# Oral physicians

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**IN BRIEF**

- Compares the funding differences in the US and UK dental systems and discusses the implications of this on the ability of dental practices to be concerned about the patients' overall health.
- Discusses the lack of opportunity in the US for the use of mid-level providers (particularly in underserved areas) as employed in the UK and elsewhere.
- Elaborates on issues regarding titles such as doctor and physician in the US and UK.

OPINION

In response to Stephen Hancocks' editorial *Sawbones no longer*, this paper examines the future role of oral physicians and patients' need for dental professionals to play a larger part in overall healthcare. Whilst the financial structures behind the US and UK dental systems differ, it can be questioned whether the outcomes of impending change will be as diverse.

Oh, would it be so that, following the earlier visions of Barmes and Nash,[1] the concept that dentists should assume the mantle of oral physicians[2] with more responsibilities as health professionals could become a reality in the United States. The extent, however, to which these expanded roles can be adopted in various countries depends very much on the existing socio-political-economic constraints of patients and providers, one of the major differences being how much of basic dental care is covered by third party payment, leaving the elective dental care procedures to market forces.

Patients in the UK visit their dentists on a regular basis, whether in need of treatment or not, while seeing their primary care providers only on an as-needed basis. Moreover, UK patients are appreciative that someone whom they trust is able and willing to play a significant role in prevention as part of overall healthcare. Dentists can counsel their patients and help or refer for nutritional deficiencies, tobacco cessation, and alcoholism.[3] Dental specialists can also have an important role as oral physicians,[4] with periodontists focusing on oral manifestations of systemic disease such as diabetes.[5-7]

Although less obvious but important nonetheless, in another example orthodontists are in a unique position of seeing their patients during their most formative years, once a month for two years, and thus have the opportunity to detect craniofacial anomalies, other developmental, eating, and behavioural disorders, such as autism spectrum disorders and attention deficit-hyperactivity disorder. In spite of recent documentation by Glick and Greenberg, Lamster, and others[6,8,9] that dentists can have a role in primary care acceptable to patients, there is still great resistance by organised dentists in the US to expanding dentists' responsibilities and/or allowing anyone but licensed dentists to provide any level of dental care. Ostensibly the official position of organised dentistry and the US government agencies is to increase access to dental care at lower cost. This approach is certainly a much more expensive method for increasing access to care than supporting the training of tried and true mid-level providers in various parts of the UK and Canada etc, who are currently being trained in Minnesota and Alaska[10,11] under the auspices of the US government's Indian Health Services. Such documented success elsewhere[12,13] has not kept the American Dental Association from trying, albeit unsuccessfully, to stop such training, ostensibly because they were or will be practising dentistry without a licence.

Paradoxically, the fact that dentists are called 'doctor' in the US and many other countries implies that they have a significant role in the overall healthcare of their patients. The reality is that rather than embracing greater involvement in overall healthcare, dentists are moving away from using their medical and surgical knowledge, citing scope of practice constraints and possible lawsuits for not recognising or following up on possible manifestations of systemic disease, such as hypertension, cancer, eating disorders, developmental and behavioural problems, such as autism spectrum disorder and attention deficit-hyperactivity disorder.

In Iran, for example, where physicians and dentists are addressed as 'doctor', the first point of entry into the healthcare system may be either a physician or dentist, who then treats or refers the patient to the appropriate healthcare professional. Having many more physicians than dentists in a world where almost everyone needs some type of dental care results in decreased access to dental care at higher cost. In the US, for example, dentists have higher income than primary care and family physicians.[13] Simple economics explains the increase in applications to dental schools.[14,15] Dentists in the US want to continue to function as a business rather than a health profession, resisting any attempts to become a specialty of medicine and the accompanying government bureaucratic entanglement as *de facto* oral physicians. Dentists already have the status of a doctor without the life and death responsibilities. The corollary of this situation is that dentists may well be overtrained for what they actually do and possibly undertrained for additional primary care responsibilities.

Even with the increase in the mostly proprietary dental schools[13] seen in the

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US and elsewhere as one way of increasing access to lower cost dental care, the curricula only give lip service to biomedical training, nevertheless representing themselves as having the same medical training as many university-based dental schools. Even the degrees awarded by US schools are being perverted away from the original distinction between DMDs initiated at Harvard, and subsequently followed by the Universities of Louisville and Oregon. The differences in the degrees then were ostensibly due to those with DMDs having more emphasis on the medical aspects of training than those with the DDS. Because the general public still views the training of the DMD to be superior to the DDS,[16] many schools in the US now award the DMD, even allowing those with a DDS to change retroactively to the DMD for a fee.

Following from the traditional glorification of titles in the UK, the title 'doctor' has stimulated some pretentious hypocrisy. At least to the keepers of the faith in the UK, the idea that the dentists should be called 'doctor', let alone oral physician, was decried in the *Journal of the Royal Society of Medicine*.[17] In an editorial rebuttal, I pointed out that physicians (and dentists) in the UK do not even have a doctoral degree, only bachelor's of medicine (MB) or bachelor's of dental surgery (BDS), at least until they have successfully defended a doctoral thesis. Tradition alone grants the title 'doctor'. If they subsequently become surgeons, their designation reverts to 'Mr' or 'Ms'. Ludicrous as it may appear today, when I briefly worked in a UK hospital eons ago, the female surgeon with whom I was working was called 'Mister', and the male nurse assisting her was addressed as 'Sister'.

There may be some hope in the US, where individual states are trying to expand the role of hygienists. In Kansas, for example, 'specially trained dental hygienists would be allowed...to perform more basic dental services, like temporary fillings and [extracting deciduous] teeth...'.[18]

The problem for the US is that except for tobacco control, there is as yet no compensation for non-dental procedures performed by dentists as oral physicians.

Although there are apparently medically-trained oral physicians in the UK and/or in Australia[19] and dentists are already *de facto* oral physicians, I believe the time is now to endorse the new superordinate designation for dentists as oral physicians,[20] with a broader mandate for the oral physicians in the UK who are primarily trained as physicians, perhaps somewhat similar to the stomatologist in China, a title which truly reflects what services they are capable of providing. As such they can then oversee all dental services, whether provided by dentists or non-dentists who would be limited to simple restoration and emergency treatment. The resulting increase in efficiency and delegation of routine tasks will leave time for the dentists as oral physicians to provide limited preventive primary care. Hopefully, medical insurance in the US, and the equivalent in the UK, will cover the preventive services for dentists as oral physicians screening for chronic and other diseases with oral manifestations.

Finally, regardless of whether dentists are willing to accept more responsibility for overall healthcare, they may soon realise that mid-level providers are here to stay and that the public will not be able or willing to distinguish dentists from non-dentists who provide needed care at reduced costs. If for no other reasons, the dentists must re-invent themselves as oral physicians to return to their rightful role as complete health professionals. It is only because of academic freedom that Harvard University allowed us to demonstrate that general practice dental residents could be trained to provide limited preventive primary care as oral physicians.[21]

In summary, Stephen Hancocks' editorial *Sawbones no longer*[2] provides a clear and present warning, as well as an opportunity to make much needed changes, in how the dental workforce is distributed. Although the pathway toward achieving these changes may well differ between the US and the UK, the common end justifies cooperating on the means.


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