QUALITY OF HISPANIC ORAL HEALTH IN THE U.S.: PERCEPTIONS OF DENTISTS AND A CALL FOR IMPROVEMENT

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QUALITY OF HISPANIC ORAL HEALTH IN THE U.S.: PERCEPTIONS
OF DENTISTS AND A CALL FOR IMPROVEMENT

by
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Submitted to Brigham Young University in partial fulfillment
of graduation requirements for University Honors

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ABSTRACT

QUALITY OF HISPANIC ORAL HEALTH IN THE U.S.: PERCEPTIONS OF DENTISTS AND A CALL FOR IMPROVEMENT

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Bachelor of Arts in Spanish

An examination of the perceptions of U.S. dentist’s regarding the quality of Hispanic oral health in the United States. This thesis investigates both the dentist’s potential for making positive change and the challenges that stand in the way of improving the state of Hispanic oral health. Twelve dentists were spoken with by phone to discuss three main questions. Those chosen for the calls practice in the ten states with the highest percentage of Hispanics. An analysis was conducted of the recorded calls that consisted of comparing each response with patient demographics, practice location and years of experience. Responses were categorized and analyzed numerically in graphs to study trends and patterns.

Patient education and pro bono dental work were the two most frequently mentioned responses regarding how dentists can improve Hispanic oral health. Similarly, the current state of patient education and level of pro bono dental work were the two most mentioned responses regarding barriers that hinder progress for Hispanic oral health. Although Hispanic oral health is objectively worse than the U.S. population at large, 66% of dentists were not aware of this reality and thought that Hispanic oral health was not “worse than the general U.S. population” while 33% thought that Hispanic oral health was worse. Given the divided responses, the perception
among dentists about Hispanic oral health quality in the U.S. varies greatly. This suggests that many oral healthcare professionals are likely unaware or incorrectly informed concerning this struggling demographic. This identifies the need to make sure dentists across the U.S. stay better educated on issues of race, ethnicity and culture within the world of oral health.
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TABLE OF CONTENTS

Title .................................................................................................................................................. i
Abstract ........................................................................................................................................... ii
Acknowledgements ........................................................................................................................ iv
Table of Contents ............................................................................................................................. v

I. Introduction .................................................................................................................................. 1

II. Methods ....................................................................................................................................... 4

III. Summary of Conversations ........................................................................................................ 7

   A. Limitations--Question One: Hispanics: Worse Oral Health? ..................................................... 7
   B. Findings--Question One: Hispanics: Worse Oral Health? ............................................................. 9
   C. Findings--Questions Two and Three ............................................................................................ 25

IV. Results & Discussion ................................................................................................................ 49

   A. Question One ............................................................................................................................. 49
      Figure 1: Worse or Not Worse Oral Health? ................................................................................. 50
   B. Question Two ............................................................................................................................. 52
      Figure 2: Items Mentioned—Question Two ................................................................................. 54
   C. Question Three ........................................................................................................................... 54
      Figure 3: Items Mentioned—Question Three ................................................................................. 57
   D. Findings from Questions Two and Three .................................................................................... 57

V. Strengths/Limitations of Research ............................................................................................. 59

   A. Strengths of Research ................................................................................................................. 59
   B. Limitations of Research ................................................................................................................. 59

VI. Conclusion .................................................................................................................................. 61

Works Cited ................................................................................................................................... 65
I. Introduction

After learning to speak fluent Spanish while living in East Los Angeles for two years and having decided to work towards becoming a dentist myself, I at once sought for ways to connect these two distinct fields that interested me so much (the Spanish language and dental work). After some significant thought, I began to see dentistry and the Spanish language not as two distinct worlds, but as a very tight-knit, connected web of challenges. These two fields of interest began to be so deeply connected in my mind that I made it a personal goal that I would dedicate a large portion of my career as a future dentist to using Spanish in order to help underserved Hispanics achieve better oral health. I began to research the challenges and statistics regarding these issues to identify the specific areas that need improvement.

Before continuing, I’d like to note that I will use the term “Hispanic” throughout my thesis as a general term to mean a Spanish-speaking person living in the United States of America. That being said, I acknowledge that “Hispanic” is a term that often includes people from many different Spanish-speaking countries with unique cultures and customs. However, for the sake of being simple and clear throughout my thesis, I will use the word in this paper as defined above. Additionally, I will use the term “White, non-Hispanics” to refer primarily to U.S. citizens who speak predominantly English and who generally have multiple generations of White, non-Hispanic ancestors who came before them.

Here are some of the findings I came across in my preliminary research.
Preliminary Findings:

According to a study done by the Hispanic Dental Association, 45% of Hispanics living in the United States do not have access to health insurance (Hispanic Dental Association 3). In another study, done by the Pew Hispanic Center, it was found that of the Hispanics who don’t have health insurance, the reason that 41% of them don’t have health insurance is that they consider themselves to be almost always healthy, and therefore do not need it (Livingston).

Additionally, in 2011, it was found in a self-evaluation of their personal health, that 67% of Hispanics said that their health is “good” or “excellent.” At the same time, however, 65% of Hispanics say that they have had at least one dental problem in the past year, compared to the percentage of the rest of the population at 53% (HDA, Crest, and Oral-B 3).

In an article from 2015, results show that almost 80% of Hispanics prefer to communicate in Spanish regarding issues of health, but that nearly 30% report having difficulties in obtaining health information written in Spanish (Gonzalez). Additionally, results of a study done in 2014 showed that 21% of Hispanics wrongly thought that brushing one’s teeth would remove cavities (P&G).

According to Centers for Disease Control and Prevention, “Non-Hispanic blacks, Hispanics, and American Indians and Alaska Natives generally have the poorest oral health of any racial and ethnic groups in the United States. The greatest racial and ethnic disparity among children aged 2–4 years and aged 6–8 years is seen in Mexican American and black, non-Hispanic children…and among] Mexican Americans aged 35–44 years, [who] experience untreated tooth decay nearly twice as much as white, non-Hispanics” (Disparities).

In a study about Hispanic oral health, Cortés, Ph.D., quoted, “Latino children's health disparities are important because the percentage of Latino persons in the United States continues
to grow; Latinos are 16.3 percent of the total population in the United States and young children comprise a significant portion of this population” (Cortés).

A study was conducted to examine home oral hygiene routines of Mexican-American mothers of young children in a low-income urban neighborhood. Mothers were interviewed about their oral hygiene routines, and it was found not only that childhood caries are disproportionately high among Mexican-American children, but that, “Most (87%) of the urban Mexican-American mothers in the study do not initiate oral hygiene practices in compliance with ADA recommendations” (Hoeft).

These findings were both saddening yet fascinating to me. The more I learned about these issues, the more questions I began to ask myself. I found myself with a desire to dig to the root of these problems and figure out what needs to be done to make positive changes in the world of Hispanic oral health in the United States.

This thesis seeks to uncover the core issues as to why Hispanic oral health in the U.S (in many statistical areas) is lagging behind that of White, non-Hispanic Americans. The purpose of exposing these challenges is to better educate patients and health care professionals in order to make significant, lasting changes for good.
II. Methods

As part of my thesis research, I decided to contact by phone at least one currently practicing dentist in each of the top ten U.S. states with the “highest percentage of the population that is Latino”. Given the data from the Pew Research Center, in 2014 the top ten states with the highest percentage of the population that is Latino were New Mexico, Texas, California, Arizona, Nevada, Florida, Colorado, New Jersey, New York and Illinois. Note that while I did speak with one dentist from each of the ten states, I spoke with twelve dentists total (two from Illinois and two from California) (Stepler).

As I planned the nature of these phone calls and as I thought about the type of data I desired to collect, I chose to take a very non-selective approach in choosing dentists to talk with over the phone. In the selection of these dentists, I did not create fixed or controlled variables amongst factors of race, years of professional experience or percentage of Hispanic patients. I chose to proceed with this less selective approach so that the data gathered would come from a large variety of backgrounds and contrasting work environments. The vast differences in information given from dentists with unique backgrounds would allow for a fascinating examination about the ways in which cultural, locational and financial factors contribute to a dentist’s attitude about the oral health of Hispanics.

The commonalities that were shared among all the dentists spoken with were that they reportedly had “some experience working with Hispanics,” they were general dentists and they were all currently practicing dentistry at the time of the phone call.

As a result, I was able to speak with both White, non-Hispanic dentists and Hispanic dentists to examine how race/ethnicity may play a role in these issues. I was also able to talk with dentists who primarily treated Hispanic patients and those who treated much smaller
percentages of Hispanic patients to see how patient demographics would play into a dentist’s view of these issues. I additionally spoke with dentists who practice in large cities and dentists who practice in very rural areas to uncover the ways in which a dentist’s work environment may shape his/her perception of Hispanic oral health. In summary, the purpose of the non-selective approach was to study a broad range of backgrounds amongst dentists to discover and analyze trends that would be difficult to see otherwise.

To make sure the collected data was sufficiently organized, I gathered the following information about each of the dentists spoken with: ethnic demographics of their patients, the city in which they practice and the years of experience they have as a practicing dentist.

As I began to search for dentists practicing in these states who would be willing to have a phone conversation with me, the process of getting in touch with dentists proved much more difficult than I initially expected. The primary means of finding dentists to speak with resulted from referrals of friends or acquaintances of mine who personally knew a particular dentist. Another effective means of finding dentists who were willing to speak with me came through using their contact information on websites of dental school faculty lists. Essentially all other means of networking proved incredibly unsuccessful. Especially unsuccessful was the method of calling directly to dental offices to explain my thesis over the phone. The receptionists who answered the calls would almost always say that the dentist was too busy or they would take note of my contact information and never contact me back.

