NEOLIBERAL CARIES AND MORAL DECAY: ORAL HEALTH INEQUALITIES ALONG THE TEXAS/MEXICO BORDER

by

Caleb N. Miller, BA BS

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Committee Members:

Emily K. Brunson

Neill Hadder

Ana Juárez

Monica Schoch-Spana

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TABLE OF CONTENTS

Page

I. INTRODUCTION

Oral health is an important aspect of life. The overall health of an individual is, to some extent, dependent upon their oral health, since the oral cavity acts as a gateway into the body. Thus, poor oral health can have a direct, and even life threatening, effect on the overall health of the individual. Further, the appearance of teeth and a person's smile has a significant impact on how others perceive them. However, even though oral health is vitally important to both the physical and social health of the individual, its importance is often ignored. I chose to research oral health because I find it to be an important window into the workings of the United States medical system. Additionally, I find it fascinating how the ideologies that perpetuate our beliefs concerning oral health and oral health care are often disparate from the reality.

In order to conduct this research I lived out of the camper shell covering the bed of my pickup truck in a south Texas RV park. My sleeping arrangements were comfortable, and their uniqueness also allowed me to get to know my neighbors at the RV park (since everyone was either leery or curious about me). I was able to get to know a few of my neighbors quite well. My closest neighbor was Tom, an elderly white male who lived alone. Tom was pleased to have what he termed "a hobo" living behind his trailer. He was interested in my studies in cultural anthropology and my work at the Texas/Mexico border. This encouraged him to discuss his youth, which he spent traveling across Africa, where he and his friends were captured, robbed, and released by soldiers, and he was forced to trachea punch a man attempting to rob him at knifepoint. Further, my research focus caught him by surprise. Tom had just recently overcome what he believed was to be his death: a series of strokes that resulted from rotten teeth.

Tom's doctors were unable to determine why he was having strokes, and his condition did not improve after the surgical removal of part of an artery in Tom's neck. Luckily, one of Tom's friends suggested that his health condition may be resulting from a rotten tooth. Tom visited a dentist and had two of his molars removed, and his condition improved significantly. When I met Tom, he was still experiencing a new dawn after accepting and overcoming death.

Unfortunately, Tom's medical and dental bills were extensive, stranding him in south Texas longer than he had intended. Because Tom still had dental work he needed to complete, he asked me what I thought about the dentists in Mexico. I explained to him that they were significantly less expensive, and that everyone I had spoken with felt that they were just as good as dentists in the US. Tom seriously considered visiting Mexico in order to complete the dental work he still needed. The only thing that was keeping him in the United States was his lack of a passport, and fears concerning the difficulties of reentering the US.

The cost benefits of visiting dentists in Mexico are frequently utilized by retired US citizens, such as Tom. However, this is not the only population that finds respite from the US dental system in the dental chairs of Mexican border towns. It is also common for Texas citizens of all ages who live, or grew up, along the border to utilize the services provided by Mexican dental practitioners. Furthermore, open minded Texas residents of diverse backgrounds who live throughout the state also often find themselves in a position in which their best option is to forgo as visit to a local dentist, and instead journey south to Mexico.

Oral health is a vital aspect of our overall health, but unfortunately it is often out of reach for a significant number of United States citizens. Additionally, oral health has become an unquestioned symbol of both beauty and status in the United States, resulting in further stress, hardship, and stigmatization for those without the means to reach the acceptable standards of a smile. As dental costs have continued to rise, many US citizens have found alleviation from these repercussions in Mexican dental clinics along the border. My research is positioned at an important place and time in the progression of the United States medical system. By focusing on oral health and the use of Mexican dental care this research is able to offer a unique perspective that can help further illuminate some of the ideologies and systemic structures surrounding health care in the US.

Though previous research has touched on the use of Mexican dental care by United States citizens, its focus was primarily on retired Winter Texans who travel to the border seasonally. For my research, I have excluded this population, and focused on non-retired US citizens who utilize Mexican dental care. Additionally, there has been little anthropological research on oral health that uses qualitative methodology, or examines the ideologies that surround oral health.

The goal of my research is to help shed light the on prevalence of oral health inequalities in the United States, and offer some suggestions to help address this issue. For this reason I have chosen to write my thesis in an article format rather than a traditional thesis format. In this way, my research is more accessible and can be published in academic journals. I plan to apply my research by condensing my findings and publishing them as an op-ed in order to help add to and facilitate the discourse on oral health at the public level. These two components are found in the following two

chapters. Chapter two is composed of my research and results that I intend to publish in an academic journal, and chapter three is the op-ed that I intend to publish in a newspaper or magazine intended for a general audience. Through these two formats, my findings can help provide a resource for the general public and future scholarly research.

II. NEOLIBERAL CARIES AND MORAL DECAY: ORAL HEALTH INEQUALITIES ALONG THE TEXAS/MEXICO BORDER

INTRODUCTION

It was a hot Saturday afternoon in June, and I was the only one seated in the waiting room of a dental clinic in Nuevo Progreso, Mexico. The front of the clinic was glass, and I could clearly see the busy sidewalk outside. Street vendors and tourists moved by the window, but the noise of the street was hardly audible in the waiting room; the most prominent sound came from a soccer game playing on a TV mounted in the corner. As I gazed out the front entrance, shielded from the heat and the chaos of the sidewalk, Lucy, a white female in her thirties, entered the clinic, accompanied by a white male in his early fifties.

Lucy lurched over to the front desk, signed her name on a clipboard, and then plopped down in a chair next to me. As she did this, her exaggerated movements embellished the discomfort of walking in the heat outside, and the comfort of sitting in an air-conditioned room. I informed her about my research, and, with slurred speech, she immediately began telling me about her experiences with this dentist.

> *I come here all the time. I used to live in East Texas. Everyone is poor there. So unless you are getting a filling or a cleaning, you can't afford to go to the dentists there. I know about fifteen or sixteen people who go to the dentist here. We all used to rent a van together so we could split the gas, and then all drive down here and visit the dentist. We would all schedule our appointments on the same day, get everything done, and then go back. This dentist is the best. I don't want to go to another dentist in the U.S. ever again.*

As she speaks to me, Lucy opens up an orange prescription bottle filled to the lid with painkillers. She takes out a couple and swallows them with coconut water.

> *Do you want to come in the back with me and see them take out my teeth? It's crazy. After you see it, you won't want to stay back there any longer because it's*

gross…See, they've replaced all of these (She smiles so I can see her teeth and points at the teeth in the top row). They had to pull all eight of them. In the US it would have cost me over $35,000 to get all this work done, here it's only cost me $8,000, no, maybe $10,000. I'm not sure because I haven't had it all done at the same time. See they replaced all of these. (Lucy opens her mouth again and points to all of her visible teeth in the top and bottom rows.)

The door to the back of the clinic opened and a female dentist dressed in light blue scrubs called Lucy to the back. Lucy asked the dentist if I could accompany her, and see all of the work she has had done. The dentist agreed. Lucy was led to a dental chair, and I positioned myself in front of her. As Lucy spoke to me the dentist grabbed a pair of sharp, circular tweezers and clamped them on her bottom teeth. Lucy winced in pain, but she continued talking: "I love this town. Did you know it's still owned by the cartel but the mayor pays them off? That's why it's so safe here."

