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FROM THE EDITOR

Inequity Along the Medical-Dental Divide

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It's obvious that our mouths are part of our bodies. Yet within the modern health care system, it's hard to imagine any other body part that is treated as distinctly. The isolation of oral health affects how we pay for oral health care, who provides that care, and, most importantly, how patients access it. Although the separation of medicine and dentistry in the United States stems from decisions made decades and even centuries ago, it continues to have lasting and meaningful impact on the lived experiences of millions of Americans, especially those from at-risk communities already poorly served by the medical system.[1]

This is what led me to become a physician. Working as a dentist in a community health center, I was heartbroken by the failings of our health care system to prevent suffering caused by oral disease. Yet, for many people in pain from a dental problem, the first (and sometimes only) stop is not to a dentist, but to a physician, physician assistant, or nurse practitioner in a primary care practice or emergency department. Only about 50% of patients who visit an emergency department (ED) with a toothache ultimately see a dentist within 6 months of their ED visit,[2] and 21% of patients with a toothache-related ED visit return to the ED for the same problem.[3] As a current resident physician, I am regularly struck by the frequency with which oral health issues arise in both the hospital and the clinic. I am equally struck by how much of this suffering I am unable to treat even having a dual identity as a physician and a dentist. The technological, financial, and educational barriers that continue to exist between dentistry and medicine, highlighted by contributors to this issue, contribute to the pain, poor health, shame, and lost hours of work and school caused by untreated dental disease.

These barriers to oral health care are yoked to societal harms that impact health and well-being on a larger scale, including structural racism, environmental injustice, and workforce inequity. Yet as we work to bring about needed change both inside and outside of health care, there is also an opportunity to rectify the exclusion of oral health care from health policy and health delivery systems. Many groups are making remarkable strides to do so—from sovereign tribal nations training a unique oral health workforce to meet community need[4] to accountable care organizations that integrate oral health services into primary care funding.[5] Health policy initiatives to increase integration of behavioral and physical health and to address the social determinants of health can serve as paths forward for oral health care innovation as well.

Poor oral health affects other health outcomes, including diabetes, heart disease, and preterm birth.[6,7] Some studies even suggest that providing dental treatment to high-risk patients with these conditions might reduce overall health care costs and rates of hospital admission.[7,8] While these are important areas of inquiry, the most important reason to bridge the medical-dental divide is not to reduce costs or the risk of other health conditions, but because oral health itself is critically important to human dignity and well-being.

Exploring the ethics of oral health within the *AMA Journal of Ethics* is itself a milestone insofar as it acknowledges that oral health is a vital component of human health and that delivery of oral health care is a component of health care ethics. Authors from diverse disciplines, including medicine, dentistry, social work, nursing, and economics, explore how our current system of medical and dental separation harms patients and clinicians and how the future of health care can bring about innovation that will ensure oral health for individuals and communities.

When the first physicians gathered in the 1840s to found the United States' first dental school, it would have been hard for them to imagine the system of dental care that sprang from their efforts and the ways it has evolved over time through both historical accident and intentional policy decisions. This separation continues to cause tangible and preventable harm to the patients I meet as both a physician and a dentist. Health equity is not attainable without also understanding the idiosyncrasies and injustices embedded in the oral health care system and working to eliminate them. This issue represents an effort to do just that.

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