Reclaiming Dentistry

A Blueprint for Practitioner Empowerment in the Corporate Age

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QUINTESSENCE PUBLISHING

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INTRODUCTION

A New Vision for Dentistry

A middle-aged lawyer—let's call him Tim*—with a complicated implant history arrived at my office in considerable distress. As I reviewed Tim's file, a familiar sense of dismay settled in. His original treatment plan, designed by a periodontist and a general dentist, had gone wrong. The implants had been positioned incorrectly. Both dentists had since retired, and no one knew the specifics of the implant system they had used. A young dentist—let's call him Dr Y—had taken over the practice and referred Tim to me.

Dr Y and I developed a new treatment plan, and I placed new dental implants using a well-known, globally recognized system. I sent Tim back to Dr Y with the specific brand name and sizes for the implants and the new prosthesis.

A few months after the prosthesis was placed, however, Tim returned to me in a panic; the screw securing the prosthesis had broken. Dr Y had tried to remove the broken screw but was unsuccessful, leaving Tim frustrated and rapidly losing confidence.

I examined Tim and quickly realized the issue: Dr Y had used a prosthesis from a different implant family that was incompatible with the implants I had placed, leading to the screw breaking. It was a mess, and

*Some names and identifying details are changed throughout this book to uphold confidentiality.

I felt the weight of responsibility settling on my shoulders. This patient had already lost faith in three dentists, and now he was walking around Manhattan without any front teeth.

As I carefully removed the broken screw—a delicate and painstaking procedure—I reflected on the state of our profession. Unfortunately, Tim's case was not unique. I often see patients who float from dentist to dentist, searching for relief. Instead, they get caught up in a system that is broken. How did we arrive at a point where subpar care has become so common?

The answer is complicated, but I believe there are three main drivers. First, I believe that recent changes in dental education have had significant unintended consequences for our field. The shift to "comprehensive care" in dental schools has diluted specialization. New graduates are expected to handle everything from basic cleanings to complex procedures, often without sufficient training, mentorship, or experience. It is no coincidence that Tim's problems were exacerbated by a provider who had undergone this type of dental education.

Second, the rapid expansion of the corporate model is reshaping the dental field and making it harder to maintain consistent, high-quality patient care. Dental Service Organizations (DSOs) are quickly acquiring practices, putting pressure on independent dentists to compete with larger marketing budgets, lower fees, and production-driven business models that together undermine personalized care.

Finally, the mindsets of the next generation of dentists are shifting. Millennial and Gen Z dentists, burdened with significant student debt, are often forced to prioritize short-term job security over long-term career growth. Their debt, along with a focus on work-life balance and concerns about burnout, increasingly leads these generations toward corporate dental models, making it less likely for younger dentists to purchase independent practices from retiring dentists. This shift has profound implications for the future of dentistry.

By not establishing their own practices, these new dentists miss opportunities to build lasting legacies. Thus, they're less likely to mentor the next generation of dentists, severing a vital chain of knowledge transfer that has long been the backbone of our profession. Additionally, I believe that working within corporate frameworks often restricts their ability to innovate, take risks, and develop the entrepreneurial skills that have historically propelled advancements in dental care.

Lacking the deep community roots and long-term relationships that come with owning an independent practice, these dentists struggle to develop the same level of commitment to patient outcomes and professional excellence that has traditionally defined our field. Consequently, we risk losing the core essence of what makes dentistry a trusted and respected profession devoted to enhancing people's lives.

These three major trends—along with other factors including expanded dental benefits, a shortage of hygienists and assistants, increasingly expensive technologies, a focus on esthetic dentistry, and an aging patient population—have created a complex and challenging environment for our profession.

I empathize with new graduates entering the field with limited practical experience, minimal mentorship, and significant student debt. I also empathize with older dentists who wish to retire but are reluctant to become employees of profit-driven corporations, fearing their legacies might fade away. Most importantly, I empathize with patients like Tim, who struggle to find the quality of care they deserve.

We have to do better. We have to reclaim dentistry.

A New Way to Deliver Care: Collaborative Dental Entrepreneurship (CDE)

Throughout my 30-year career in Manhattan—one of the most competitive dental markets in the United States—I've evolved from a traveling periodontist to owning my first practice to building a network of 7 practices with 13 providers and 45-five staff members.

