

Why Dentists Should *Become* Oral Physicians: A Response to Dr. Donald Giddon's "Why Dentists Should Be Called Oral Physicians Now"

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Submitted for publication 3/13/06; accepted 3/21/06

In the February issue of the *Journal of Dental Education*, Dr. Donald Giddon wrote a Perspectives article entitled "Why Dentists Should Be Called Oral Physicians Now."¹ Dr. Giddon had previously expressed the point that dentists should be called oral physicians in a point/counterpoint article in the *Journal of the American Dental Association*, in which Dr. Leon Assael took the counterpoint.² Dr. Assael's view was that dentists do not need to be called oral physicians, nor to become such in any substantive manner. My perspective is different from both Giddon's and Assael's. I believe dentists need to *become* physicians of the oral cavity, no matter what they may be called.

In December 1994, at the Eastman Dental Center of the University of Rochester School of Medicine and Dentistry, I delivered a speech entitled "The Oral Physician: Creating a New Oral Health Professional for a New Century" in honor of the ninetieth birthday of Dr. Basil Bibby. It was subsequently published in the *Journal of Dental Education*.³ In the speech and article, I called for a major transformation of the professional curriculum in dentistry to one that would result in the graduation of a dentist who could be understood and recognized as a physician of the oral cavity. Earlier, in 1994, I had proposed an oral physician curriculum for the University of Kentucky, a curriculum that was subsequently agreed upon by the Colleges of Dentistry and Medicine. It included the first three years of the medicine curriculum, including the full year of clinical clerkships in year three. These three years were to be followed by two calendar years of clinical training in dentistry. At the conclusion of the five-year program, an individual would have completed the requirements for

and could have been awarded both the M.D. and D.M.D. degrees. The Kentucky oral physician curriculum would have provided as many clock hours of training in clinical dental skills as currently exist in the typical curriculum in dentistry. I justified the need for such a transformation based on the significant changes in the environment of dentistry, which I characterized as biological, epidemiological, technological, demographic, professional, and economic. The curriculum was never fully implemented for reasons that have been described.⁴ However, I continue to endorse such an educational transformation and believe the environmental forces operational over ten years ago, which prompted the call for change, are even more intense today.

In January 1995, the Institute of Medicine (IOM) of the National Academy of Sciences released its major study of dental education, *Dental Education at the Crossroads: Challenges and Change*.⁵ In the report, the IOM indicated that dentistry should become more closely integrated with medicine. While acknowledging it was the most "far-reaching option," the IOM suggested that one of the several paths that dentistry might elect to pursue would be to become a specialty of medicine. The oral physician curriculum I proposed would move dentistry in that direction. The IOM report further suggested that for dental education to "preserve the status quo would be a path toward stagnation and eventual decline." I believe that decline is apparent today.

I cannot agree with Dr. Giddon's point that dentists should consider changing our designation from "dentist" to "oral physician," absent dentists being truly educated as physicians of the oral cavity. Changing our name changes nothing of substance; it

is merely a marketing strategy. Some health-related professionals may have appropriated the term “physician,” e.g., chiropractic physicians, as Dr. Giddon documents; but this does not make them physicians. The term “physician” is generally understood as being applied to one with a traditional education in allopathic or osteopathic medicine, holding either the Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree. If dentists want to be called oral physicians, they should participate in a curriculum such as the oral physician curriculum referenced above and thus qualify as physicians—physicians of the oral cavity.

Dr. Giddon does seem to think that some additional training is required for dentists to become oral physicians and therefore to be entitled to be designated such. However, he suggests, “only minor changes are currently needed, such as continuing education courses.” My perspective is very different. Dr. Giddon indicates that the education of dentists over the past century has resulted in a significant increase in the amount of education they receive in the basic biomedical sciences. This is true; however, the average number of clock hours of education in the basic biomedical sciences for dentists is still less than one-half that of physicians.⁶ In spite of the IOM’s recommendation that basic biomedical science education for dental and medical students be integrated, this has not happened. Furthermore, dentists receive virtually no education in clinical pathophysiology, in spite of the IOM report’s recommendation that at least one rotation in a relevant medical clerkship be included in the dental curriculum. Dental curricula provide only minimal education in physical diagnosis. Today’s typical graduating dentist would not know how to perform even a basic general physical examination—certainly a procedure one would expect of anyone who would presume to be called a physician, even an oral physician. Merely “minor changes,” consisting of continuing education courses, cannot overcome the rather glaring educational deficiencies of dentists for us to be legitimately called and understood as physicians of the oral cavity.

Dr. Giddon correctly describes dentists as “paramedical professionals.” Dentists as currently educated and trained are “para,” which by definition means we are near or alongside physicians, though not really physicians. Dr. Giddon seems to believe that because we are close to physicians, or that because we are the only health professionals caring for

the oral cavity, we should be called oral physicians. This is not enough. We must become physicians of the oral cavity before being called such.

