

**Perspective of Change:
The story of civil rights, diversity, inclusion and
access to education at HMS and HSDM**

Interview with Reuben Warren | August 28, 2019

JOAN ILACQUA: Today is August 28, 2019, and I'm Joan Ilacqua. I'm here with Dr. Reuben Warren, and we're doing an oral history interview for the Center for the History of Medicine. Dr. Warren, do I have your permission to record us?

REUBEN WARREN: You do.

JI: Excellent. So just to start us off with hopefully an easy question, if you could please tell me about yourself. Where did you grow up?

RW: Well, I was born in San Antonio, Texas, but I grew up for the most part in California -- military family, so we traveled early years, but after the fifth, sixth grade, I was pretty stable between Northern California -- there's Berkeley -- and Southern California -- that's Los Angeles. So I really grew up, as one would say, in the inner city of South Los Angeles, California, one of two children. I have an older brother who is an attorney, and me and my brother and my mother, and she's one of 13, so I had uncles and aunts and cousins all over Los Angeles.

JJ: So growing up, you know, did dentistry have a role in your early life? What drew you to dentistry?

RW: Not dentistry, per se, but the suffering from what I've learned now are oral health challenges, oral health problems. Again, there were few, if any, dentists in South Central Los Angeles, where I grew up, so when you went to see a dentist, it was usually to get a tooth removed, and so there was not a good feeling about dentists or about going, so my interest in dentistry really was trying to respond to unnecessary suffering, not life or death. You know, people really are very attentive about life or death situations, but suffering is something that's overlooked, and so I really felt that I wanted to do something to reduce the suffering in populations who I viewed were suffering the most, including me. I used to say I have two missing -- I had been to the dentist twice before I actually went to dental school, and I have two missing teeth to prove it.

JJ: So when you were living in California, and you studied at San Francisco State University as an undergrad, at that point, had you already gravitated toward I'd like to be a dentist in the future, or were you sort of feeling out other career options?

RW: Well, I wanted to be a dentist early on, before I even started college. It came out of the need to help reduce the suffering, so I actually started college in Los Angeles, at Los Angeles State College, and after two years, I hadn't taken any courses to go to dental school. I was playing basketball, so it didn't register, and I transferred after two years to Prairie View A&M and HBCU right outside of Houston, Texas, and got really focused and a lot of attention on what it took to get to dental school, requirements, and really got some good, good guidance and advising. So I stayed there one year and then transferred to San Francisco State University, where I completed my requirements and went on to school, so it really preceded college, my interest in the field.

JI: And so when you were thinking about which dental school to go to, did you choose Meharry immediately, or what brought you to Meharry?

RW: Meharry chose me. As I say, I'm a resident of California, and I applied to the five dental schools in California and to Howard and Meharry, and I got into Howard and Meharry. So it was not my choice. In retrospect, it was the best place for me, but a local dentist, who was a Meharry graduate in San Francisco, said that, "You need to go someplace where they're going to teach you how to be a good

dentist, and Meharry is the place." So it was not my choice initially, but I didn't get into but two schools, so it was a blessing in disguise.

JJ: Excellent. And so going to Meharry at that point in time, could you describe [05:00] what dental education was like when you went?

RW: Dental education was very connect to community health. Meharry historically was founded to improve the health of African Americans, 1876. So after that, in being at Meharry, I understood that dentistry was a small picture. The bigger picture was community and oral health. And so it helped me to expand my vision or my intention about being a dentist. It was a tremendously good opportunity for me. Traveled a lot. I had the chance to really see what the impact of oral health or oral disease had on populations across the country, rural, urban, north, south, east, and west. It was a tremendous experience.

JJ: And so did you immediately go to the Harvard School of Public Health after dental school, or were there steps in between dental school and pursuing public health education specifically?

RW: Well, actually the Meharry experience drove me to public health, because I realized at my time at Meharry that one-on-one, one patient at a time was not going to do it. So I

looked for a way to engage in population health, and that brought me into formal education in public health. So I actually not focused my attention on dentistry, but more on community health, and that's why I applied to the Harvard School of Public Health as opposed to applying to the Harvard School of Dental Medicine. I got in both, but I chose to go the public health route, which would give me an opportunity to look at oral health within the context of systemic health is where I found the greatest interest. Oral health needs are met after systemic health needs are met, so you just can't go directly to oral health without going through the whole gamut of health concerns.

JJ: Could you tell me a bit about what it was like to attend Harvard in the 1970s?