Lucy winced again as the dentist wiggled her bottom row of teeth back and forth with the tweezers. I watched as her bottom teeth came loose and were lifted from her gums. Underneath these teeth was a row of yellow, plaque covered metal anchors, along with what looked like bits and pieces of her previous set of teeth. Lucy smiled up at me with drool running down her chin. Her top row of teeth were white, clean, fake, and waiting to be removed; her bottom row of teeth rested on a stainless steel tray next to her. Looking up at me, she said: "See, it's crazy right? From here on, I can't talk anymore, and you don't want to see them take off the top row anyway, it's even worse. I'll have drool and blood running down my face." I thanked her, said goodbye, and returned to the waiting room. As I sat down and began taking notes, an announcer on the TV shouted "Gooooooooaaaaaaaaaallllllllllll!"

Oral health is an important aspect of life in the United States, and can be a source of great distress. However, sufficient dental treatment is not equally available to everyone. This inequality is multifaceted and can result from disparities in income, health benefits, and access to dental professionals. To address this unequal access to care, some US citizens seek dental care outside of the country, including along the Texas/Mexico border. The example described above demonstrates a typical experience of seeking oral health care in Nuevo Progreso, Mexico. Lucy was able to receive a level of dental care that was not affordable to her in the US. Even so, she held the belief that it was her decision not to visit a dentist in the US. In this paper, I examine this phenomenon. Particularly, I examine how oral health inequalities in the US and the resulting experience of traveling to Mexico for dental care are driven and informed by structural and ideological pressures that motivate, push, and pull US citizens to seek dental care in Mexico.

BACKGROUND

Commodification and Medical Tourism

The commodification of health care in the United States has been discussed extensively (Rylko-Bauer and Farmer 2002, Pellegrino 1999, Strathmann and Hay 2008). Dental care, however, has a unique place in this discussion. The term 'commodification' implies that health care underwent a process to become a commodity. Conversely, dental care has always been understood by dental professionals as a commodity purchased with discretionary funds (Strudevant 1995:4). The market based nature of dental care is so fundamental that, in one of the most prevalent training text books, dentists are taught that "financial situation can indicate a patient's *commitment* to dental care" (Sturdevant

1995:179, emphasis mine). Furthermore, some dental professionals have expressed that, though they do have an ethical obligation to relieve pain, anything more is "a luxury for those who cannot afford it" (Dharamsi, et al. 2007:1588). For many, the only way to afford this luxury in the United States is through dental insurance. This creates a system in which many who are suffering from oral health problems forgo visiting the dentist, either because they do not have insurance or because they cannot afford the costs of dental care (CDC 2012:3). Additionally, these individuals will continue to be priced out of dental care, because "there is little incentive for cost cutting when providers are free to set their own fees and when those who receive medical services are not directly billed" (Joralemon 1999:83).

For some United States citizens faced with the daunting cost of health and dental care, traveling to other countries for high quality, less expensive treatment is their best option (Crooks 2010:5, Buzinde 2012, Sobo et. al 2011:119). In recent years, medical tourism has become a worldwide billion dollar industry (Bookman and Bookman 2007, Connell 2006, India: Medical Tourism 2007, Hopkins et. al 2010, Smith 2012). For example, it is common for US citizens living in the southern United States to cross the Mexican border in search of cheaper dental care, sometimes labeled dental tourism (Dalstrom 2012, Su 2011).

Previous research has touched on the use of dental clinics in Nuevo Progreso, Mexico by US citizens (Dalstrom 2011), providing a description of the "two types of patients" who travel to Mexico for dental care:

> The first type has always sought care there, and thus it is an extension of a preexisting association with Mexican medicine. The other type of patient is one who has no previous experience with Mexican dental care. Sometimes these differences are articulated as a 'cultural' vs. 'economic' choice where the cultural

> background of the Hispanic population drives them to go to Mexico while the cost-saving benefits drive the Anglo (Dalstrom 2011:189).

This dichotomy is descriptive of those who have historically utilized Mexican dental care, but it does not explore the modern struggles and barriers that may be faced by these populations when navigating the US dental system for medical treatment. This perspective does not address the experiences of Lucy and others like her: those who are suffering or in dire need of oral health care but face barriers that have been completely priced them out of US dental care.

Embodiment and Access to Dental Care

Structural barriers that limit access to adequate care are inherent in the United States dental system. Though dental caries and other oral health problems are a common experience in the US, individuals who fall below the poverty line are more likely to suffer from oral health diseases and have fewer opportunities to receive professional treatment (CDC 2000:63). Thus, Lucy and fifteen of her friends carpooled to Mexico instead of visiting a local dentist. This is because dental care is costly in the US. Depending on where a person lives and what dentist they visit, dental fillings cost $100-$300, tooth extractions cost $100-$200 per tooth, and crowns cost $700-$1200 (Average Cost for Dental Procedures 2015). While dental insurance will cover some of these costs, this does not help the 108 million people in the US who are without this type of insurance (Health Resources and Services Administration 2015).

In the United States, health insurance is closely linked with employment benefits (Sered and Fernandopulle 2005:25). For many individuals to have adequate access to health care, they must work for an employer that provides proper health insurance coverage. Because the health care of employees is deeply entangled in the overall profits

of companies, affordable health insurance is often still out of reach for many employed US citizens. Walmart, for example, pays 40% less on health costs for its employees than the national average. This helps the company sell products for less than its competitors at the expense of employee health benefits. The health coverage Walmart does offer is also inadequate, with monthly premiums costing over 20% of the income of its employees. Because of this high cost of health coverage, only 40% of Walmart's eligible employees sign up (Sered and Fernandopulle 2005:25).

Even when individuals have health benefits from their employers, dental care is often not covered. This is because employers are not required to offer dental benefits to their employees. This often results in higher-paying jobs having more health benefits provided by employers, such as dental coverage, than lower paying jobs (Sered and Fernandopulle 2005:196). When uninsured Americans are asked what their first priority would be if they could afford health care, they often reply: "my teeth" (Sered and Fernandopulle 2005:166).

The appearance of teeth is both a window into various health factors—including tooth decay and metabolic diseases (Khalid and Quiñonez 2015:784)—and a way to embody social class in the United States (Sered and Fernandopulle 2005:168-169, Lee 2014:228). Furthermore, embodied inequalities expressed by oral health in adulthood have been shown to be determined by the individual's socioeconomic status at age five (Thomson 2004:351, Wilson 1920:50). Consequently, the employment opportunities and resources available to adults are directly reliant upon the resources of their childhood household (Sered and Fernandopulle 2005:179, Thomson 2012:31). This is because employers are significantly less likely to hire individuals with unsightly teeth (Sered

2014). Not only does family background of an individual determine oral health status, which in turn determines resources and employment opportunities, family background has also been shown to be the primary determinant of occupational status at all levels of employment (Jencks et al. 1979:214-217).

