Perspectives

Why Dentists Should Be Called Oral Physicians Now

Donald B. Giddon, D.M.D., Ph.D.

Dr. Giddon is Clinical Professor, Department of Developmental Biology, Harvard School of Dental Medicine, and former Dean, New York University College of Dentistry. Direct correspondence and requests for reprints to him at Harvard School of Dental Medicine, 188 Longwood Avenue, Boston, MA 02115; 781-235-2995 phone; 781-235-2996 fax; donald_giddon@hms.harvard.edu.

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A lthough health care is becoming increasingly complex, medical specialists including dentists are becoming more isolated from participation in total health care. Given this isolation and the shortage of health care in the United States, medicine faces a challenge to “find synergies and new health care and education models by building bridges among the health professions.” While potential patients and politicians seem to be agonizing over how to provide universal health care, a variety of health and quasi-health professionals see this seeming chaos in the U.S. health care system as an opportunity to be of service, while others see it as a potential financial bonanza. For example, some traditionally trained physicians are performing unnecessary surgeries, often in proportion to the number of surgeons. Similarly, physicians with varying amounts of specialty training and now dentists in California are fighting over who should be allowed to do cosmetic surgery of the head and neck. Within the dental profession, several subspecialties, such as periodontists, prosthodontists, and oral and maxillofacial surgeons, are having their own turf war over dental implants. Chiropractors, who have limited medical and no surgical training, are expanding their scope of practice to include nutritional counseling and kinesiology, have created subspecialties such as chiropractic internists, and may actually assume other primary care functions in medically underserved areas. The result of this blurring of boundaries is potential financial gain for selected health practitioners who are willing to provide often unnecessary health care services for which they may or may not be trained.

Unfortunately, some health practitioners have lost sight of the ultimate goal of being a health professional—that is, to relieve and hopefully prevent suffering without doing any harm. Even more disturbing are the health practitioners who view a license to practice as a right rather than a privilege to enhance the human condition. For actual and potential patients, the situation has thus become more confusing because of their uncertainty over what types of health care services should be provided by different types of health care providers.

There is no doubt, however, that some paramedical personnel, particularly those at the doctoral level, can and do provide significant health care services. For example, because osteopathic physicians are considered to be the closest in training and experience to physicians, they have been granted the same privileges and responsibilities as M.D.’s in some states since the early 1900s. For scope of practice and licensure, they are now equivalent to M.D.’s in all states, but must list themselves as doctors of osteopathy (O.D.’s). While veterinarians are probably the most broadly trained paramedical professional, their role in treating humans has largely been limited to triaging of the wounded during disasters.

One approach to this mixed bag of disparity and opportunism is to redistribute and reclassify those who provide health care in accordance with their training. A reasonable beginning would be to expand the public’s perception of who should be called a physician. The Oxford English Dictionary definition of a physician—“one legally qualified to practice the healing art” by virtue of training and experience—would certainly seem to include all those who provide “healing” to some or all parts of the body. Medicare has already expanded the definition of physician to include doctors of osteopathy, dentistry, optometry, podiatry, and chiropractic medicine and even psychology.
Moreover, in the Netherlands and Germany, doctors or those who practice the healing arts are referred to as “arts,” which for a dentist becomes “tooth doctor” or “tandarts” and similarly “Zahnarzt” in German. Prahl-Anderson has recently, in fact, called for a formal change in the designation of dentists in the Netherlands to oral physicians.

Other major paramedical health professionals who are currently licensed as physicians (with a preceding specialty adjective) in many states are chiropractors, podiatrists, and optometrists. Optometrists are permitted to be called optometric physicians in nine states (S. Cooper, BA, oral communication, February, 2004) with limited prescription privileges specific to the eye in all fifty states but no admitting privileges. As noted above, chiropractors have now become chiropractic physicians in twenty-nine states, with recent further aggrandizement, in spite of the fact that they have no surgical training or prescription or hospital privileges. The podiatric physician or surgeon, né chiropodist, now has both hospital admitting privileges and prescription authority.