However, these practices are neither traditional solo nor group approaches. Rather, they are structured around principles that maintain the best elements of traditional dental care while adapting to today's market realities. I refer to this model as collaborative dental entrepreneurship (CDE). In this book, I'll open my practice doors to demonstrate how CDE operates, why it is effective, and how you can establish your own CDE practice or join an existing one.

CDE works for younger dentists seeking long-term careers in which they can build equity and grow their skills. It also works for established dentists who want to foster a thriving practice rooted in mentorship, collaboration, and sustainable growth. Finally, it works for retiring

dentists looking to transition ownership in a manner that creates a lasting legacy of ethical, patient-centered care.

In a CDE practice, Tim would have had a very different experience:

- He would have called his general dentist, who would have immediately recognized the need for a specialist. Rather than attempting a procedure outside his expertise, the general dentist would have referred Tim to a prosthodontist within the CDE network. Because CDE networks are multispecialty, the prosthodontist would be a trusted colleague, not an outsider, ensuring seamless collaboration.
- The prosthodontist would have collaborated with a network periodontist to develop a treatment plan together. The periodontist would have successfully placed the implants, the prosthodontist would have placed the prosthesis, and Tim would have returned to the general dentist, hygienist, and periodontist for ongoing maintenance.

In a CDE practice, dentists are not just transient employees. Each associate has the opportunity to build equity, which encourages them to invest in the ongoing care of their patients. The younger associates collaborate closely with more experienced dentists and specialists, continually enhancing their skills to ensure that patients receive high-quality, consistent follow-up care, while also advancing in their profession. In Tim's case, he would have benefited from a team that knew his history, maintained strong and established communication—including shared records—and was dedicated to his long-term well-being, rather than being shuffled from one anonymous provider to another.

In a CDE practice, everybody wins. Patients receive better care, younger dentists flourish, and retiring dentists can transition smoothly without sacrificing their legacy.

Building a CDE practice network isn't easy, but if I can do it, anyone can. I'm not special. I'm just a periodontist who wants to survive and make a difference for myself, my profession, and my patients. In these pages, I'll share the roadblocks I faced and how I overcame them. I'll also guide you on maintaining a CDE practice, including how to build a strong team, measure results, and integrate new technologies.

The views expressed in this book will challenge many established perspectives in dentistry, and I expect some readers may initially react defensively. This is natural. We are an emotional profession, deeply

invested in our work and proud of our accomplishments. But I ask you to consider my arguments not as attacks on individual practitioners, institutions, or corporations but as constructive criticism born from a deep love of our field and concern for its future.

After 28 years of clinical practice, I've witnessed dramatic changes in dentistry—technological, organizational, and educational.

Some will dismiss my observations as merely the perspective of a high-end, niche practice. Others will question my assessment of corporate dentistry's negative influences or defend our current educational models. These are valid reactions, especially from dedicated dentists who successfully treat patients every day. And while I'll do my best to persuade you that there is work that needs to be done, this book isn't about declaring absolute truths. Rather, it's about starting crucial conversations about where our profession is heading and how we can influence its course.

Different approaches to dentistry can and should coexist. However, we must look beyond our individual practices to consider the field's overall direction. The evidence and arguments presented here affect us all. It's true that I'm known for being outspoken and opinionated. But my views are grounded in extensive experience across clinical practice, education, and business management. I state them strongly because I believe the stakes are high. I invite you to consider my point of view with an open mind, focusing not on defending what was or is, but on building what could be. Our profession's future—and more importantly, our patients' well-being—depends on our willingness to engage in dialogue about our challenges, not to minimize them or accept the way the field is evolving.

How will you respond to the challenges and seize the opportunities of our current moment? We can't simply give in to market pressures, nor can we continue operating practices according to the traditional model. Instead, we must cultivate a third, better way. I urge you to open your mind to this new model of care.

It's not just about securing our own futures—it's about leaving a positive legacy for the profession we love.

CHAPTER 1

The Decline of the Solo Practice

From the Golden Age to Generalized Dentistry

Dr J had been a force in the field for over four decades, known for his skilled hands and gentle touch. But at 72 years old, those once-steady hands were beginning to betray him. Patients started to notice a slight tremor as he worked, and his colleagues whispered their concerns.

Dr J knew it was time to consider stepping back, but the idea of selling his practice—his life's work—to a corporation wasn't what he envisioned for his patients, some of whom he had known since they were children. He tried to find a younger dentist to sell to, but the available candidates were either burdened with debt, lacked the considerable capital needed to meet rising costs, or simply weren't interested in becoming business owners. Ultimately, he sold to a corporation.