The belief in social mobility is at the core of United States ideologies surrounding the "American Dream" and helps individuals of the lower class endure inequalities by providing them hope, if not for themselves, then for their children (Kerbo 2006: 391). Unfortunately, the chances for upward mobility of the lower classes in the US are below average when compared to other industrialized nations (2006:391). The "embodied inequality" of unsightly oral health has become a physical representation of the barriers in the US that prevent upward mobility for the lower classes. In this way, oral health operates as "a means of maintaining class boundaries" (Kerbo 2006:401). Those with adequate resources can achieve an upward mobile smile, while lower class individuals who suffer from unsightly oral health are structurally contained, trapped in a negative feedback loop in which the barrier keeping them from adequate employment is a need to visit the dentist and the barrier keeping them from the dentist is the need for adequate employment (Grenfell 2012:101). This process results from, and is informed by, prevalent ideologies in the US concerning oral health.

Ideology and the United States

Ideology permeates all aspects of life in the United States, acting as "reassuring fables" that establish, defend, and protect patterns of belief that surround social structures (Canguillhem 1988:29, Geertz 1973:231). These patterns constitute an imaginary relationship with the everyday reality experienced by the individuals of a culture, and

must be unpacked and deciphered in order to discover the reality that is being alluded to (Althusser 1970:44). When unpacking oral health care in the US, there are a few ideologies that stand out as the defenders of the system. First, ideologies of progress, superiority, and cleanliness operate through oral health as a way to protect and solidify social class in the US. These ideologies engender the image of the US as superior to other countries, just as upper class Americans are superior to the lower classes. Perhaps most importantly, understanding how "the cultural trope of individual responsibility" (Waquant 2009:213) that drives, defends, and reproduces the prevalent system of neoliberal economics is key to understanding the seeming lack of importance placed on oral health in the US. These ideologies of responsibility effectively create the image of the ideal, self-sufficient American, and fuel the legitimacy and morals of competition and the free market. These ideologies have become so successful that "it is easier for us to imagine the end of all life on earth than a modest change in our economic order" (Zizek 2012). Finally, all of these ideologies have served a vital role in the establishment of biomedicine as the only viable health care option in the US, including oral health.

Progress, Superiority, and Cleanliness

Ideologies of progress, superiority, cleanliness, and being 'American' have long permeated life in the United States (Ortner 1973:1340, Hoy 1995:87). These beliefs are internalized for many US citizens, and are used to provide a source reference as they strive to "move ahead in the system" (Hall 1976:65). These ideologies were solidified in the late 19th and early 20th centuries by the cultural evolutionary theories of Herbert Spencer, Lewis Henry Morgan, and Edward Burnett Tylor (Lock 2010:19, Kerbo 2006:261). And unfortunately, their theoretical concepts of 'survival of the fittest' and

'savage to civilization' still echo in nationalist ideologies today (Canguilhem 1988:37, Kerbo 2006:261-263, Versen 2009:420).

In the early 20th century, Henry Ford instilled these ideas in his immigrant factory workers (Hoy 1995:137); a Ford Motor Company pamphlet informed them, in reference to describing the 'ideal' US citizen, "Notice that the most advanced people are the cleanest" (Meyer 1980:71). This association between cleanliness and superiority is still widely prevalent today. Classifications such as 'dirty' or 'unhygienic' are a way to label people as lower, less civilized, and thus, un-American. Stating that a group of people is unclean or dirty is also a way to say that they are less educated and lazy (Holmes 2013:137). These ideologies work both on an individual level (e.g. how individuals are judged based on poor oral health (Sered and Fernandopulle 2005:168)), and on a national level (e.g. U.S. stereotypes about the country of Mexico, and Mexican citizens (Lugo 2008:58, Holmes 2013:163)). All of these criticisms are deeply entangled with ideologies of progress. To progress from savage to civilized is to progress from dirty to clean, from immigrant to American.

Ideologies of cleanliness and superiority help create the framework for how oral health is perceived in the United States. Mary Douglas has shown that rituals of cleanliness are entrenched meanings that extend far beyond rationality and physical health. Douglas explained that "dirt offends against order" (Douglas 1966:2) and "that rituals of purity and impurity create unity in experience" (1966:3). Ideologies of cleanliness in the United States position US citizens to be in continuous conflict with contamination, dirt, and microorganisms. We wash our hands, brush our teeth, clean our bodies, and disinfect our homes. The stinging scent of chemicals indicates a sterilized

environment. Warfare metaphors decorate our language and signify a battle against invading microorganisms (Joralemon 1999:6). Our disinfectants, our technologies, our medications, and our healthcare professionals are our weapons against the dirt and infection hiding on every surface. The forefront of science also leads the charge in sterilization and purity. The controlled environment of particle accelerators and surgical theaters establish our visible peaks of what is pure, as do the unnaturally white teeth of the celebrities at our pinnacles of beauty and ideation (Khalid and Quiñonez 2015:784, Blumhagen 1979:114).

Rituals concerning oral health are not only important for the overall health of an individual, but are also deeply entangled in ideologies of purity, hygiene, individual responsibility, and morality (Kunzle 1989:29). These rituals of hygiene extend beyond the rationality of health and can only be fully understood by examining how they operate ideologically. As Horace Miner noted sixty years ago in his satirical article, *Body Ritual Among the Nacirema* :

> Were it not for the rituals of the mouth, they believe that their teeth would fall out, their gums bleed, their jaws shrink their friends desert them, and their lovers reject them. They also believe that a strong relationship exists between oral and moral characteristics (1956: 504).

The chemicals that whiten our teeth, the mechanical sounds of our electric toothbrushes, and the smell of a dental drill on enamel, provide the evidence of the beliefs and values surrounding oral health. These rituals guide United States citizens as we race after blurred visions of purity and progress. Bleach and lasers can increase tooth sensitivity (ADA 2016), but also bring us one shade closer to a culturally promoted image of success. The artificial whiteness of the culturally desired smile demonstrates that the purpose of these rituals is not primarily about physical health. When a white

smile indicates health, attractiveness, and success, it does not seem like it should be acceptable to artificially skip to the finish line. Fortunately, ideology does not rely on logic and reason, but instead on illusion (Canguilhem 1988:31). We ascribe to the illusion that a healthy smile is always earned through disciplined hygiene rituals and a healthy lifestyle, and strategically forget that a healthy smile also significantly depends on resources and access to adequate dental care. The unfortunate result is that those who cannot afford to visit the dentist not only suffer from the pain of toothache, but are also blamed for their unsightly teeth.

Neoliberal Ideologies

Neoliberal ideologies of oral health place the locus of responsibility on the individual by establishing the "frontline defense in disease prevention" as a healthy lifestyle, daily hygiene routines, and periodic visits to a dental professional (Oral Health in America 2000:189, Clarke et. al 2003:162, Sinha and Gibbs 2004:200). The hegemonic nature of this attitude is illuminated by the published perspective of the 2010 Surgeon General. Here, issues of oral health disparities were framed as the result of "the majority of Americans" taking their oral health for granted, and the solution to this "silent epidemic" lies in educational programs (Surgeon General's Perspective 2010:158-159). Thus, poor oral health is seen—at least from the Surgeon General's perspective—as resulting from the behavior of individuals, and structural factors, like access to dental professionals, are consequently ignored (Sobo and Loustaunau 1997:34).

