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Oral medicine in Europe: past, present and future

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In brief

Discusses the history of oral medicine.

Discusses the education and practice of oral medicine in present day Europe.

Suggests that European countries need to agree a consensus definition of oral medicine.

Oral medicine (OM) is a relatively young dental specialty usually dealing with the oral healthcare of patients suffering from chronic recurrent and medically-related disorders of the mouth and maxillofacial region and with their diagnosis and mostly non-surgical management. The beginning of OM goes back to 1925 in the USA and 1950s in Europe. However, official specialty recognition is more recent and within Europe, it is only in the UK, Croatia and Israel where OM is recognised by local registering authorities, although in several other European countries it is viewed as a distinct field of study. Despite a broad agreement in OM syllabi and clinical practice, there are still some important differences in its definition and scopes within Europe. It is crucial that European countries agree a consensus definition of OM and clarify competencies and limits, so they may move from institution and region-specific approaches to an international framework. According to the European Directives, it is timely to recognise a minimum three year standard curriculum at a post-graduate level which will lead to uniformity of training for OM residencies in European country members and will eventually provide guidelines for a broader OM specialty recognition.

Introduction

Oral medicine (OM) is generally defined as the branch of dentistry related to the oral healthcare of patients suffering from chronic recurrent and medically-related disorders of the mouth and maxillofacial region and with their diagnosis and mostly non-surgical management. OM was originally called dental medicine and it is sometimes now termed oral and maxillofacial medicine and, in the Ibero-American world and in Southern Europe, is also called stomatology.[1]

Scopes and definition are not the same everywhere as, for example, in the UK, OM is defined as 'the speciality of dentistry concerned with the oral health of patients with chronic, recurrent and medically-related disorders of the oral and maxillofacial region, and with their diagnosis and nonsurgical management',[2] whereas in the USA, OM is 'the speciality of dentistry concerned with the oral healthcare of medically complex patients and with the diagnosis and non-surgical management of medically-related disorders or conditions affecting the oral and maxillofacial region.'[3]

Similar differences exist among European countries which are likely the result of cultural economic differences, heterogeneity of settings and healthcare systems.[4] However, this variability is going to influence training and clinical practice and could represent significant obstacles in developing a syllabus for an international OM curriculum.

A brief history

The beginning of OM goes back to 1925, when in the USA, Francis McCarthy was one of the first to combine dermatology and pathology knowledge to manage patients with complex oral mucosal manifestations. Dr McCarthy was also the first academic to introduce an OM lecture at a dental school at Tufts.[5] The first OM scientific organisation was established in 1945 by Dr Samuel Charles Miller and his university colleague Dr Sidney Sorrin and was named the Academy of Dental Medicine (AADM). In 1964, AADM was re-named the American Academy of Oral Medicine (AAOM).[1] Other important personalities in American OM were Dr Lester W. Burkett, Joseph F. Volker, Irving Glickman, Herman M. Becks, Harold R. Gelhaar and more recently Dr Sol Silverman Jr.[6]

In the 1950s and 1960s, certified training programmes in oral medicine spread throughout the USA and, as a result, the founding members of AAOM recognised the need for an examining board to establish uniformity of training for oral medicine residencies. The first OM Board exam was held in 1956. It took, however, many decades for OM, to become, in the USA an officially recognised dental specialty, based on approval of the application submitted by the American Board of Oral Medicine in 2015 to the American Board of Dental Specialties.[7]

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In Europe, key persons for the establishment of OM as a separate and independent specialty were often trained oral pathologists such as Jens Pindborg who had already, and single-handedly, created the discipline of oral pathology in the first half of 1950s.[8]

In the UK in the 1950s an interest in OM was shared by those who already had clinical expertise and a research interest in oral surgery and oral pathology. However, it was the Nuffield Foundation's decision to fund the first two Chairs in oral medicine that was pivotal in the establishment of the specialty.[9] Martin Boyes filled one of these Chairs in Oral Medicine at Newcastle University and Martin Rushton filled a Chair in Dental Medicine at Guy's Hospital. Professor Brian Cooke also established an OM unit in Cardiff, Wales and Professor Sir David Mason, a department of OM and pathology in Glasgow, Scotland. Professor Sir David Mason and Dr Dean Millard (University of Michigan School of Dentistry, USA) initiated the prestigious series of World Workshops in Oral Medicine which continue to flourish today.[10]

The British Society for Oral Medicine (BSOM), possibly the first European OM scientific organisation, was formed on 24 February 1981, but it was not until 1992 that a Specialist List in Oral Medicine was introduced by the General Dental Council in UK.[9]

Other existing European OM societies are listed in Table 1.

The concept of a society representing all of Europe was initiated by Professors Miguel Lucas-Tomas (Spain), Jens Pindborg (Denmark), Sir David Mason (United Kingdom) and Dr Dean Millard (United States) when they met in Madrid, Spain in 1991 to discuss a multinational association of oral medicine.[1]

There were other meetings with other colleagues in Granada, Spain (1993), Belfast (1995), and London (1997) and then, in London in 1998, Professors Crispian Scully (United Kingdom) and Isaac van der Waal (Netherlands) formally founded the European Association of Oral Medicine (EAOM) along with Professors Sir David Mason, Tony Axéll (Scandinavia), Antonio Azul (Portugal) and Stephen Challacombe (United Kingdom).[1]

Present day

Currently, OM presents a quite uneven scenario across Europe both from an educational and from a clinical point of view.

Educationally, one of the major prerequisites for an auspicious, optimistic and promising future for OM is the specialty recognition, which, unfortunately, at present does not apply in many European countries.[11]

OM has been reported to be recognised as a specialty by local registering authorities in Europe in the following countries: Croatia, Israel and United Kingdom.[1]

Moreover, OM training is a distinct field of study in Finland, Greece, Ireland, Italy, Spain and Sweden.[4.]

