



Representing Distinguished Doctors

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ABSTRACT

Convention in many US states asserts the predominating myth that only physicians can be called doctors. However, even the core of the word “doctor” being “docere,” translates into “to teach,” thus capturing the full breadth of professionals and returning the title to its rightful honorary collective of doctoral-trained professionals. With the dawn of tighter legal restrictions imposed by state entities, current written laws forbid the use of the word “doctor” by making it synonymous only with physicians. Effectively, this monopolizes the term “doctor” and consequently excludes other highly qualified doctoral-trained professionals, likely infringing on their constitutional rights. Presently, there is a great deal of discourse between the medical and legal professions regarding the merits of such a matter, and this paper aims to discuss some of the salient points to provide more clarity in the use of the title “doctor” for all doctoral-trained professionals who would stand to face occupational or legal repercussions in instances where the title would be exercised. The goal is for an equitable professional representation by title, returning an expropriated term to those who have achieved professional doctoral training and expertise.

Keywords: titling law, constitutional law, doctoral-trained professionals, professional parity, healthcare enterprises, clinics, healthcare management, state medical board, state nursing board

Currently, there is landmark legal action undertaken by Jacqueline Palmer, DNP, APRN, MSN, RN with two of her fellow Doctor of Nursing Practice (DNP) colleagues, bringing a lawsuit against the Medical Board of California (MBC), the California Board of Registered Nursing (CBRN), and subsequently, the California Attorney General (CAG) [1]. Each is presently in possession of their doctorate, and yet the state of California upholds written law forbidding the use of the title Doctor/Dr./Doc by this group of DNPs, or similar healthcare professionals in healthcare settings, thus instilling fear of state legal action and possibly limiting, if not eliminating, certain career opportunities. Such restrictive laws have been repeatedly enforced in states like California, where laws have not kept pace with the ongoing evolution of the healthcare system and the expanding professional opportunities and roles that bolstered a stratification of those who possess doctorates that provide vital direct and indirect patient care or services. Additionally, current legal restrictions also appear to call into question the validity of being able to publicly and professionally self-identify as a doctor for the roughly 88 doctoral

degrees in the U.S. when one considers a predominating myth that “only Physicians can be called Doctors (MD/DO),” that may be debunked with one simple phrase [2,3]:

"All Physicians are Doctors, BUT not All Doctors are Physicians"

Therefore, a "Physician" should be properly identified by the term "Physician" since it is *specific* to the professional identity of an MD or DO. Whereas, "Doctor" is a *general* umbrella term that refers to many different doctoral-level trained professionals (i.e., DMSc – Doctor of Medical Science for Physician Associates, DNP, DPT – Doctor of Physical Therapy, DPM – Doctor of Podiatric Medicine, PhD – Doctor of Philosophy, PharmD – Doctor of Pharmacy, JD – Juris Doctor, etc.). Thus, any professional who has achieved the honorary degree of a doctorate has earned the right to use the *title* Doctor/Dr./Doc.

Effectively, placing the term “Doctor” or “Dr.” or “Doc” before a professional’s name conveys a generalized *title* reflecting their training that achieved the level of a doctorate. Dating back to the 1300s, one finds the PhD was appropriately titled “Doctor,” derived from “docere”, which means “to teach” [4]. On top of that, the act of calling a person who possesses a doctorate in a professional healthcare setting by the title “Doctor” here is intended to properly recognize the Doctor publicly using a proper salutation for a professional who has achieved the doctorate conveyed through the *title* Doctor/Dr./Doc. Various professionals achieve a doctoral degree in many different fields of expertise, and the MD/DOs (physicians) would not lay claim to expertise over another expert with a doctorate in their specific discipline because this would undermine the incredible scope of expert knowledge and experience achieved and the significance of its application.

Where it stands at this venture in the U.S., most state medical boards have written into law the right of a physician (MD/DO) to monopolize the title “Doctor” or “Dr.” or “Doc” in professional settings, specifically as it applies to the healthcare enterprises or clinics, on any sign, business card, letterhead, or, in an advertisement [2,5]. This creates professional possession by MD/DOs that does not accurately reflect the totality of all professionals with doctoral degrees who have earned the title of Doctor in these given institutions and does not allow for professional recognition through the use of the title Doctor. The laws are written to *intertwine* the definition of a doctor as being synonymous with only an MD, DO, and Physician. Such inaccurate language is presently upheld by the Medical Board of California’s “§ 2054 Unlicensed practice” or the Physician Assistant Board’s (PAB) “§ 2054 Unlawful Representation as a Physician” [2,3,6]. Contrary to the MBC and PAB, the CBRN requires Nurse Practitioners to identify themselves under “§ 1481. Categories of Nurse Practitioners” as either an “RN” or “NP” without explicitly providing Nurse Practitioners with guidance on the use of the term Doctor when they possess a doctorate (i.e., DNP) and refers to MD/DOs as “Physician” specifically, and not the more generalized Doctor terminology that has been the subject of this debate [7].

