Rationalisation and 'McDonaldisation' in dental care: private dentists' experiences working in corporate dentistry

Alexander C. L. Holden,*[1,2] Lee Adam[3] and William M. Thomson[3]

Key points

This research highlights how corporatised dentistry has encapsulated the principles of hyper-rationality, or McDonaldisation, in providing dental healthcare services.

The implications for patients and dentists of increased efficiency, predictability, calculability and control, characterised by McDonaldisation, are considered.

While the values and interests of consumers may be well served through the corporatisation of dentistry, this should not detract or diminish the nature of the caring relationship between patients and their dentists.

Abstract

Introduction This study examines how dentists experience the corporatisation of dentistry and the impacts of rationalisation. The emergence of corporate dentistry in the early twenty-first century has introduced greater competition into the dental marketplace. Ritzer's theory of 'McDonaldisation' explores the rationalisation of services through corporatisation and provides an apt framework with which to understand the qualitative insights gathered through this project.

Methods Semi-structured interviews and reflective journals were used to collect insights from dentists who were working in private practice. Data were then subjected to thematic analysis.

Results A total of 20 private dentist participants provided 22 separate interviews and multiple reflective accounts. Following analysis, three key themes emerged: 1) opportunities provided by corporate dentistry; 2) balance between professionalism and commercialism in corporate dentistry; and 3) competition between independent and corporate dentistry.

Conclusions The participants' insights demonstrate how Ritzer's four dimensions of rationalisation – efficiency, predictability, calculability and control – have been encapsulated by corporate dentistry in Australia. Corporate interests in Australian dentistry are perceived to improve competition and offer opportunities for younger and less experienced dentists, but the findings also suggest that those leading corporate dentistry need to ensure that rationalisation does not diminish the caring relationship between dentists and patients.

Introduction

The corporatisation of dentistry has arisen as a phenomenon in many countries during the early years of the twenty-first century.[1] In Australia, the first corporate dental practice group was founded in 2001, with five large corporate groups in operation by 2012.[2] The establishment of corporate-owned dental practices was facilitated by a legal precedent that removed the barrier to non-dentists owning practices. In New South Wales (NSW), a landmark case in 1996 quashed an appeal from the (now defunct and superseded) Dental Board of NSW, determining that the Board had erred in preventing a corporation from opening a dental clinic.[3] The Board's decision was based partly upon a belief that a health fund opening a dental clinic might cause future hardship to private dentists. The court held that this consideration, based on professional protectionism, was impermissible. In the decade since the establishment of the first incorporated dental practice group, data from 2012 suggested that around 6% of the approximately 6,000 dental practices in Australia at the time were owned and operated by corporate entities.[2]

Dental care in Australia is provided predominantly through the private sector, with around 85% of care being provided by practitioners in community-based private practice.[4] Public dental services are provided by the individual state and territory governments, with the local states and territories as well as the Commonwealth (federal) government providing funding for these services. Eligibility for public dental care in Australia is means-tested, with around a third of the public being eligible to receive care.[5] The capacity of the public dental services means that only around 20% of those eligible may access state-funded care.[6] While Australia operates a universal healthcare scheme called Medicare, most

[1]The University of Sydney School of Dentistry, Faculty of Medicine and Health, Australia; [2]Sydney Dental Hospital and Oral Health Services, Sydney Local Health District, NSW, Australia; [3]The University of Otago Faculty of Dentistry, Division of Health Sciences, New Zealand.
*Correspondence to: Alexander Holden
Email address: alexander.holden@sydney.edu.au

Refereed Paper.
Accepted 23 September 2020
https://doi.org/10.1038/s41415-021-3071-3

© 2021 The Author(s), under exclusive licence to British Dental Association

dentistry and oral healthcare is excluded, with only the Child Dental Benefits Schedule offering eligible children dental care in either public or private practice settings through this Commonwealth-funded scheme. The cost of dental care is a major barrier for Australians, with 23% of adults aged 15 years and above reporting that cost prevented them from accepting recommend treatment and 24% stating that they would have difficulty paying a $200 bill for dental treatment.[7]

The health professions have traditionally been anti-competitive, both in the sense of their relationships with the laity and within the professions themselves. This can be seen in the inaugural codes of ethics of both the American Medical Association[8] and the American Dental Association,[9] both documents decrying the practice of professionals competing against each other or engaging in commercially competitive behaviours. The profession's desire for control over the practice of dentistry and autonomy of the way they chose to provide care meant that members were expected to behave in a courteous fashion towards each other, this professional expectation stemming from the profession's enjoyment of exclusivity in providing services. The attrition of dentists' professional monopoly through the deregulation of practice ownership has disrupted the model of how private practice dentists operate and work.

