International Journal of Creative and Open Research in Engineering and Management
ISSN: **3108-1754 (Online)**
Volume 02 Issue 03 March-2026 | Impact Factor: 3.5

The Mouth as Text: Pain, Silence, and Clinical Power in Dental Experience

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How to Cite this Article:

Radhika, N. (2026). The Mouth as Text: Pain, Silence, and Clinical Power in Dental Experience. International Journal of Creative and Open Research in Engineering and Management, 02(03). https://doi.org/10.55041/ijcope.v2i3.137

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Abstract

This paper explores the mouth cavity as an anatomical site that is a symbolic, cultural, and phenomenological site, which is central to speech production, identity formation, and social presence. This paper says that dentistry forms a distinct paradox in the clinical context: the organ where patients express their experiences turns into a place of silence, examination, and treatment at the same time. Based on the idea of medical gaze developed by Michel Foucault, phenomenological theory of embodiment, and the literature of narrative medicine, the paper critically examines the dental appointment as the space that is organized around unequal power dynamics, corporeal susceptibility, anticipatory anxiety, and a temporary loss of verbal agency **(Charon, 2006; Foucault, 2003; Merleau-Ponty, 2002)**. Unlike most of the clinical settings, dentistry literally gets into the mouth of the patient, thus turning the mouth, as a tool of expression, into a tool of action. This change transforms the experience of self, pain, and communication of the patient. The paper also submits that dental pain cannot be perceived solely as a physiological phenomenon; it is also mediated by memory, language, cultural discourses, and a prior experience of fear **(Charon, 2006; Frank, 2013)**. Combining the humanities with dentistry, the study will introduce a medical humanities model of dental practice, which will restore the central focus on patient voice, dignity, and communicative care. This could make the way of ethical sensitivity in dental practice more profound and enlarge the intellectual perspective of dental education.

Keywords: mouth, dentistry, medical humanities, embodiment, silence, pain, patient voice, medical gaze, narrative medicine

Introduction

The mouth holds one of the unique positions in the corpus of human experience. It serves both as a biological organ and as a symbolic medium and, at the same time, plays a dual role, both utilitarian and expressive, personal and social. Using the mouth, people pronounce words and give emotional expressions like smiling or singing, and socially approved behaviors like kissing or protesting. As a result, the mouth is revealed as one of the most important vehicles with the help of which identity is projected and interpersonal relations are realized. When, however, it comes to the dental practice, this familiar and expressive organ gets a remarkable metamorphosis and, in the meantime, loses its traditional functions, substituting them by acting as an investigative site to be explored, to be illuminated, to be diagnosed, to be incised, to be drilled, to be extracted, to be restored, and to be repaired.

It is important to note that this change is not only complicated by technical elements but also reflects on interpretative and existential levels. The patient, who normally employs his oral cavity as a channel of self-expression, is forced into the situation of a dental procedure to abandon this form of expression. The mouth, traditionally the symbol of agency and self-expression, is objectified, being the object of manipulation by the practitioner. Even though the patient is awake, aware, and anxious most of the time, full communicative ability is lost as soon as the procedure starts. It has created a very specific kind of vulnerability that makes dentistry one of the few types of medicine. Therefore, the dental experience is not merely a biomedic experience but a human experience that is affected by silence, fear, anticipation, dependence, and trust.

The present paper argues that the medical humanities and literary theory can be used to better understand the field of dentistry. The paper is a re-conceptualization of the mouth as a tissue and a text using the concept of the medical gaze of Michel Foucault, phenomenological reflections on embodiment, and insights provided by narrative medicine about the patient **(Charon, 2006; Foucault, 2003; Merleau-Ponty, 2002)**. The authors do not mean by text only a written object, but rather a culturally intelligible, symbolically saturated, and meaning-saturated object. The dentist interprets the mouth as a locus of pathology, lesions, cavities, calculus, malocclusion, or surgical need, whereas the patient interprets it as a part of selfhood, dignity, memory, and vulnerability. The conflict between these two ways of apprehension is the essence of the dental experience.

