

Episode: ***Ethics Talk – Why Oral Health Care Is the Way It Is***

Guest: Lisa Simon, MD, DMD; Mary Otto

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[mellow theme music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff.

Your mouth is important to your health. As the entryway to your body's digestive and respiratory tracts, a healthy mouth sets your body's functioning. Poor oral health can indicate systemic general health problems. For example, oral lesions might indicate HIV infection, and periodontitis might be associated with cardiovascular disease.

Your mouth also serves important social roles, expressing pain and joy, talking and smiling. The way our mouths function and look influence, for better or worse, how people respond to us and how we orient ourselves to the world.

So, given the profound importance of our mouths, both to our health and to our functioning in the world, why does our health system, our reimbursement and payment structures, and health professions curricula treat mouths as something that are separate from bodies and treat dentistry as something separate from medicine? These questions are the focus of this month's issue of the *AMA Journal of Ethics, Inequity Along the Medical/Dental Divide*.

To understand where we are today, we first need to go back to Baltimore in 1840.

MARY OTTO: Chapin Harris and Horace Hayden went to what was then known as the Maryland College of Medicine. It's now the University of Maryland Medical College. And they approached the physicians there with the idea of adding dental instruction to the medical course that was being offered there. And as the story goes, the physicians sent them away with this remonstrance and said the subject of dentistry was of little consequence, [scoffs] and that event has gone down in the annals of dental history as the historic rebuff.

HOFF: That was Mary Otto, a health journalist and author with whom we'll talk more later about the history of dentistry and how that historic rebuff in 1840 grew into the medical-dental divide we see today.

Up first, however, is editorial fellow, dentist, and physician Dr Lisa Simon. Dr Simon is a Faculty Affiliate at the Harvard Medical School Center for Primary Care and a Fellow in Oral Health and Medicine Integration at the Harvard School of Dental Medicine in Boston, Massachusetts. Dr Simon joined *Ethics Talk* to discuss how her unique entry into medicine via dentistry helped illuminate how the medical-dental divide maintains inequity in access to health services, quality of those services, and health outcomes. Dr Simon, thank you so much for being on the podcast. [music fades out]

DR LISA SIMON: Thanks, Tim. Thanks so much for having me.

HOFF: To begin broadly, why did you want to develop a theme issue on this topic?

SIMON: I have a pretty unconventional background for an internal medicine resident, which is that before I went to medical school, I went to dental school, and then I worked as a dentist in a Federally Qualified Health Center. And then I was on faculty at the Harvard School of Dental Medicine and conducted research on oral health policy and oral health inequities. So, my choice to go to medical school was actually really driven by what I witnessed as a dentist, both personally, because I felt very helpless because I was seeing all of these other facets of my patients' lives in the ways it informed their health and their oral health and really couldn't do anything about it because I was a dentist, and I worked in this siloed system where I couldn't even send a message to somebody else in the health system.

HOFF: Mmhmm.

SIMON: But also, I felt like I was seeing the ways, structurally, that my own personal experience had such important implications for how we think about oral health in our health care delivery system, in our health care training system, and just the experience of being a human being who has health care needs in America.

HOFF: Mmhmm.

SIMON: So, my motivation to go to medical school was because I felt oral health was ignored. And I saw that as a way to be more personally satisfying for me as a clinician, but also to try and make change in this sphere.

And so, being able to do this theme issue is really exciting because one, I was able to bring together voices of people I admire so enormously who bring such incredible thoughtfulness to this topic. But also, here I am, seven years after I started to decide this might be what I wanted to do, and it's a real opportunity for reflection to think about how I've been able to continue to think critically about this issue and hopefully incrementally make the world a little bit of a better place.

HOFF: Do you have a specific event or patient experience or something that sort of crystallized your understanding and your perception of the way that the disparities of dental access impact people's health?

SIMON: I have so many experiences from my patients, especially at FQHC that I carry with me in ways that I don't, even for the patients I see now as a primary care physician, whom I also adore and find such a privilege to care for.

HOFF: Mmhmm.

SIMON: I think there was also a sense of just the overwhelm of every, the magnitude of need I was seeing and how every patient, even though they were individuals with their own distinct needs and their own distinct stories, came with this tragedy of delay, that every single person would've benefited from seeing me or from getting dental care more generally 10 years before they ever visited with me.