Proponents in favor of the dogma that only Physicians should be recognized as doctors in a healthcare or clinical setting will likely preface their opinion with claims on patient safety, mental fatigue, provider burnout, and delayed or disrupted care [8]. Yet, to date, there does not appear to be a significant or reliable evidence-based consensus, nor quantifiable supportive widespread reporting of such claims, and likely undermines the public and professional awareness of doctorate diversity that presently exists in these environments. With that said the

healthcare administration and its various departments are composed of multiple different healthcare professionals, that may include, but are not limited to, DNP (NP), DMSc (PA), physicians, and administrators with degrees ranging from DBA (Doctorate of Business Administration), DrPH (Doctor of Public Health), DHA (Doctor of Health Administration), PhD, EdD (Doctor of Education), to name a few. Each of these respective key stakeholders is critically needed in their collective efforts to provide the supportive services and leadership necessary for their healthcare enterprises to be a success.

Interestingly, a recent Medscape survey found that more than half of physicians thought Physician Associates and Nurse Practitioners who obtained doctorates would provide a higher quality of care for their patients and serve to improve their career development [2]. This appears to be the trend as well, with trailblazers in the healthcare industry implementing DNP (NP) and DMSc (PA) in various roles. From a Commander's position at a U.S. Army hospital, to the CEO, to management, etc., however, nearly in every circumstance these positions come with a gag order on their ability to represent themselves fully as a "Doctor." Take for example Colonel Amy Jackson, DMSc, MPAS, PA-C commander of the Keller Army Community Hospital that supports West Point that was once a traditionally physician-only held position, or Regina Cunningham, PhD, RN, AOCN, FAAN, CEO of the University of Pennsylvania Hospital, and Branville G. Bard, DPA as Vice President for Public Safety at Johns Hopkins University and Medicine [9-11]. These are incredible leadership positions by healthcare professionals (key stakeholders) with a diverse array of doctorates, yet are unable to represent themselves in this capacity and receive public recognition with the title that properly identifies them as a doctor.

Both lawyers representing the three Doctor of Nursing Practice healthcare professionals have further laid out the unfair practices of the law, particularly in light of a recent prosecutorial outcome that effectively capsized the career of Sarah Erny, DNP, NP, RN in the state of California [12,13]. Sarah Erny, DNP had allegedly represented herself in social media and professional settings as a "Doctor Sarah," "Doctor Sarah Erny," "Dr. Sarah Erny," or "Dr. Sarah," without *consistently* further identifying herself as a Nurse Practitioner. Despite the fact Sarah possesses a doctorate and is being truthful about the appropriate *title* she earned, the current laws and regulations in a civil judgment penalized her \$19 750 and requires her to refrain from using the title "Doctor or Dr." The District Attorney, Dan Dow, cited the American Medical Association's (AMA) "Truth in Advertising Campaign" report whereby a patient survey found 39% of respondents thought the DNP was a medical doctor, and 19% were under the impression the Nurse Practitioner was a physician [14]. Also, in this very same survey, 88% of respondents replied that they believe only licensed "medical doctors" or "osteopathic physicians" should be able to use the title "physician." Notice the *title* was not "doctor" in this case for this specific survey question administered to the patients, because even the AMA is dubiously adjusting the terminology, initially correctly comingling the title "physician" with "medical doctor" and "osteopathic doctor," however then wrongfully injecting their report with a follow-up question that did not show up in the survey presented to the patients, asking the question "Who is a doctor?" The language used in the AMA's report now reflects the title "doctor" in a question about "who is a doctor?" and in an about-face, states that 9 out of 10 patients believe a "medical doctor" or "doctor of osteopathic medicine" should use the term "physician." Notice the patients specifically commented on the use of the *title* "physician" and were not given the question using the *title* of "doctor" in the survey. The AMA conveniently left this fact out, because it was articulately displayed in the published report to mislead readers into believing this was a fact

as opposed to a play on word association. So, to clarify then, Sarah Erny, Jacqueline Palmer, and her DNP colleagues, like the AMA's 88% of respondents from their very own survey, correctly identify the title "physician" with an MD/DO. The issue on hand, as it stands today, does not raise issues with these DNPs for using confusing or misleading representation as a "physician." Hence, the argument about doctoral degree holders such as DNPs, using the standalone title "Doctor" from the paper "Truth in Advertising Campaign" conducted by the AMA is irrelevant even to their own reported findings.