Therefore, the study follows an interdisciplinary intervention. It shows that clinical management of the mouth cannot be separated from interrogations of power, embodiment, and communication. Moreover, it suggests that a humanities-informed practice of dentistry can raise a more caring and ethically receptive practice whereby it is recognized that the patient in the chair is not an oral pathology but a speaking subject whose speech is limited in time in the course of treatment **(Charon, 2006; Frank, 2013)**.

The Mouth Beyond Anatomy: Speech, Identity, and Symbolic Meaning

The mouth in a traditional clinical speech is often diminished to a collection of anatomical structures and functional elements. It is described as soft tissue, dentition, gingiva, palate, tongue, salivary flow, mucosal lesions or accessibility during surgery. Such descriptions are medically necessary, but fall short of representing the experiential meaning of the mouth in a lived human life. The mouth is not only anatomically significant, but it also has some symbolic significance. It is a transitional point between the inner and outer reality, between the body and the language, between food and speech.

Since childhood, the mouth has been the centre of relationality. It is fed, it cries and it is one of the first places of contact with the outside world. The mouth would have social and cultural meanings as human development takes place. With the help of it, people speak and are identified socially. Emotions, confidence, embarrassment, affection, irony or discomfort can also be projected using facial expression and smile. As a result, the mouth is greatly engaged in the mechanisms of identity formation and social interaction. It is therefore no wonder that the oral disfigurement, halitosis, loss of teeth, malocclusion, or even the exhibited decay, which are usually caused by the dental conditions, tend to impact not only the functional capacities, but also the self-esteem and public confidence. At least in this regard, it is the mouth that is a part of the world that is not merely of anatomy, but of representation and social sense.

The mouth is also culturally encoded. Teeth, smiles, oral hygiene, and the appearance of the face are given different meanings across different societies. As an example, white teeth can be a symbol of beauty, discipline, and health, and missing teeth can be viewed as a sign of poverty, old age, neglect or trauma. Speech, which is passed on through the mouth, is linked to education, civility, intimacy, resistance, and power. Therefore, the mouth is a site of convergence between the body state and social meaning. The further contemplations that Susan Sontag offers on the cultural meanings that have been assigned to the body and illness help to understand that the states of the body are barely seen as being solely biological, but are interpreted through metaphor, stigma, and social expectation.

Due to the density of this symbolism, the patients fail to perceive the mouth as a disconnected part of their body. Rather, it is felt as intimate and emotional. When dental treatment is taken, the object of investigation is thus not simply tissue, but a significant part of the self. The shame which some patients undergo in connection with bad oral health, with bad teeth, with bad odor, or with missing teeth cannot be turned into clinical terms; it is the presence of the mouth in dignity and social being. Treating the mouth in most cases is working with the vulnerability of the patient on a very intimate level.

These are the reasons why dentistry holds a unique place in the field of healing professions. The dentist works in an already saturated part of the body with personal and symbolic meaning. Any theoretical explanation of the experience of the mouth must then commence by recognizing that the mouth is not merely a medical location, but a location of identity, exposure, as well as meaning.

The Clinical Gaze and the Objectification of the Mouth

Michel Foucault formulated a strict conceptualisation of the oral cavity clinical treatment paradigm which he has termed the medical gaze. He points out in *The Birth of the Clinic* that modern medicine redefines the human body as a site of systematic observation, classification and intervention; the patient is thus transformed as a suffering person into a clinical case to be unpuzzled by signs, symptoms, lesions and anatomical deviations **(Foucault, 2003)**. This fusion of knowledge and power is achieved through the process of clinical observation.

The gaze in dentistry takes a very strong form. The patient sits back on a chair, with the light shed on him, and he is asked to keep the mouth open. Both visually and instrumentally, the oral cavity is accessed. Mirrors, probes, scalers, suction tips, elevators, burs, syringes and forceps boost the capability of the clinician to observe and intervene. The mouth is apportioned into quadrants, surfaces, pockets, margins, roots, crowns, occlusal relations, and pathological sites; accordingly, it forms a map of conditions to be interpreted.