HOFF: Hmm.

SIMON: Specific patients that really stick out to me are a woman who had experienced incarceration and came without any dentition. So, she had dentures made and only had one picture of herself with her natural teeth that we could use to kind of determine what the dentures should look like. And I didn't realize at the time that she was sharing this photo with me how precious it was to her for that reason.

HOFF: Wow. That's amazing.

SIMON: Yeah. What an amazingly resilient and beautiful person she was.

HOFF: Absolutely. And I think people generally don't appreciate the relationship building that can happen between dentists and their patients in the same way that they do with other kinds of health professionals for some reason.

SIMON: Yeah. And I think in some ways, especially when you're sort of making dentures or seeing someone for care that's been long delayed, you actually get a lot of frequency of seeing them, and that's a really amazing relationship to have.

I think the flip side, though, is that often I think the dental profession is responsible for some of the distrust and fear that people feel when they go to the dentist. I think it's especially thinking from the lens of trauma-informed care, there's a lot of vulnerability that goes into a dental visit. You're literally lying with someone on top of you, you're opening your mouth, you can't talk, and those are sort of innate vulnerabilities that anyone might feel. But also, I think many, many people, and not just low-income people, but my colleagues who are physicians, tell me about how they are afraid their dentist or their dental hygienist will shame them or make them feel ashamed or that they'll be embarrassed.

And I think that that's something that dentistry as a profession needs to grapple with because we know from motivational interviewing and from sort of psychology that making people feel ashamed doesn't motivate behavior change. And we've come so far in the rest of medicine, moving away from that and trying to destigmatize people who need our care, and it feels like that has not fully permeated dentistry yet. And I think that has really dramatic implications, especially for the people who need oral health care the most. And I will say that shame runs so deep and is so, it's sometimes independent of the health care clinicians themselves. I have primary care patients who know that I'm also a dentist and are too embarrassed to show me their teeth.

HOFF: Huh.

SIMON: So, that goes deep, I think, in our society.

HOFF: Yeah. Moving on, what is something that you've learned about your theme issue topic during your research that surprised you? And given that this has been such kind of a long development for you, you might have to think back to the last time you were surprised about this topic. But does anything come to mind?

SIMON: Oh, this is a really great question. I actually have to think about this. I think this is less of like a singular fact that surprises me. But I feel like when I first decided I was going to go to medical school and I was going to start all over again in some ways, people responded—and I experienced a lot of shock and shame—and people's response was like, "Why would you do this? What a crazy thing to do." And the implication behind a lot of

it was oral health doesn't really matter. Are you sure you aren't just doing this because you are too good to be a dentist, and this is your way of fixing that? There was a lot of not disbelief, but kind of dispassion.

And I have found that even in the last five years that there's been a real sea change where I'm not explaining or justifying myself anywhere near as much as I used to. And I think the broader health system is starting to think more holistically about the kind of care we want to provide for our patients and for what health care as a human right actually entails. And I think that level of inclusivity, maybe it shouldn't surprise me, but it still continues to when I meet someone who has never done oral health research, has never been to dental school, and just gets it. That's happening more and more, and I'm so grateful for it every time I encounter it. And I guess I don't want to stop being surprised by that. It's such a gift.

HOFF: Has the shift between dentistry and medicine changed the way that you think about or approach health care? Or do you essentially see it as doing the same kind of thing just in different contexts and with different, let's say, tools and approaches?

SIMON: I definitely think about it more as a spectrum. I haven't practiced dentistry since before COVID. I was practicing through medical school, but then COVID made that very challenging. And I bristle when I hear someone in my hospital say, "Oh, did you know Lisa used to be a dentist?"

HOFF: Mm.

SIMON: And I'm like, "I am a dentist."

HOFF: [chuckles]

SIMON: Nobody burned my dentist card.

HOFF: Right. [laughs]

SIMON: I got to keep being a dentist. So, obviously, I think it's really near and dear to my identity as a clinician and as a professional, and I want both of those things to kind of knit together. But I think the one thing that learning to be a primary care provider has given me a sense of is just how little time non-dental providers have to integrate oral health care. And I realized that because I don't ask patients to pull their masks down to look at their teeth even though I'm a dentist.