Regarding the dentists that were willing to speak with me, I first explained the premise of my research and the idea of my honors thesis and then explained that I was not conducting a survey or a questionnaire, but rather was holding a conversation with a key informant who was
qualified to expound upon the broad field of dentistry. After asking if I had permission to record
the phone call or take notes, I began with the following three questions/prompts:

1. As a part of the oral healthcare world, do you sense that there is a general understanding amongst oral healthcare professionals that Hispanic oral health is worse than the general U.S. population?

2. For dentists who have a desire to help Hispanics achieve better oral health, what have you seen them do, or in what ways have you seen them make a difference? In other words, what lies in the power of the dentist with regard to helping Hispanics receive improved oral health?

3. Regarding dentists with a desire to help Hispanics achieve better oral health, what barriers stand in their way? What makes it difficult for a dentist to make a positive difference?

If permission had been granted, the call was recorded and notes were taken. Calls generally lasted between 15-30 minutes in duration.
III. Summary of Conversations

A. Limitations--Question One: Hispanics: Worse Oral Health?

“As a part of the oral healthcare world, do you sense that there is a general understanding amongst oral healthcare professionals that Hispanic oral health is worse than the general U.S. population”?

Before proceeding any further with analysis of question one, an explanation of said question is required. The initial research I conducted before making any phone calls with dentists (as seen above in the preliminary findings section) was finding literature that talked about the current situation of Hispanic oral health in the U.S. In that search, I discovered that Hispanics, as a general demographic, were typically in worse shape than non-Hispanic Whites regarding most statistics about oral health. Since the majority of the U.S. population is classified as non-Hispanic Whites, I decided to refer to non-Hispanic Whites as “the general U.S. population” in this question. While doing so, however, I of course understood that the other demographics that make up the rest of the U.S. population must be implied in that phrase as well.

After having conducted all my phone calls, and during the phase of analyzing my data, I have come to realize that there were a number of flaws with this question that I hadn’t seen when I initially formulated it. Following are the four main problems with question one:

1. The question is long and wordy, and as a result, many of the dentists misunderstood the question itself. During the phone calls, the majority of the dentists misunderstood my question to mean, in effect, “Do you personally feel that Hispanic oral health is worse than the general U.S. population”? Many of the dentists answered according to their personal opinions instead of commenting on what “oral healthcare professionals” across the U.S. think.

2. Question one assumes that the dentist understands and believes that “Hispanic oral health is worse than the general U.S. population.” Given that this Honors Thesis is my first significant research thesis, I naively assumed that the dentists I was going to talk with would understand this as
common knowledge. As mentioned above, my preliminary research convinced me that Hispanic oral health was indeed worse, as a general demographic, than the other demographics living in the United States. After conducting my calls, however, I realized that many of the dentists did not have that same understanding or belief. Though I did not do so purposefully, I learned that I should always strive to remove any biases from my questions when doing research and never assume that those being talked with think a certain way or have a particular understanding of a certain issue.

3. To say “the general U.S. population” is very vague. I was unclear on specifying what that really meant. While I intended it to mean everyone who was not Hispanic that is living in the U.S., I did not specify the specific demographics that I was comparing Hispanics with.

4. My claim that “Hispanic oral health is worse than the general U.S. population” may be an impossible claim. That is to say, there are many factors that go into the oral health of a particular demographic of people, and the issue of oral health may be too large and complex to be able to claim a broad, blanket statement of this nature. It is possible to compare specific statistics relating to oral health, like the number of reported cavities in 2016 of Hispanics vs. non-Hispanic Whites in the U.S., for example, but to say that a demographic has worse oral health than all others may be a claim that is too general and that cannot be sufficiently proven.

After analyzing the recordings of the phone calls, I realize that without often realizing it, when I recognized that the dentist didn’t fully understand the question, I transitioned to exploring instead what their personal beliefs were on the matter. That is to say, I transitioned to asking them essentially: “Do you personally feel that Hispanic oral health is worse than the general U.S. population”? I recognize that it may have been better to instead remain firmly rooted in question number one, and correct the dentists or clarify the question as needed to make sure they fully understood what I was asking. Later in the thesis, I will discuss the times in which I strayed from question one and what I learned as a result.

While I was greatly disappointed in myself for having gone through the entire process of the phone calls without truly grasping the faults of question one, I have come to terms with the
fact that this is a thesis for the Honors Program, and not a Masters or Ph.D. Thesis. Looking back on the process I went through to make these phone calls, especially since this is my first exposure to writing a thesis of this nature, I have come to terms with the fact that my research methods were not perfect or without flaw. That being said, I have learned much through my mistakes about how to effectively collect data and research in clear, meaningful ways. Additionally, the problems with question one did not lead to a lack of significant findings. In fact, there are many important pieces of information and patterns that I have learned from the way in which each dentist answered question one. We will explore those findings in the coming paragraphs.

B. Findings--Question One: Hispanics: Worse Oral Health?

To most effectively analyze the findings from the answers of question one, we will look at the way each individual dentist answered the question and what that tells us about their understanding or opinions of the world of Hispanic oral health. Regarding question one, a close reading of each dentist’s response will reveal how well they understood the question being asked. Regardless of how well they understood the question, there is important and useful information contained within each phone call. Below are the written transcriptions of the significant parts of each research phone call.

Those who stated whether they personally thought Hispanics have worse oral health than the rest of the U.S. population instead of commenting on the views of other oral healthcare professionals:

- **Dentist 1, DMD, MBA**
  - **Demographics:**
    - 85% Hispanic
• 10% Black, non-Hispanic
• 5% White, non-Hispanic

○ Practice Location:
  • Bronx County, NY
  • Dentist 1 is aware of the dental culture and issues that dentists face who practice in New Jersey.

○ Time Practicing:
  • 13 years

Merrill: “As part of the oral healthcare world, do you sense that there is a general understanding amongst other oral healthcare professionals that Hispanic oral health is worse than the rest of the U.S. population.”

Doctor: “Yes. I agree with that….in that the oral care of Hispanic people is not better than the counterparts, even in the same age. For example, a Hispanic who is 35 years old versus a White, non-Hispanic who is 35 years old, for the most part, we can say that the oral healthcare in Hispanic people resembles a little bit more the oral care of an African-American patient of the African-American population of the United States.”

Merrill: “So you do feel that Hispanic oral health is worse than the rest of the U.S. population? Is that what you’re saying?”

Doctor: “Yes.”

Merrill: “And you feel like generally dentists sort of acknowledge that and recognize that?

Doctor: “Yes. They acknowledge that and they recognize it, yes.”
• **Dentist 2, DMD, PA**

  o **Demographics:**
    - 85% White, non-Hispanic
    - 8% Hispanic
    - 5% Black, non-Hispanic
    - 2% Asian, non-Hispanic

  o **Practice Location:**
    - Alachua County, FL

  o **Time Practicing:**
    - 27 years

I was unable to record the phone call with Dentist 2 so I do not have direct quotations from the phone call. However, during the call, I took careful notes and will explain the ideas that he expressed during our conversation.

In response to question one, he replied by saying that he doesn’t know or necessarily believe that Hispanic oral health is worse than the rest of the U.S. population. In his practice, he has not seen that to be true. He commented than in his experience, there is no specific race that generally struggles any more than another. The answer that dentists give to this question will depend more upon the area in which they live because depending on the demographics of one’s patient base, a dentist will be exposed to only a number of races/ethnicities and not exposed to others. He ultimately decided that he felt like Hispanic oral health was not worse than the rest of the U.S. population because in his practice, older patients have more oral health problems than any other group he works with. He said he simply doesn’t see in his patient base that Hispanics have any worse oral health than the rest of the U.S. population.
Dentist 3, DDS

Demographics:
- 95% White, non-Hispanic
- Less than 4% Hispanic
- 0.5% Black, non-Hispanic
- 0.5% Asian, non-Hispanic

Practice Location:
- LaSalle County, IL

Time Practicing:
- 21 years

Merrill: “So you being a general dentist, do you sense in the dental world, that there is a general understanding amongst other dentists and oral healthcare professionals that Hispanic oral health is worse than the general U.S. population?”

Doctor: “I don’t know that I’m in that camp, no. That’s not really my observation.”

Merrill: “Do you think it’s something that most dentists, if they don’t speak Spanish, then they don’t really choose to invest much into that, or look into it very much?”

Doctor: “I don’t know if I have a good answer to that. We have a fair amount of Hispanic patients that come to our practice, so all that I can speak for, obviously, is my cross section of [the town I practice in], which is about a 30 mile radius…So of the maybe 500 to 1000 patients that we have that are Hispanic, I don’t really see race as what distinguishes between healthy mouths and a not-so-healthy mouth. I’m not seeing that in my practice anyway. It has a whole lot more to do with the culture of their family in my opinion than race or anything else…I don’t see it. I mean I have Hispanic patients who have pristine mouths, and garbage mouths, and White
patients who have the same. So I’m not seeing that myself. But again, it’s [LaSalle County], Illinois.”

Merrill: “As far as their understanding of good oral healthcare, do you see any differences at all between your Hispanic patients and your White patients?”

Doctor: “I really don’t, I really don’t. I see the same misunderstandings in both categories really, and the same understandings. The same both ways.”