He planned to remain an employee for another few years, but due to what he considered rushed appointments and pressure to upsell unnecessary treatments, he retired within the year. This left his practice in the hands of two young dentists, who also moved on within the year.

Dr J's story is not unusual. Dental service organizations (DSOs)—also known as "corporate dentistry"—are rapidly acquiring practices,

with their market share nearly doubling over the past 8 years.[1] As of 2022, almost 23% of dental practices were affiliated with DSOs, and this number is projected to reach a staggering 39% in 2026.[2]

This corporatization of dentistry is no longer a trend to debate. It's a reality we must address because it is effectively transforming the landscape of our profession. While many practitioners react defensively to this statistic or question its validity, the evidence of corporate dentistry's growing influence is undeniable. As someone who has witnessed this evolution firsthand, I can attest that the impact extends far beyond DSOs, seeping into every corner of dentistry as independent dentists struggle to remain in the game.

In other words, the field is nearing a tipping point. As dentists, we must ask: Is this the future we want for ourselves and for our patients? If not, what can we do to create a different future?

Our goal cannot be to revive the solo practice. As we'll see in these pages, that ship has sailed. Instead, we need to find a new model that addresses the modern challenges we all face. To do this, we need to confront those challenges head-on.

There are many reasons for corporate expansion, and it would be remiss of me to blame only outside forces for the current state of the field. We need to consider the whole picture, including the self-inflicted wounds we've caused to our profession. In other words, before we can fix the future, we need to examine our past to see where things went wrong.

Model #1: The Historic Model—1950s to the Mid-1990s

Mid-20th-century dental offices in the United States were mostly small, single- or double-chair operations run by solo practitioners who built strong, personal relationships with their patients. The local dentist was not just a healthcare provider but also a trusted member of the community.

Primarily, general dentists (GDs) drove the field, with prosthodontists playing a secondary role. These two types of practitioners referred patients to other specialists: periodontists for gingival disease treatment and implant placement, endodontists for root canal therapy, and oral surgeons for third molar extractions and oral cancers. GDs and the specialists they referred to were predominantly solo practitioners

with their own practices. They all collaborated to provide routine care and periodontal maintenance and to manage tougher cases. In short, everyone stayed in their well-defined lanes and got along:

- The **general dentist** (GD) diagnosed, treated, and managed overall oral health needs, including preventive care, cleanings, diagnostic services, and restorative treatments like filling cavities and repairing chipped or broken teeth. Some offered minor cosmetic procedures, crown and bridge work, and simple root canal therapy. They completed a 4-year undergraduate degree followed by 4 years of dental school to earn either a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) degree.
- The **endodontist** specialized in diagnosing and treating issues related to the dental pulp—the innermost part of the tooth—and the tissues surrounding the roots. They were experts in performing root canal therapy. In addition to earning a DDS or DMD, they completed an additional 2- to 3-year training to become a "specialist."
- The **prosthodontist** focused on restoring and replacing missing or damaged teeth. In addition to earning a DDS or DMD, they completed an additional 3-year residency program in prosthodontics to become a "specialist."
- The **periodontist** specialized in treating and maintaining the structures surrounding and supporting the teeth, including the gingiva, alveolar bone, periodontal ligament, and cementum. In addition to earning a DDS or DMD, they completed an additional 3 years of training to become a "specialist."
- The **oral surgeon** (also known as an *oral and maxillofacial surgeon*) focused on diagnosing and treating a wide range of diseases, injuries, and defects in the head, neck, face, jaws, and the hard and soft tissues of the oral and maxillofacial region. Oral surgeons had, at minimum, a DDS or DMD plus 4 years of specialized surgical training. Many also held a medical degree (MD).
- The **orthodontist** specialized in the diagnosis, prevention, and management of dental malocclusion bite pattern and misalignment of teeth as well as dentofacial orthopedics and facial growth. In addition to earning a DDS or DMD, they completed a 2- to 3-year training program to become a "specialist."

Innovations developed slowly, and care was typically low-tech, allowing dentists time to adapt. They faced little pressure to invest in expensive training or equipment to remain competitive. For example, dentists began using radiographs in their practices in the early 1900s, and change was incremental until the dawn of digital imaging in the 1980s. This long period of technological and treatment stability enabled dentists to amortize their equipment costs over many years, maintaining stable and predictable overhead, while younger dentists didn't face prohibitively high costs when purchasing an existing practice or establishing their own.