In the UK, the profession supported lifting restrictions on corporate entities from owning and operating dental practices.[10] In the Australian context, the Australian Dental Association Inc. displays a sceptical perspective on the role of corporate-owned dental practices, noting a tension of purposes in its current position statement that the primary responsibility of a corporate owner 'is to maximise the return to shareholders', while the primary responsibility of a dentist 'is the duty of care to a patient'. The document goes on to state: 'There is a potential conflict of interest between the responsibilities of an employed dentist and corporate owners of dental practices'.[11]

There is a definitional issue with understanding what constitutes a corporate dental business and how this is separate and distinct from a non-corporate dental business. Many independently owned practices are strictly corporate businesses due to their structure. For the purposes of this research, a corporate dental business was defined as one that is owned (either wholly or predominantly) by non-dental professionals and that incorporates non-dental management as a core part of the business's operations. The American Dental Association's Health Policy Institute has attempted to define different classifications of dental group practices.[12] This classification is difficult to transport into the Australian context, given that some American states have continued prohibition of practice ownership by non-dentists.

In endeavouring to understand the context, operation and impact of corporate dentistry, Ritzer's theory of 'McDonaldisation' offers a useful framework. It comprises four components: 1) efficiency; 2) predictability; 3) calculability; and 4) control.[13] These components of Ritzer's theory provide insight into the phenomenon of 'hyper-rationality'. Ritzer's theory used the example of the fast food industry as a grounding example, demonstrating how the principles of rationalism have been translated into other sectors, including healthcare. Ritzer's theory effectively encapsulated how social activity and organisational logics are guided by the pursuit of hyper-rationality. The concept of McDonaldisation demonstrates how this hyper-rationality offers producers, consumers and managers more efficient, predictable, calculable and controlled ways of achieving set objectives in a world characterised by an ever-increasing dynamism.[14]

There is a lack of research investigating the role of corporate dental services within the Australian oral healthcare context. The insights provided in this qualitative examination will help to situate the role of corporate dentistry within the context of dentistry existing as a commercial endeavour in healthcare provision. In understanding how corporate practices in dentistry have impacted service provision and the experiences of dentists working in private practice, we will apply the theory of 'McDonaldisation' proposed by George Ritzer.[13] Through applying Ritzer's work in this research, we will explore how the application of McDonaldisation to oral healthcare may create what Waring and Bishop[14] refer to as 'irrationalities', whereby the process of corporatisation and hyper-rationality may conflict with the essence of healthcare provision, and how these possible impacts upon practice might be managed.

Methods

Ethical approval was obtained from the University of Sydney's Human Research Ethics Committee (project: 2019/687). Participants were recruited through a multifaceted strategy of advertising: 1) on social media; 2) to the leadership of the NSW branch of the Australian Dental Association; and 3) to the participants of a graduate scheme run by a corporate dental practice group. Only those participants who held a current clinical role in private practice and who had full licence to practise dentistry in Australia were included in this study. Participants provided consent to participate and were interviewed using a semi-structured interview format which allowed for participants to express their thoughts around core topics of relevance. The interview questions were developed with reference to a scoping review of the tensions between commercial and professional obligations in dentistry that we conducted before this research.[15] Interviews were conducted by one researcher (ACLH), being recorded and transcribed verbatim. Participants were invited to provide written reflections using an online journalling platform and were also invited to participate in a follow-up interview around one month after their initial interview. The textual data were explored using thematic analysis as articulated by Braun and Clarke,[16] through a process of iterative coding to reveal irreducible and linked themes and categories within the data.[17]

Results

In total, 20 dentists engaged in private dentistry in different practice environments took part in this research. All participants were interviewed, with several providing follow-up written reflections and two participating in follow-up interviews. The demographic characteristics of the participants are summarised in Table 1.