- **Dentist 4, DMD**

  - **Demographics:**
    - 50% African-American
    - 15% Hispanic
    - 10% Asian, non-Hispanics
    - 25% White, non-Hispanics

  - **Practice Location:**
    - Bell County, TX

  - **Time Practicing:**
    - 2.5 years in Bell County, TX
    - First started practicing in McLennan County, Texas & Otero County, New Mexico for 2.5 years. Both locations there were 90% White, non-Hispanic and 10% Hispanic.

Merrill: “Do you, as part of the oral healthcare world, sense that there is a general understanding amongst oral healthcare professionals that Hispanic oral health is worse than the general Caucasian, U.S. population?”
Doctor: “I have a comment. I’d say they’re pretty average. Yeah, about the same as most of my other patients. Definitely where I work, it’s a lower socio-economic situation. A lower income demographic. So maybe [Whites] just match the Hispanic population in my area.”

- **Dentist 5, DMD**
  - **Demographics:**
    - 50% Hispanic
    - 50% Other, non-Hispanic
  - **Practice Location:**
    - Bernalillo County, NM
  - **Time Practicing:**
    - 34 years

I was unable to record Dentist 5’s answer for question one, but I took careful notes of his response.

In response to question one, Dentist 5 responded that the standing of one’s oral health has nothing to do with their race. He said it has nothing to do with being Hispanic. Instead, the quality of one’s oral health has to do with one’s economic status, and whether they can afford dental services or not. Additionally, the quality of one’s oral health is related to the fear (or lack thereof) one feels towards visiting the dentist, and that fear causes one to avoid visiting the dentist and therefore often have worse oral health.

- **Dentist 6, DDS**
  - **Demographics:**
    - 70% Hispanic
    - 20% White, non-Hispanic
5% Black, non-Hispanic
5% Asian, non-Hispanic

- **Practice Location:**
  - San Diego County, CA

- **Time Practicing:**
  - 28 years

Merrill: “You, as an experienced healthcare professional, do you sense that there is an understanding amongst other dentists around the country that Hispanics have worse oral health than the rest of the U.S. population?”

Doctor: “I see a lot of Hispanics but I also see non-Hispanics, and I don’t see where there’s a huge difference. It’s more like the economic level. People that are more underserved would not go to the dentist as much. But I really do see the difference when the economic level is a lot worse. It doesn’t have to be Hispanic. I see a lot of African-Americans, I see a lot of non-Hispanic Whites, that they were worse.”

Merrill: “So you feel like it’s more about their economic status, rather than their race?”

Doctor: “Yeah, yup.”

- **Dentist 7, DDS**

  - **Demographics:**
    - 85% Hispanic
    - 10% Vietnamese, non-Hispanic
    - 4% Other (White/Black, non-Hispanic)
    - 1% Immigrants (Somalia, Afghanistan)
Merrill: “You, being a part of this oral healthcare world, do you as a dentist sense that there is a general understanding amongst oral healthcare professionals, or other dentists, that Hispanic oral health is worse than the rest of the U.S. population?”

Doctor: “Well. Can you ask it again, the first part?”

Merrill: “Do you sense that other dentists in the United States understand well that Hispanic oral health is worse than the rest of the U.S. population?”

Doctor: “Okay, yeah, I understand the question now. I don’t know about the other providers, but I can give you actually the perspective from me because I studied in Mexico and I saw a lot of Hispanic patients. I’m going to go to Mexican, because that’s what I know, and that’s mainly what I see at the clinic. The Mexican population, or Hispanics, usually goes to the dentist when there is pain. An American, a Caucasian person, or an American that was born here, they go every six months as preventive measurements. So they go and they get the x-rays checked and they do the whole exam, the whole treatment plan. And for Mexican people, it’s not in their culture; it’s not in our education system to go as a preventive measurement. We go when it hurts. And usually it’s like, ‘Oh, I’m not going to go the doctor because nothing hurts!’ When I get something, I get probably an M.O.D. very close to the pulp. I’m like, ‘Ok, so we need to treat this because if this goes to the pulp, we don’t want to do a root canal’, and my Mexican patient will be like, ‘Oh, but it doesn’t hurt yet’, whereas, an American patient, a Caucasian, would be, ‘Oh, okay, let’s treat it before it turns into a root canal’. And that’s saying it’s the majority. So
it’s mainly on the education that we have as a population, that we go when it hurts. So more like a palliative treatment instead of being a preventive measurement like an American population.”

Merrill: “Do you feel that Hispanics do generally have worse oral health than Caucasians in the United States?”

Doctor: “Hmm. That’s a tricky question because now with the Obamacare and the patients that have Medi-Cal, they keep coming every six months because it’s paid for. So they’re improving their oral health, but I don’t know about before, because again, it’s in the American culture to brush as you’re very young and floss as you’re very young. Your first visit is at one year old, two years old or four years old, but you go every six months so you have more education. So yeah, you have better access to the dentist, whereas in Mexico, not as much, or being a Mexican here, there are a lot of illegal people also who are scared to go to the dentist because they don’t know if they’re going to report them. So I think because of that, just because of education, their oral hygiene, yes, I would have to say that it is…I don’t want to say worse. It depends also on the economic status because a lot Caucasians are very bad because they do drugs. And in the Mexican culture, we don’t do drugs. It’s not in our culture to do more drugs. The meth mouths that I see, they’re mainly in Caucasians.”

Merrill: “So perhaps you’re saying it’s not that Hispanics have worse oral health, it’s just that the…history of Hispanics in general doesn’t have a culture of going to the dentist often, so maybe the culture is more difficult to help them to come to the dentist?”

Doctor: “Yeah, so it’s just lack of education…as a preventive measure. That’s the important thing. In Mexico, it’s more the palliative treatment. You go when it hurts. Here, you go because you need the check-up. So that’s very important.”
Dentist 8, DMD

Demographics:
- 70% Hispanic
- 25% Black, non-Hispanic
- 3% White, non-Hispanic
- 2% Middle Eastern/others

Practice City:
- New York City, NY

Time Practicing:
- 19 years

Merrill: “Do you feel that there’s a general understanding that Hispanic oral health is worse than the White population, or the majority population?”

Doctor: “It depends where you’re serving, not who you’re serving. So if you are in a practice on 5th Avenue and Park Avenue, and your prices of course in that practice are very high, you may get Hispanic patients, but Hispanic patients that can afford it. They fall under different levels. I talk about cultural determinants of health and I talk about social determinants of health. And if you look around at that information, people who are in public health…people are very aware of this issue of social determinants. Because where you live, and where you go to school, and where you go shopping and where you play determine what type of health you’re going to have. So if we have a Hispanic that is in South Bronx or Washington Heights, they’re going to have different health than the Hispanic that lives on 5th Avenue. So that’s your question, but I really don’t even know how to answer that question.”
The same way you told me about you, I’m going to tell you about myself. I’m from Colombia. I’m an immigrant. That means I’m here by myself. I left my family behind. I go to Colombia once a year…And I came to this country already with a dental degree. So I came to learn English, and somehow I stayed. So when I came, it took me a while to be able to go to school here. I didn’t have the money. I came to New York to learn English and I stayed…Washington State, back in the day, didn’t have fluorinated water…and I saw rampant decay in non-Hispanics. Before I thought, ‘Ooh! This is only a problem for Hispanics!’ No. It’s a problem of the underserved. And…when I was in Columbia, my public health teacher used to tell me, ‘Oh! The States are developed, they have fluoride…and they won’t have cavities. They will have other problems: ortho, perio,’ and so my dream was to become an orthodontist, because cavities were not going to exist. And here we are 30 years later and cavities are bad, and not only in Hispanics. Not only in African-Americans…non-Hispanic, non-African-Americans who are underserved.

I went to Montauk [New York] when I was learning English. Montauk is two hours away from New York City…We went there to pick up strawberries, and I was talking to the farmers, and they were non-Hispanic farmers. And they didn’t have teeth! And they smiled, and their gums were horrible, and cavities all over. And I was thinking to myself, ‘Oh, my teacher lied to me!’ I was very confused. I came to America, the land of opportunities, everything’s good, good social services, good public health, so then how come I’ve seen so many cavities?

So when you are asking me if I sense that the healthcare professionals think that Hispanic oral health is worse than the rest of the U.S. population, it depends who you talk to. It depends who they’re treating. So that would be my answer. I don’t have an answer.”
During my conversation with Dentist 9, I did not ask question one word for word as I did with essentially every other dentist. I have no good explanation as to why I didn’t stick more closely to the wording of question one. It was a mistake in my research but I still learned valuable information from his response.

Merrill: “Amongst your Hispanic patients, or in general, do you feel like there is a need to improve Hispanic healthcare in the United States? Do you feel like it’s an area that needs improvement generally?”

Doctor: “I guess I would have to say no. I think there’s plenty of healthcare available. I think they have as much access to care as any other group. They might not be as aggressive in seeking the care for various reasons, but there are a lot of things out there to help them receive dental care. I think it might be more of an economic issue where the low-income people tend to have worse dental care than people that have more money. It doesn’t seem to be only with Hispanics, in my opinion. But I deal with a lot of Hispanics. Maybe almost a majority.”
Merrill: “Are the Hispanics you see in your office, are they generally more financially well off who can afford dental care? In other words, do you feel like there’s a large portion of Hispanics who are not receiving any sort of dental care, in Arizona, for example?”