HOFF: Mmhmm.

SIMON: When I have conversations with other oral health providers about how we can get there to be oral health screening or questionnaires in the primary care setting, now I'm the one who's like, "Oh no! You don't understand. That's not going to be possible." So, hopefully, there'll be a balance between those two things. But I think it is really invaluable to have a sense of what the clinical life of a primary care provider or a dentist looks like to understand how we can really integrate services across those two realms. Because there's this idealized and beautiful version where everything's perfectly integrated. But in practice, there are these very real limitations that we have to navigate and figure out how we can build a system that is just and good, but also doesn't totally burn out every single person who works in it.

HOFF: [chuckles] Right. Just and good and also possible. Yeah.

SIMON: Yeah, [laughs] exactly.

HOFF: Do you see more, I don't know if interest is the right word, but more of your medical colleagues wanting to have time to do those sort of dental inspections and things like that? Are more people talking about the importance of doing that kind of screening?

SIMON: Yeah, I think what people really want is the ability to refer seamlessly. And I think that because so much has happened in health care to make some of those referrals for other things easier, people react with shock when it's so much harder to get a dental referral.

HOFF: Mm.

SIMON: So, we are used to having a warm handoff to a behavioral health provider, being able to follow up through messaging or in-person with that provider to figure out how we can care for our patients to get asynchronous recommendations on if we need to change somebody's medication regimen for their mental health issue. But in dentistry, we have none of those things. It's literally like Googling a list of dentists who may or may not accept Medicaid if your patient has Medicaid and telling the patient to call every single one of them until they find somebody who will accept them.

HOFF: Right.

SIMON: And it's just so much more frustrating and so much less helpful. There's so much less we can do. And I think people are realizing that it doesn't make any sense that for most of the body, we can really provide pretty good integrated and thoughtful care, and then for one thing that patients very frequently need, we can't.

HOFF: Mmhmm.

SIMON: And so, even more than saying, "Oh, I wish I knew how to do an oral cancer screening," I find my colleagues saying, "This is ridiculous. Will you teach me how to refer my patient to a dentist? Like, how do I call a dentist?"

HOFF: [chuckles] Right.

SIMON: Which is maybe sort of showing where we're starting.

HOFF: Right.

SIMON: But I think it gives me hope because we should have the expectation that it's easy. And I want people who aren't me (who went to dental school and medical school for way too long) to care about this and to say that it's ridiculous.

HOFF: Right. Hmm. Well, it seems like you've been touching on it in your responses so far, and I'm sure there's many more lessons that people could take from this issue. But if you had to boil it down to the three most important lessons for clinicians to take away, what would those be?

SIMON: Oral health care is health care. If I just had to pick one, I think it'd be pretty easy to hang my hat on that one. The way oral health care is provided in America is a cause for and a perpetuator of unacceptable inequities in preventable suffering. And the broader health care system and those that operate in it have an enormous potential to improve oral health for the better because there has been so little activism on the part of anyone outside of oral health for so long.

HOFF: Mm. Great. Thank you. I think that wonderfully captures a lot of the really great stuff presented in this issue.

To wrap up, what do you think are some of the most exciting things happening in the field today? What about the future of the integration, perhaps, of dentistry and medicine excites you and our audience should know about?

SIMON: I'm not sure what it will be like when this podcast is being listened to, but right now, in September 2021, there is a lot of excitement over the possibility of a Medicare dental benefit. Medicare has never included a dental benefit, and this is probably the closest we've ever come to it being passed. And that's because there are bills in both the House of Representatives and in the Senate, as well as part of Biden's budget reconciliation bill that is supporting a Medicare dental benefit. And I'm very excited about that prospect. I think Medicare could be really transformative for how we deliver oral health care.

But I think the other piece of that is that it's pretty mind blowing to realize that there are people in the Biden administration right now who are not ignoring oral health. And in fact, the Center for Medicare and Medicaid Services appointed the first ever Chief Dental Officer to CMS. There's never been a dentist in that role, and it's just such an amazing and exciting evolution because it's again, seeing this sort of external validation that this is important. And I think that even though I hope it does pass, we don't get the Medicare dental benefit this year, I think it shows the opportunity for progress and a kind of change that is going to be integrated with the health care system because it's thought about in the same way. [mellow music returns]

HOFF: Mm. That does all sound very exciting, and we'll see where we are when this issue comes out in January of 2022. In the meantime, Dr Simon, thank you so much for all of your work on this issue, the work on your article, and for being on the podcast with me.