Meanwhile, societal attitudes were undergoing a sea change that greatly benefited all dentists. Interest in oral health surged, partly due to educational campaigns by dental professionals and organizations. The concept of preventive dentistry began to take hold in the public consciousness, and the general population started to recognize the importance of regular cleanings, proper oral hygiene, and early intervention to prevent more serious dental issues.

Many consider this period the golden age of dentistry, and many practitioners still remember it fondly and with nostalgia. I know I do. When I arrived in the United States in the early 1990s, dentistry was indeed in this golden age, and it was beautiful. It was a respected profession, and people trusted their GDs and admired their specialists as true healthcare experts. Patients committed to come in every 3 months for a cleaning, alternating between their GD/prosthodontist and their periodontist, a practice rarely seen outside of Sweden. Patients enjoyed receiving treatment. They valued the care and were willing to pay out-of-pocket for it. Such dedication did not exist anywhere else in the world at that time.

However, change was coming.

The Rise of Dental Implants

Advances in implant technology during the early 1990s significantly disrupted the traditional care model, resulting in changes to the roles of GDs, periodontists, and prosthodontists while also increasing demands on solo practitioners. The previously distinct responsibilities began to blur, and the barriers to entry of the solo practitioner grew.

First, digital imaging and 3D modeling technologies produced remarkably detailed images of the jaw, enabling precise implant placement

planning. This significantly reduced the risk of complications. Meanwhile, new materials, such as titanium and zirconia, made implants look better, perform better, and last longer. There are too many groundbreaking innovations to list here; the point isn't so much what changed but rather what the effects were. As success rates for permanent tooth replacement increased, the technology gained wider adoption, leading to higher patient demand and acceptance.

These rapid advancements in implant technology required ongoing education and increased investment in new equipment for dental professionals. Additionally, they resulted in a significant income boost for two surgical specialties: oral and maxillofacial surgery and periodontics. This created tension among the specialties that added pressure to the solo practice model.

Model #2: The Traveling Periodontist—Late 1990s to Early 2000s

In response to these changes, a new practice model emerged: the traveling periodontist. Instead of maintaining their own practices that relied on referrals from GDs, periodontists began to travel between GD and prosthodontist offices to place dental implants within those practices. In 1998, I was one of the first to do this in New York City. For a year, I moved between GD and prosthodontist practices, traveling from Brooklyn to Queens without a practice of my own.

This new approach had two key drivers:

- GDs benefited by keeping more implant procedures in-house. This provided patients the convenience of remaining with a single office while still accessing specialized care. GDs also tapped into a new income stream, as they received a portion of the implant revenue.
- Recent periodontal graduates were drawn to this model because it offered a steady income without the pressures of managing a full practice. Burdened by student debt, many favored the simplicity of working in various practices and placing implants without needing to establish long-term relationships with patients or referring dentists.

However, this shift proved to be negative in the long term for GDs, specialists, and patients, and the model ultimately failed. I experienced this structural failure firsthand.

First, for the patient, it didn't work because no specialist was available for emergencies after procedures. Patient care extends far beyond the initial treatment. You cannot complete a procedure, such as placing a crown, and then consider the case closed. Dental health is dynamic, and complications can arise over time. These may include mechanical issues, such as a damaged restoration, or biological problems, such as inflammation. The responsibility for a patient's oral health is ongoing, requiring vigilance and continuity of care to address any long-term issues.

Imagine a GD calling in a periodontist to perform a procedure. The periodontist might tell the patient, "Come back next week for a follow-up," or "I'll see you in 3 weeks." But the visiting specialist would move on; there was nothing for them long-term. In the model of traveling periodontists, patients often slipped through the cracks. The periodontists had little motivation to follow up on patient care.

The in-house model also posed significant challenges for GDs. It increased their income in the short term, but it was driven by money rather than strategy. When building a business, having a sustainable strategy for growth and continuity is crucial. GDs lacked that vision with the in-house model, which made it shortsighted and doomed from the start. While it appeared at first that GDs maintained their patient relationships, poor outcomes and potential complications ultimately damaged their reputations and eroded patient trust over time. Being a jack-of-all-trades in a competitive healthcare market leads to mediocrity and missed opportunities for true excellence and differentiation.