Doctor: “I feel like I could be a lot busier myself as a dentist. If there were a lot of people who needed a lot of care, I’d like them to come to my office and make me busier than I am. So I guess I feel like there are too many dentists and not enough patients. I think there are a lot of dentists who could be busier and could be treating them.”

Those who primarily commented on the views of other oral healthcare professionals:

- **Dentist 10, DDS**
  - **Demographics:**
    - 70% Hispanic
    - 25% White, non-Hispanic
    - 5% Black, non-Hispanic
  - **Practice Location:**
    - Adams County, CO
  - **Time Practicing:**
    - 10 years

Merrill: “As a general dentist in Colorado, do you within your sphere of influence of Dentistry, sense that there’s some understanding amongst oral healthcare professionals that Hispanics have worse oral health than the rest of the U.S. population than Whites or other demographics?”

Doctor: “I think it’s pretty well understood that that’s the case. We see a lot of periodontal disease untreated. A lot of Hispanic patients that have type two diabetes and they
have uncontrolled diabetes. So you get some periodontal repercussions from that and I’ll have patients that come in, and the last time they went to the dentist was when they were a kid, and they’re 45 years old. There is a lot of untreated disease there. So you don’t have to look hard for things to do. But that’s kind of true in our entire patient population. In my demographic, we’re just in a very underserved part of town, so we see that in the White population as well. But definitely there’s a high propensity for dental disease among our Hispanic patients. And it’s not really their fault. It’s not usually because they’re a mess and they’re drinking Mountain Dew all day. It’s just because they haven’t had a chance to get good dental care their whole life. So there’s definitely a need.”

Merrill: “And amongst those who come in with those sorts of challenges, like not having been to the dentist for 30 years, is that equally spread amongst Whites, Hispanics and any other demographics you have?”

Doctor: “I would say that for the most part, our White population that has grown up in the states has had more access to care. They haven’t always taken advantage of it, but they have seen the dentist more frequently than some of our migrant population that has either come to the U.S. in the last decade and has either just been working so much and couldn’t afford to get the care, or they’ve become a citizen and now they can qualify for some benefits. So I think there’s still a discrepancy between the White, Black and Hispanic population. And I would say the Hispanic population is definitely less well served. But I think that that’s improving. I think that’s improving because a lot of those patients that couldn’t get care, at least in Colorado now, they have a state Medicaid benefit for adults that’s much better than it was. That changed in 2014 with the Affordable Care Act, and that’s giving a lot more adults opportunities to get care that they weren’t getting before, and that includes the Hispanic population.”
Merrill: “Do you feel like there is a general understanding amongst oral healthcare professionals that Hispanic oral health is worse than the rest of the U.S. population?”

Doctor: “Well I’m not so sure about all the dentists. I’m not sure if all the dentists are aware of that. I know that the Hispanic dentists, that we are aware of that. And personally…we know, and that’s what we work for, to try to improve the Hispanic population’s oral health. So I’m not so sure because my relation with dentists from different countries is very limited, because I work at an office and all the dentists there are Hispanic. And [where I work] there are people from everywhere, but the people that are closest to me are Hispanic also. So I’m not really sure if everyone is aware. I know that the Hispanic dentists are aware of that, but I can’t tell you about anyone else.”

Merrill: “Do you feel that Hispanic oral health is worse than the rest of the U.S. population?”

Doctor: “I can tell you that that’s true from what I’ve read and from studies and some research that has been done. And so I’m telling you again, it’s really hard for me to tell you
because I’ve worked only with Hispanics so it’s hard for me to compare. And I’ve been working in this same place since I graduated, so I don’t have anything to compare. But yeah, that’s a fact.”

- **Dentist 12, DDS**
  - **Demographics:**
    - Vast majority Hispanics
  - **Practice Location:**
    - Maryland & Las Vegas, NV
  - **Time Practicing:**
    - 8 years in Maryland
    - 3 years in Las Vegas, NV

Merrill: “For you, being part of the oral healthcare world in the United States, do you sense that there is a general understanding amongst oral healthcare professionals that Hispanic oral health is worse than the rest of the U.S. population?”

Doctor: “Yes…I think they understand the need because most of the Hispanics are on the lowest of the economic scales. And when I worked in Maryland, when I worked part-time for the public health department, we saw a lot of children with a lot of decay. What was happening, was when these people moved from their countries, mostly the people that were coming from Central America, they changed their diet completely because they think buying their kids candy and filling their diets with soda is good, but they don’t know. So we saw rampant decay on children a lot, and we had to send our hygienist to teach them nutrition. A lot of baby bottle decay. They would put the babies with a sugar bottle to go to sleep. So I think most dentists probably know. At least at NYU, that was a class.”
Merrill: “So you definitely do feel that Hispanics have worse oral health than the rest of the population?”

Doctor: “Most likely, yes. I think Hispanics have more caries and Chinese have more periodontal disease.”

C. Findings—Questions Two and Three:

In the coming section, I will group together the responses for questions two and three for each dentist to most easily analyze the results. We will look at the following two questions:

- **Question Two (What can be done?):** “For dentists who have a desire to help Hispanics achieve better oral health, what have you seen them do, or in what ways have you seen them make a difference? In other words, what lies in the power of the dentist with regard to helping Hispanics receive improved oral health”?

- **Question Three (Barriers?):** “Regarding dentists with a desire to help Hispanics achieve better oral health, what barriers stand in their way? What makes it difficult for a dentist to make a positive difference?”

- **Dentist 1, DMD, MBA**
  
  - **Demographics:**
    - 85% Hispanic
    - 10% Black, non-Hispanic
    - 5% White, non-Hispanic
  
  - **Practice Location:**
    - Bronx County, NY
    - Dentist 1 is aware of the dental culture and issues that dentists face who practice in New Jersey.
  
  - **Time Practicing:**
    - 13 years
Question Two:

Merrill: “As a dentist with a desire to help Hispanics, what have you seen dentists do to make a difference? In other words, what lies in the power of the dentist with regard to helping Hispanics receive improved oral health?”

Doctor: “You can go into different areas. You can provide education for the community… [Patients] understand that they have teeth that they need to be taking care of, but they don’t give that the importance of it. They’re shrinking the awareness of the importance of taking care of their teeth. Many people think that as long as I don’t lose my front teeth, that is okay…Education is very important, and the cheapest thing that a dentist can do for the community.”

Question Three:

Merrill: “Regarding dentists with a desire to help Hispanics, what barriers stand in their way? What makes it difficult for a dentist to make a positive difference? What are the main challenges?”

Doctor: “I think that the main challenge is the cost of dentistry. It doesn’t matter how much you want to give to the community. Giving back implies a cost. And sometimes we have to be very careful how much we’re going to give back. Because you can translate it into something that is really humanitarian, but also there are financial implications. If you’re going to the pharmacy… you know how much a toothbrush is going to be now days, right? It can be like 5 to 6 dollars. And that’s only a toothbrush. Imagine the equipment, the material, everything that we have to use in order to restore a tooth if that’s what you’re planning to do. If that’s the way that you want to give back to the community. I think cost is one of them.”
Also, the cost of dentistry makes it impossible for some patients to go to the dentist often. And I think that the most important factor that is a challenge for people to access dental care is finances.

And the second one I think is education. The lack of education, the importance of oral care and the relationship with Hispanic diseases.”

- **Dentist 2, DMD, PA**

  - **Demographics:**
    - 85% White, non-Hispanic
    - 8% Hispanic
    - 5% Black, non-Hispanic
    - 2% Asian, non-Hispanic
  
  - **Practice Location:**
    - Alachua County, FL
  
  - **Time Practicing:**
    - 27 years

I was unable to record the phone call with Dentist 2 so I do not have direct quotations from the phone call. However, during the call I took careful notes and will carefully explain the ideas he expressed.

**Question Two:**

In response to question two, he said that if a dentist has a desire to help others, they need money. It’s plain and simple; it all comes down to money. Dental students should know the tuition costs for the dental schools they’re applying to, they should think about living expenses and they should think about all other expenses that will set them back during dental school.
Students who don’t have the support of wealthy parents will struggle with heavy debt. For those who want to practice in underprivileged areas and serve the community in that way, they need to be prepared to make a much smaller income than they may otherwise be able to make. It’s common to have $400,000 in debt out of dental school. When you leave dental school with that much debt, do you now buy a practice that will cost you an additional $250,000? What about a house? You can quickly find yourself a quarter million dollars in debt, and in a situation like that, can you possibly serve the underprivileged? In a situation like that, you will need to first sort out your personal finances. What helping the community ultimately comes down to is money.

Perhaps one thing that could help students leave dental school with less debt is if there was some program where you serve and give back to the community for “x” years and then your debt will get wiped free. Dr. Matilsky commented that he was making $40,000 a year when he finished dental school.

*Question Three:*

In addition to what was said in response to question two, Dentist two commented that it may be difficult for dentists to begin serving the community immediately out of dental school due to a lack of work experience. He commented, however, that dentists who are fresh out of dental school certainly *can* make a difference in their communities and that a large part of what they should focus on is learning to take out teeth, because that will be one of the most useful skills in helping the underserved community.

- **Dentist 3, DDS**
  - **Demographics:**
    - 95% White, non-Hispanic
- Less than 4% Hispanic
- 0.5% Black, non-Hispanic
- 0.5% Asian, non-Hispanic

- **Practice Location:**
  - LaSalle County, IL

- **Time Practicing:**
  - 21 years

**Question Two:**

Merrill: “For dentists who have a desire to help Hispanics achieve better oral health…talking about Hispanics who can’t afford normal services, have you seen dentists reach out in certain ways to help those Hispanics?”