In Greece, although OM is not yet a specialty, a well-structured three years post-graduate programme exclusively dedicated to OM combined with oral pathology training is present and it is recognised by the Ministry of Education.

In the majority of the remaining European countries, OM post-graduate training is combined with other dental disciplines such as oral surgery, oral pathology, oral and maxillofacial surgery, periodontology and oral radiology.

In France, the Conseil de l'Ordre des Médecins (Council of the Medical Association), after political negotiations, suppressed stomatology as a specialty of medicine and replaced it with chirurgie orale (oral surgery). OM is now a skill and competence of pathology and dermatology.[1]

Bruce Baum and the late Crispian Scully, Editors of a leading journal in OM, *Oral Diseases*, stated that there should be much more medical experience and training for OM specialists.[11]

Many OM practitioners who qualified in the past have both dental and medical degrees in some areas in Europe, but this is not the always case for the USA. In some instances, for example in Italy, the double qualification was due to the peculiar education pathway, as until 1981 a devoted dental degree did not exist and to become a dentist an undergraduate should first obtain a medical qualification and then specialise in 'odontostomatology', essentially the last three years of a current European dental degree. It is probably worth highlighting that 'odontostomatology' was a medical speciality.

However, since in most European Countries OM is now considered a dental specialty, most oral medicine specialty-training programmes in the last decade have moved closer to the USA model that dictate that OM practitioners are no longer required to earn both medical and dental degrees.

According to Baum and Scully,[11] the degrees practitioners of oral medicine have earned might be totally irrelevant, but it is critically important that they have a general understanding of medicine and biomedical science.

Interestingly, despite variation in the duration of post-graduate training in OM, there seems to be a broad agreement between syllabi. For example, most of the training programmes consider essential competencies to include the diagnosis and management of

Table 1 National oral medicine societies in Europe

Country	Date of foundation	Active societies
Croatia	1997	Croatian Society for Oral Medicine and Pathology (CSOMP)
Greece	2000	Hellenic Society of Oral Medicine and Oral Pathology (HSOMP)
Greece	2008	Greek Association of Oral Medicine
Israel	Late 1980s	Israeli Society of Oral Medicine (ISOM)
Italy	1992	Societa' Italiana di Patologia e Medicina Orale (Italian Society of Oral Pathology and Medicine, SIPMO)
Portugal	1984	Academia Portuguesa de Medicina Oral (Portuguese Academy of Oral Medicine, APMO)
Romania	2014	Academia Portuguesa de Medicina Oral (Portuguese Academy of Oral Medicine, APMO)
Spain	1988	Sociedad Española de Medicina Oral (Spanish Society of Oral Medicine; SEMO)
United Kingdom	1981	British Society for Oral Medicine (BSOM)

oral mucosal disease and the diagnosis and management of oral/facial pain.[4]

A recent survey among 282 OM practitioners worldwide[12] showed that the most common clinical activities in OM practice are the diagnosis and management of oral lesions, salivary gland disorders, and oral manifestations of dermatologic, gastrointestinal, and HIV diseases and facial pain, which was consistent with previous reports.[13–15]

Nevertheless, there are still significant differences in the definition of OM clinical practice. For example, the vast majority of surveyed OM practitioners from Israel, Spain, Italy, Croatia and Sweden, consider provision of dental treatment for medically complex patients within the scope of oral medicine practice.[12]

However, in the UK, the regulatory authority, the General Dental Council, has defined a new independent specialty, named special care dentistry that should 'provide preventive and treatment oral care services for people who are unable to accept routine dental care because of some physical, intellectual, medical, emotional, sensory, mental or social impairment, or a combination of these factors.'[16]

So what?

In the authors' opinion, it is crucial that European countries agree a consensus definition of OM and define its competencies and limits.

In that regard, the EAOM Diploma in Oral Medicine represents a unique opportunity to increase the knowledge among dentists and physicians who are working in the field of OM and to facilitate the establishment of a pan-European level of competence in oral medicine.[17]

Since the European directives dictate a three-year post-graduate programme for all dental specialties, it is timely to recognise the need to define a minimum three year standard curriculum at a post-graduate level which will lead to uniformity of training for OM residencies in European countries and will eventually provide guidelines for a broader OM specialty recognition. So far, only two dental specialties, orthodontics and oral surgery, are automatically recognised in those European states where they exist (point 5.3.3 of Annex V).[18]

Education, research and clinical practice in OM will likely benefit from activities such as congresses with verifiable continuing professional development hours, consensus conferences to create guidelines, position statements on ongoing clinical issues, and guidance to prepare clinical and experimental protocols for mechanism-based research for many of the diseases in which OM is centrally involved,

It is very likely that the steady growth of OM could be greatly helped by organisations such as EAOM and national societies, and a substantial part of our future should be spent facilitating communication and collaboration among different countries and allied specialties.

There are indeed several examples both in allied medical (eg dermatology) and dental specialties (eg periodontology) showing that a more integrated multi-national approach could work better to produce guidelines/position papers that can influence decision makers.[19,20]

Building upon the development of oral medicine over the past 80 years, it is also essential to strategically align the future of collaborative, international OM with the scientific principles and healthcare policy strategies developed by national and international institutions such as the World Health Organisation. Synergistic coordination among the various interested bodies is the logical next step toward achieving this alignment.

Despite the diversity of cultures and heterogeneity of settings and healthcare systems in Europe, we are very likely sharing common objectives and we should move from institution and region-specific approaches to an international framework in which unifying concepts in the field can be defined and implemented.

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