Letters to the Editor

Please e-mail letters for publication to Dr Kamran Abbasi [kamran.abbasi@rsm.ac.uk]. Letters should be no longer than 300 words and preference will be given to letters responding to articles published in the *JRSM*. Our aim is to publish letters quickly. Not all correspondence will be acknowledged.

Miss, Mister, Doctor

How we are titled is of little consequence

I found the editorial (April 2006 *JRSM*¹) on how we are titled most interesting. This is a continuation of the debate that the dental profession has been having for many years, fuelled by both an influx of overseas graduates styling themselves as 'Doctor', and by the development of the role of dentists from 'toothwrights' to practitioners with a more holistic approach encompassing the oral health and well-being of those in their care.

However all of us, physicians, surgeons, general practitioners and dentists have one thing in common—patients. But that may be about to change. The same week as the editorial appeared, the chief executive of the Sussex Partnership NHS Trust ordered staff not to refer to people receiving medical care as patients but as clients.

This not only demonstrates a misunderstanding of our roles but also devalues both practitioners and those that we care for. Patients are not simply clients or users of health services. Patients are those receiving care, who are given time, are listened to and treated with sympathy, understanding and expertise. There is something special about the term patient, and although to give a precise dictionary definition is difficult, it is well understood by those who deliver the care.

How we are titled may well, as the editorial states, be of little consequence; far more important is how we refer to, and perceive, those in our care.

Competing interests None declared.

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REFERENCE

- 1 Treasure T, Tan C. Miss, Mister, Doctor: how we are titled is of little consequence. *J R Soc Med* 2006;**99**:164–5

My surgeon's name is . . .

Some of the most famous British surgeons have been neither 'Dr' nor 'Mr'. For example, Lord Lister and Lord Moynihan. After the Second World War, the Council of the Royal College of Surgeons of England consisted of one

Lord (Webb-Johnson), and no less than 12 Sirs.¹ Even perhaps the most colourful and unforgettable fictional British surgeon was called Sir Lancelot Spratt!² The patients of all these surgeons were in no doubt as to whom their surgeon was despite the variations in their titles. This variation in surgeons' titles continues today and also includes military surgeons, where service and rank determines title (e.g. Surgeon Rear Admiral).

When meeting people and introducing ourselves in a professional setting, we explain who we are and what our role is by way of basic communication. After this initial contact, whether you have identified yourself as a Dr/Mr/Prof/Sir/Lord or by military rank will make little difference to your patient once they feel secure under your care. Your title is unlikely to appear above the head of their bed, as their name board will usually read 'Consultant—Spratt' or even 'Consultant—LS'.

A title is an honour bestowed upon you, which some may choose not to use. Ibery and colleagues³ have clearly shown that one group of British surgeons would not want to drop their honorary title of Mr (Master) or the female equivalent. To do so would lose a part of British medical tradition, dating back to 1540 and King Henry VIII. A tradition and history that other surgeons around the world can only aspire to.

Competing interests None declared.

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- 3 Ibery N, Patel PM, Robb PJ. Do surgeons wish to become doctors? *J R Soc Med* 2006;**99**:197–9

Distinguishing titles

Ibery *et al.* have written an interesting paper looking at the pros and cons of the appellation 'Mister' to describe the surgeon (April 2006 *JRSM*¹). While I have no opinion either way on the matter, I do think their argument that the title helps distinguish physician from surgeon when they share a common surname is a rather weak one. Here in the

antipodes we have found the use of Christian or first names solves such a problem quite easily.

Competing interests None declared.

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To protect and serve the patient

We read with interest the article by Treasure and Tan (April 2006 *JRSM*¹). The authors state, 'Being a surgeon is doing what a surgeon does'. There is no doubt that this is the case, as the quality of care provided by clinician's will eventually speak for itself. A good surgeon doing good work has fulfilled the role of serving the patient. The authors go on to conclude that, 'How we are titled is of little consequence'. Perhaps in Plato's *Republic* or any other concept of an ideal world this may well be true. However, when it comes to protection of the patient there is one title and grade that does matter—the hospital consultant.

It is true that the term 'consultant' is now commonly used to describe a person giving advice to either another person or an organization on a particular subject in which they are supposedly an expert, such as the heating engineer. It is also true that a variety of titles, such as Mister, Miss, Doctor and Professor, are used by those in the hospital consultant grade depending on their specialty or academic position. However, when a patient is sent to hospital to see the hospital consultant there is no confusion as to who it is they are going to see. The consultant is the clinician who will have the ultimate responsibility for the clinical care of a patient. It is a term that patients are familiar with and understand.