RW: It was very exciting for me, because being at the School of Public Health, it allowed me to interact with students, faculty globally, and again, not looking at "dentistry," per se, but looking at public health and helping to realize that the issues were not clinical, the outcomes were clinical, and that issues in health, including oral health, were more systemic and dealt with issues of poverty, issues of racism, issues of sexism, issues of geographical displacement. So the opportunity to look at the broad array of public health was the Harvard experience. Upon

graduation, I left and joined the faculty at the University of Lagos in Nigeria. So I was wanting to look at global health, and that's what the Harvard public health experience showed me, that health has no boundaries, nor does disease.

JI: Excellent. So I'm not sure if I'm jumping chronologically here, but from the research I did on your career, you had a residency at the School of Dental Medicine.

RW: I did.

JI: Was that before or after going to Nigeria?

RW: Before. I did the doctorate in public health, and during that time, we did a lot of interaction with the School of Dental Medicine. I had two colleagues who actually came into public health through the School of Dental Medicine opposed to coming directly through public health, so that put me in contact with the dental school on an ongoing basis. One of the giants at the time was Jim [Dunning?], so the opportunity to work with Jim Dunning was really good. So I got [10:00] in contact with the School of Dental Medicine through that kind of experience. But then not only was I in the School of Dental Medicine, but I took courses in the med school, I took courses in the School of Design, I took a course in the law school. It was just an opportunity to go and follow your dreams, and that's what

Harvard did, provide the opportunity to pursue whatever venue you chose, and so it was great for me. And again, applying that to community -- because I was practicing part-time in Roxbury, which was a very high need black community, and so it allowed me to balance the theory with the practice, and so it helped me to understand that you can't separate oral and systemic health, nor can you separate medical and dental care, and that was part of the Harvard message for me, which was good.

JJ: Excellent. So looking forward again, could you tell me about your experience in Nigeria?

RW: Yes, upon graduating from the Harvard School of Public Health and finishing the residency, I joined the faculty of the University of Lagos, a relatively new dental school. It was part of the medical school. But I went there really thinking I was going to increase the number of -- strategy to increase the number of dental personnel -- that is, dentists and dental therapists -- because that's what I thought would improve oral health, but what I found out is that was only a small part of it. A colleague there had done some research, looking at the increase in dental caries and what that was related to, and it was related directly to the importation of refined sugars, which had nothing to do with dentists, (laughs) so yet again, spoke

to issues beyond "clinical care." So that period in Nigeria, I was able to travel throughout the country and really look at what they would say the natural history of oral disease, and again, it was really, really, again, grounded with the public health background, made me very comfortable in that Nigerian environment. Met a lot of folks who did work outside of oral health, because you just don't do dentistry in places of high need, so I was able to interact with pediatricians and other health professionals and nurses, so it was really a good opportunity.

JJ: Excellent. So sort of looking broadly at your career, you've held many roles (laughs) at many different institutions, and it seems like this connection between community health, public health, and education sort of runs through your career. So I don't have a specific question. I'm wondering if you have any stories about the type of work that you did, you've done, and that you continue to do.

RW: Right. What I've learned is that you start in one area and stay opened to other opportunities. I was tremendously interested in community health before going to the School of Public Health, and that drove me to public health, and understanding community health and public health are different. Community health is an intention to improve the

health of populations. Public health is the science of improving the population health. So I've learned how to quantify community health. I also learned in that trajectory that the issues to resolve oral health concerns did not rely in large part on the dental profession. They're outside of our domain. I was the Associate Director for Minority Health at the Center for Disease Control and Prevention, and because I was a dentist not working in dentistry, I was able to impact on other issues where dentistry would have otherwise been left out. I was the state dental director for Mississippi, and the same thing occurred there. The issues that preceded oral disease, oral health, had to be addressed before you could get to oral health. If I wasn't a dentist, I would have never gotten [15:00] to oral health. So it allowed me to recognize that the interconnectivity of oral and systemic health was critically important, and that's population based, and that was a lesson learned. And also I learned that the issues of health go beyond "the health care delivery system," and the system was dependent on other factors, and the consequence of those other shortcomings is what resulted in poor oral and systemic health.