While this play on words may seem harmless, it would appear the AMA weaponizes the use of the *title* "Doctor" by anyone other than a "physician" as a potential risk to patient safety, and yet there is no reliable data or research to support their claims. To fully comprehend how this occurs, one must look closer at the physician profession and who, or what, they represent. To start, the AMA itself reported their membership is now roughly 271 660, while the American Osteopathic Association (AOA) stands at 178 000 out of a total of 1 077 115 professionally active physicians in the U.S. [15-17]. Thus, the AMA's "Truth in Advertising Campaign" report represented only 25% of total professionally active physicians (MDs). Even if the AMA attempted to represent physicians from AOA membership, this would only amount to 42% of the total professionally active physicians (MDs & DOs) in the U.S. Consequently, this would translate to more than 75% of physicians who the AMA cannot claim to represent, and it's feasible any number of physicians may not be in agreement with the AMA's political positions and/or claims. Especially when all physicians, DNPs, DMScs, and additional doctoral-trained professionals, recognize that a minority opinion does not qualify as meeting the threshold for real-world evidence (RWE aka empirical evidence), or meeting stronger evidence required for evidence-based medicine/practice (EBM/EBP), and/or the majority needed to qualify for a professional recommendation, where RWE and/or EBM/EBP may lack the ethical or safety requirements for patient protections [18]. When basic raw data is lacking from claimed adverse outcomes by the AMA from the widespread use of the title Doctor in a hospital enterprise or clinical setting, the argument rapidly deteriorates into a professional and ethical bias that does not meet the criteria for either real-world data (empirical) or evidence-based data. Therefore, when looking at these confounding variables, the AMA's insulated claims from the "Truth in Advertising Campaign" report are at best an under-represented assumption, and do not meet the criteria in research for RWE (empirical), the gold standard EBM/EBP, or professional recommendations. This explains why the AMA does not report a single legitimate and tangible data set of adverse outcomes that were harmful to patients as it applies to their survey results. Accordingly, taking the AMA's survey report at face value, this would effectively not apply to healthcare professionals with doctoral degrees who truthfully represent themselves with the appropriate title of "Doctor."

This has likely galvanized lawyers Donna Matias, JD, and Caleb Trotter, JD to explore legal remedies with their clients Jacqueline Palmer, DNP, and her two DNP colleagues [13]. As it pertains to this matter today, the MBC, PAB, CRNB, and the CAG expropriated the title "Doctor" from those who have rightfully earned the highly revered professional doctorate that should allow them to engage in conversations and truthfully disclose the "Doctor" title that accurately reflects the doctorate earned and the training possessed. These Doctors of Nursing Practice should not be treated any differently from Podiatrists (DPM), Veterinarians (DVM), or Chiropractors (DC), who are readily referred to legally as "Doctors" in social media and professional settings. Particularly when one recognizes that the terminology "Doctor" does not

appear on the medical license of a California “physician” and/or “surgeon” because the state of California also uses accurate language to describe an MD/DO by either a “physician” and/or a “surgeon.” In the MBC, PAB, and CRNB’s current state, the laws and regulations are written in such a fashion as to force DNP healthcare professionals against their will to falsify their credentials and training in all social and professional interactions through means of seizure over the word “Doctor.” Notwithstanding the state of California’s rationale, such laws and regulations would serve to restrict the DNPs from speaking truthfully about their credentials and may limit professional career opportunities, and may establish unfair competition for occupational positions, and even upward mobility, which translates to a potential incalculable deprivation of life, liberty, and income.

Henceforth, it is critical to recognize that the roughly 88 doctoral degrees possess the rights, privileges, and responsibilities of the *title* “Doctor/Dr./Doc” as reflected on their diplomas, which does not infringe on the use of the occupational term that only MDs or DOs use, which is “Physician.” It’s simple to see that *none* of the other doctoral degree holders are calling themselves by the title “Physician,” and are all equally “Doctors” and thus this argument is an unjust titling law and should be unenforceable by the state medical boards. Restricting the Doctor/Dr./Doc title from professionals with a doctorate would infringe upon these professionals’ accurate display of their title and degree and may be grounds for state and/or federal Constitutional review. Especially when one considers they are not implying or explicitly falsifying their identity as a “Physician,” and are instead clarifying that they are a Doctor within their right, based on the display of their accurate credentials.