There are a number of other quasi-health practitioners with limited biomedical training, such as naturopaths and herbalists, who call themselves doctors and occasionally physicians. These peripheral groups have in fact caused reactive legislation in several states to restrict the title of “physician.”

Based on the twin factors of scope of training and completion of licensure by examination process, only the dentist and possibly the podiatrist should be allowed to append physician to their professional title. These health care professionals are the only two paramedical providers who must have general knowledge of the structure and function of the entire body, as well as of their special area of expertise in the craniofacial or foot area, respectively. Podiatrists are actually more limited than dentists in the sense that they have only the feet from which to detect and possibly treat a more limited number of systemic diseases. As recently noted by Goldhaber, the dentist is already a de facto oral physician, being the only health care professional responsible for the care of the oral cavity and surrounding craniofacial area. Over 100 systemic diseases are manifest in the mouth and surrounding craniofacial area. Moreover, with the increasing complexity of health care and the interrelation of oral and systemic disease, such as cardiovascular disease, the dentist as an “oral physician” must work very closely with other physicians.

Unfortunately the present trend of medical specialists, including dentistry, is to become increasingly more isolated.

As noted earlier, however, some dentists do recognize their responsibilities and opportunities by becoming involved in a variety of roles reflective of primary care functions, such as counseling for tobacco cessation, recognition and referral of hypertension, skin cancer, and domestic and substance abuse, as well as the recognition and treatment of the dental ravages of eating disorders such as bulimia.

Historically, dentists should have been first among the several paramedical professionals to change their name to “physician” with a qualifying adjective. They have really not changed their designation since the 1300s when they separated from physicians to become barber surgeons, becoming dentists in the eighteenth century. As I have noted previously, the oral physician concept is not new. Nash, Goldhaber, Bertolami, Donoff, and others have described the oral physician of the future, but with additional medical training and other curricular revisions that would take at least a decade to implement. Overlapping the question of whether D.D.S. or D.M.D. should be the doctoral degree with ostensibly the same curriculum, the real problem—as pointed out by Hendricson and Cohen—is that dental education, even in the twenty-first century, remains dichotomized into the technical aspects of teeth and supporting structures contrasted with the oral physician model with expanded training in the pathophysiology of systemic disease. I suggest instead that only minor changes are currently needed, such as continuing education courses.

The case for becoming physicians is even stronger today than in previous years. As indicated by Goldhaber, basic science and clinical medicine courses have increased in dental schools in the last century, and dental education now includes postgraduate clinical internships and residency programs in hospitals. Consequently, as DePaola and Slavkin point out, dentistry now has an opportunity to participate in major reform of the health care system.

In recognition of the scope of contemporary dental education, the possibility of expanding dentists’ primary care functions to meet public health needs not addressed by other providers, and the potential for dentists to play an important role in responding to bioterrorism, a bill was introduced recently in the Massachusetts legislature to permissively change the designation of dentist to oral physician (House Docket
2306). Why are these expanded roles not generally known by the public or endorsed by dentists? One explanation is that dentists, or for that matter any of the other paramedical health care professionals, are unwilling to provide services for which they may be trained, but the public does not want them to perform.37 Moreover, because the public is unaware of dentists’ training and capability, patients are not likely to compensate these doctors/physicians for services not ordinarily expected of this category of health care practitioner. Unfortunately, the dental profession, which enjoys what are perceived to be the benefits of independence from medicine, including a higher average salary than physicians—at least when comparing general dentists with primary care physicians in group practice ($174,350 for the general dentist in 200238 and $150,000 for primary care physicians in group practice in 200239)—may not want to incur the bureaucratic disadvantages of managed care and related problems.

To accomplish these changes in name and associated responsibilities, both the dental profession and the public must participate in an educational program designed to increase knowledge of what the dental profession can do and improve attitudes toward dentists’ assuming these new roles.

REFERENCES