Doctor: “Well, I can speak for our office. In Chicago, it might be different where there is a complete Latino population. We don’t make a difference. We have free dental days sometimes. But we don’t have free Hispanic dental days; we just have free dental days. People have the concept in their minds that if they do not have dental insurance, they have no access to dentistry. And because…Hispanic people and poor people don’t have insurance, they…say ‘I have no access’ (even though they can have access) so they don’t go and they don’t bother. And it’s also in their culture, whether you’re White, Hispanic, black or yellow, if you’re family says ‘my mom had dentures, and I know I’m going to get them someday,’ you don’t have a culture of oral hygiene. So it tends to be primarily because many Hispanic people and Black people fall into that lower socio-economic scale…If you’re poor and you don’t have insurance, you don’t take care of your mouth and you therefore don’t have good teeth. I think it’s more of your place economically than it is your place racially, in my opinion.”
I’ll get the occasional guy who doesn’t have insurance who comes in and gets a tooth ripped out every once in a while, but that’s not a Hispanic only thing. That’s White, black, Filipino, Asian, whatever. I don’t see much of a racial component there.”

*Question Three:*

Doctor: “Access and poverty is one thing, but not just poverty, just not having insurance. So maybe you’re not in poverty but you don’t have insurance so your thought is, ‘I can’t go because I can’t afford it’, which is a misconception largely.

So here’s the challenge: who in America right now…doesn’t know about brushing and flossing? There isn’t anybody. Everybody knows about it. Whether you care about it I think is the bigger issue. Some people just don’t care. It’s just not part of their value. They’ll say things like, ‘Oh, my parents never took me as a kid, so I didn’t think it was important. And the truth of it is, it’s extra effort. You have to be a little more organized, a little more on the ball; you have to make it a priority, it has to be a value. And if it’s not, it’s not. So you can tell someone about brushing and flossing for 10 hours a day, but if they don’t care and don’t want to, they’re not doing it. Not going to happen.”
Question Two:

Doctor: “As a dentist, I don’t think a dentist has a big enough reach to help those patients. But I think the government is doing a lot to help their kids. There’s a health insurance program…where the state covers a lot of their dental problems and costs and issues. And so I feel like the states are reaching out and trying to help those patients.”

Merrill: “So you feel like the dentist doesn’t really have much power or control to really make a difference in helping patients who don’t have health insurance, but that the government can do a lot.”

Doctor: “Well, yeah. I’m a big believer in the free market. The government didn’t really help me go to school or do much for me. I give away a lot of dental work. When my patients
come in, I’ll help them out. I help out a lot of patients from my church. I just kind of work for free. But no, I don’t feel like the individual dentist’s responsibility is to go out there and offer services to them. Because there are a lot of programs out there where the government covers a lot of that stuff. And that’s actually pretty lucrative for some people that are taking advantage of it.”

Question Three:

Doctor: “A big thing is the debt and reimbursement rate. People are coming out of dental school with four to five hundred thousand dollars in debt nowadays. So when you’re coming out with that much, even though you have desires to do well and treat people good, the bottom line is you have to pay off that debt, so there’s no room for compassionate service in there. It’s kind of a sad irony that you go into this field to help people and just the cost of your education prohibits it. I’m at the point, we’ve actually been very lucky, we’ve actually paid off all our student loans, so now, at this point, I don’t have to worry about money nearly as much. I have a very successful office, so I am able to give away quite a bit of dental work. I probably give away $3,000-$4,000 of dental work a month to people that just can’t pay for it…So for most people there is debt. And by being in debt, they can’t start their own dental offices; they have to go join the big corporate dental chains to pay off debt. And once you’re in that model, the majority of them don’t make nearly as much as you can in private practice. So I think it’s the cost of education that is prohibiting a lot of good will in dentistry.”
Dentist 5, DMD

Demographics:
- 50% Hispanic
- 50% Other, non-Hispanic

Practice Location:
- Bernalillo County, NM

Time Practicing:
- 34 years

Question Two:
Merrill: “Is there anything a dentist can do to help lower class people who struggle financially to get good dental care...or is the dentist powerless in that area?”

Doctor: “Well it depends on your setting. What kind of clinical setting you’re in. If you’re in a public health setting, certainly that’s going to motivate people to get some work done. If you’re in a private practice setting, of course you have your own overhead to consider, so you’re kind of limited in what you can do in reaching out to someone in that regard.”

Merrill: “So do you feel like those dentist in private practices generally have more difficulty in serving or helping lower class individuals?”

Doctor: “No, I don’t think so. I think it just comes down to bringing people in the door, taking care of them. Most dentists I think do some pro bono work of some sort. Up to a point. You can’t give it all away, but you try to help people out where you can, and you try to do your best with that.”
Merrill: “So if I understand correctly, a dentist can serve and help where he can, but ultimately there isn’t much to be done for those who are of low financial status and can’t afford dental care?”

Doctor: “Well not in a private practice setting. Like I said, in a public health setting you can do more. But in a private practice…you’re limited. And that has nothing to do with who the patient is (Hispanic or non-Hispanic), those are just the realities of business.”

**Question Three:**

Merrill: “What makes it difficult for a dentist, whether in private practice or a public health setting to make a positive difference in the lives of those of low economic status?”

Doctor: “It’s mainly a question of educating people on what the benefits are, in getting the care that they need. That’s the biggest challenge. There are some situations where it has never been emphasized in the family. There are just certain social things like that that have never been emphasized.”

- **Dentist 6, DDS**
  - **Demographics:**
    - 70% Hispanic
    - 20% White, non-Hispanic
    - 5% Black, non-Hispanic
    - 5% Asian, non-Hispanic
  - **Practice Location:**
    - San Diego County, CA
  - **Time Practicing:**
    - 28 years
**Question Two:**

Merrill: “What lies in the power of the dentist with regard to helping Hispanics receive better oral health?”

Doctor: “I think understanding the cultural differences. What the families are like, what they do at home, how much they eat, how they eat, what kind of foods they eat, and the cultural differences. For example in Mexico, they eat a lot of acidic candy: very, very highly acidic, spicy candies. They dissolve the enamel and they produce more cavities. There are cultural differences that non-Hispanics wouldn’t know. But by knowing, you could reach out the patient and target those cultural differences and better understand them. And also the language barriers are very important; to be able to speak Spanish and communicate with the patients.”

**Question Three:**

Merrill: “What do you feel like makes it difficult for the dentist to make a positive difference in the lives of Hispanics? What challenges stand in the way of a dentist who wants to help out and improve that situation?”

Doctor: “The language barrier is probably it. That’s the major issue out there. If you can’t communicate with the patient, how are they going to understand? Latinos are much more open to whatever the dentist says. They see a dentist almost…not like a God, but like a leader. They’ll completely trust you. They just think that you understand the profession and they just trust you straight up. Honestly, whatever you say, you will hear, ‘yes doctor, yes doctor, yes doctor’. You’re never going to hear, ‘Why are you doing that? And why are you doing this?’ And you do see that a lot in non-Latino cultures.

There is a lot of questioning going on and there’s not so much trust. But [Latinos] would like to understand. They just feel a lot more comfortable…when you have somebody who really
understands their culture. They’re going to cooperate more. They’re going to be more friendly.

Even if a non-Spanish speaking doctor tries to learn a little bit of the language, even that is
enough for the patient to really trust you more. They’ll trust you a lot more if you try to
understand them better. They are very trusting but they might be a little bit more afraid internally
unless they know they’re being understood. They’ll trust you in terms of the treatment that you
have laid out for them but they may still feel fear inside if they don’t have a connection.

Latinos are not very good on following up on their general health issues. They’re not
good at going to the physician and making sure their blood pressure is good and their sugar
levels are controlled. And all this effects dental treatment. I see that a lot. Especially the men,
they don’t take care of their general health. So that’s…where my Latinos might me lagging,
because since they’re not following their medical health as much. They may seem to have more
problems with their mouths. But also the socio-economic level because as the socio-economic
level improves, it gets better.

Another thing is that diabetes, they don’t control very well. I take their blood pressure.
Just this last week, I had several, all male, patients who were Latinos. It had to be Latinos! I
know they don’t follow their health. So I take their blood pressure over and over and say,
‘You’ve got to keep going to your physician!’ We know that the mouth is connected to the
body.”

- **Dentist 7, DDS**

- **Demographics:**
  - 85% Hispanic
  - 10% Vietnamese, non-Hispanic
  - 4% Other (White/Black, non-Hispanic)
- 1% Immigrants (Somalia, Afghanistan)
  - Practice Location:
    - San Diego County, CA
  - Time Practicing:
    - 5 years

Question Two:

Merrill: “For dentists like yourself who do want to make a difference in Hispanic’s lives, what lies in the power of the dentist to help Hispanics achieve better oral health?”

Doctor: “Education. Constant education…Talk to the parents and teach them. Even nutrition—I see a lot of baby bottle caries. They don’t know that if they give them the baby bottle at night with milk, it’s going to give them cavities. They don’t know. They don’t understand…I think we’re going to have to target the younger generation now instead of trying to solve old habits for 50-year-old people. Instead trying to target the teachers and the parents so they can teach the kids. I think just education.”

Merrill: “So how does one achieve educating families or the younger generation?”