In addition, GDs faced significant challenges:

- GD offices had to invest heavily in equipment, such as drilling units and necessary materials, unless the traveling periodontist supplied them. Advanced imaging technology required a substantial investment in expensive machines that had previously been outsourced to specialized centers.
- Proper sterilization, maintenance, and cleansability were required, adding operational complexity.

- Generating sufficient patient volume to justify the return on investment was challenging, even though equipment depreciation provided some tax relief.
- Monthly lease payments for the equipment remained a financial burden.

Relying on traveling periodontists also introduced additional risks:

- Traveling periodontists were often young and inexperienced, leading to complications that sometimes required lengthy and expensive treatments.
- Patients might need to be referred to other specialists, with the GD potentially covering costs to avoid malpractice claims.
- Malpractice insurance costs increased, as coverage had to expand to include the traveling periodontist.

From a strategic and financial perspective, this model was flawed for the GD from the outset.

The traveling model didn't work well for periodontists either. By relinquishing their role in providing ongoing periodontal care, they lost a steady flow of returning patients and a reliable income stream. More importantly, they lost a key metric for evaluating their professional success. By treating patients regularly and maintaining their gingival health over time, periodontists could measure the effectiveness of their treatments and the overall health of their practices. The shift to focusing on one-time, high-value implant procedures trapped periodontists in a shortsighted model that lacked growth potential. Without a stable patient base or the means to evaluate success through continuous care, periodontists began to gauge their performance solely by the volume and profitability of implant placements. This transformation reduced their role from comprehensive, long-term care providers to technicians specializing in implant surgery.

Experiencing this trend and its shortcomings firsthand, I quickly realized that this was not what I had trained for. In search of a long-term solution, I decided to return to the basics. After a year of traveling, I purchased a small, seemingly insignificant practice that was generating only $150,000 annually, primarily from cleanings. I built it up—sometimes I ask myself how—but I did it. The practice grew and endured through some of the worst economic challenges of our generation, which I'll

discuss in detail in later chapters. Despite these truly difficult times, I was much happier. I could ethically treat my patients.

However, it was clear that my path wasn't available to everyone. As a young dentist, I escaped the common problem of student debt that plagued most of my fellow graduates. During this period, the cost of obtaining a DDS or DMD degree ranged from $50,000 to $80,000, often on top of existing undergraduate debt. Aspiring periodontists faced an additional 3 years of specialized education, costing an average of $70,000. Consequently, recent graduates in periodontics typically graduated with total dental education debt as high as $190,000.[3] Prosthodontists and endodontists faced similar financial burdens. While these numbers may look laughingly low compared to the debts of today's dental students—the average debt in 2024 is $312,700[4]—the high income and low overhead of traveling from practice to practice for many remained not a choice but a necessity.

The shortsighted model of the traveling periodontist couldn't last—and it didn't. However, this was not due to others successfully implementing the positive changes I did. Instead, a new pressure emerged on the old model. Implant manufacturers began intensifying their efforts to train more dental professionals in implant placement. They believed that if every dentist could extract a tooth and place an implant, they could eliminate the specialists who bottleneck the process. A bottleneck, of course, slowed their sales. Many GDs welcomed the new training because they felt they were missing out on a larger share of the revenue: why pay a periodontist when they could perform the procedures themselves? This represented a shift in the professional power dynamic, with increased direct competition between GDs and specialists.

With the explosion of continuing education programs, soon GDs, prosthodontists, and even endodontists were all getting in on the considerable implant action. Projections suggest that general practitioners will be responsible for placing 33% to 50% of all dental implants in the near future.[5]

This trend toward generalization was not limited to implant procedures. In fact, it was part of a broader shift in dental education and practice—one that would transform the entire landscape of dental care.

A third practice model was emerging: generalized dental care.

Model #3: The Age of Generalized Dental Care — Early 2000s to the Present

In 1992, dental education underwent a seismic shift with the introduction of the "comprehensive care" model. In my opinion, this seemingly innocuous change marked a turning point in American dentistry, initiating the decline of the specialized, patient-centered approach that had previously defined the field. While designed to create more well-rounded practitioners, this new educational paradigm ultimately undermined the foundation of quality dental care that patients had come to expect and that practitioners had worked so hard to establish. I believe that this was truly the beginning of the end for our beloved US dentistry.