Not surprisingly, approaches that place responsibility on individuals rather than address social and structural problems, have failed to reduce oral health disparities in the US (Lee and Divaris 2014:229, Watt 2007:4). Furthermore, they ignore the

overwhelming amount of scientific evidence indicating that health is primarily correlated with economic, political, and social factors (Navarro 2011:118-119). In oral health, the repercussions of this 'collective bad faith' (Holmes 2013:87) are visually documented in the smiles of the disadvantaged.

Ideology and Biomedicine

In the United States, science has come to be perceived as the ultimate source of knowledge and truth (Sobo and Loustaunau 1997:107). Consequently, the empirical nature of scientific findings, and their supposed validity and objectivity, give the perception that medical data, and biomedicine, exist within nature and outside of cultural influence (Rhodes 1996:168). Moreover, biomedicine has taken credit for the improved life expectancy and lower mortality rates in Western societies that occurred in the early 20th century (Gaines and Davis-Floyd 2004:103). As a result, biomedicine has become the dominant medical system in the US (Singer and Baer 1992:79).

Significantly, even though biomedicine has gained cultural authority by claiming credit for this general improvement of health outcomes, much of this improvement is arguably the result of the overall rise in standard of living (e.g. cleaner water, sewage treatment, etc.) (Mckeown 1976:78). However, the association between biomedicine and improved health outcomes, whether fully deserved or not, has helped engender widespread ideologies in the United States that the most advanced biomedicine is the optimal standard of dental care, and the most advanced biomedical technology provides the best health outcomes (Gaines and Davis Floyd 176).

Ideologies surrounding biomedicine in the United States are hegemonic and mirror many of the ideologies and beliefs associated with 'the American way' (Sobo and

Loustaunau 1997:120, Singer and Baer 1992:79). At the core of these ideologies are ideas and feelings that include free enterprise, hard work, competition, national superiority and the seemingly unquestioned goal of progress (Ortner 1973:1340, Lock 2010:17). Biomedicine's 'manifest destiny' presents itself as a continuous search for cures and the expansion of technological capabilities. And even though the direction of biomedical progress may still be towards "a condition of general happiness" (Bury 1987:5), because of its inherent relationship with capitalism, it is also guided by political interest (Lock 2010:17), as well as the bottom line (Rylko-Bauer and Farmer 2002:479). Unfortunately, this obscures the most prevalent sources of suffering, disease, illness and oral health disparities: socioeconomic status, poverty, and access to adequate resources (Rhodes 1996:166-167). Further, these areas of "societal decay" (Nations 2002:229) are also overshadowed by motives of profit inherent in US biomedicine.

All of these ideologies and the social and economic structures they support and protect are part of a dialectic that directs the experience of oral health care in the United States. Further, this dialectic is the driving force that influences the decision to travel to Mexico for dental care and provides the framework for how US citizens experience Mexico's health care system. In this paper, I examine the experience of non-retired United States citizens traveling to Mexico for dental care. Focus is placed on the motivating factors contributing to the decision to utilize dental care in Mexico, with particular consideration directed towards the structural pressures in the US pushing these individuals towards Mexico, and the ideological barriers that they must overcome.

METHODS

I conducted research in Nuevo Progreso, Mexico, a small town located across the south Texas border between Brownsville and McAllen, Texas. Just across the bridge separating Mexico from the United States is Nuevo Progreso's main street, home to around 113 dental clinics. When US citizens first step over the international bridge into Nuevo Progreso, they are immediately offered dental care and pharmaceuticals by street salesmen, or voluntarios (Dalstrom 2011), attempting to draw them off the street into one of the many dental clinics. This is why Lucy's stash of painkillers was not worth a second glance while in the dental clinic waiting room. Alongside the voluntarios, the sidewalks are crowded with street vendors, all focused on selling their wares to everyone who passes buy. Surprisingly, the police presence in Nuevo Progreso is scarce. Although the rare military convoy Toyota Tundras with mounted machine guns, overloaded with heavily armed military personnel, can be seen to pass by the dental clinics.

I used a mixed methods approach to study the experiences of United States citizens using Mexico dental care; my methods included: interviews, participant observation, direct observation, and surveys. To collect data I spent time in Nuevo Progreso, observing dental clinics and speaking with the US patients who use them. I also conducted participant observations in dental clinics in Mexico, including undergoing dental consultations from five different dental clinics. Surveys were administered in person to dental clinics located around the Texas/Mexico border.

Interviews provided the primary source of information for this research. All interviews were audio recorded and transcribed. I recruited dental patients directly from waiting rooms of Nuevo Progreso dental clinics and through flyers that were handed out

in Nuevo Progreso, and posted both around the Rio Grande Valley in Texas and the Texas State University campus in San Marcos, Texas. Topics discussed in the interviews included the push and pull factors drawing these individuals to Mexico for dental care, including their current state of employment and health benefits; how they would describe their experiences with the dental care they received; how they chose the Mexican dentist the visited; how their experiences in Mexico compared with similar experiences in the United States; and what they believed were the prevailing beliefs in the US concerning Mexican dental care. Ultimately, 21 US citizens between the ages of 18 and 60 who traveled to Mexico for dental care participated in an interview. Of the participants, 11 visited dentists in Nuevo Progreso, 5 in Matamoros, 3 in Reynosa, and 2 in Nuevo Laredo (for demographic details on these individuals, see Figure 1).

All data collected from interviews was analyzed using content analysis. Direct observation and participant observation field notes were used to provide further context to the emergent themes. Further, field notes taken concerning conversations with dental professionals in both the United States and Mexico, and waiting room patients in Nuevo Progreso, was used to provide additional context to the analysis. After completing data collection I created and finalized a master code list, and analyzed emergent themes.

Surveys were completed by 9 dental clinics in Nuevo Progreso, and 21 dental clinics in south Texas along the stretch of highway connecting Brownsville, Texas to McAllen, Texas. These surveys gathered data on the dental clinics including: the number of patients treated, patient demographics, pricing, and years of operation. This information provided contextual data into the similarities and differences between the dental clinics on both sides of the border. The survey data was also used to understand

how the average number of dental patients seen by south Texas dental clinics compares to the national average. Finally, open ended questions were used to understand how dental clinics in the United States perceive Mexican dental care, as well as the effect the recent violence along the Texas/Mexico border has affected patient demographics

RESULTS

Cultural Perception of Mexico and Mexican Dentists in the United States

"That maybe it's because Mexico being Mexico and all the stereotypes that they have on Mexicans." -Juan (23 year old Hispanic/Mexican American college student)

The experiences associated with visiting a dentist in Mexico were found to be predominately positive. However, there are still barriers associated with the perceived danger of visiting a dentist in Mexico that must be overcome before United States citizens are seated in a dental chair in Nuevo Progreso. These dangers manifest from ideologies of inferiority and fear concerning Mexico, the border, and immigration. Many of these US ideologies have exacerbated beliefs concerning immigration (Hoy 1995:87) and engender perceptions of recent Mexican immigrants as poor, lazy, dirty, uneducated and often dangerous. These negative perceptions of Mexican immigrants are also transferred to Mexico as a whole. Furthermore, the US/Mexico border has been transformed from a place of excess, sin, and cheap commodities (Arreola and Curtis 1993:78-79) into a place of drug trafficking and significant danger (Mercille 2011, Tuckman 2010). Currently, this danger is a barrier, forcing even those with familial ties in Mexico to be wary and plan their trips with great care. All of this is concisely summed

up when US citizens are asked about the perception of Mexico in the US, and their response is simply, “It’s Mexico.”