To illustrate the definitional challenge presented by corporate dentistry in the Australian context, one participant who worked part-time at a particular practice as a locum was not sure whether that business was corporate-owned or independent, being aware only that the owner did not work on-site, if indeed they were a dentist. Participants were asked for their perspectives on corporate dental practices and how these entities fitted within

© 2021 The Author(s), under exclusive licence to British Dental Association

Table 1 Participant demographic characteristics

Characteristic		Number of participants
Sex		
Male		12
Female		8
Years since qualification (average: 17)		
0–1		1
1–10		6
11–20		7
21–30		2
31–40		4
Type of practice (role)		
Private (independent)	Principal/owner	7
	Self-employed associate	9
Corporate	Clinical director	1
	Self-employed associate	3
Scope of practice		
General dentist		17
Specialist dentist		3
Current location of practice in Australia*		
New South Wales		15
Victoria		3
South Australia		1
Queensland		2

Key:
* = one participant practised in multiple states.

the wider cultural and professional milieu of dentistry. Three themes emerged from this research that related to the role and impact of corporate bodies in Australian dentistry:

1. Opportunities provided by corporate dentistry
2. Balance between professionalism and commercialism in corporate dentistry
3. Competition between independent and corporate dentistry.

Opportunities provided by corporate dentistry

Many participants acknowledged that corporate dental practices offered opportunities to dentists, especially those who were new to the oral health workforce:

- *'It's alright, there is a lot of negativity, but really what's the point of all that negativity, we just have to move forward [...] right now, realistically, there is more job offers from corporates [...] it depends where you are of course, location, than from other practitioners. So it's a real option for a lot of students, so we can be as negative as we want, or we can be supportive'*
- *'I guess they [corporates] have a place in that they provide jobs for perhaps the less experienced dentists. They seem to, I mean they say you do very much run a very strict numbers game in terms of they have a strong push towards meeting targets and things, but I guess it's just like any industry'*.

It is noteworthy that this participant classified dentistry as being 'just like any industry', suggesting that the dental profession may be conflicted about whether it is a profession – driven by professional values – or more appropriately termed an industry, which is primarily driven by commercial ideals and principles.

Participants also suggested that, in some instances, corporate dental practices were able to provide more support to clinicians:

- *'I think [...] they probably bring some aspects into dentistry that improve patient safety if anything around organising things like HR a little bit better. They do a lot of things well which I think has a filter through effect into other parts of the profession'*
- *'Corporates, or well-organised corporates, will provide better services to the clinicians to do their work by removing all the hassles of staff management, equipment management, patient management, I would argue that what the corporates are doing [...] is that we are giving the dentists more resources to do a better job and to do more of it'*.

Balance between professionalism and commercialism in corporate dentistry

Participants also commented that both independently owned and corporate dental practices may impose targets on the practitioners who work there; in both groups, some use targets to measure the productivity of dentists and others do not:

- *'I have colleagues who have mentioned similar targets being imposed by more private solo or run dental practices. I don't think it's exclusively a corporate issue. I think it's one that is evident throughout dentistry'*
- *'If you're an associate dentist, I've worked under some bosses where they're actually not corporates, these are private owned centres, that do push us and it was a little bit uncomfortable for me'*.

Participants also addressed their perceptions of whether corporate dentistry was solely focused on making profit, rather than patient care:

- *'So the fallacy seems to say that the corporate is only interested in profits because private practice is interested in profits too, they wouldn't do it if there wasn't something at the end of the day for the risk and investment'*.

There was appreciation that profit was an important consideration for any practice owner, whether a corporate or an independent, and that in itself the making of a profit from dentistry is not problematic. As discussed in earlier themes, it is when the commercial aspects of running a practice as a business begin to be favoured over providing a professional healthcare service. There was acceptance

© 2021 The Author(s), under exclusive licence to British Dental Association

from all participants that this could happen in any practice environment. Participants who worked in independent private practice recognised that corporate practices have a particular niche in Australian dentistry:

- '*I feel that perhaps the corporates provide slightly more affordable dentistry to a wider number of people*'
- '*It's not great for the dentist but I think there are definitely benefits for patients. And corporates, despite what we say about the 100% recall rate, it makes sure that patients actually show up regularly and actually do get their clean and they do offer incentives*'.