Many dentists don't recall this shift because they are either retired or have never experienced it. I belong to the "in-between" generation, and I will never forget it. In the early 90s, I was a postgraduate student in my first year of periodontics. Then, if I wanted to learn periodontics, I would attend the periodontal clinic. If I wanted to study endodontics, I would go to the endo clinic, and so on.

In 1992, however, they changed their tune: "Now, the dentist must learn everything in one place because we're going to turn them into super general practitioners who can provide all services in one location." GDs would perform periodontal procedures, implants, endodontics—everything—and educators were eager to support them.

In my opinion, this shift has presented significant challenges to how we deliver specialized care in America. Interestingly, the same dynamic never occurred in medicine. Doctors recognized that specializing resulted in higher incomes and significantly better patient outcomes. In dentistry, however, the opposite approach was encouraged. Dental students were told, "You can pay $100,000 in tuition because you're going to learn to do everything, and then in no time, you'll pay it back."

It was an impossible promise to keep, both financially and in terms of education.

In my opinion, the American Dental Association (ADA) played a role in this shift, largely through its support of the Commission on Dental Accreditation's (CODA) revisions to the accreditation system. As part of this change, the field transitioned from the term "specialist" and adopted "advanced education." For example, I completed an additional 3 years beyond my DDS degree and earned a "Specialty in Periodontics." Today,

the education remains the same, but the degree has been rebranded as "Advanced Education in Periodontics." Similarly, prosthodontics has lost its specialty designation; what was once called a "Postgraduate Specialty in Prosthodontics" is now referred to as "Advanced Education in Prosthodontics." Endodontist specialists have experienced a similar change in terminology.

My understanding is that the current policy direction within accreditation bodies is to remove the term "postgraduate," further blurring the distinction in the public's perception.

Some may believe that words don't matter, but language reflects a deeper shift in philosophy. As specialists came to be seen as just slightly more "advanced" than GDs, the perceived need for true expertise began to erode. This became evident, for example, in the increasingly common practice of one GD teaching another how to place an implant in a continuing education setting, much like an apprentice passing skills to a fellow apprentice.

Please don't misunderstand me; GDs are not inherently inferior to specialists. Some of my best friends and most skilled and respected associates are GDs, and I admire them greatly. They're not less capable, intelligent, or ethical than specialists. Most come from a place of good intentions, wanting to serve their patients who are busy, distracted, and often not financially able to access specialized care. However, there is just not enough time in a 4-year program to learn everything. As a result, GDs learn a bit of everything, but not enough of anything.

In other words, the problem lies not with the people but with the system. In the United States, the first 2 years of dental school primarily consist of basic science and intensive coursework. It isn't until late in the second year that they finally introduce dentistry. When I attended dental school in Europe, the program spanned 5 to 6 years. We didn't first go to college, so we went directly into dental school and learned everything over 5 years with 3 years of clinical practice before we graduated.

In America, dental education is condensed into 4 years, with only 2 years of clinical dentistry. Traditionally during the clinical years, students learn how to administer anesthesia, make a smooth filling, clean teeth, chart correctly, as well as create proper crowns and three-unit bridges. But now with this comprehensive care model, they must also learn how to do implants, full dental reconstructions, esthetics, prosthodontics, endodontics, oral surgery, and more. Students have just 2 years to

absorb all this information, resulting in them graduating with limited practical dental skills.

I believe that this educational shift has had wide-ranging consequences, even impacting postgraduate programs. Students entering these advanced programs often lack essential skills that should have been mastered during their predoctoral education. Consequently, postgraduate educators find themselves teaching basic competencies before they can engage in specialized training. I witnessed this issue firsthand during my time as the creator of the periodontics program at Lutheran Medical Center in Brooklyn, as director at NYU Dental College for nearly a decade, and in many other academic settings in which I taught.

The inadequate preparation of dental school graduates is an open secret within the dental education community, yet it remains a topic rarely addressed publicly. This knowledge gap has fueled the proliferation and popularity of continuing education courses in dentistry. These courses have become essential, not just for staying current with new techniques but often for filling in basic skill deficits that should have been addressed in dental school. This trend underscores a systemic issue in dental education that requires urgent attention and reform.