Hippocrates said, 'Life is short, the art (of medicine) long'. The extensive and arduous training required to become an National Health Service hospital consultant is precisely because of the significant and consequential responsibility, which goes hand in hand with the consultant grade. The hospital consultant is a grade and not just a title, such as Mister or Doctor.

Change is inevitable in any progressive system or organization. However, relentless changes are not always for the best. The NHS hospital consultant grade has an international standing and reputation. Dilution of this grade and title, whether by the confusion of having nurse consultants or propelling clinicians without adequate training to the consultant grade is, therefore, ill-advised and illogical.

Preservation of the reputation of the NHS hospital consultant is ultimately inseparable from the protection of the public.

Competing interests None declared.

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Doctor or Mister?

As someone who has had a changing rank title throughout his professional life, I am enjoying your debate on what doctors should be called. Having retired from the Royal Navy, I am the chief executive of a medical research charity, and I am now a Fellow of the RSM—and there should be another debate on what that title means. But my rank has clearly confused the RSM who now seem to have solved the problem by addressing me in writing as 'Doctor'.

At the same time, an insurance company I have been in correspondence with addresses me as 'Rear Moore', a title that would probably be approved of by the consultant gastrointestinal surgeon with whom I also have dealings—who incidentally calls himself 'Mister'.

Competing interests None declared.

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Do surgeons wish to become doctors?

Soon after my appointment to a consultant post in Liverpool I made a domiciliary visit to a lady who addressed me as Mister. I took it upon myself to give her a short homily as to why I should be addressed as Doctor, pointing out that only surgeons, who were really trumped up barbers, assumed the title Mister on gaining their surgical qualification. Furthermore, I added that the medical or physicians' qualification went back over 2000 years and that the Hypocratic oath forbade us from cutting 'even for the stone'.

I was rather proud of myself for such a clear didactic account of how we physicans should be addressed until her daughter came into the room.

'Let me introduce you to Dr Davies,' said my patient, 'he's not a Mr yet.'

Since then I have been content with any title my patients may wish to confer on me.

Competing interests None declared.

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Puzzling titles

The editorial by Treasure and Tan (April 2006 *JRSM*¹) about the origins and meaning of medical titles—Mister, Miss and Doctor—made interesting reading. These terms are indeed often puzzling for many patients. What struck us though was the assumption that it is necessary in this day and age for medics to be addressed by these titles at all. Why not call us by our given names—John Smith and Anne Brown? And perhaps even John and Anne once we've got to know one another a little better. Do we really need the continual ego-massage of being called Doctor or Mister (knowing the user has taken the trouble to learn its surgical meaning)? We are aware that these titles make our patients uneasy—why don't we ditch them?

There are of course benefits to moving away from these titles among work colleagues too. Over the last decade, industry has come to recognise the benefits of a flat structure and less rigid observance of hierarchy; bosses and employees are now mostly on first-name terms and companies are found to be more effective as a result. The rigid hierarchy in the cockpit has been responsible for at least one airline crash—the co-pilot felt too timid to over-rule the captain, even though he feared the plane was heading for a mountain in the fog. As a result, the airline industry has taken steps to break down these hierarchical inhibitions. Perhaps it's time for the medical profession to follow suit?

Competing interests None declared.

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Preferred titles

I was interested to see that the survey on preferred titles (April 2006 *JRSM*¹) was restricted to ENT surgeons. In my first pre-registration house job many years ago, one of my 'chiefs' was a bombastic and irascible ENT surgeon who, on one occasion when a nurse had the temerity to address him as 'doctor', responded 'Call me sir, I'm not a doctor!' I considered it an unwise career move to observe that 'sir' was also inappropriate as he was neither a knight nor a baronet.

Strictly speaking, the only people entitled to use the title 'doctor' are those holding doctoral degrees, whether in medicine, philosophy, music, science, law or whatever.

Indeed, in Germany, if one remarked that a person was a doctor, one would immediately be asked 'of what?'.

I agree that the term 'specialist' is unsatisfactory. Perhaps hospital consultants could use the term 'professor', which simply means that they profess to know something; but it would sound impressive and enhance their placebo effect. The teachers at Hogwarts School of Witchcraft and Wizardry are all called professor, and it must be admitted that the magical arts and the practice of medicine have a very great deal in common.

Competing interests MD and a visiting professor.