This common statement has effectively compacted ideologies of United States superiority over Mexico (Arreola and Curtis 1993:93), and all of the negative perceptions and stereotypes associated with Mexico. Just by saying “because it’s Mexico,” US citizens are able to express all of the negativity commonly associated with Mexico that is perpetuated by US culture and the media. ‘Mexico’ has now become a derogatory word to describe Mexico; it expresses the stigma (Goffman 1963:5) associated with Mexico in the United States: the prevalent feelings of danger, violence, crime, poverty, uncleanliness, and all around inferiority.

These perceptions and stereotypes are transferred to, and must be overcome by, the dental clinics in Mexico that cater to patients from the United States. These patients understand this negative perception of Mexican dentists, yet for them it is not a powerful enough deterrent to keep them away and overshadow the benefits of Mexican dental care. When asked how she feels the rest of the United States might perceive dentists in Mexico, Victoria, a Columbia born naturopath physician, explained, “I think that they feel like it’s kind of dirty. They maybe believe that they’re not professional. That they don’t have a degree.” Previous research conducted on Nuevo Progreso dental care also demonstrates the engrained nature of these ideologies of progress and superiority used to compare the US and Mexico through the use of language that associates the US with modern and, in effect, Mexico as primitive (Dalstrom 2011:224-225).

All of these beliefs towards Mexican dentists are taken into consideration when US patients visit a dentist in Mexico for the first time. This was expressed by Loretta, a

31 year old, black woman, from Houston, who works as a funeral director: “I was skeptical because I didn't know if they knew exactly what they were doing. Again, I didn't know if they cleaned the utensils properly, if my mouth would get infected or if I would get some kind of cold or something. I was skeptical. “

Apart from the geographic distance and the recent surge in violence along the Texas/Mexico border, lack of knowledge concerning the education and skill of dentists in Mexico creates the largest barrier preventing US citizens from utilizing dental care in Mexico. Due to the significant health risks that are present in many dental procedures, it is often difficult for individuals to overcome the barrier resulting from the stigma associated with Mexico and visit a Mexican dentist for the first time. This process was explained by Leroy, a 35 year old ,white, male, bus driver from Corpus Christie who brings tourists to Nuevo Progreso. Leroy had a broken tooth he could not afford to fix in the United States and suffered from tooth ache for almost a year before getting it treated in Mexico. Leroy explained: “I was fairly hesitant. I avoided it for quite a while, probably a year. People kept telling me [to go to Mexico], so I finally decided to bite the bullet and do it. I was not disappointed; at all. I wish I had done it sooner.” Leroy went on to elaborate on his hesitance with visiting a dentist in Mexico: “You can’t walk twenty feet without seeing a dentist. Actually, I had been here with the tooth I had the pain with, I had been down here with that tooth, with that same problem twice before I actually did anything about it. And I wish I had taken care of it earlier.” Finally, Leroy discussed his general feelings towards Mexico: “I still think it’s dirty [Mexico]. I just don’t think the dentists are that bad. Yeah, I’ve never really thought bad about Mexico though. It’s just kind of crumby. The border town is anyway.” When taking into consideration the

importance placed on rituals of cleanliness concerning oral health in the United States, Leroy's initial hesitance is understandable.

Access and Rebellion in the United States

"Because it's really expensive, and a lot of people do not have insurance to cover that. So if you don't make enough money, you end up with a broken pocket if you go and see a dentist in the United States."-Victoria (44 year old, naturopath physician)

The "neoliberal Leviathan" (Wacquant 2010:197) has a significant impact on whether individuals travel to Mexico for dental care. Everyone I spoke with at the border about my research gave me the same answer for why United States citizens use Mexican dentists: "because of the price." This is the main factor pushing US citizens to seek care from dental professionals in Mexico. Dental care in the US is too expensive for many to afford, creating a system where there is no real choice in oral health care in the US. Yet, the individual is still blamed and held responsible for poor oral health. Rylko-Bauer and Farmer explain that:

> A new model has emerged out of this privatized environment or 'managing the poor'—creating the illusion that the poor now have 'choices' and can be 'smart consumers'—thereby absolving the state and the health care industry (and other powerful actors) of responsibility for ensuring decent care (2002:491).

"Because of the price," grounds the individuals' decision to travel to Mexico for dental care in the consumerist discourse that surrounds health care in the United States (Strathman and Hay 2008:). Furthermore, when individuals provide this answer at the border, they do it in a way that frames it as such an obvious and simple answer, that to research it is a waste of time. Mexico is cheaper; end of story. In the survey data, dental clinics in south Texas countered this explanation by reframing the decision to utilize Mexican dental care into "You get what you pay for." This response is also firmly

situated in the same consumerist discourse**.** Unfortunately, these answers obscure, and make light of, the overwhelming systemic factors in the United States that lead many to "choose" a less expensive health care option.

However, not everyone perceives it as simply a financial decision. A young man in his late twenties explained while walking towards the international bridge to Mexico that he chose Mexican dental care because "the US system is so corrupt." Many who visit dentists in Mexico have this same distrust and animosity towards dentists in the United States. These feelings lead them to rebel against a system of more conveniently located dental providers, and instead seek dental care in Mexico. Some of these individuals also hold the belief that their decisions are significantly impacting the profits of dental clinics in the United States. As Loretta explained:

> It's way too expensive. I think they're losing a lot of money because a lot of people are coming here, and other clinics around Mexico, to get their teeth cleaned. The same work is done the exact same way. I feel like they're just way too expensive and their losing millions of dollars, probably billions, because people are coming here.

Or as Leroy, explained: "One of the things that—maybe this is my opinion—that having access to the dentist down here has kind of driven the price point down for the dentists in Corpus. They know that they are, in some ways, competing with the dentists here."

This perspective is also documented in the previous research conducted on dental care in Nuevo Progreso. The search quotes a McAllen dentist who explained that a program allowing the dental insurance provided to local school district employees to be accepted by Mexican dentists makes it "hard to compete with foreign dental offices" (Dalstrom 2011:226). Additionally, south Texas dentists "are forced to support this i*nequality* by paying the taxes that pay for the cross-border program" (2011:226,

emphasis mine). Finally, the McAllen dentist explains that because "people are going out of the system" for more affordable dental care in Mexico, he is "losing money and patients" (2011:227).

However, the survey data collected in south Texas indicates that these beliefs and claims are not true. The mean for the number of patients seen per week by these clinics was 114 patients, which far exceeds the national average of 67 patients seen per week by a general practitioner (ADA 2010). Furthermore, the increased violence along the border has resulted in an influx of patients to south Texas dental clinics, since many who would use Mexican dental care do not risk crossing the border. According to one surveyed dental clinic, this influx actually "aggravates the lack of access" to dental care in south Texas; a far cry from Loretta's beliefs and the claims of the McAllen dentists.