Doctor: “The lower your economic status, the less educated you’ll be and the poorer your oral health will be. You have…Mexican educated people and their teeth look great. So I think we may be targeting Hispanics in the lower middle class…Just going to the Hispanic neighborhoods and doing events or workshops. Instead of [dentists] being so productive and saying to their patients, ‘Ok, so this is your exam and you have 10 cavities and you have Perio.’ Okay, good, but explain to them why they have Perio. What can you do to change it from moderate to slight? Or what can you do to maintain the bone? Or what can you do to educate them in carbohydrate and sugar intake; brushing, flossing and all those things. Sometimes we use words during their
checkups that they don’t understand and they don’t know what’s going on. Teach the staff, the assistants.”

Question Three:

Merrill: “What are the challenges that stand in the way of dentists like you who want to help Hispanics; what are the challenges that stand in their way?”

Doctor: “It could...be the patient’s commitment. The patient has to commit. If the patient is not receiving the information just because they’re reluctant to learn or they’re lazy or they have other priorities, maybe we’re putting our expectations too high. Maybe some dentists just don’t want to; lack of motivation from the patient and the dentist. Maybe we need more funds.”

Merrill: “Is that a challenge, not having enough funds to help Hispanics?”

Doctor: “I don’t see that we don’t have funds. If I don’t see improvement in a patient’s gingivitis or gum disease, it’s because of the patient because we have all the tools for them to succeed, but if the patient is not compliant, then there is nothing that we can do.”
Dentist 8, DMD

Demographics:
- 70% Hispanic
- 25% Black, non-Hispanic
- 3% White, non-Hispanic
- 2% Middle Eastern/others

Practice City:
- New York City, NY

Time Practicing:
- 19 years

Question Two:
Merrill: “You have obviously had extensive experience with helping Hispanics achieve better oral health. So what are the ways in which you’ve seen [dentists] able to make a difference?”

Doctor: “I have to tell you that it’s challenging. Part of it is the financial aspect of it. Providing dental care is expensive and with the current reimbursements, it gets difficult. It depends if people have insurance…I don’t have a lot of exposure to that. A Hispanic dentist who has a private practice is going to have different input and different answers. I don’t have a public health degree. I am a general dentist…My barriers are different than a private practitioner may have…It gets hard to provide good services when you don’t have enough reimbursement to cover your expenses…So that’s a barrier.”
I think the power of the dentist is to do a little more homework. But it’s hard because we’re busy. People have to make money. So I don’t know. Dentistry is changing; it’s evolving. We have to do more research. We have to do more thinking out of the box.”

*Question Three:*

Doctor: “You cannot change their health literacy. We try to educate them, but if you cannot change the way they live, it is going to be hard for them to follow the recommendations that you’ve given them.”

- **Dentist 9, DDS**
  - **Demographics:**
    - 80% Hispanic
    - 15% White, non-Hispanic
    - 5% Other, non-Hispanic
  - **Practice Location:**
    - Yuma County, AZ
  - **Time Practicing:**
    - 19 years
    - (1 year in Phoenix, AZ; 18 years in Yuma County, AZ)

*Question Two:*

Merrill: “Have you noticed any dentists who have tried to reach out to those who can’t afford dental care or who don’t have as much access to that? Or in other words, have you seen dentists who try to make a difference in helping Hispanics achieve better oral health?”

Doctor: “Yeah, they have what they call a ‘Mission of Mercy’ where a lot of dentists get together on a specific day and provide free health care for anyone who comes. They’re not going
to get everything done that day, but they can get something done. And they do a lot of stuff. I’ve never gone to it. I know some dentists who have…That’s one thing that happens in [Yuma County]. They go to a big huge place in Phoenix and…volunteer their time. It’s just for one day though.

There’s Medicaid. We call it access care. AHCCCS. It stands for Arizona Health Care Cost Containment System. It’s just a Medicaid program, a government program. If people qualify because of their income then they get pretty good services for their kids until they’re 21. And there are some services for adults too. So I feel like most people that qualify for that, if they take advantage of it, then there’s pretty good care.”

Merrill: “So is the way that works is if they are under a certain income level, that the government will pay you, for example, as a dentist to give them healthcare?”

Doctor: “Right.”

Merrill: “And the government will pay full price, whatever you charge for the services for them?”

Doctor: “No. They pay a contract fee. So they give you a list of what they’ll pay for all the different procedures, and you say, ‘yes, I want to do that,’ or ‘no, I don’t.’ If you sign up for it, then you accept the patients at lower fees. But if you see enough of the patients, then you can make a living just doing those kids. So there have been group practices that have come to town, and all they want to do are these access kids, so they really go out and advertise heavily to try to bring them in as fast as they can and the dental care, in my opinion, isn’t always the best quality. They’re trying to help the Hispanics, but they’re making money. It’s not like they’re after Hispanics. They’re after people that have access to Medicaid.”

Merrill: “Are there any other ideas that come to mind?”
Doctor: “I know there are sealant programs where people go into the schools and perform dental sealants which help prevent problems and there are prevention things going on where people go and educate different school classes and stuff like that. But as far as actually doing the dentistry, not that I know of.”

Question Three:

Merrill: “What makes it difficult for you as a dentist to make a change in the healthcare world for Hispanics?”

Doctor: “Well, the big barrier is the economic [factor]. Who is going to pay for the care? The language can be a barrier. I do speak Spanish, which helps a lot. A lot of time the parents don’t speak English. But I deal with a fair number of adults too that are Hispanic. I feel like it’s just kind of an awareness type of an issue, where they don’t really realize their teeth are rotting, or what is really available out there. I think if they knew that access was available for their teeth, or the Medicaid…then they might be more likely to seek the care. I think it’s just apathy.

And then there are the obvious problems that people are just terrified of coming to the dentist anyways. No matter what economic level they have. It crosses all genders and races and everything. People are afraid of the pain, the unknown and what the price is going to be.”
○ Dentist 10, DDS

○ Demographics:
  - 70% Hispanic
  - 25% White, non-Hispanic
  - 5% Black, non-Hispanic

○ Practice Location:
  - Adams County, CO

○ Time Practicing:
  - 10 years

Question Two:

Merrill: “So talking about the ways in which dentists can help Hispanics, in what ways have you seen dentists be able to help Hispanics achieve better oral health as a general population?”

Doctor: “I couldn’t speak for all dentists, but I know we’ve really strived in our office to make it bi-lingual friendly. Whether it be answering the phones or having assistants that can translate. And also just having enough fluency, because that’s a huge barrier…the language barrier and being able to communicate and know what their needs are and also to be able to explain to them why we want to do X, Y and Z on their treatment plan. So we’ve tried to knock down that barrier.

We also have a discount plan in our office that is for cash patients that aren’t insured. It saves them thirty to forty percent. And we always offer that to every patient, regardless of their race.
We’ve also done some health fairs in Colorado. Nine News has a health fair and they really try to cater to the Hispanic population and they always have things printed in both languages, and that’s pretty common I think now. So that’s one thing. But sure, there are more ways that we could improve on that. It’s just hard to know all what to do.”

Merrill: “So you mentioned the discount plan. How exactly does that discount plan work in your practice?”

Doctor: “So any patient can sign up for it, even if they have insurance. And with a one-time fee, they become a member for one year with that one-time fee, or they can do an automatic debit out of their account for eleven dollars a month and then they’re on the plan. And it basically has its own fee schedule with discounted prices. So instead of a crown being $650 or $700, a crown is $510. So across the board, you just get a discounted fee. So it’s not really insurance, it’s just a discounted plan.”

*Question Three:*

Merrill: “Regarding those dentists who have desires to help Hispanics in the U.S., what makes it difficult for a dentist to make a positive difference with Hispanics and their oral health?”

Doctor: “I think it’s mostly having that population know that you accept them and that you want them as patients. So it’s going to come down to marketing, how you market your practice. And if you’re marketing on Spanish radio…or even Spanish TV channels, I think you’re going to be able to reach those populations better. Because a lot of times I think they just don’t know where to go, and I think a lot of our success in that regard has come from word of mouth just because we see so many patients that speak Spanish. And if we do a good job (and we always strive, of course, to do a good job) then they’re going to talk to their friends. But they’re a
family centered community in general. So you treat one person nicely, and sometimes you end up seeing all of their cousins and aunts and uncles, which is great. But I just think more outreach. I think so much of it is just communication. And that’s the biggest barrier. Just letting them know that…there is no judgment about their dental history.”

- Dentist 11, DDS
  - Demographics:
    - 90% Hispanic
    - 10% White, non-Hispanic
  - Practice Location:
    - Cook County, IL
  - Time Practicing:
    - 7 years
    - (1 year in Colombia, 6 years in Chicago)

**Question Two:**

Merrill: “So for dentists who want to help Hispanics, what can be done to help Hispanics? What lies in the power of the dentist to improve their oral health as a Hispanic population?”

Doctor: “So we do a lot of outreach. Well…not a lot. We could do more. Mostly we do prevention and promotions which means we go to health fairs to give oral hygiene instructions and to do free cleanings and to take care of the patient’s mouths and let them know if there is anything that is really bad and would make them need to go to the dentist. We also provide fluoride to children at these health fairs. It’s very limited what we’ve done. There is a clinic where I go with the students that gives free dental services. And I’m not so sure if all of the
patients that go there are Hispanic, but from what I remember, every single patient I’ve seen there is Hispanic, so I just go there as a volunteer to supervise the students. And we work close together with the student chapters so we do outreach. Most of these outreach chapters, we do with the students because they want to get involved and they want to have experience. It’s hard to get dentists to go to these outreach programs because everyone’s so busy; they have to be at work, they have to take time off to go and volunteer. There are a few dentists who will do these outreach things, but there are very few that I know.”