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An insult

The tone of your recent editorial, 'Miss, Mister, Doctor: how we are titled is of little consequence', and article, 'Do surgeons wish to become doctors?' (April 2006 *JRSM*^{1,2}), on who should be called 'Doctor' is unnecessarily offensive. I have a DMD (Doctor of Dental Medicine, *Dentariae Medicinae Doctor*), followed by a PhD (in psychology). In Germany I would be referred to as 'Doctor Doctor', and when I served as a professor in the Netherlands, I was called 'Professor Doctor Doctor'. It did not matter whether I was a physician, surgeon, podiatrist, veterinarian, dentist, and/or psychologist.

In several places in the two publications the authors take umbrage at the very idea that dentists should be called doctors. For example, in the article by Ibery *et al.*, 'Do surgeons wish to become doctors?', the authors state, 'dental surgeons in general dental practice, who also hold a bachelors degree, are now styling themselves Dr. We are uncertain as to the origin of this creeping doctorization'.

To compound the insult, you separate doctors from dentists in your comparisons, rather than referring to them as physicians and dentists, who are both called doctor in the USA and elsewhere. Even that distinction would become blurred if the change being proposed by the Commonwealth of Massachusetts legislature to redesignate dentists as oral physicians comes to pass.

Competing interests None declared.

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Celecoxib

Caldwell *et al.* (March 2006, *JRSM*¹) concluded that there was an increased risk of myocardial infarction with celecoxib. However, their meta-analysis was limited to preexisting data from six studies and no new information.

Other meta-analyses of case-controlled/cohort observational studies² and clinical trials³ did not show increased risk of cardiovascular thromboembolic events with celecoxib compared with nonselective NSAIDs.

Based on their inclusion criteria, the authors could have included additional studies in their meta-analysis. Synopses of more than 50 celecoxib clinical studies including serious adverse events (SAE) and fatalities are available at the website [<http://www.clinicalstudyresults.org>].

The authors also queried differences in the reporting of cardiovascular events from the CLASS trial in a Food and Drug Administration briefing document⁴ and in a published paper.⁵ This is due to differences in analytical criteria. In the briefing documents, if the time of last dose of study medication was unavailable, time of last visit or laboratory test was utilized as a proxy. This analysis gave 13 cardiovascular deaths (celecoxib: 5, comparator NSAIDs: 8) occurring within 28 days ending treatment⁴. White *et al.* reported all cardiovascular deaths within 30 days of the end of treatment. Where the time that treatment was stopped was not available, it was assumed death occurred on study medication. This gave a total of 20 (celecoxib: 10, comparator NSAIDs: 10).⁵

The USA Food and Drug Administration and the European Medicines Agency, Europe, have conducted reviews of celecoxib safety, including data from all trials

utilized by Caldwell *et al.* and concluded that celecoxib could continue to be marketed with appropriate warnings on cardiovascular risk. Only a properly powered, prospective clinical study can definitively assess the relative safety of nonselective NSAIDs and the COX-2 selective inhibitors. PRECISION (Prospective Randomized Evaluation of Celecoxib Integrated Safety versus Ibuprofen or Naproxen), a large clinical study meeting these requirements is currently in final stages of preparation.

Competing interests The authors are employees of Pfizer Inc.

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- 4 US Food and Drugs Administration CLASS Advisory Committee Briefing Document. [http://www.fda.gov/ohrms/dockets/ac/01/briefing/3677b1_01_searle.pdf] Accessed 15 May 2006
- 5 White WB, Faich G, Whelton A, *et al.* Comparison of thromboembolic events in patients treated with celecoxib, a cyclooxygenase-2 specific inhibitor, versus ibuprofen or diclofenac. *Am J Cardiol* 2002;**89**:425–30

CORRECTIONS

James F E. Depression: epidemic or pseudo-epidemic? [Letter]. *J R Soc Med* 2006;**99**:220

The final sentence should read: 'It seems that human behaviour, as with other sciences, needs its own specific language—a subject discussed by C P Snow (*The Two Cultures*. Cambridge University Press).' The journal quoted in reference 5 should be *Neurophysiology*.

Byfield D, McCarthy P. Systematic review of spinal manipulation: flaws in the review [Letter]. *J R Soc Med* 2006;**99**:277–8

Ernst E, Canter P. Systematic review of spinal manipulation: authors' reply [Letter]. *J R Soc Med* 2006;**99**:279–280

The authors' reply by Ernst and Canter contains an editorial mistake. The sentence 'Byfield and McCarthy's claim that our approach "lacks statistical validity"—is embarrassing—we did not use any statistics in this paper' refers to an earlier draft of Byfield and McCarthy's letter. Their letter was amended shortly before publication and this sentence should have been removed from the authors' reply.