The Clinical reading is fundamental to professional care, but it also causes a change in the state of the patient. The individual sitting in the chair is at least momentarily transformed into a dental organism to be examined by the experts. The experience of the patient is controlled by the procedural priorities of the clinician. Such a complaint as this side hurts is converted to diagnostic terms: irreversible pulpitis, pericoronitis, impacted third molar, periodontal abscess, temporomandibular dysfunction, or surgical complication. Although this translation is not oppressive in itself, there is an imbalance in power. The dentist speaks, describes, and performs; the patient acquiesces, usually without having equivalent interpretive power. The work of Arthur Frank comes in handy in this context since we are reminded that the modern clinical systems can unwillingly turn the story of the ill person into the logic of institutional interpretation **(Frank, 2013)**.

The objectification of the mouth is particularly impressive since it is traditionally one of the places of privacy and self-control. In the majority of social situations, people regulate their speech, expression and oral exposure. The same cannot be said in dentistry. The patient is requested to maintain the mouth open, stay motionless, endure pain, and have faith in the actions of the clinician. The mouth is not just perceived, but controlled. Manual access and technical intervention therefore increases the authority of medical gaze.

The fact that dental practice is not wholly coercive does not follow. The nuance is subtler. Dental care is not only needed, but it can be helpful, and the advantages are mediated in an imbalanced system of knowledge and body exposure. This paradigm can be utilized to explain the reasons as to why even basic operations can be met with fear out of proportion; the agony is not caused by pain itself but by the fact that the patient is in a state of clinical legibility and passivity in a very personal sphere of the body **(Foucault, 2003)**.

Pain, Fear, and the Silent Patient

The fact that dental treatment interferes with the communicative ability of a patient can be viewed as one of the most unique aspects of the field. Patients, in most medical experiences, are still allowed to describe their pain, ask questions, complain, and bargain for understanding. The commencement of dental procedures, on the contrary, fills the oral cavity with tools, cotton rolls, retractors, suction, water spray, and anesthetic numbness, thus greatly restricting verbal agency. As a result, patients have to use gestures, muted voices, or pre-determined cues to express their experience.

This imposed silence is more than that. The oral cavity is the organ of speech, and speech is one of the major indicators of subjectivity. A patient feels more vulnerable when he or she cannot communicate due to anxiety, nociception, or confusion. Despite the general alertness of dental patients, who perceive auditory stimuli, pressure on the body, smell, taste, as well as the sense of time, they fail to report the changing experience accurately. Therefore, dental anxiety usually results in a feeling of helplessness, as opposed to being a strictly nociceptive reaction.

Dental pain, therefore, has to be framed in a wider psychosocial context which goes beyond nociception and tissue damage to include anticipatory, autobiographical, and symbolic aspects. The buzz of the drill, the smell of eugenol or cautery, the sight of needles, the mechanical force of the extraction, the tiredness of mandibular opening, the fear of choking and the general feeling of helplessness all contribute to the unpleasant experience. The fear is also built out of memory and imagination, and therefore, anxiety may persist despite the nociceptive pain being relieved by local anesthesia. This is explained by the fact that Frank analyzes illness narratives and how suffering in the body is mediated through the previous narratives and the anticipation of things to come **(Frank, 2013)**.

Patients with dental phobias usually have accounts that are dated before they visit the operatory. They can be the result of childhood experience, family lessons, previous traumatic events or the indirect accounts. Communication is internalized in the body and thus a patient can say it is impossible to treat me as I am so much scared of treatment in the dentist but this reaction can be a past experience of fear and not the present pathology. As a result, cultural narratives moderate the experience of dental pain. A narrative medicine model created by Rita Charon is especially relevant, as it illustrates how the suffering of the patients is conditioned by narratives that help in mediation and communication **(Charon, 2006)**.