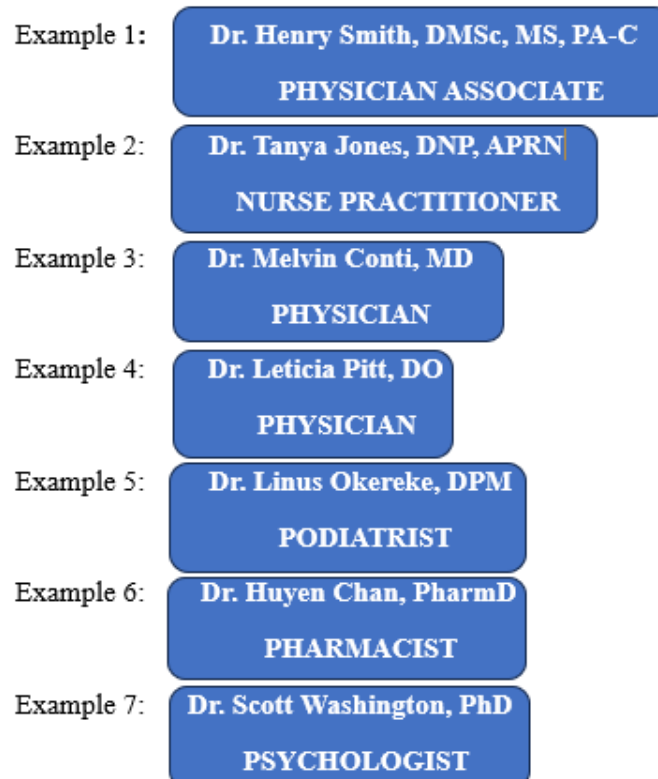
Tangible examples already exist in a society that supports professional parity concerning possessing a doctorate and legally having the grounds to properly represent oneself accurately with credentials as a Doctor. Here are just a few examples of Doctors operating within their fields of expertise for consideration:

- Example 1: For wisdom tooth extraction, you’d go to a DDS (doctor or dentist) for their expertise in dentistry, instead of an MD or DO.
- Example 2: For physical rehabilitation following a total knee replacement, you’d go to a DPT (doctor or physical therapist) for their expertise in physical therapy, instead of an MD or DO.
- Example 3: For placement of an intrauterine contraceptive like Mirena, you’d go to a DMSc (PA)/DNP (NP)/MD/DO (doctors) for their expertise in Primary Care, Family Medicine, or OB-GYN, instead of an MD or DO who subspecializes in Neurosurgery.
- Example 4: For adult psychiatry therapy, you’d go to a DMSc (PA)/DNP (NP)/MD/DO/PsyD or PhD in Psychology (Psychologist) (doctors) for their expertise in Psychiatry, Primary Care, or Family Medicine, instead of an MD or DO Nephrologist.
- Example 5: For a bunionectomy, you’d go to a Podiatrist/DPM (doctor) for their expertise in Podiatry, instead of an MD or DO in Family Medicine, Internal Medicine, or Pediatrics.
- Example 6: To fill a prescription for your medication, you’d go to a Pharmacist/PharmD (doctor) for their expertise in Pharmacy, instead of an MD or DO.
- Example 7: For designing spacecraft, you’d go to a PhD Aerospace Engineer (doctor) for their expertise in Aerospace Engineering, instead of an MD or DO.
- Example 8: For legal representation, you’d go to a JD Lawyer/Attorney/Esquire (doctor) for their expertise in law, instead of an MD or DO.

As already seen, in many healthcare enterprises and clinics, the medical badges worn by healthcare professionals place the specific professional/occupational identity in bold large letters, some with color coding, to clarify their roles while operating inside the facilities, such as “PHYSICIAN,” “PHYSICIAN ASSOCIATE,” “NURSE PRACTITIONER,” “PHARMACIST,” etc. [8]. Such administrative practices are appropriate to this environment, where there should be no ambiguity in these professionals’ identities. Specifically, then, as it applies to healthcare enterprises or clinics, a proposed real-world application of how the title Doctor should accompany professional credentials is reflected on medical badges below in Examples 1-7. These new medical badge language recommendations are intended to transparently and equitably distinguish Doctors collectively, starting with a thorough explanation of the proposed real-world application where medical board restrictions would be relinquished.