Question Three:

Merrill: “What makes it difficult for a dentist to help Hispanics? What is it that causes the dentists to not go to those clinics and help?”

Doctor: “I think it’s time restrictions. When one is busy at work, it’s hard for someone to take time off to go volunteer. They have families and all that, so mostly time restrictions I would say.”

- Dentist 12, DDS
  - Demographics:
    - Vast majority Hispanics
  - Practice Location:
    - Maryland & Las Vegas, NV
  - Time Practicing:
    - 8 years in Maryland, 3 years in Las Vegas, NV

Question Two:

Merrill: “What lies in the power of the dentist to be able to help Hispanics?”
Doctor: “…There is a program (the Hispanic population is very prevalent here in Las Vegas), so we visit High Schools and middle schools and we educate them and we educate the parents. Also we visit Hispanic community centers over the weekend. We have oral cancer screenings for adults. So all the public health programs help a lot. When I was living in Maryland, the public health department was very rich, so they had eight or nine clinics just for the Hispanic population and we weren’t charging them anything. We had a clinic for children and for pregnant women. Mostly Hispanics. Nevada is a poorer state. I don’t think this state has the capacity for that.”

Merrill: “So is it just the money from the state that allows these programs to exist?”

Doctor: “For public health, yes. So also the dental schools, they can have grants for programs like this too. Every Tuesday, I had sixteen dental students from the third year. It was good practice for them too. All these kids have a lot of cavities so they were having a good experience and the students were giving a good service.

Also you can have mobile vans. In New York, they have mobile vans and they go to different neighborhoods and provide services.”

Merrill: “So are those clinics completely free to those Hispanic patients?”

Doctor: “Most of the time they’re free or they’re paying on a very, very low scale. Like twenty dollars per visit or five dollars per visit. You can go to the schools. You can also establish services through churches. You can do oral campaigns. [You can work on publicizing or educating] through the radio.”

*Question Three:*

Merrill: “What makes it difficult for someone like you, or any dentist, to make a positive difference?”
Doctor: “I think the main barrier is speaking Spanish. Most of the patients that come to the school…are Hispanics. Most of my students are working on Hispanic patients. And the patients tend to want a student that speaks Spanish. And luckily, we have a lot of them because a good portion of our students are Mormons from Utah and they have gone to their service in Latin-American countries and they speak perfect Spanish. So I think the language barrier might be one of the most important factors.”

Merrill: “Any other thoughts come to mind as far as things that make it difficult? Any other barriers that stand in their way besides the language?”

Doctor: “Yeah, the economic status. Some of these people have very low incomes and sometimes they can’t afford to go to the dentist or they don’t have dental insurance.”
IV. Results & Discussion

A. Question One:

“As a part of the oral healthcare world, do you sense that there is a general understanding amongst oral healthcare professionals that Hispanic oral health is worse than the general U.S. population”?

Despite misunderstandings related to question one, each response was unique and provided valuable insights into how the dentists think about the oral health of Hispanics in the U.S. Each dentist, regardless of how well they understood the basis of question one, commented (to some degree) on whether they personally feel that Hispanic oral health is worse than the rest of the U.S. population. Below we will make observations and conclusions by comparing each dentist’s response to this matter with the demographics of their patient base. For the sake of collecting organized data, the following two categories (“not worse” and “worse”) will be vast simplifications of each dentist’s response. However, for more detail on each doctor’s full answer, see the above conversations. (Next to each doctor’s name is the percentage of his or her patients who are Hispanic).

- Doctors who believed that Hispanic oral health is not worse than the rest of the U.S. population:
  - Dentist 2, DMD, PA (8%)
  - Dentist 3, DDS (4%)
  - Dentist 4, DMD (15%)
  - Dentist 5, DMD (50%)
  - Dentist 6, DDS (70%)
  - Dentist 7, DDS (85%)
- Dentist 8, DMD (70%)
- Dentist 9, DDS (80%)

- **Doctors who believed that Hispanic oral health is worse than the rest of the U.S. population:**
  - Dentist 1, DMD, MBA (85%)
  - Dentist 10, DDS (70%)
  - Dentist 11, DDS (90%)
  - Dentist 12, DDS (“vast majority”)

### Percentage of Dentists that thought Hispanic Oral Health is Worse/Not Worse than the Rest of the U.S. Population

<table>
<thead>
<tr>
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<th>Percentage of Dentists</th>
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<tbody>
<tr>
<td>Worse (33%)</td>
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<tr>
<td>Not Worse (66%)</td>
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![Figure 1](image)

Out of the eight dentists who were in the “not worse” category, four of them have patient bases of 50% Hispanic or lower and four of them have patient bases of 70% or higher. Having essentially four dentists below and four above the 50% line entirely splits this category in half statistically. In other words, half of the dentists in the “not worse” category had relatively small Hispanic patient bases while half of the dentists had relatively large Hispanic patient bases. From this data, we may reasonably conclude that this viewpoint (the belief that Hispanic oral health is not worse than the rest of the U.S. population) may be shared quite evenly amongst both dentists who treat very few Hispanics and those who treat many Hispanics.
Given the statistics cited in the “preliminary findings” section of my thesis, I personally believe that to some extent, Hispanic oral health (as a general demographic) is indeed worse than the rest of the U.S. population. I understand that the meaning of that declaration is slightly unclear (as mentioned previously), however the statistics cannot be refuted. That being said, it is somewhat disconcerting to me that a majority (66%) of the dentists thought otherwise. If I am correct in declaring that Hispanic oral health is worse than the rest of the U.S. population, then given this majority statistic, there is a clear lack of education amongst dentists on these important matters.

Conversely, of the four dentists in the “worse” category, all four of them had patient bases of more than 70% Hispanics. Given this significant finding, it is reasonable to infer that the vast majority of dentists in the “worse” category will see mostly Hispanic patients (in the case of this thesis, 100% of the dentists). One can then infer that the average dentist may be inclined to believe that the racial demographic constituting a majority of their patient base has “worse” oral health than their other patient demographics. For example, a dentist whose patient base consists of 80% White, non-Hispanic Americans may be more inclined to believe that White, non-Hispanic Americans have worse oral health than the rest of the U.S. population, even if that is not in reality the case. This hypothesis calls for additional testing and research, and if confirmed on a larger scale would be a significant finding to reveal the negative impacts that one’s daily experiences have on altering one’s perception of reality.

Additionally, this finding shows that dentists who do not put forth effort to educate themselves on matters of race and oral health (that reach outside the realm of what they see on a daily basis) may have views or beliefs that are inaccurate or outdated. If shared amongst thousands of dentists across the U.S., this lack of knowledge about struggling demographics
could prevent significant action from being taken to improve the problems. On the other hand, if more dentists throughout the U.S. consistently educated themselves on matters of struggling demographics, more action would be taken to help those in need and the rates of improvement would be accelerated.

B. Question Two:

“For dentists who have a desire to help Hispanics achieve better oral health, what have you seen them do, or in what ways have you seen them make a difference? In other words, what lies in the power of the dentist with regard to helping Hispanics receive improved oral health”?

Below is a list of summarized, general phrases that were given in response to question two. For the more detailed responses, see the full conversations listed above in the thesis.

Following the responses below is a numerical graph of the data.

- **Dentist 1:**
  - Educating patients is a cheap way to make a difference.

- **Dentist 2:**
  - Dentists cannot make a meaningful difference without money.

- **Dentist 3:**
  - Free dental days in the community where dentists donate dental work.

- **Dentist 4:**
  - Dentists generally don’t have a big enough reach to make a significant difference.
  - Government-run health insurance programs.
  - Pro bono work in the dental office.

- **Dentist 5:**
  - Pro bono work in the dental office.
○ **Dentist 6:**
  - Dentists can make an effort to understand cultural differences.
  - Learning the patient’s language.

○ **Dentist 7:**
  - Educating patients, staff and assistants. Specifically, dentists can go to Hispanic neighborhoods to do events or workshops for the community.

○ **Dentist 9:**
  - Free dental days in the community where dentists donate dental work.
  - Medicaid helps patients.
  - Educate children in schools about oral health.

○ **Dentist 10:**
  - Dentists can:
    - Make their offices bi-lingual.
    - Offer discount plans to patients.
    - Participate in health fairs to educate the community.
    - Make sure all paper materials in their office are printed in each language spoken by their patient base.

○ **Dentist 11:**
  - Outreach fairs to serve and educate the community (give free cleanings).
  - Donate fluoride/other materials to those in need.
  - Dentists can donate time to clinics that offer free dental services to community.

○ **Dentist 12:**
  - Visit high schools and middle schools to educate parents.
○ Visit Hispanic community centers to educate community.

○ Offer free oral screenings for adults.

○ Public health programs can offer free services.

○ Publicize and educate through the radio.

○ Establish free dental services through churches.

○ Mobile vans are used to provide services in the community.

Figure 2

C. Question Three:

“Regarding dentists with a desire to help Hispanics achieve better oral health, what barriers stand in their way? What makes it difficult for a dentist to make a positive difference”?

Below is a list of the mentioned items given in response to question three. The responses listed below are general phrases summarizing detailed responses. For more detail, see the full
conversations listed earlier in the thesis. Following the responses below is a numerical graph of the data.