JJ: Excellent. (clears throat) Could you tell me a bit about your divinity degree? I see that as having a connection to bioethics, but if it doesn't, (laughs) please don't --

RW: It has a greater connection to health promotion and disease prevention. What I've learned that -- particularly dealing with oral health -- that people learn how to cope, and in the coping process, they learn about strategies to see beyond what is and to continue to have expectation. And it seemed to me as a traveled throughout and did the work throughout the world that people were affirming things that seemed to be impossible, that they had beliefs in things that seemed to be unbelievable. And what I actually learned is about how do people see beyond the disease and the depression and the devastation of illness, sickness, and disability. And they had a vision beyond themselves, and I wanted to do was how do people actualize themselves in the midst of physical disability? And so I became very interested in theology and spirituality -- not religiosity, per se. And so I was able to look at the foundation for people to have hope when hope seemed hopeless and to have faith when faith seemed impossible, and it was very inspiring. How do you hold on in the midst of disease and despair? So that time in seminary helped me to understand how that happens. And quite frankly, it helped to broaden

my description of health. You know, the classic WHO's physical, social, and psychological well-being. Well, I understand from my seminary and other limited experience that spirituality is a critical part of health -- not religion, per se, but spirituality -- and to be able to see beyond your current circumstance to what ought to be beyond what actually is.

JJ: Excellent. So we're heading towards actually one of my last two questions, and this question is looking throughout your career and thinking about diversity and inclusion as well as access to care, what's changed? What's changed over your career, and what still needs to change?

RW: Let me hear the question again?

JJ: (laughs) So it's kind of a big question. I should have broken it down. But over the course of your career and the work you've done, especially in terms of community health, you know, what has changed, and what changes do you think still need to occur?

RW: Yeah. I think not much has changed, to be quite honest. There's been a lot of rhetoric about what ought to be, a lot of focus on health disparities, a lot of focus on economic conditions, but the same issues remain. The populations that suffer the most continue, the populations that have greater access continue, but the reality is that

the system barriers beyond this "social [determinants?]" but the system barriers create disparity, [20:00] and until the system barriers are minimized or reduced -- barriers like where you live, barriers like the opportunities provided based upon who you are -- until those are addressed openly and candidly, then we're going to have the repeated health disparities. You may recall the 1985 Secretary's Task Force on Black and Minority Health, and they coined a term called excess deaths, and excess deaths are the number of conditional, preventable deaths experienced by the black population that would not have occurred if the death rate was the same as the non-Hispanic white population. So that simply said that these are preventable conditions within the black population. That was in 1985. They repeated the study in 2002, and those 60,000 excess deaths had gone up to 83,000 excess deaths, so there was the presumption of structural change, and more resources were committed, but the disparities worsened. The gaps widened. So I think we're missing the mark.

JJ: So my question was going to be what do you think we need to do to change it, but that's a huge question to ask you (laughs) in an interview.

RW: Oh, I think we need to rethink what health is and spend less time defining it and more time describing it and then

design strategies based upon that broadened description of health and not look at health as an individual enterprise but as a group issue within the context of one's social and physical environment. You can't be sick by yourself, and seldom can you be healthy by yourself, so we need to look much broader than the "classic health care delivery."

Health care represents about only 15 percent of health, so spending all our time, energy on health care, per se, I think does little to improve the health of populations. Of course, if you're disproportionately ill, then you need more health care, but no matter how excellent the health care system is, it will not impact on health in any meaningful way.

JJ: Excellent. So my last question is just are there any other new stories or thoughts that you would like to share with me today?

RW: Yeah. I think the one good story is my experience in Boston was excellent, because it provided opportunities for me to observe leadership -- not leaders, but leadership -- and discern what are the qualities of leadership, and interestingly about Boston, if you think you've got something going on, you'll bring it to Boston, whether you've got something going on or not, it doesn't matter. So there were a lot of people, a lot of interventions, a

lot of engagement in Boston, and so I was able to really test some thoughts and some ideas, and what became real clear is that you've got to have a vision of what you think ought to be -- a vision of what ought to be beyond what you see, beyond the physical, per se, but what ought to be. And then you've got to have a way to get there. You got to have a way to translate that vision into what I would call a plan of action, an action plan. And then third and most importantly, you've got to be tenacious. You just can't give up, and you have to make it in spite of, not because of, the system. And my journey has been in spite of what appears to be the easy resolve, how to you negotiate beyond that? So that notion of what ought to be and that part of my theological education is to be able to have a notion of what ought to be. Perfection is always the goal, and you can't lose sight of what you think perfection ought to be, and in the midst of disaster, despair, it gets muddled, and if you lose that vision, you become part of the problem as opposed to part of its resolve.

JJ: Wonderful. Well, Dr. Warren, thank you so much for taking the time to talk with me today and for being part of this project.

RW: Okay, I hope that this conversation is helpful.

JI: Oh, it's exceedingly helpful, and I appreciate that you took the time to share with me.

RW: Okay.

JI: Let me turn off the recorder --

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