The procedural silence also has an effect on trust. Without the freedom of expression, the burden of responsibility is disproportionately placed on pre-procedural explanations and sensitive communication by clinicians. In case the patient feels that no one is listening to him until the treatment process starts, the silence that will prevail is more painful. On the contrary, when a patient has been actively listened to, informed, and reassured, the absence of speech can be interpreted not as an act of agency erasure but as a temporary reliance in a trusting therapeutic relationship.

It is the iconography of the silent patient that therefore plays a very critical role in dental ethics. Dentistry's silence is not a side effect of the treatment but a component of the structure of the encounter. It shows how clinical exigencies may temporarily silence the voice of the patient, and at the same time, trigger the profession to come up with humanistic approaches that help to respect the dignity even in the face of speech being non-existent at the moment.

Embodiment and the Phenomenology of Dental Experience

Phenomenology offers a valuable approach to the methodology of dental experience in that it prefigures the lived body and not the body as it appears externally. Maurice Merleau -Ponty believes that the body is not just some inert object in the world but a condition by which the world is experienced **(Merleau-Ponty, 2002)**. Although clinical dentistry often uses objective terms to explain what the procedures entail, the experience of a patient undergoing the same procedures is perceived internally.

The importance of this difference is in the fact that the experiential paths of clinician and patient are different. As far as the clinician is concerned, a procedure can include debridement, scaling, injection, extraction, root planning, osteotomy, suturing, or restorative preparation. To the patient, on the other hand, the same intervention can be represented by the experience of jaw fatigue, clumsy swallowing, invasive pressure, inexplicable metallic sounds, saliva build up, numb lips, a sense of disorientation, or the disturbing feeling of being ignorant of what goes on in the mouth. These phenomena are not marginal; they represent the experience of treatment.

The internal integration and functional use of the oral cavity in daily life make dental embodiment especially prominent. Patients can have the mouth in strange positions during treatment: they may have their mouth open, they may have their mouth open and separated, they may have their mouth open and anesthetized, and they may even have a foreign object in the mouth or they may have temporarily lost sensation in their mouth. Even after the procedure, a feeling of anaesthesia, bleeding, or swelling, or discomfort with eating hinders the development of a disoriented bodily awareness that makes formerly transparent bodily states conspicuous. This change in body consciousness is directly in line with the phenomenology **(Merleau-Ponty, 2002)**.

Phenomenology also explains the reason behind the presence of embarrassment and disgust during dental treatment. The mouth is normally dealt with socially tacitly; saliva, odor, plaque, pus, and blood are usually kept out of others' sight. These personal aspects of embodiment are revealed and dealt with professionally in the dental chair. Some patients feel humiliated when they are in such conditions, especially when they have oral neglect or visible illness. The notion of abjection by Julia Kristeva can be applied in this case, as it deals with the psychic disturbance of the bodily substances and boundaries that question the distinction between the clean and the unclean, the self and that which needs to be expelled **(Kristeva, 1982)**. This affective aspect cannot be summarized into pathology per se; it arises out of the distinction between the lived body and the examined body.

Temporal dimension is another element of phenomenology. A process that is clinically quantified in minutes can be perceived as lengthy and oppressive by a patient, who has his/her mouth paralyzed and his/her focus is on every single sound and pressure. As a result, the dental chair is a place where time slows down, body consciousness increases, and the patient feels acutely vulnerable.

These observations suggest that great dental practice requires more than technical expertise. It involves an understanding of the inside experience of treatment. The phenomenological patient is not just a recipient of interventions, but an embodied subject who is negotiating fear, sensation, exposure, and modified self-awareness.

Narrative Medicine and the Ethics of Listening

When Foucault explains the structural asymmetry of the clinical setting and phenomenology, with its emphasis on lived experience, it sheds light on the subjective reality of the patient, and narrative medicine becomes a channel of restoration of the voice of the patient. Narrative medicine upholds that illness and treatment are not merely physiological happenings, but also narratives in which individuals make sense of suffering, fear, hope, and healing **(Charon, 2006)**. The patient comes to the clinic not as a biological body without memories, assumptions, and emotional meaning but as a person who already has these.

