Dr. Dentist
Alexander Holden looks at what is in a name...

Traditionally, all surgeons in the UK and Ireland are designated the title “Mr” or one of the appropriate female equivalents. Our medical colleagues graduate with the title “Dr” until those that want to follow the surgical pathway are elected to one of the Royal colleges and become “Mr.”, “Mx” or “Miss” again. This all harks back to the days where surgery was carried out by barber-surgeons who did not have formal medical training, usually on the basis of apprenticeships. When the fields of medicine and surgery became more integrated, surgeons kept their titles as “Mr.” as a reference back to these origins.

As dentists, we do not have a choice of career pathway between dental medicine and dental surgery in the same way; we all graduate as dental surgeons so by default our title is “Mr.”. However, perhaps as a result of modern globalisation, many dentists now refer to themselves as “Dr.”. Upon graduating, I did exactly that; I was given a badge with “Dr Alexander Holden” written on it and shortly afterwards my bank cards said the same thing.

Personal choice
Although my bank cards today still say “Dr.”, I do not introduce or advertise myself as this professionally; my patients know me as Alex and my referral letters are sent from Mr. Holden. This is simply a matter of personal choice; I am a dental surgeon, not a dental doctor. I would be quite happy to be in a practice where other dentists chose to call themselves “Dr” but as I am devoid of a doctorate, I will stick to “Mr.”.

Although I do not use it, I feel that it is important for dentists to be able to use the courtesy title if they wish; medical doctors in this country do not graduate with a doctorate in medicine so it is purely a courtesy title for them too. My views go beyond this non-objection in that I feel that perhaps dentistry is currently lacking a coherent career pathway for young dentists and this should be considered as a further possible change to dentistry in the UK. The pathway has suffered somewhat of recent times; traditionally dentists would graduate, complete VT and then after a period as an associate, buy into a practice. Now that being a practice owner does not necessarily pay more than being an associate and the prices corporates are willing to pay for practices is greater than that which new buyers can afford; the traditional career pathway is somewhat scuppered. Combine this with the possibility of a new contract in the NHS and direct access which will potentially favour the use of DCPs over associates for some roles and the old career pathway might be considered well and truly closed.

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Change for better
DF1 and DP2 (Dental Foundation) were credible and valid steps in attempting to make dentistry similar to medicine in its initial stages after graduation. I strongly believe that the new change has been for the better as now DF1 is more holistic in its view of dentistry; VT could perhaps be accused of being prescriptive of a career in practice whereas DF1 is more exploratory of dentistry as a whole.

Holistic is an interesting word to choose as it could equally apply to the new direction dentistry is following. As a profession we are waking up to the idea that dentistry is more than just what we can do in the dental surgery; our reach and arguably our responsibility stretches beyond, now looking at patients as more than just a mouth and re-evaluating our place in healthcare in general especially as in many cases we will see patients more often than their medical GP will.

To this end, is it possible to consider a similar dichotomy in dentistry as there is in medicine? This is especially pertinent as new restorative dentistry is moving towards more minimally invasive techniques and a chemotherapeutic approach with fluoride application than the more traditional ‘drill and fill’ surgical approach.

The research into periodontal disease is highlighting ever more that periodontitis is more of a multi-factorial, systemic condition than we once considered it to be; no longer is it simply because patients don’t brush their teeth (although oral hygiene is by far the most important factor in chronic periodontitis.) The links between coronary heart disease, diabetes and other systemic, inflammatory and immunological conditions is not simply one way. This surely calls for us as dentists to be more holistic in our approach?

Dichotomy
To recognise this new dichotomy of practice, will we see a change in dental education, so that dentists graduate with more of a general orientation like medics, to then become more like dental physicians or alternatively dental surgeons? The days of the generalist seem to be numbered; the new contract may well favour the specialisation of dentists to new degrees, with DCPs becoming more responsible for generalist work.

With the increasing emphasis upon skill-mix and an increasing political pressure to save money, just how long will it make sense for us to be as generalist as we are now?

We are not currently in a situation where the technology and materials are suitably tested and developed along with teaching and research, for this dichotomy to be fully realised. It does however seem to be inevitable that the more research takes us towards regenerative and preventative dentistry, the more the role of the dentist will change from surgeon to physician.

It is already the case that dental public health (very much non-surgical in approach) is a specialty examined and gained from the Royal Colleges of Surgeons, not from the Faculty of Public Health which is part of the Royal College of Physicians. This is simply due to an anomaly created by how the dental specialties are organised. This raises a question of how it can be justified having separate dental public health specialists when the determinants for oral diseases and most chronic diseases are common to one and other? It would actually be much better to have one overarching specialty of public health that covered the health needs of the oral cavity as well as the rest of the body.

Refocus
This need for a holistic approach is possibly more obvious in the specialty of dental public health, but I do believe that as we move further into the future and the surgical management of caries and other oral disease becomes less and less invasive, perhaps we need a similar re-focus of how dental training is organised, our affiliations to which faculties are appropriate and perhaps even a serious discussion about how we define ourselves as professionals.

References


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About the author

Alexander Holden is dentist in NHS and private practice who is also undertaking further training in law and dental public health.