. For this reason, the IAS would likely benefit from the support of a **voluntary advisory body** consisting of qualified subject matter experts, who have no conflict of interest, to enhance the College's ability to provide well-informed advice on new ideas or practice models.[41] At least one additional staff resource would also be required to develop and implement the program.

- **Time to Implement:** The IAS is estimated to take 6 to 12 months to implement as it would require the development of: a pilot program proposal (including Council's approval of the proposal), distinct intake/response processes, the assembly of a voluntary advisory body, and supporting communication materials.[42] As described above, the pilot program could be reviewed for its effectiveness after an initial period (e.g., 12 to 18 months) to determine if it achieved its objectives, and if it should be extended, shut-down, or otherwise changed. This will help mitigate the risk that the College invests substantial time and resources into a program that may not produce substantive benefit.
- **Anticipated reactions:** Registrants and the public are expected to have a neutral or positive reaction to the IAS, as it would provide a new avenue for innovators to engage more directly with the College on new ideas or business practices that have the potential to improve the quality or delivery of services for patients.
- **Other considerations:** Given the described risks associated with this option, and that it would be novel among health regulatory Colleges in Ontario, staff are proposing that the RCDSO bring an IAS pilot program proposal to Council for approval to implement the program.

[40] pursuant to paragraph 3(1)(10) of the Health Professions Procedural Code under *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18.

[41] The Law Society of Ontario (LSO) launched a regulatory sandbox called the Access to Innovation (A2I) program in November, 2021. The A2I program leverages a voluntary advisory council of subject-matter experts who work under strict obligations to ensure confidentiality and avoid conflicts of interest. The Advisory Council is outlined here: https://lso.ca/about-lso/access-to-innovation/a2i-team

[42] As an example, LSO's regulatory sandbox was launched 6 months after it was approved by LSO's Board of Directors.

Table 3. Proposed elements of an Innovation Advisory Service (IAS) pilot program

Aspect	Innovation Advisory Service (pilot program)	Practice Advisory Service
Primary Mission	**To help dentists and the public better understand how the regulatory framework for dentists in Ontario applies to innovative ideas or new dental practice models and enable information gathering to support proactive risk-management by the College.**	**To help dentists and the public access information on safe, competent and ethical oral health care.**
Main Corresponding College object under the *Regulated Health Professions Act, 1991*	To develop, establish, and maintain standards and programs to **promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues**.[1]	To develop, establish and maintain programs and standards of practice to **assure the quality of the practice of the profession**.[2]
Objectives	1. Encourages registrants and members of the public to proactively seek advice from the College on innovative ideas or practice models. 2. Helps the RCDSO stay up to date on new trends to inform the regulation of new innovations or practice models.	1. Helps registrants identify resources to guide decision-making and understand their responsibilities. 2. Helps the public understand what they should expect from their dentist. Provides general information/resources and discusses options when a patient has a conflict with their dentist.
Program Design Elements		
Scope	Answers questions involving regulatory and ethical issues **related to an innovative idea or practice model**.	Answers questions involving a **broad range of** clinical, regulatory, and ethical issues.
Enlists subject-matter experts	Designated **voluntary advisory body** composed of independent subject matter experts in dental practice models and regulation would provide strategic advice to the IAS team. Could consult internally with various College departments and occasionally seek the advice of external legal counsel.	Consults internally within the PAS team and with other College departments (e.g. Policy, PCRA, Registration, FIP). Occasionally seeks advice from **external legal counsel**.
Time limited	Yes – e.g., **12 to 18 months**, after which the program would undergo an effectiveness review.	No – PAS exists in perpetuity.
Intake process	Would use an **intake form**[3] to solicit detailed information about the innovative idea or practice model to support the development of well-informed advice.	Receives **telephone and e-mail inquiries** either directly or indirectly from other College departments with various levels of detail.
Response	• The IAS would likely have **longer response times** than PAS given that inquiries are likely to be more complex in nature and may require engagement with the voluntary advisory body. • Responses could be provided over e-mail, telephone and/or video call depending on their complexity.	• In 2024, PAS responded to 99% of inquiries within **5 business days**, with follow-up timelines as necessary.[4] • Responses are provided over telephone and by e-mail.

1. Section 3(1)(10) under of the Health Professions Procedural Code under the *Regulated Health Professionals Act, 1991*.
2. Section 3(1)(3) under of the Health Professions Procedural Code under the *Regulated Health Professionals Act, 1991*.
3. Intake form example from the Ontario Energy Board: https://www.oeb.ca/_html/sandbox/Sandbox-Project-Proposal-Form-template-2.0.docx
4. RCDSO. (2025). 2024 College Performance Measurement Framework. Link.

Chapter 5. Resources to support decision-making and professional judgement

Option 5: Develop resources to support patients' decision making and registrants' professional judgement related to dental practices or dental practice models. This options includes two components:

a. Developing new College resources and/or sharing pre-existing resources to help patients determine if the care provided by a particular dental practice is right for them.

b. Developing a resource that provides general guidance to support the professional judgement of registrants who are considering providing orthodontic treatment through a DTC practice model.

Intended Outcomes:

Guidance proposed under Option 5a and 5b would help protect the public interest by enabling more informed decision-making by patients, and by supporting the professional judgement of registrants when working in DTC models of care.