Participants suggested that the bureaucracy and management of corporate dental practices were more problematic than the dentists who work there, with dentists seeking to behave professionally and appropriately, but the business itself working outside these boundaries of professionalism:

- '*I saw this side of them where they seemed to be perfectly happy as a corporation to deceive the public* [through false advertising] *to advance their aims. The dentists inside that were very different. I can't say that I've ever met, we've certainly seen some of the stuff coming out of there that hasn't been done really in good faith, but I've never met a dentist who wasn't trying to act professionally within that group*'.

Competition between independent and corporate dentistry

One of the challenges for corporates in dentistry is addressing how patient loyalty to a corporate brand may be encouraged over loyalty to a particular dentist. Independent practices rely on this loyalty to practitioners, towards both associates and practice owners, to sustain the patient flow of the practice and ensure that patients attend regularly. Corporate dental practices must try to mitigate any damage that might be done by having turnover of dentists, with patients associating their loyalty to the corporate entity itself. Participants were aware of this challenge and cited this as a weakness of the corporate model of dental practice:

- '*I think it comes down to the personal relationship that the dentist has with the patients, and if you've got a corporate model there seems to be a lot of turnover of dentists within those models. Now I'm sure there's exceptions and all, but I would say as a rule, you know they churn through quite a lot of dentists. And I just see that as something that will fail eventually, 'cause I think people want to go in and see the same dentist, or the same face behind the counter, and they want to have that relationship, regardless of whether they live in a city or live in the country, they want that familiarity*'
- '*So I think they do get comfort in knowing that it's a family, that I'm going to be here for 30 years, or you've got the same faces there all the time. I think people get comfort in that, and know that there's a continuity of care*'
- '*The practice has always been run as more or less that personal relationship, which is what we were doing, we have a personal relationship. So, putting a name on it was the whole idea that people knew who they were dealing with and they would be the same people and so on. But, you know, that was almost, not necessarily a direct reaction, but a reaction to the way that more or less corporatisation was going where the dentist becomes more or less irrelevant within a brand*'.

It is evident from the statements above that dentists are heavily invested in a belief that patients value continuity of care very highly. However, this may be true only for dental procedures and treatments that have not lost their therapeutic association. It may be that patients will happily visit the cheapest or most convenient provider when seeking services that are not linked to health (such as teeth whitening) but would take an entirely different approach when considering treatments that were essential to health. One participant suggested that dentists were wrong to assume that loyalty to a particular practitioner was foremost in patients' minds:

- '*Patients were no longer loyal to an individual practitioner. They are loyal to availability, accessibility, affordability [...] So, the choices are being made by the patient now, not by the practitioner. I think maybe a lot of [dentists] think that the patients are here for their benefit, and I think the opposite*'.

Several participants suggested that their colleagues disliked corporate business models in dentistry because those threatened the viability and sustainability of their own businesses:

- '*I guess a lot of the adversity to corporatisation is really from independent practices that are afraid of being swept away or having all their patients taken away from them into preferred provider practices, which is happening at the moment*'
- '*I don't think they're all bad but I think they're bad for the dentists. I think they sort of help encourage this feeling of fearmongering which should've been present with an oversupply, which is what drives people to want to push higher, like, treatment because you feel like a corporate's coming*'.

This fear of competition could contribute to some of the dubious practices described earlier, whereby dentists found themselves being pressured to engage in 'finding' treatments and to increase their acceptance rate for treatments. This may be one of the negative impacts of perceived threats from competition within dentistry.