Dr. Assael, in his counterpoint, stated that “for dentists to call themselves ‘physicians,’ dentistry must merge completely with medicine and grant the M.D. degree.” I agree with this statement. However, he went on to argue against such and for maintaining the current autonomous status of dentistry from medicine; with that I disagree.² Dentistry is most appropriately understood conceptually as a specialty within medicine, not a discipline separate and autonomous from medicine. Dentistry is to medicine as otolaryngology, ophthalmology, dermatology, and other defined specialties are to medicine, i.e., equivalent specialties of medicine. Just as dentists are designated “dentists,” members of these specialties of medicine are designated respectively as “otolaryngologists,” “ophthalmologists,” and “dermatologists.” My use of the term “oral physician” is not in any way intended to discount the appropriateness of the designation “dentist” for a health care professional who specializes in treating oral diseases. Even if dentists were educated in an oral physician curriculum as I propose, it would still be appropriate to call them dentists. We call dermatologists “dermatologists,” not skin physicians. Rather, I use the term “oral physician” to indicate my belief that a substantive change is needed in the education and training of a dentist. For dentistry to take its rightful position as a specialty of medicine, alongside other specialties of medicine, there must be an equivalency of education and training in the basic biomedical sciences and the core of clinical medicine.

Why must those wanting to practice dentistry become dentists who are truly physicians of the oral cavity? Because the stomatognathic system is part of the human body. There is no reason to believe that the first twenty centimeters of the alimentary canal is or should be treated conceptually or practically as different from the rest of the human body. Oral health is intimately related to general health and well-being. As Dr. Giddon affirms, over 100 diseases have oral and craniofacial manifestations, and the oral cavity is a mirror of human health. Millions of Americans are medically and pharmacologically compromised and experience oral health problems. Dentists must become physicians—oral physicians—in order to understand and accommodate to the altered health status of their patients; new competencies must be developed.

Additionally, the education of dentists must be integrated with and comparable to the education of other physicians for oral health to be understood and appreciated by all physicians. Oral health does not receive the attention it deserves from physicians as they neither understand nor appreciate its significance. This is primarily due to the fact that physicians are not educated and trained in an environment in which oral health/dentistry is a component. Dentistry evolved in the nineteenth century as an autonomous professional educational program, separate from medicine, because of two factors: the overwhelming prevalence and severity of dental disease, which was understood as able to be managed only by mechanical means; and the lack of understanding of these nineteenth-century educators of the integral relationship of the oral cavity and its health to general physical health and systemic disease. Today we have brought the ravages of dental disease under a measure of control, and we have a broad array of interventions to prevent dental disease. Additionally, we have come to understand the integral relationship of oral and systemic disease.^{7,8} Separation from medicine may have served the public well in the past. It no longer does.

Simply changing the designation of dentists to oral physicians will not address any of these important issues. Furthermore, changing what we call dentists will not address the major problem in dentistry identified by the Institute of Medicine: the isolation that dentistry experiences from medicine.⁵ As the report noted, "Dentistry and dental education are made vulnerable by their relative isolation from the broader university, from other health professions, and from the restructuring health care delivery and financing that characterizes most of the health care delivery system." The IOM report went on to call for closer integration: "Dentistry will and should become more closely integrated with medicine and the health care system on all levels: research, education, and patient care."⁴

Health care policy has evolved in such a manner that oral health is fragmented from general health care policy so as to diminish the importance of oral health vis-à-vis the health of other organ systems. This segregation has created significant disparity problems; only integration of dental education and dentistry with medical education and medicine will resolve them. Dentistry must become fully integrated into the nation's health care education and delivery system for oral health to receive its justified and equitable share of concern and financing both from and for the public.⁹

One may choose to call dentists whatever one will, but the significant and important issue is not what one is called but rather what one is. Dentists must *become* physicians of the oral cavity. To be such, they must receive the same core education as physicians of any other organ system. Any change in nomenclature short of such a substantive educational change is meaningless.

REFERENCES

1. Giddon DB. Why dentists should be called oral physicians now. *J Dent Educ* 2006;70:111-4.
2. Giddon DB, Assael LA. Should dentists become "oral physicians"? *J Am Dent Assoc* 2004;135:438-47.
3. Nash DA. The oral physician: creating a new oral health professional for a new century. *J Dent Educ* 1995;59:587-97.
4. Nash DA. The cultural wars are not imaginary. *J Dent Educ* 1996;60:891-4.
5. Field M, ed. Dental education at the crossroads: challenges and change. An Institute of Medicine Report. Washington, DC: National Academy Press, 1995.
6. Tedesco L. Issues in dental curriculum development and change. *J Dent Educ* 1995;59:97-147.
7. Beck JD, Garcia RG, Heiss G, Vokonas P, Offenbacher S. Periodontal disease and cardiovascular disease. *J Periodontol* 1996;67:1123-37.
8. Glick M. Exploring our role as health care providers: the oral-medical connection. *J Am Dent Assoc* 2005;136:716-20.
9. Nash DA. And the band played on. *J Dent Educ* 1998;62:964-74.