Even though those who visit Mexican dentists may feel like they are rebelling against the United States system, they are actually supporting it on a much grander scale. By visiting Mexican dentists, US citizens are unknowingly led by, and supporting, the neoliberal ideologies, philosophies, and practices that are implemented and promoted in poor countries, such as Mexico, by the United States. The free market of dental care in Nuevo Progreso, vocalized by voluntarios towards US citizens crossing into Mexico, exemplifies the hypocritical way the US promotes capitalism in poor countries. This is because even though the US promotes the value of the free market in other countries, this philosophy is not actually practiced on US soil (Kerbo 2006:563, Navarro 2007:50). For example, dentists in the United States are not competing with one another for patients, only the 'right' patients, while they all draw profit from the same well of insurance providers. Furthermore, their prices are not a reflection of free market competition like

those in Nuevo Progreso. For the survey, when asked to provide average treatment prices, south Texas dental clinics often resorted to complex, generalized charts. They then made sure to clarify that prices were highly dependent on each patient and they were only able to provide an average. Dental clinics in Nuevo Progreso simply wrote down their price.

Unfortunately, the rebellious attitude associated with visiting a Mexican dentist is just obscuring another example of the United States' appropriation of cheap resources from Mexico that could otherwise be used to serve the local Mexican population (Kerbo 2006:563, Smith 2012:5). Although US citizens who visit dentists in Mexico are unwilling actors in this global exhibition of power and influence, Mexico is their best available option for maintaining their health and wellbeing. While seated at a restaurant in Nuevo Progreso, Dean, a half white and half black 29 year old veteran of the War in Iraq, currently a student at UT Pan Am, explained:

> So I drive one hour, pay eight hundred dollars, but if I go across the border over there [Texas] it's five thousand dollars. So somebody on a budget like me, that's making life decisions: buying food, you know? I'd rather take the risk. Because at the end of the day that's another debt. That's if they don't find something else. You know, that's what I don't trust about them. I actually trust these people here [Mexico] more than I trust the McAllen dentists.

Distrust of United States Dentists

"I mean that was the main thing when I was in the dentist in the US You go in there and you feel like they're more worried about getting your money, than actually taking care of you." -Leroy (35 year old, white male, bus driver, from Corpus Christie)

One of the primary reasons for opting to travel to Mexico for dental care is distrust of dentists in the United States. This distrust results from the direct experiences patients have while navigating the US dental system. Dean, for example, needed to undergo dental work in order to meet the health requirements of joining the Peace Corp.

Dean found a dentist in McAllen, Texas who was part of the International College of Dentists, an organization that offers free dental consultations to Peace Corp applicants. However, his experience with this free consultation left him with feelings of distrust and anger. The free consultation resulted in a treatment plan that far exceeded what Dean was able to afford. Additionally, once the McAllen dental clinic realized that Dean was not insured and could not afford the treatment, he felt a shift in how they treated him.

> Ok, honestly, as soon as…they realized that I didn't have dental insurance, they were like in a hurry to get rid of me. They already assumed that I didn't have the five thousand dollars, which they were right, but you know, I could have it. You know? Bastards.

This experience led him to look for a dentist in Nuevo Progreso. There, Dean was able to find a dentist also associated with the International College of Dentists who provided him treatment that he could afford. Concerning his experiences with both dentists, Dean explained: "I trust him more [Mexico]; all day…When I was looking at the bill [US] there were some medical terms that I didn't understand and it's as if they just throw them in there. I don't know if they were even gonna charge me for the cup that I was spitting in." Dean went on to elaborate on his dissatisfaction with the United States dental system:

> Because by charging, by bringing up the price, by trying to suck everything out of the insurances, you make it unaffordable for people who don't have insurance. You know? They price it so high, expecting the insurance to go and pay for it that I believe that it is corrupt. You know? It's ridiculous. Sure I understand that they have to pay high premiums of insurance or whatever, but the fact that they can't answer to me what all I'm being charged for, how they came up to that five thousand dollars, to me, raises flags of corruption. You know, this is the person billing me, and you can't even tell me what you're billing me for. Here it's straight up. I know exactly what I'm getting billed for.

In the United States, patients often distrust the extent of the treatment recommended by their dentists. Juan, a 23 year old student at Texas State University

whose parents operate a dental clinic in Mexico, explained his feelings about his first visit to a dentist in the United States:

> But I did feel like he was recommending me stuff just for the sake of giving me service. And I wasn't gonna be charged because I was insured by the government. So probably wouldn't trust a hundred percent on their recommendations. And again their recommendations is not bad for you, but sometimes it's not necessary.

Patients who visited both dentists in the United States and Mexico often found a difference in professional opinions concerning treatment. These differences in opinion led Marty, an eighteen year old, Hispanic, college student who grew up in the Rio Grande Valley, to the belief that he was lied to by his south Texas dentist. This realization occurred after he traveled to Mexico to treat cavities diagnosed in the United States:

> So we went to a place in Edinburg, here in the States…I got a cleaning, and the dentist said that I had three cavities…He said, 'Just come back next week and we'll do all three cavities'…I was pretty content, like, 'I'll do the cavities; I'll do the cavities here.' And then my mom was like, "no we're not going to do them here; we're going to see if we can do them over there in Mexico because it's cheaper." And then we went to Mexico, the dentist there…said just one of them had [a cavity], and it was very minimal…He said that it's not enough to dig more into the tooth…He said there's really no need to do that and waste your teeth…He said to come back next summer…to see if it got worse or not…Instead of doing it now [because] it's not that bad.

A dental assistant from a dental clinic in Nuevo Progreso also described a similar situation:

> Another example is this woman who came in with her daughter. They didn't have insurance and they had already visited a dentist in America that told them that her daughter had six cavities that needed to be filled. Here we charge $50 dollars per filling so it was going to cost the woman $300 dollars. She brought her daughter in and we were only able to find two cavities. We were going around in circles trying to find the other four cavities but we couldn't find them. We kept saying, "Where are the other fillings they are talking about?" We finally realized that the other fillings were made up. Over in the United States they try to make money off of things that aren't there. We don't do that here. The woman came in with $300 to pay for her daughter's fillings, and left with $200.

Though differences in oral health philosophies and access to superior technologies can significantly influence the diagnosis of tooth decay, research participants felt strongly about how they were treated by their dentists in both the United States and Mexico. These findings suggest that it is common for US patients of Mexican dentists to believe that their previous dentists in the US cared more about money than the oral health of their patients. In contrast, patients tend to extend more trust towards Mexican dentists, because they feel dentists in Mexico care more about their patients than how much their patients are paying them.

Symbolic Violence and Cultural Capital

"The media and all that stuff, they have a lot of influence of having this perfection, like you know, this view on having the perfect teeth. It makes someone perfect, or it makes someone good, or the ideal. We have this thing of ideal. And how if you're not that specific ideal, then you're not good, or you're not considered perfect, or unique, or nice."

-Maria (22 year old, Hispanic, college student from Brownsville TX)

Finally, symbolic violence was found to be inherent in the ideologies surrounding oral health in the United States. Symbolic Violence is present when individuals believe they deserve their lowered position in the social hierarchy due to the arbitrary devaluing of a quality (Grenfell 2012:101). Though the variability of culturally acceptable teeth is wide ranging, there is a consensus to what indicates attractive teeth in the United States (straight, white appearance), and what indicates unattractive, or unhealthy teeth (severely discolored, rotten, missing, etc.).