Rationale:

Feedback from the consultation concerning practice models and corporate dentistry (Appendix F) revealed that sometimes, patients' usual dental practice does not always align with their needs or values.

- Some patient respondents noted that their usual dental practice does not meet their expectations because the practice does not have evening/weekend appointments, the practice/dentist does not accept the assignment of benefits,[43] the patient does not see the same dentist at each appointment, and the patient does not feel like a trusting dentist-patient relationship has been established.

Additionally, findings from the Literature Review (Appendix E) suggest that DTC orthodontic treatment, specifically, has the potential to improve access to care but can result in poor treatment outcomes for some patients if registrants are not appropriately involved in the provision of care and if the standards of the profession are not met. [44]

- Benefits of DTC orthodontic treatment include financial and physical access to care and convenience. In a survey of 470 patients who underwent or were undergoing DTC orthodontic aligner treatment, most respondents (93%) indicated that cost and (65%) convenience, were their main reasons for opting for DTC aligner treatment. Only 13 percent of respondents indicated that they chose DTC aligners because they did not have access to a dentist/orthodontist and/or their dentist/orthodontist did not provide aligner-based treatment.[45]
- The greatest risks for DTC orthodontic treatment can occur if there is no full clinical evaluation prior to approving patients for orthodontic treatment (e.g., no review of recent radiographs or other dental records prior to treatment) and/or there is little to no supervision, monitoring, or dentist-patient communication throughout the course of orthodontic treatment. Other risks include the possibility that the patient may not be provided with all the information that is necessary to inform their decision to proceed with treatment if they have

[43] The assignment of benefits means that a patient's insurer pays the patient's dentist directly, and any fees not covered by the patient's plan must be paid by the patient to the dentist. See the Ontario Dental Association's Making a Dental benefits Claim webpage (Last accessed, June 2025) for more information.
[44] Wexler, A. Nagappan, A., Beswerchij, A. and Choi, R. (2020) Direct-to-consumer orthodontics: Surveying the user experience. *The Journal of the American Dental Association* 151(8), 625-636. https://pmc.ncbi.nlm.nih.gov/articles/PMC7391059/
[45] Ibid.

limited engagement with the dentist, and that dental impression errors that may be carried over into aligner treatment.[46] Collectively, these risks have the potential to lead to poor treatment outcomes or damage to patients' oral health.

Council's feedback:

Council appreciated that this option would provide additional protection for patients. If the proposal is approved, this option could be implemented in an earlier phase of the PMCD Implementation Plan.

Implementation Considerations

- **Regulatory Tools:** Under Option 5a, new guidance (in the form of College articles, case scenarios etc.) could be developed with the aim to improve patient awareness of different practice model elements and support patients in considering the advantages and disadvantages of different dental practices depending on their needs (e.g., "five questions to ask your dentist about their practice").

- Under Options 5b general guidance (e.g., in the form of an RCDSO Connect Newsletter article) could be developed with the aim to highlight College standards and other resources that are of particular importance to consider when practising in DTC companies/models.
- These resources would help to address the following (see Appendix H and Appendix I for the full list of issues and opportunities, respectively):
    - Issue 5: DTC orthodontic treatment that lacks necessary clinical oversight in one or more steps of treatment.
    - Issue 6: Provision of orthodontic treatment directly to the consumer with the involvement of a dentist, but where one or more of the steps in treatment are not carried out in accordance with regulatory requirements and/or do not meet the standard of care.
- **Risks**: There are no risks to patients associated with Option 5a or 5b. The College occasionally provides advice on issues that affect the practice of dentistry in Ontario in accordance with its public protection mandate. For example, in March 2024, the College provided general guidance for registrants in its newsletter regarding how to manage patients of a former DTC orthodontics company, SmileDirectClub. Advice on the topic of working in DTC orthodontic treatment models would follow a similar approach. A more prescriptive regulatory approach (i.e., new requirements for the provision of care in DTC models) was considered but is not recommended for several reasons including the risk that it would encroach on registrants' clinical autonomy.

- **Resources/Costs**: The development of proposed resources for the public and registrants is within the capacity of existing College staff (e.g., PAS, Policy, Communications) and would follow existing processes. The development of new resources would not generate new administrative costs for the College.
- **Time to Implement:** College resources, such as case scenarios, FAQs, webpages or RCDSO Connect articles, can be developed in a few months.
- **Anticipated reactions:** Registrants and the public are expected to have a neutral or positive reaction to the development of new resources as they would clarify existing

[46] Belgal, P., Mhay, S., Patel, V., and Nalliah, R.P. (2022). Adverse Events Related to Direct-To-Consumer Sequential Aligners—A Study of the MAUDE Database. Dentistry Journal 11(174) 1-9. p 2

expectations for registrants (rather than set new requirements), and support patient decision-making. DTC orthodontic companies may react negatively to new College guidance for registrants working in DTC orthodontic models if there are perceived negative impacts of the guidance on their business.

Conclusion

As the dental practice landscape in Ontario continues to change, so may its impacts on patient care. The options presented in this Report provide the RCDSO with an opportunity to leverage Standards of Practice, resources, education, and information gathering activities to help address known issues and opportunities, and aid in the mitigation of unknown/future issues related to dental practice models.

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