Discussion

The study set out to show how private practitioners either experienced or perceived the corporatised dental environment in Australia. It has found that the participants involved in this research have varying perceptions of the corporatisation of dentistry, with practitioners reporting both positive and negative perceptions and experiences of corporate dental entities. In interpreting and understanding those observations, it is useful to apply Ritzer's McDonaldisation model, with its four components of McDonaldisation: 1) efficiency; 2) predictability; 3) calculability; and 4) control.[13]

Efficiency

The participants noted how corporate bodies in dentistry sought efficiency by providing effective supportive services to clinicians in order to maximise focus on clinical practice, supporting prior observations that the drive for efficiency provides corporates with the ability to expand services while cutting costs.[18] The participants specifically referenced how this allowed a greater amount of dentistry to be provided by practitioners within corporate dental practices, suggesting that corporate practices were very focused upon a 'numbers game'. A contradiction of perspectives arose from the participants' commentaries; some reported that they perceived corporate dental practices to be primarily concerned with the pursuit of productivity and profit, while others suggested that this was no different to the motivations and considerations of independent, dentist-owned practices. The professional rhetoric that some of the participants displayed, which is evident within the earlier discussed position statement from the Australian Dental Association Inc.,[11] asserts that

© 2021 The Author(s), under exclusive licence to British Dental Association

dentists who own practices have more virtuous intent than corporate businesses which are only driven by profits. One participant's example of the practitioners within a corporate practice working sincerely to provide good care, but being thwarted by the corporate's culture, illustrates the assumptive dichotomy that dentists are solely concerned with professionalism, and corporate businesses with profit and commercialism. Another participant acknowledged the reality that all dental businesses, whether corporate or independently owned, needed to be cognisant of profit.

Efficiency is also concerned with how services might be extended so that a larger proportion of the population might access care. This is achievable through lowering the cost of services through efficiency savings. Participants were of the view that rather than solely competing against the established private, professionally owned dental sector, corporate dentistry was able to offer more affordable care to a demographic of patients who would otherwise be unable to afford routine dentistry in private practice. Participants also suggested that corporate dental environments were ideal for younger and more inexperienced dentists to work in. This could be suggestive of a belief that the standard or grade of corporate dentistry is expected to be lower and/or that corporate practices offer more supportive environments for less experienced clinicians.

Predictability

Considering predictability within Ritzer's thesis is oriented towards the standardisation of services, often through the use of best practice and evidence-based guidelines. While the use of clinical guidelines in dentistry is not habitual within the professional culture of Australian dentistry, another component of predictability is the use of common branding and common experience to create brand affinity and loyalty. Using Ritzer's key example of a multinational fast food restaurant chain, consumers can access a restaurant anywhere around the globe and experience the service that they would expect at home. Mottram notes that the mechanistic, rapid nature of corporatised healthcare met patients' expectations of a convenient, modern-day health service.[19] Considering how the participants' viewpoints contribute to the predictability of corporate dental care revealed a tension between diametrically opposed beliefs surrounding how corporate practices and independent practices view and value the patient-dentist relationship, specifically relating to continuity of care and patient loyalty. Some of the participants advocated that one of the key weaknesses of the corporate model in dentistry was a perceived lack of value being placed on patient loyalty to practitioners, with corporate practices instead seeking loyalty to their brand. The dichotomy presented by the participants between patient loyalty to a particular clinician and patient loyalty to consumerist ideals also speaks to a professional anxiety relating to a perception of many practitioners that dentistry is not a fungible service. Despite this, one of the participants did refer to dentistry as being 'like any industry' which would support the corporate strategy of valuing consumer-centric considerations over those which assume that all patients find intrinsic value within personalised, continuity-driven dental care.

Calculability

In Ritzer's theory, calculability (whereby accounting and quantitative measurement become intrinsic features of services) is a core element of corporatisation. A key aspect of calculability in hyper-rationality is how practitioner activity is closely monitored, often publicly displayed and may be incentivised.[14] The participants expressed that calculability was apparent in both independent and corporate dental practice, and that the behaviours of setting targets and placing pressure on dentists to be productive that are often solely associated with corporate dentistry also occurred in independent dentist-owned practices. This finding is unsurprising given that most dental practices, both corporate and independent, are funded based on activity, encouraging a focus upon the production of treatments which have a payment value associated with them.[20]