- **Dentist 1:**
  - Financial burden on dentist.
  - Patient inability to pay for services.
  - Lack of patient understanding of good oral health.

- **Dentist 2:**
  - Financial burden on dentist.
  - Lack of dentist work experience.

- **Dentist 3:**
  - Patient inability to pay for services.
  - Patient lack of insurance.
  - Difficulty of educating patients so that they change their behavior for good.

- **Dentist 4:**
  - Financial burden on dentist.

- **Dentist 5:**
  - Difficulty of educating patients so that they change their behavior for good.

- **Dentist 6:**
  - Language barrier.
  - Difficulty of educating patients so that they change their behavior for good (helping them break unhealthy cultural habits).

- **Dentist 7:**
  - Lack of patient commitment to thoroughly follow through with treatment plans.
- Lack of commitment in dentists to educate their patients thoroughly.

- **Dentist 8:**
  - Financial burden on dentists.
  - Helping Hispanics break unhealthy cultural habits.
  - Patient’s lack of insurance.

- **Dentist 9:**
  - Financial burden on dentists.
  - Lack of education amongst Hispanics.
  - Apathy in patients.
  - Fear of the dentist.

- **Dentist 10:**
  - Successful marketing to patient base to help them know that they are welcome and wanted by the dentist and his/her office.

- **Dentist 11:**
  - Donating time to serve can be a heavy sacrifice for many dentists.

- **Dentist 12:**
  - Language barrier.
  - Patient’s lack of insurance.
  - Patient’s inability to pay for services.
Figure 3

D. Findings from questions two and three:

Interestingly, the top two most mentioned results in both questions two and three are essentially identical. That is to say, regarding question two, the top two most mentioned responses for what a dentist can do to help Hispanics is to educate patients and donate free dental care. Curiously, regarding question three, the top two most mentioned responses about the difficulties dentists face in helping Hispanics are to educate patients and donate free dental care. This finding is significant and interesting because it reveals that two of the most significant
things dentists can do to make a positive impact may also be two of the most difficult things to do. Implications of this finding will be discussed in the “conclusions” section.
V. Strengths/Limitations of Research

A. Strengths of research:

As mentioned previously, I chose to take a non-selective approach in dentist selection meaning I essentially was willing to speak with any dentist that would talk to me as long as they had experience working with Hispanics and were currently practicing in one of the desired states. I really believe that in many ways, this approach was one of the strengths of my thesis. It allowed me to hear opinions and beliefs from dentists of different races and vastly different cultural backgrounds. This allowed me to analyze the ways in which cultural backgrounds and patient demographics shape a dentist’s view of the world of oral health.

Additionally, I think the casual manner by which the phone conversations were conducted allowed for organic conversations with real information that the dentists really believe to be true.

B. Limitations of research:

That being said, I do recognize a number of limitations to my research. Firstly, I recognize that data with fixed variables can often be very powerful in clearly showing trends and patterns. For example, I could have chosen instead to speak with ten Hispanic dentists who treat 90% Hispanic patients or higher, or I could have chosen to speak with ten White, non-Hispanic dentists whose patient bases consist of less than 5% Hispanics. I recognize that conducting this type of data collection may have been more organized and neat as I analyzed patterns and trends.

Additionally, perhaps the most significant limitation of my research was the small number of dentists I spoke with. In total, I spoke with twelve dentists. I recognize that twelve participants in a research study is a small amount.
Lastly, if I had the chance to conduct the research calls over again, I would make sure to use identical wording when asking my three questions. That is something I didn’t do, and if I would have, my data and collected responses perhaps could have been more telling and interesting as I compared them with one another. Instead, I treated each phone call as more of a casual conversation and made sure to ask each dentist the general questions, but I often used slightly different wording while talking with each dentist depending on the direction of the conversation.

Given that this was one of the first significant research studies of my college career, I was unaware at the time I was conducting the phone calls that it would have been useful to use identical wording with each dentist. And although I lacked significant experience in the field of academic research when I began my thesis, I have learned a great deal about what researchers should and shouldn’t do to conduct a successful research study and achieve meaningful results.
VI. Conclusion

To summarize, two main findings resulted from analyzing my research phone calls:

1. As discussed with regard to question one, it can be inferred that the average dentist may be inclined to believe that the racial demographic constituting a majority of their patient base has “worse” oral health than their other patient demographics, when, in reality, that may not be true.

2. As discussed with regard to questions two and three, the data shows that perhaps the most meaningful and significant steps that dentists can take to help Hispanics achieve better oral health may also be the most difficult and taxing things to do on the dentist.

So how does one make sense of these findings? Why does this matter, and where do we go from here? With regard to conclusion number one, may this be a wake-up call to all U.S. dentists to recognize the importance of staying educated on the current challenges and statistics in the world of oral health. The fact that there was such a broad and varied range of opinions regarding responses to question one shows that most dentists are not on the “same page” in their understandings of this important topic. If the majority of dentists in the U.S. accurately understood the current state and condition of Hispanic oral health, there would not have been such a split in the opinions of those who commented on the matter. Regardless of who is right, it shows that perhaps as much as a majority of U.S. dentists lack significant understanding on matters of oral health and the demographics that are most struggling.

Perhaps dental schools could focus their curriculum more on the need for dentists to stay educated throughout their careers on matters of culture and oral health. For example, regulations could be implemented that would require dentists to participate in regular courses or seminars on the current issues of oral health throughout the United States. Whatever the channel by which increased awareness is brought about, struggling demographics would greatly benefit if more dentists were made aware of their challenges.
Additionally, given the small sample size of my research study, I would propose to those who have the means to do so, to conduct a study similar in nature to question one, but on a larger scale. That is, to ask a larger number of dentists about their perceptions of the current state of oral health of different demographics in the U.S., comparing their responses with the demographics of their patients. If my analysis of the responses to question one were confirmed on a larger scale, this would reveal that the demographics of one’s patient base greatly influence or alter one’s perceptions of reality. This finding would add to the urgency of implementing mandatory continuing education for dentists so that they stay knowledgeable with accurate, current information about struggling demographics and thereby have a greater likelihood of improving said challenges.

Regarding the findings from questions two and three, a call for a larger-scale research study also would solidify the validity of the claim that the most impactful steps that dentists can take to help Hispanics achieve better oral health are also the most difficult and taxing steps for the dentist.

If this finding were confirmed on a larger scale, it would prove that the majority of dentists believe that making a difference in the community is very challenging. Given the vast importance of helping underserved populations, serving the community should not be so painstakingly difficult. Looking at the two most frequent responses as discussed above, educating patients, as one of the top ways to help Hispanics, was also reported to be one of the most difficult things to do successfully. Perhaps further research on how to successfully educate underprovided communities would reveal new tactics on how to make positive changes that dentists could implement without excessive difficulty.
Additionally, donating free dental care was the most frequently mentioned way to make a positive impact on underserved communities but was also the second most mentioned item in the list of difficult things for a dentist to do to make a difference. This reveals the sobering reality that dentistry is very expensive, due to the cost of school and running a practice. It is the unfortunate reality that until one has resolved their own financial debt, it is often difficult to serve others through financially taxing methods like donating free dental care on a regular basis.

Perhaps if dentists generally had fewer expenses, they would serve the community more fully. Student loan debt was frequently mentioned in the research calls as one of the main factors that made it difficult to donate dental care. It was mentioned repeatedly that giving free dental care to others when one had hundreds of thousands of dollars of debt to his or her name is unrealistic and unwise. This topic may be of great importance for further research and study. Is the cost of dental school so high that it is inhibiting graduates from helping the community? If the expenses dental school students and practicing dentists face were lowered, would that really cause an increase in service to the underserved communities? Additionally, are there ways in which dentists can donate free care to the community without significant personal financial loss? These types of questions would be valuable to explore.

Lastly, as suggested by one of the dentists during the research calls, it would perhaps be of great use to both dentists and the underserved communities if there were programs implemented that allowed dentists to serve the underprivileged communities in return for an elimination or reduction of student loan debt. For example, a dentist could agree to give X amount of hours of community dental service a week for 4 years and the government would pay their student loan debt entirely. This idea is similar in nature to dentists who serve in the military, but instead of serving soldiers, dentists would be serving underprivileged civilians in their
communities. This is a call to those in positions of influence regarding these matters to explore further options of serving the community in return for diminishing student loan debt.

The vast world of Hispanic oral health is a complicated network of challenges and problems. And like most things in life, there will never be a shortage of problems and there will always be room for improvement in the sphere of helping those in need. This thesis has identified a number of areas of weakness that deserve special attention from healthcare professionals and all who may be able to create lasting change.

To those interested in the scope of this thesis, I hope that instead of causing a feeling of the significant distance that lies ahead of us, it will create a motivation to act and a desire to make small, meaningful changes within each of our individual spheres of influence. If this thesis were to only influence one dentist or one government official to make even a small change within their community, it will have been well worth the effort. Instead of looking for grand, large changes to make, I invite all reading this to consider a few small and simple adjustments that could make a lasting impact for good.

For dentists around the U.S., perhaps one small change could be an adjustment in the way they educate their patients. Another could be an increased commitment to do a little more outside research on issues of oral health each week. And another could be a strengthened resolve to donate a little more time to serving their community each month.

Lasting change in the world most often does not often result from the large efforts of one, but from the small efforts of many. May we strive always to help those in need and to do all we can within our spheres of influence to lift those who cannot stand on their own.
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