SIMON: Thanks so much. I'm so thrilled about all of this. It's really nice to talk to you, Tim.

HOFF: Up next, we talk with health journalist Mary Otto, a member of the Association of Health Care Journalists and author of the book *Teeth: The Story of Beauty, Inequality, and the Struggle for Oral Health in America*. She guides us through a history of dentistry from that fateful day in 1840 to today's oral health inequity. Mary, thank you so much for being on the podcast. [music fades out]

OTTO: Tim, it's a joy to be with you. Thank you for inviting me.

HOFF: So, 1840 is a date that comes up a lot in the issue this month, and I imagine that most of our listeners are likely unfamiliar with that date as it relates to the history of dentistry. So, to begin with, can you tell us what happened in that year and how it set the stage for the divided medical-dental services that we have today in the U.S.?

OTTO: Yeah, it's a very interesting story. The creation story of the American dental profession kind of dates back to 1840, as I learned, as I worked on my reporting for this book. And it was the year of the founding of what is remembered and recalled as the world's first College of Dentistry, and the events unfolded in Baltimore in 1840. At that point, at that time, dentists learned their skills—what was then regarded as a trade—through the preceptorship system that dated back to the Middle Ages. They practiced with a more experienced practitioner and learned whatever skills that practitioner saw fit to pass on to them. And then they often got on their horse and rode off into this developing country, and they set up their temporary offices in taverns and inns and houses and provided services and then moved on. And the services were pretty routine: a lot of extractions, some restorations. A lot of them sold patent-type medicines to relieve pain.

But two men, Chapin Harris and Horace Hayden, were both living in Baltimore at that moment in history. And both of them had a broader vision for what they called then the dental art and the dental science, the science and art of dentistry. Horace Hayden was an older man, a kind of a polymath. He was also a geologist, a man of letters. And Chapin Harris was a younger man who'd learned his skills from some believe his brother who was a physician and dentist in Ohio. But Chapin Harris had a real hunger for knowledge. He imported books from Europe, where the science of dentistry was a little bit more advanced. He even translated a book from French into English. He annotated a book from London. And these two men got together and decided dentistry was worthy of professional status in this country like other specializations were beginning to blossom at that time in medicine.

And as the story goes, they went to what was then known as the Maryland College of Medicine. It's now the University of Maryland Medical College, and they approached the physicians there with the idea of adding dental instruction to the medical course that was being offered there. And as the story goes, the physicians sent them away with this remonstrance that the subject of dentistry was of little consequence, [scoffs] and that event has gone down in the annals of dental history as the historic rebuff.

HOFF: Mm, mmhmm.

OTTO: The two men went a few blocks away, opened their College of Dentistry, began teaching courses. Chapin Harris wrote what is remembered as the first college dental textbook. They established a professional society for dentists and a peer reviewed journal for dental science that same year, or in those same months. And the profession of dentistry was born. Other dental schools around the country and even in other parts of the world took off along this model, but it laid the groundwork for a separate profession where to this day, patients have to navigate out of our larger health care system, often, to find dental care. Our medical and dental records are often kept separately. Our financing systems for our two, for health care and dentistry, are separate. And it's a divide that exists to this day.

HOFF: Yeah, absolutely. So, what sort of people first were going into dentistry when it was sort of first established as a more professional trade? For example, there's the connection between barbers and surgeons and things like that. Was it mostly people who were already in the health professions, or were dentists coming from some other particular place?

OTTO: Well, before the professional standards and educational program was established, dentists came from many walks of life. As you mentioned, there were barbers, there were blacksmiths, there were other people who were skilled with their hands in different ways

who provided dental care. I remember reading a book about the early beginnings of the University of Maryland, where young medical students or people who were hoping to get into medical school would be doing jobs to help doctors by washing out bottles and delivering medicines and occasionally pulling teeth. So, it was a kind of a job that might have been relegated to aspiring health care providers in some places.

HOFF: Mmhmm.