Control

Many of the participants suggested that corporate dental practice was good for patients and the public, but bad for dentists. The elements of efficiency, predictability and calculability all feed into control, the fourth component of Ritzer's McDonaldisation theory. Corporatised dental practice, as with any corporatised model of business, is concerned with hyper-rationality – how costs and expenses can be minimised, profits increased and consumers enticed. In a 2018 study, O'Selmo *et al.* found that associates within UK corporate practice environments reported lower levels of control and autonomy than those who worked in independent practices.[21] O'Selmo *et al.* attribute this difference to the effects of rationalism within corporate practices. One of the concerns about the loss of dentist autonomy is how professional obligations may be swept away in favour of the business goals and strategy of the corporate entity.[22] Traditionally, the medical professions have been able to avoid the increasing bureaucracy of healthcare due to the high levels of autonomy bestowed upon them within health systems.[23] However, the 'creeping bureaucratisation of healthcare work'[14] has started to address the perception of a lack of political accountability in healthcare, with rationalism being used to curb the monopoly interests of professionals.[24]

Irrationalities

The irrationalities created by the application of McDonaldisation to oral healthcare are twofold, as evidenced within the participants' narratives. First, the tension between the nature of dentistry existing as a profession and as a business needs to be considered. A risk that has been observed with corporatised dentistry is the establishment of patients as commodities to the business, with their worth being attributable to their value as paying consumers, not as patients who may be experiencing dental disease.[25] Second, participants alluded to corporate environments being better suited to less experienced practitioners, suggesting that the nature of the dentistry carried out in these practice environments could lead to de-skilling. This assertion is consistent with similar observations made by Waring and Bishop.[14] Ritzer suggested that 'McDentists' (from a phraseology coined by Ritzer using the prefix 'Mc' to denote the impacts of McDonaldisation upon that industry) offered simplified services: 'McDentists [...] may be replied on for simple dental procedures, but patients are ill advised to have root canal work done by one'.[13] This assertion may hold truth for both corporatised and independently operated services; if a service predominantly focuses upon the provision of routine care (exam and simple cleaning) for the majority of patients, then practitioners may become de-skilled in providing more complex care. This is not ostensibly an issue with corporatised care, instead being an indication of a lack of effective utilisation of skill mix in practice with the appropriate dental professionals providing care.

The rationalisation of dental care was acknowledged by many of the participants as being a beneficial development for the patient-consumer of oral healthcare. Through

© 2021 The Author(s), under exclusive licence to British Dental Association

corporatisation, patients are encouraged (and expected) to become proactive in the way in which they choose their practitioners, review their experience, and are able to access care in a more patient-centred and convenient way.[14] There is a risk that the emphasis that rationalised healthcare services place upon patient choice may have an illusory nature,[26] with services being standardised and uniform so that there is no real choice provided to patients. Despite this, it is important to understand that rationalism may help to address instances where the monopoly interests of practitioners are contrary to those of patients.[27]

Conclusions

The impact on dentistry of corporate entities owning and/or running dental practices has also been a relatively unexplored area of inquiry in dental research, despite there being reported examples of anecdotal criticism and negative sentiment relating to corporate dental practices.[28] The negativity that some participants displayed – due to a belief that some corporate dental practices focus predominantly on business considerations, require practitioners to meet financial targets and encourage competition in dentistry – could also be levelled at some independent, dentist-owned practices. Some participants suggested that corporate dental practices contributed to a fear of competition and losing patients, thus increasing perceptions of competition. Corporate dental practices were also described as enhancing patient choice in dentistry and the array and environment of treatments on offer. It is not possible to condemn corporate dental practices for their contribution to these elements of commercialism in dentistry; they contribute in a way that enhances the consumer focus of dentistry – the caveat being that corporate dental businesses, like all providers of dental care, have a social responsibility to ensure that the key rhetoric in relation to enhancing patient and consumer choice and empowerment translates into practice, and is the driving force in providing care.

Acknowledgements

This research was supported by an Education and Research grant from the Dental Council of New South Wales.

Conflict of interest

The authors declare that they do not have any conflicts of interest in relation to this work.

Author contributions

AH, LA and WMT all contributed to the design of the research, analysis of the data and drafting of the final manuscript.