The association between oral health and power is well established. As early as 14th century Europe the Italian scholar and poet, Francesco Petrarch, explained that the

loss of teeth results in the loss of power (Kunzle 1989:30). Later, this association was more famously echoed by Freud in *The Interpretation of Dreams* (1965:398). In the current United States, power, or cultural capital (Bourdieu 1986:3), associated with healthy, white teeth, creates social advantage and manifests in a social hierarchy (Horton and Barker 2010:215). And for unsightly oral health, the converse is thrice as true (Nguyen 2003:447). For example, in the US an ideal set of teeth has become a simulacrum associated with people who are rich, famous, and in the public eye (at the top). While an unhealthy set of teeth is associated with people who are destitute, unclean, immoral, and self-destructive (at the bottom). This hierarchy is internalized, and normalized, and often manifests in the types of jobs for which individuals qualify. Those with unhealthy, unattractive teeth understand this, and realize that they do not qualify for jobs that require many face to face interactions with customers or clients.

This is exemplified by Wendy, who is 60 years old, white, and the manager of an RV park in south Texas. Before becoming the manager of an RV park, Wendy was a hostess at a prominent restaurant in south Texas. Wendy slipped and broke her dentures on a counter top at work; so Wendy began saving her money for new dentures. Instead of waiting for Wendy to save enough money, the owners of the restaurant decided to help her and scheduled Wendy an appointment with their dentist in Matamoros, Mexico. The owners of the restaurant explained that they relied on Mexican dental care, because as private business owners, they did not have dental insurance and it was not affordable for them to visit US dentists. Wendy received a loan from her father and could afford dentures from Mexico; however she did not have a car. So, the owners of the restaurant

drove Wendy back and forth between the United States and Mexico and Wendy got a new set of dentures.

Sometimes even good deeds can expose the presence of symbolic violence. When asked why Wendy thought the owners of the restaurant were so adamant about helping her get a new pair of dentures, she said, "I feel like she [one of the owners] thought that the customers didn't think it was right that I didn't have teeth, or something like that. So, she made the decision to take me." The restaurant owners provided a different reason. They explained that they helped Wendy because her accident occurred at work, and they felt responsible. However, they also had strong opinions concerning the appearance of their employees' teeth:

> If I see people with a problem with their teeth—dirty, or snarly—I immediately think negative thoughts…And as an employer too, I look at that. And if they [potential employees] don't have a good appearance, I probably won't hire them, because my customers are going to think the same thing.

Wendy was lucky that her employers cared about her. Yet she also understood that by breaking her teeth, she no longer qualified for her job. Wendy understood this even though her employers never told her, or even openly acknowledged that this was part of the reason they went through so much trouble to help her. This is because, as Petrarch humorously noted over 600 years ago, the loss of teeth encourages the…solitary life" (Kunzle 1989:30).

The symbolic violence and cultural capital associated with oral health is further exemplified by Daniel, a 45 year old Hispanic man who grew up in the Rio Grande Valley. After getting his chipped front tooth fixed by a dentist in Nuevo Progreso, Daniel conveyed how happy he was to be able to smile again:

> Before I was always like this [clenches lips together] for like two weeks and wouldn't smile. I had my tongue on it, and I'm feeling it, and feeling it…I couldn't smile. I didn't want to smile. You know what I'm saying? You don't want to smile. Your like this [clenches lips]. 'What the hell is wrong with you?' 'I chipped my tooth.' But now I feel natural. I'm smiling.

By traveling to Mexico for dental care, both Wendy and Daniel were able to reacquire the cultural capital they had both lost by breaking their teeth. At least in Wendy's case, this acquisition of cultural capital would have been financially out of reach if she did not have access to a dentist in Mexico. She explained, "I can't afford to go and pay a thousand dollars for a denture, I just can't do it. It would take me probably six months to save up for it."

Daniel was obviously aware of the importance he placed on the appearance of his own teeth; but, he had never considered the social hierarchy surrounding the appearance of teeth. Daniel came to realize this hierarchy as he described the treatment of a co-worker, while responding to a question about the relationship between oral health and social status:

> He's missing his tooth. He's not missing it completely, it's like bits and pieces of it are still there, and it's all like black…and everyone makes fun of him…but it's like it's ok to make fun of him. You know what I'm saying? He gets no respect…Your smile is like the first impression. If you don't respect yourself, nobody is gonna take you seriously. Yeah, I know what you're saying, social status. Yeah man, people with fucked up teeth, they don't get much respect. They're seen as like lower status. I hadn't thought about that, but yeah. If you got good teeth, you know, yeah, I see it. Everybody wants status.

Neoliberal ideologies concerning individual responsibility were found to be present in the everyday language concerning oral health in the United States. It is a widely held belief in the US that oral health is the responsibility of the individual and poor oral health is indicative of failing at this task. As explained by Jorge, a Hispanic male from Harlingen, Texas: "I guess it would have to be something like first

impressions, and smiling is going to show your pearly whites, and that's automatically going to say, 'well, he never took care of himself,' or, 'he sort of takes care of himself.' And it will show that they had any dental work, obviously."

Interestingly, many of my informants expressed that, even though they interpreted poor oral health as an indicator of character, they also explained that they held these beliefs even though they knew it may not be fair to the person they were judging. Marty expressed this while discussing his feelings towards girls with bad teeth:

> I mean, when I look at like, I guess, girls. I don't want to talk to somebody that has—this is mean—but I don't want to talk to somebody…that doesn't have good teeth, or whatever. That just shows me that they didn't care enough to take care of them, but then again you never know what's going on behind like their financial stuff.

One of the restaurant owners, expressed similar feelings. After explaining the importance of smiling and first impressions, and the negative judgements that result from unsightly teeth, he said, "And that might be a very superficial judgement call on my part, but I'll own up to it. I do it. You know? I like people who have a pleasing appearance."

CONCLUSION

The pull of affordable dental care in Mexico offers United States citizens the so-called "choice" of traveling to Mexico for dental care. However, by doing so they are inadvertently reproducing the system of neoliberal economics that obstructs access to dental care in the United States. Furthermore, their supposed 'choice' is yet another example of US exploitation of the abundant, inexpensive resources and labor of Mexico, in order to mitigate strain on the US system. This way, issues of class and privilege are overshadowed by ingrained beliefs concerning responsibility and morality.

In order for us to affectively address issues of oral health inequality in the United States, we must address issues of class privilege inherent in the US medical system. An initial step towards addressing these problems is to change the way we, as a country, collectively think about oral health. If we can problematize poor oral health as the result of factors outside of the realm of individual responsibility, we can alter the current discourse. In this way we can help lower class individuals overcome some of the barriers preventing them, and their children, from upward mobility and economic success. However, if we find it too difficult to make this small alteration in our beliefs surrounding oral health, we should champion policies that allow less restricted access to adequate dental care. Our current system permits patients of Mexican dentists to return to the US with appropriate smiles which allow them the opportunity to be more productive US citizens. Even so, this new smile won't buy them access to dental care in the United States.