OTTO: But in the early days it was kind of like anyone who decided to call himself a dentist was one until the professional standards and the colleges were established.

HOFF: Hmm, mmhmm. That brings to mind the AMA had at one point something that was somewhat ominously called the Propaganda Department that responded to public inquiry and assisted regulatory agencies in identifying quackery and medical practice that wasn't really in line with the AMA's goals as a professional organization. Was there anything similar to that in the history of dentistry?

OTTO: That's interesting. I can't tell you that for sure, although I know that these dental schools that opened up in the wake of 1840 were very, were not all of the highest quality, if you could imagine that.

OTTO: Mmhmm.

HOFF: There was a very famous report in 1926 where a microbiologist named William J Gies was contracted to do a study of the standards of dental education. And he visited every dental school in the U.S. and Canada, and he came out with a report that was pretty scathing. He asked for higher standards of education and professional standards and stated that dentists needed to step up their game in terms of their training. And also, it was a critique that dentists should not just be dental engineers and dental surgeons, but dental physicians and dental sanitarians, to look at oral health—he didn't call it that, I don't believe, specifically—but to look more broadly than just these surgical procedures, as they were called, to restore or treat disease.

HOFF: Mm, mmhmm. There's a long history of moral claims being made about the health status of individuals, and we see that still to this day. And much of your book, *Teeth*, examines the role that dentistry has had in creating and maintaining both class and beauty standards, especially as it relates to people's smiles and obviously the way they present themselves that way. How did dentistry come to fill that role, and can we draw comparisons between aesthetic dentistry and things like cosmetic plastic surgery, services whose marketing relies on achieving these sort of unachievable body image standards?

OTTO: That's a very interesting question. That question too, in a sense, goes back to 1840. And in 1840, I found out in my reporting for the book, the U.S. issued the first patent for a camera, and it was defined as a device for making likenesses. And the patent was issued to Alexander Walcott, who was a dentist. And it was also in that year that Henry Fox Talbot invented the photographic negative, and he called his images calotypes, which is drawn from the Greek word "kalos" that means beautiful. And photographs held up a new kind of mirror to us all. We suddenly, they had a way of objectifying beauty that hadn't existed before, and also, their reproducibility standardized beauty in a way that we hadn't seen before. So, in a sense, mass media was born in 1840. You know, the seeds were sown in that year.

HOFF: Mmhmm.

OTTO: And the Hollywood Smile is kind of strange maybe. That actually was born during the Great Depression. There was this dentist named Charles Pincus, who he'd just opened a dental office in Hollywood when the Depression hit. And you'd think, oh boy, that was a bad time to open a dental practice. But Charles Pincus, like so many other Americans, went to the movies during the Great Depression to sort of escape the grim realities of life. And he looked up at this silver screen, and he noticed that a lot of these new movie stars didn't have perfect teeth. And he went back to his office and invented this little device called a Hollywood Veneer. And they were these snap-on devices that the stars could wear to create the illusion of perfect teeth. And it was an impossible illusion, of course. Little Shirley Temple, we watched her grow up, and we never saw her lose her baby teeth. She wore these veneers throughout her childhood and adolescence.

The cosmetic dental boom as we know it now really took off in the 1980s, along with a lot of other kinds of cosmetic surgery as I understand it. And of course, there were new products, new kinds of veneers, and things that dentists could use. But the cosmetic boom more largely was also driven by developments like a U.S. Supreme Court decision that began allowing medical advertising, which, you know.

HOFF: Mm.

OTTO: So, providers could create demand for these cosmetic procedures, and banking deregulation that allowed the creation of medical credit cards so customers, patients could pay for these procedures, which are often very expensive. So, dental and other kinds of cosmetic surgeries kind of share this, rose in the same climate of deregulation and self-improvement, and of course, this kind of demand that was created for these services.

HOFF: Mmhmm.

OTTO: And some have raised concerns over the years about this blurring of lines between caregiving and selling these procedures and about whether these are patients or customers who are receiving these services. Concerns about body dysmorphic disorder, whether that informs some patients to, or people, to seek out these procedures, hidden costs of medical credit cards. But they continue to be very popular procedures.

HOFF: Popular and I would imagine lucrative.