References

1. O'Selmo E. Dental corporates abroad and the UK dental market. *Br Dent J* 2018; **225:** 448–452.
2. Levitch G. Corporatised dentistry 10 years on. 2012. Available at https://www.levitch.com.au/wp-content/uploads/2014/03/2012-9-10-Corporates-10yrs.pdf (accessed May 2021).
3. NSW Law Reports. NIB Health Care Services Pty Ltd v Dental Board of New South Wales. 1996. Available online at https://nswlr.com.au/view/39-NSWLR-362 (accessed May 2021).
4. Chrisopoulis S, Harford J E, Ellershaw A. Oral health and dental care in Australia: key facts and figures 2015. 2016. Available online at https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia-key-facts-and-figures-2015/contents/table-of-contents (accessed May 2021).
5. Australian Institute of Health and Welfare. A discussion of public dental waiting times information in Australia: 2013–14 to 2016–17. 2018. Available online at https://www.aihw.gov.au/reports/dental-oral-health/discussion-of-public-dental-waiting-times/contents/table-of-contents (accessed May 2021).
6. Duckett S, Cowgill M, Swerissen H. Filling the gap: a universal dental care scheme for Australia. 2019. Available online at https://grattan.edu.au/report/filling-the-gap/ (accessed May 2021).
7. Australian Institute of Health and Welfare. *Oral health and dental care in Australia*. Canberra: AIHW, 2019.
8. American Medical Association. Code of Ethics. 1847. Available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/ethics/1847code_0.pdf (accessed May 2021).
9. Horne W C. Transactions of the American Dental Association, at its sixth annual session. *Dent Cosmos* 1866; **8:** 62–90.
10. O'Selmo E. The history of dental bodies corporate and the role of the BDA in their development. *Br Dent J* 2018; **225:** 353.
11. Australian Dental Association. Policy Statement 5.3 – Practice Ownership. 2017.
12. Guay A, Warren M, Starkel R, Vujicic M. A Proposed Classification of Dental Group Practices. 2014. Available at http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0214_2.pdf (accessed May 2021).
13. Ritzer G. *The McDonaldization of Society: Into the Digital Age*. Thousand Oaks: SAGE Publications, 2018.
14. Waring J, Bishop S. George Ritzer: rationalisation, consumerism and the Mcdonaldisation of surgery. *In* Collyer F (ed) *The Palgrave Handbook of Social Theory in Health, Illness and Medicine*. pp 488–503. Basingstoke: Palgrave Macmillan, 2015.
15. Holden A C L, Adam L, Thomson W M. The relationship between professional and commercial obligations in dentistry: a scoping review. *Br Dent J* 2020; **228:** 117–122.
16. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; **3:** 77–101.
17. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nurs Health Sci* 2013; **15:** 398–405.
18. Aday L A, Begley C E, Lairson D R *et al*. *Evaluating the Healthcare System: Effectiveness, Efficiency, and Equity*. Chicago: Health Administration Press, 2004.
19. Mottram A. 'They are marvellous with you while you are in but the aftercare is rubbish': a grounded theory study of patients' and their carers' experiences after discharge following day surgery. *J Clin Nurs* 2011; **20:** 3143–3151.
20. Grytten J. Payment systems and incentives in dentistry. *Community Dent Oral Epidemiol* 2017; **45:** 1–11.
21. O'Selmo E, Collin V, Whitehead P. Associates and their working environment: a comparison of corporate and non-corporate associates. *Br Dent J* 2018; **225:** 425–430.
22. Watson M. Corporate dentistry in 2032? *Prim Dent Care* 2012; **19:** 117–122.
23. Freidson E. *Profession of medicine: a study of the sociology of applied knowledge*. Chicago: University of Chicago Press, 1988.
24. Starr P. *The social transformation of American medicine*. New York: Basic Books, 1982.
25. Holden A C L. Consumer-driven and commercialised practice in dentistry: an ethical and professional problem? *Med Health Care Philos* 2018; **21:** 583–589.
26. Harrison S. New Labour, Modernisation and the Medical Labour Process. *J Soc Policy* 2002; **31:** 465–485.
27. Alford R R. *Health care politics; ideological and interest group barriers to reform*. Chicago: University of Chicago Press, 1975.
28. Chong B S, Berman A M, Billis G *et al*. Corporate dentistry: Upholding dental standards. *Br Dent J* 2018; **225:** 1048.

Open Access.
This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by/4.0.
© The Author(s), under exclusive licence to British Dental Association 2021

© 2021 The Author(s), under exclusive licence to British Dental Association