This point of view is especially acute in the field of dentistry as the speech of the patient is often shortened when the treatment process starts. Therefore, listening has to be done prior to and during the intervention. By asking patients to share their past experiences, fears, or certain phobias, clinicians get access to aspects of pain that cannot be seen in radiographs or during intraoral examinations. A patient can be afraid of pain, of the needle, or of the sound of the drill, or of the embarrassment of having an oral condition, or of lack of control; these fears require not just to be handled but also acknowledged.

Narrative competence in dentistry refers to the skill of listening to what patients tell about their bodies and responding to them in an interpretive manner. It involves the realization that terms like I had a bad childhood experience or I am a panicking patient and cannot swallow are clinically meaningful and determine compliance, trust, and treatment outcomes. Patient narrative is not a secondary diagnosis to the patient; it is a part of the therapeutic experience. This idea is further supported in the work by Frank, who shows that the story of the ill person is the crucial component of ethical care since it reconstructs personhood, which might otherwise be diminished in the clinical systems **(Frank, 2013)**.

An ethics of listening in dentistry would then entail a clear description of the procedure, communication of consent, which is actually communicative and not just formal, pre-established cues enabling the patient to interrupt the treatment, and language that legitimizes and does not refute fear. Being empathetic here does not mean being sentimental mushiness, but rather a professional skill that recognizes the patient as a subject, whose mouth cannot be separated from being a person.

This is where the humanities play a concrete role in dental education. They remind the practitioners that treatment takes place in language-saturated and culturally mediated, emotionally charged contexts. A dentist who has been trained to treat disease solely might fail the person; a dentist who has additionally been trained in listening and interpretation might retain more trust, dignity, and cooperation.

This is not meant to substitute biomedical dentistry with literary contemplation, but to add enrichment to dentistry by appreciating that clinical success and humane care do not contradict each other. Listening has been found to enhance compliance, anxiety, and therapeutic rapport. A medical humanities approach is therefore a widening approach as opposed to a weakening approach to professional excellence **(Charon, 2006)**.

Conclusion

The most widespread way of thinking about dentistry is as a technical science of diagnosis and intervention, and this conception can be justified by its merits. However, this paper argues that there is a strong humanistic and theoretical aspect that is subsumed in the dental encounter. The oral cavity is not a collection of tissues, dentition, and pathology but rather a symbolic organ of speech, identity, intimacy, and self-presentation. Therefore, the operation of the mouth through dental intervention is an encroachment into a realm of intimate personal meaning.

Based on Foucault, phenomenology, and narrative medicine, the current essay will reveal that the treatment of the teeth represents a particular paradox: the part of the body that allows the patient to speak turns out to be the site of silence and the site of clinical power at the same time **(Charon, 2006; Foucault, 2003; Merleau-Ponty, 2002)**. The exposure, dependency, objectification, and limited communication are other sources of vulnerability of the patient. Therefore, dental suffering is not merely physiological, but embodied, narrated and culturally located **(Frank, 2013; Sontag, 2001)**.

Acknowledgment of this fact will not imply that dentistry is oppressive in its nature, but it will be an effort to enhance its ethical and intellectual self-realisation. A more humanitarian form of dentistry would be as concerned with technical exactness as with those circumstances that limit patient expression. It would give more importance to listening before taking action, explain discourse when faced with uncertainty, and give dignity in situations of helplessness. Such a method does not weaken clinical authority; it is perfected.

The mouth can be interpreted as a textual object outside the physiological makeup. It represents semantic dimensions that follow every patient in clinical situations and thus are far more than a description in an anatomic sense. Interdisciplinary communication between the humanities and dentistry helps clinicians to understand this multifaceted complexity in an integrated way. Such frameworks of collaboration allow fostering the best models of care where the professional competence and compassionate interaction, procedural implementation and interpretive analytics, scientific rigor, and selfhood of the individual are integrated instead of being discretized.

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