III. APPLIED COMPONENT

Op-ed for publication in newspaper or magazine:

"BECAUSE OF THE PRICE"

While conducting research on dental tourism in the small town of Nuevo Progresso, Mexico, everyone at the border gave me the same answer when I asked, "Why do US citizens use Mexican dentists?" Over and over again I heard, "because of the price." These people, and many others, have found dental care in the US is just too expensive to afford. Furthermore, the 108 million people in the US without dental insurance are not the only people without adequate dental care. Those who have insurance often find dental care too expensive and often still cost prohibitive. This leaves many citizens with inadequate oral health.

This lack of access to adequate dental care in the US is often ignored in favor of theories that blame those suffering from poor oral health, such as the US Surgeon General's assertion that oral health disparities result from lack of education and "the majority of Americans taking their oral health for granted." Here, poor oral health is perceived as a consequence of an individual's behavior, and more influential factors, like access to affordable dental professionals, or dental insurance, are completely ignored. This problem is complicated by the demonstrably high importance placed on teeth within the United States. Teeth visibly represent one's social and economic class. And having unsightly oral health can limit an individual's ability to find adequate employment or maintain relationships. The owner of a prominent South Texas restaurant explained:

> "If I see people with a problem with their teeth—dirty, or snarly—I immediately think negative thoughts…And as an employer too, I look at that. And if they [potential employees] don't have a good appearance, I probably won't hire them, because my customers are going to think the same thing."

Another young man echoed this sentiment, “I guess it would have to be something like first impressions, and smiling is going to show your pearly whites, and that's automatically going to say, ‘well, he never took care of himself,’ or, ‘he sort of takes care of himself.’”

The lack of access to dental health care and strong ideological associations focusing on class are what drive United States citizens to Mexico for oral care. Take Lucy, for example. I met Lucy in a Nuevo Progresso dental clinic on a hot Saturday afternoon. Lucy explained the situation she and others are in:

> I come here all the time…I used to live in East Texas. Everyone is poor there. So unless you are getting a filling or a cleaning, you can’t afford to go to the dentists there. I know about fifteen or sixteen people who go to the dentist here. We all used to rent a van together so we could split the gas, and then all drive down here and visit the dentist. We would all schedule our appointments on the same day, get everything done and then go back home

Before Lucy was called out of the waiting room, she asked me

> “Do you want to come in the back with me and see them take out my teeth?...It’s crazy.…See, they’ve replaced all of these (She smiles so I can see her teeth and points at the teeth in the top row). They had to pull all eight of them.”

I followed Lucy to the back of the clinic.

> “They had to pull all eight of them. In the US it would have cost me over $35,000 to get all this work done. Here, it’s only cost me $8,000, no, maybe $10,000. I’m not sure because I haven’t had it all done at the same time. See they replaced all of these” (Lucy opens her mouth again and points to all of her visible teeth in the top and bottom rows.)

The dentist then grabbed a pair of sharp, circular tweezers and clamped them on Lucy’s bottom teeth; Lucy winced in pain. The dentist wiggled Lucy’s bottom row of teeth back and forth with the tweezers. Her bottom teeth came loose and were lifted from her gums. Underneath was a row of yellow, plaque covered metal anchors, and what looked like bits and pieces of her former teeth. Lucy smiled up at me with drool running

down her chin. Her top row of teeth: white, clean, fake, and waiting to be removed; her bottom row of teeth resting on a stainless steel tray next to her. She said: "See, it's crazy right? It's crazy! From here on, I can't talk anymore, and you don't want to see them take off the top row anyway; it's even worse. I'll have drool and blood running down my face."

Because of Lucy's financial situation, she is unable to receive adequate dental care in the US. However, because of the strong importance placed on oral health, Lucy is forced into making the so-called choice to travel to Mexico to receive health care. Lucy, and others like her, are without options, and because of this, they are forced into inadvertently reproducing the system that obstructs their access to US dental care in the first place.

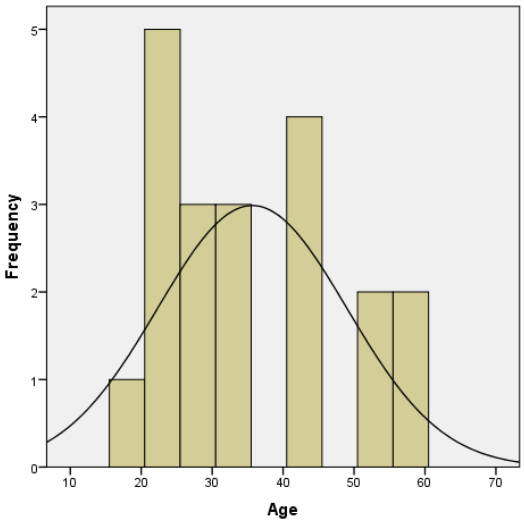
In order for us to affectively address issues of oral health inequality in the United States, we must address issues of class privilege inherent in the US medical system. An initial step towards addressing these problems is to change the way we, as a country, collectively think about oral health. If we can problematize poor oral health as the result of factors outside of the realm of individual responsibility, we can alter the current discourse. In this way we can help lower class individuals overcome some of the barriers preventing them, and their children, from upward mobility and economic success. However, if we find it too difficult to make this small alteration in our beliefs surrounding oral health, we should champion policies that allow less restricted access to adequate dental care. Our current system permits patients of Mexican dentists to return to the US with appropriate smiles which allow them the opportunity to be more

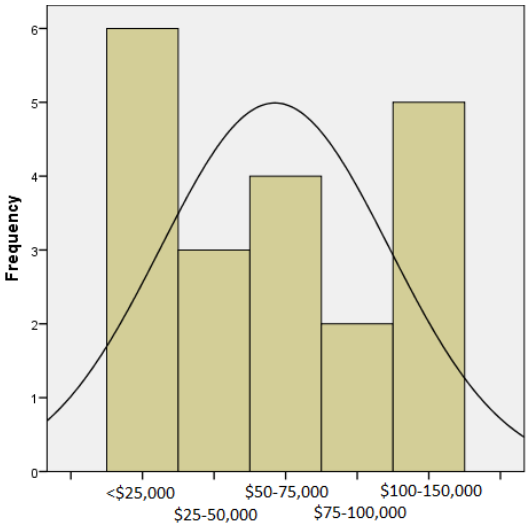
productive US citizens. Even so, this new smile won't buy them access to dental care in the United States.

APPENDIX SECTION

Race/Ethnicity	
Mexican American or Hispanic	11
White	4
Mexican	2
Black	1
Half White Half Black	1
Native American	1
Pakistan/American	1
Total	21

Annual Household Income	Frequency
<$25,000	6
$25-50,000	3
$50-75,000	4
$75-100,000	2
$100-150,000	5
Total	20





Of the 21 research participants, 12 were male and 9 were female. Out of the 11 individuals who identified as Mexican American or Hispanic, 9 were born in Texas along the Texas/Mexico border (7 in the Lower Rio Grande Valley, 1 in Laredo, and 1 in El Paso), 1 was born in Mexico, and 1 was born in Columbia. Surprisingly, the annual household income of the research participants was normally distributed between <$25,000 and $100-150,000 (demonstrated by the histogram). Furthermore, of the 20 participants who provided demographic information, 14 had health insurance, and 7 had dental insurance. Finally, 7 of the participants were college students. 2 of these students attended college in south Texas and 5 attended Texas State University.

Figure 1: Participant Demographic Information

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