Is There Uniformity and Satisfaction Among Clinical Practice Models and Faculty Compensation Plans in US Dental School-Based Oral and Maxillofacial Surgery Departments?

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Purpose: There is a lack of information regarding clinical practice models and faculty compensation plans used by dental school-based departments of oral and maxillofacial surgery (OMS) and their effectiveness. The purpose of this study was to examine *1)* the level of uniformity in clinical practice models and faculty compensation plans for US dental school-based OMS departments and *2)* the level of satisfaction expressed by faculty with their current compensation plan.

Materials and Methods: A survey was sent to the chairs of the 40 US dental school-based OMS departments asking them specific information regarding their current practice model, the faculty compensation plan, and their satisfaction with their current plan.

Results: Twenty-four of the 40 department chairs returned the survey, for a 60% response rate. The OMS practice was part of the dental school faculty practice in 50% of the departments and a separate entity in 33%. The most common faculty compensation plan consisted of an academic salary plus a faculty practice salary based on a collection-based incentive (38%), but in 25% it was based on production. Fifty-seven percent of the responding chairs stated they were not satisfied with their current practice and compensation plans.

Conclusions: There is considerable variation in the practice models and compensation plans in US dental school-based OMS departments. More than half the department chairs expressed a general dissatisfaction with their current compensation plans. The survey data indicate a need for alternative models, and this report presents one such model.
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The combined effect of decreasing state and federal governmental funding for higher education and the general decrease in rates of reimbursement from governmental and major commercial insurers during the past decade has greatly increased the economic burden on academic medical centers, including dental schools.[1-3] This also has affected recruitment and retention of full-time academic faculty, including oral and maxillofacial surgeons.

To continue to support the academic mission of medical and dental education, the use of clinical revenues has been proposed as a viable strategy.[1,4-7] Hupp[8]

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proposed application of the medical model in dental faculty compensation, and Formicola[9] described patient-centered delivery systems in which there is a certain degree of separation between educational and patient-care missions. Although there have been a few surveys of faculty practices in dental schools, these surveys have focused mainly on overall clinic organization and practice management and their relation with community dental practices.[10,11] Hence, information is generally lacking with respect to clinical practice models that might be applied to oral and maxillofacial surgery (OMS). Such information could be helpful in developing satisfactory clinical practice models that support the educational and financial needs of the department and provide adequate faculty compensation to improve faculty recruitment and retention.

The purpose of this study was to obtain information regarding specific elements of the current practice models and compensation plans in the various dental school-based OMS departments, to analyze them for areas of variation and consistency, and to determine the degree of satisfaction of department chairs with their current situations. Such information can be helpful to department chairs in evaluating their programs and making potential improvements.

Materials and Methods

To initiate this institutional review board–approved study, a 10-question survey (Fig 1) was sent electronically to all 40 chairs of US dental school-based OMS departments. The initial survey was sent on March 1, 2014, with 4 follow-up requests to nonresponders. To be included, the chairperson had to return a completed survey by July 15, 2014. They were encouraged to participate but were informed that this was voluntary and that all responses would remain anonymous. The survey sought information about the number of full- and part-time faculty in the department, the type of practice model currently being used, the type of faculty compensation plan and the activities considered in determining faculty compensation, and the percentage of full-time faculty who participate in the faculty practice. They also were asked how clinical auxiliary staff are funded and whether any of the clinical revenues of the department are retained by the school administration (often referred to as a “dean’s tax”). Space also was provided for a brief comment in those instances in which the respondent believed that the answer was not contained in the list provided. The answers were tabulated and generally reported as sums or percentages.

Results

Twenty-four of the 40 department chairs returned the survey, for a 60% response rate. The final study sample is composed of these “responders,” although in tabulating results, the percentage totals do not always add up to 100% because some responders left questions unanswered. Descriptive statistics are presented in Table 1.

The distribution for numbers of full- and part-time faculty is shown in Figure 2. The number of full-time faculty ranged from 2 to 10, with 5 being the most common response. Not all faculty participated in the faculty practice—only 50% of responders indicated that all faculty participated.

The OMS faculty practice was reported to be part of the dental school faculty practice by 50% of the responders and a separate entity in 33% of the replies. Eight percent were part of the dental school and medical school practice plans and 1 was part of a hospital practice plan. None participated only in the medical school practice plan (Fig 3).

Sixty-seven percent of responders indicated that their practice model keeps funds generated by students and residents separate from faculty practice revenues, 17% stated that all revenues are combined, and 17% noted that student-generated funds are used to pay faculty who teach only in the predoctoral oral surgery clinic.

There was considerable variation in how the clinical, administrative, and business staffs were compensated and the source of these funds. Twenty-five percent noted that the funding came from dental school clinical revenue, and 25% said it came from total departmental revenue. Forty-two percent checked “other” and provided examples that included half from the school and half from the faculty practice; a combination of dental school and medical school funds; a percentage of the school, resident, and practice efforts; the general faculty practice; and the dental school predoctoral and postdoctoral program revenue.

The amount of the dean’s tax was quite variable for the institutions that responded, and it also varied for the individual practice components (ie, faculty, resident, and student) within a given institution. The distribution of the reported dean’s tax is presented in Figures 4, 5, and 6. In those instances in which the dean retained a portion of the predoctoral clinic revenue, it was 100% in 10 instances, with 6 institutions reporting a tax that ranged from 5 to 70%, 4 reporting no tax, and 4 with no response to the question. Tax on the resident clinic was 100% in 7 instances, with another 9 reporting a tax that ranged from 5 to 70%. Four reported no tax on resident revenues, and another 4 did not respond to the question. The OMS faculty

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