Proposed real-world application: Healthcare institutions should have the unrestricted option to type the general term “Dr.” to be included before the name of the staff member on their badge, so it is accurately applied respectfully and professionally for salutation purposes by staff, patients, and colleagues to those who have deservedly earned the title of Doctor, as evidenced by the doctoral degree that is listed after their names (See Figure 1). (Disclaimer: The names depicted in these examples are fictitious. Any similarity to actual persons, living or dead, or to actual institutions, is purely coincidental.)

Figure 1. Proposed Medical Badges



In light of these clarified salient points, this would also likely stand to upgrade the archaic system that underlies ambiguous language commonly found in articles like the one Foote et al published, whereby they conducted research improperly labeling the badges with the umbrella

term “Doctor” for internal medicine residents, which should have more accurately displayed the specific word “Physician” [8]. When researchers, healthcare enterprises, and clinics propagate erroneous nomenclature, they’re undermining common sense and reinforcing the dogma that “only Physicians can be called Doctors,” which jeopardizes professional standards that inevitably place intellectual accomplishment in peril with possible undertones of disingenuous motives.

It is also worth noting, claims within hospital enterprises about role misidentification that have been documented at roughly 40% are not evidence-based and do not presently propose logical solutions to discerning between “Physicians” (MD/DO) and “Doctors” from all disciplines [8]. It’s likely because they have chosen to view this issue through a myopic lens that only represents the vested interests of the physicians, who along with state medical boards, continue to struggle to completely adopt the new model of shared, collaborative, team, equitable values in an environment that is patient-centered. This was the paradigm shift beginning in the 1950s that moved the healthcare system away from medical paternalism and into one that encouraged physicians to listen to their patients [19]. Now physicians are being challenged in modern medicine to accept a single role on a team that shares in the overall care of a patient. Hence, the stark contrast between the physician in private practice where the physician is in a role of primary authority versus the staff physician at a local commercially or publicly owned healthcare enterprise or outpatient clinic who answers to a chain-of-command similar to all other staff members.

Prospective research targeted at properly identifying between physicians and doctors while engaging in their professional duties from all other occupations who possess doctoral degrees in the same ecosystem, combined with the appropriate badge title of “Dr.” affixed to the beginning of their names, followed by a full display of their relevant doctoral degrees is highly recommended as previously displayed. Although such future research may be useful in illuminating the significant details, such investigations will likely not interfere with current litigation that may lead to an equitable outcome. While present research has failed to properly investigate this matter in a fashion consistent with objective and fair practices, there are already many healthcare enterprises that have adopted the transparent use of healthcare professionals’ degrees and occupational titles, such as Ft. Belvoir Community Hospital and Kaiser Permanente Hospital systems, which reflect PHYSICIAN and MD on badges, respectively. However, this does not entirely address this ongoing issue at hand, which is state medical boards, healthcare enterprises, and clinics that continue to enforce illegitimately monopolizing the title “Doctor” on behalf of physicians. In the same breath, state medical and nursing boards use language written explicitly into laws and regulations that restrict certain healthcare professionals with doctorates, such as Jacqueline and her two DNP colleagues with Doctor of Nursing Practice degrees. At present, these three DNPs are not permitted to represent themselves honestly as Doctors since they would face institutional backlash and professional action that could lead to serious legal consequences.

Respectfully, patient-doctor credibility is vital for all professional staff with doctoral degrees to effectively advocate and provide collaborative highly specialized relationship-centered services that translate to greater patient outcomes [20]. When professional staff members with doctorates are empowered to practice at the pinnacle of their license, there are streamlined processes in place to reduce burdensome tasks, increase organizational leadership roles, and

improve skills and expertise that support greater career and patient satisfaction [21,22]. This is greatly enhanced by distributing the accountability evenly across the entire comprehensive integrated management team of all doctors participating in culturally competent patient care [23]. In doing so, this establishes a patient-centered practice rooted in a spectrum of different forms of evidence-based principles and value-based practices that are reflected in the quintuple aim [24-27]. One may determine then; it is professionally accurate to refer to an MD or DO as a "Physician" (to be precise) or "Doctor" (in general) for all who possess a doctorate. It is time for professional parity among all doctoral-trained professionals by identifying and recognizing them by the proper terminology, salutation, and title of "Doctor."

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