OTTO: And very lucrative, very lucrative. And the dental system is still kind of in many ways, a kind of cottage industry. Providers tend to gravitate toward more affluent metropolitan areas where they feel like they'll receive a good profit for their investment in an education and in opening up an office. And sometimes they actually compete for patients in these areas while it leaves tens of millions of Americans in areas that are considered federally designated dental provider shortage areas, less affluent or rural, often more minority and ethnic communities.

HOFF: Mmhmm. Hmm, interesting. During your research for the book, and I guess in your years of research as a journalist, what are some of the misconceptions about oral health and dentistry that surprised you the most to find out that they were, in fact, misconceptions? And what do you think are some of the more common misconceptions that the general American public holds?

OTTO: I think what comes back to me over and over again, and it seems to touch almost everything, is the simple fact that our heads are attached to our bodies, but our health care system has never really reflected that fact. And it still doesn't, you know?

HOFF: Mmhmm.

OTTO: The way, and it affects everything. I heard a doctor, a doctor told me, he said, "Doctors look at the body from the tonsils out, you know?"

HOFF: [chuckles]

OTTO: And dentists, they're concerned with the oral cavity: the teeth and the gums. And it's like these two professions, I mean, they don't really often, the communication system is not really very good. Those referrals don't often work.

HOFF: Mm.

OTTO: Although, like I mentioned, the community health centers, I think they're starting to do more of that in these safety net clinics where these practitioners are working under the same roof, and they're learning to share records and have their dental and medical records together for the patients. But that's kind of a new thing. The coding wasn't even working for so many years to do that, to integrate these records. And patients have to migrate. They have to navigate across this uncharted terrain and be their own translators to kind of bridge this gap themselves. And they experience significant barriers to finding their way from one system to another due to the fact that they're older or they don't have coverage, they don't live in a community that has a dental provider.

Tens of thousands, hundreds of thousands of these patients end up in emergency rooms every year with these non-traumatic dental problems like toothaches, and they don't often get the care they need. A dental emergency, an emergency room is not set up to handle these problems. They're usually sent away with sometimes a medication and instructions to call and find a dentist, you know?

HOFF: Right.

OTTO: But that doesn't address their underlying need for oral health services.

HOFF: Right.

OTTO: And then there's the stigma, too. I mean, people are, poor oral health is a kind of disfiguring condition, and people are often stigmatized. It can hold them back from advancing economically, getting a job, advancing socially. They can be blamed for their poor oral health in ways that people aren't blamed for a lot of other health care problems.

HOFF: Right. And that kind of dovetails into the final question here about which oral health inequities are the most pressing for health professions students to learn about and perhaps especially medical students? You were talking, obviously, about how certain communities tend not to have access to dental care, those being the communities that are historically disinvested in. And then that obviously leads to the stigma that you're talking about. Are there any other particularly important intersections of oral health and health equity that you see as important for health students to learn about?

OTTO: There's a report I've gone back to so many times in my work over the years, and it's getting old. It's like a 2000 report now. And at the time, it was a landmark report. It was like the first real survey that America had ever seen of its oral health system, and it was called *Oral Health in America*. It was authored by then-Surgeon General David Satcher, and he laid out chapter by chapter where the system breaks down, where people get lost, what groups are not receiving care, the barriers to care, and the way that our oral health education works, the workforce, all these different things. And he ended this report with what he called a call for action. And that was our nation needed to build a health care system that meets the needs of all Americans and integrates oral health effectively into overall health. And that's a tall order, but it's worth, I think it's still worth thinking about. Twenty years later, it's still, many experts I talk to still see it as an important challenge.
[theme music returns]

HOFF: Well, Mary, thank you so much for your time on this podcast and for all of the work you've done and continue to do covering dentistry in America.

OTTO: Oh, Tim, I am so grateful to join you, and thank you for what you do.

HOFF: That's our episode for this month. Thanks to Dr Lisa Simon and Mary Otto for joining us. Music was by the Blue Dot Sessions. To read the full issue, listen to more episodes of *Ethics Talk*, and find CE opportunities, visit our site JournalofEthics.org. For all of our latest news and updates, follow us on [Twitter](https://twitter.com/JournalofEthics) and Facebook [@JournalofEthics](https://www.facebook.com/JournalofEthics). And we'll be back next month with an episode on tactical medicine. Talk to you then.