Of course, not everyone agrees with me on this topic. Supporters of the current system argue that the comprehensive care model produces more well-rounded dentists who are better equipped to manage the full spectrum of patient needs, especially in areas where access to specialists is limited. They point out that many patients can't afford or coordinate multiple referrals, and GDs trained across disciplines can offer more efficient, affordable care. Others believe the model simply reflects the realities of modern practice: that today's dentist must be versatile, adaptive, and clinically capable across multiple domains. From this perspective, the comprehensive model is less a dilution of specialization and more a democratization of skill. And to be fair, many graduates do go on to seek advanced education in specific fields, suggesting that the comprehensive foundation doesn't close the door to later specialization.

These arguments in favor of the comprehensive care model are understandable. I respect the intention behind creating more versatile practitioners who can offer a broader range of services—especially in communities where access to specialists is limited. GDs are often the first, and sometimes only, point of care for many patients. Equipping them to do more makes sense on paper.

But in practice, we've failed to equip them adequately. This is why I stress that my concern is not with GDs themselves, many of whom are deeply skilled, thoughtful, and committed to excellent care. The issue is systemic. We've asked general practitioners to take on more responsibility than the current educational system can realistically prepare them for. As someone who has spent decades treating complications and overseeing advanced clinical education, I've seen the fallout firsthand. When foundational training is compressed and stretched thin across too many disciplines, no one—neither patient nor practitioner—truly benefits.

My aim is not to draw battle lines between specialists and generalists. The future of dentistry depends on a strong, respectful collaboration between both. But for that collaboration to work, we must acknowledge the limits of what can be mastered in a 4-year program. We need GDs who are confident in their skills and equally confident in recognizing when a case requires deeper expertise. That recognition isn't a weakness—it's a professional strength. That is, the divide we should be concerned about isn't between roles; it's between rhetoric and reality. We can't keep expanding the scope of general practice without expanding the depth and the time of education to match. For example, in the case of the specialty of periodontics, an expansion of the depth of training was seen as necessary, and in 1996 a year of training was added, expanding the program from 2 to 3 years. I was the first class to graduate with 3 years of training. Until we reconcile with this reality, we will continue to burden GDs with unrealistic expectations and expose patients to uneven standards of care. And that, ultimately, undermines the benefits this model was meant to deliver.

I would also argue that the overgeneralization of GDs has significantly hampered the sustainability of solo general dentistry practices, leading to increased corporatization of the field. First, when you're expected to handle everything, patient outcomes decline, and the quality-of-care differences between solo and corporate practices diminish. Meanwhile, specialized equipment costs increase. Coupled with the challenges we will explore in chapters 2 and 3, this situation fosters an environment ripe for corporate takeover. Corporations, keen observers of market trends, recognize the growing complexity in general dentistry. Most dentists, shaped by a condensed curriculum and having little to no business education, are ill-equipped to handle these complexities of managing an

expanded practice attempting to do everything. This creates an increased demand for external support that corporations are eager to provide.

The homogenization of dental care also benefits corporations in other ways. While highly specialized star dentists are challenging to replace in a standardized system, the new breed of generalist practitioners fit seamlessly into a model of uniform protocols and streamlined services. This enables corporations to implement efficient, scalable operations that maximize profits.

Essentially, the standardization and generalization of dental care has helped to transform practices into attractive investment opportunities, helping lay the groundwork for the rise of DSOs and fundamentally changing the landscape of the profession. Until the early 2000s, almost 90% of dental practices were owned by individual dentists. This was about to change dramatically with the arrival of the fourth and—if we're not careful—final business model for dentists: corporate ownership and control.

SUMMARY

- The historic solo practice model, the "golden age" of dentistry, thrived on strong patient relationships and collaboration between dentists and specialists.
- Advances in implant technology disrupted traditional roles, increased revenues substantially, and increased pressure on solo dentists.
- The traveling periodontist model failed due to poor patient care and a lack of long-term, strategic planning.
- Dental education shifted toward generalized care, reducing the distinction between GDs and specialists.
- All of these factors opened the door for the next practice model: corporate dentistry.

Questions for Thought

1. How do you view the changes in the profession throughout your career? What advice would you give to younger dentists about navigating the current landscape, particularly regarding practice ownership and the pressure to sell to corporate entities?
2. As a practitioner, how have you navigated the tension between specialization and the trend toward generalization in dentistry? What strategies have you employed to maintain expertise while meeting diverse patient needs?
3. Given the gaps in dental school education highlighted in this chapter, how has continuing education shaped your practice? To what extent do you feel these courses are filling essential knowledge gaps versus advancing specialized skills, and what implications does this have for the future of dental education?

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