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Effects of Racism on Oral Health in the United States

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This paper comments on the Effects of Racism on Oral Health in the United States (US). It provides the background and sets the stage to raise questions about race: how was race defined originally, what exactly is race, and how have racial categories been enumerated? Following this path, the paper broadens the scope of view regarding data attributable to racial categories pointing to social and cultural factors that influence overall health outcomes, particularly those related to oral health. Oral health researchers, advocates, providers, administrators, program planners, and funders, among others rely on data, often compiled by racial categories. We should be aware of potential vagaries that can accompany race-based data, and its interpretation and application, regarding oral health. The paper suggests we should be mindful of other influences that affect documented differences among populations regarding their oral health status.

Keywords: *Oral Health, Race, Racism, Social Determinants of Health, Oral Health Equity, Workforce*

The Effects of Racism on Oral Health in the United States

The effects of racism on oral health in the US can be discussed only when placed in full context. Racism has been an unfortunate hallmark of US history and has been directed towards many population groups in varying ways and degrees. The handprints of racism are evident even today and have shown more vividly in the past few years. A few data will be presented; however, this paper is not intended to be a deep dive into the data documenting oral health inequities that could be attributable to racism and resultant discrimination. Those data are available in the findings of numerous national health surveys conducted routinely and among other studies that can be found in the literature.

Dominance over, and subjugation of "other people" is a core element of US history and is woven deeply into its culture. People of African descent provide the most illustrative example of this exploitation, although other populations, including American Indians, persons of Asian descent, and other immigrant groups have suffered as well. For purposes of this paper, a brief outline of selected salient historical points will provide a review of the dominance over people of African descent. The subjugation of this group, marking 400 years of US history, has covered the full gamut of the human condition, including the purchase and sale of people, separation of families, forced labor, denial of voting privileges, separate and substandard education, prohibitive marriage laws, laws of exclusion, discrimination in labor and hiring practices, segregation in housing and military service, lynching, denial of voting rights, and police disregard and abuse, among others.

Slavery and the Civil Rights Movement

The celebrated American Declaration of Independence (1776) states: "…that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness." However, that sentiment did not apply to people of African descent. The first African slaves were brought to the Virginia British Colony in 1619. By the time the Declaration of Independence was written, one hundred and fifty years of slavery had already occurred in what would become the United States of America. Fifty-six prestigious leaders of the independence movement signed the Declaration; many were slave owners particularly those from the colonies of Virginia, North Carolina, South Carolina and Georgia (Shah and Adolphe, 2019).

Ten of the first 12 US Presidents, George Washington, Thomas Jefferson, James Madison, James Monroe, Andrew Jackson, Martin Van Buren, William Henry Harrison, John Tyler, James Polk, and Zackery Taylor were slave owners. Eight of them held slaves while in office (Andrews, 2019). Jefferson had a slave mistress, Sally Hemmings, with whom he had children. Those offspring were considered and treated as being of African ancestry, rather than white. A major issue of the US Civil War (1861-1865) centered on slavery and its future. In concept the Emancipation Proclamation (1862) was intended to free slaves from their bondage. However, the post-1865 period of Reconstruction initiated a series of legal barriers, prohibitions and outright terror tactics to quell the liberation of former slaves and maintain them

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in a status of servitude and subjugation. The period from 1877 to 1964 saw the emergence of Black Codes, the Ku Klux Klan, lynching and a series of political and legal actions to limit access to education, employment, residency, marriage and societal privileges considered to be a birth right for the white population in the "Land of the Free" (History.com eds, 2020)

The Civil Rights period (1948-1965) included gains and losses. A brief summary of that period follows:

1948: Segregation ended in the Armed Services, President Harry S. Truman

1954: Brown v. Board of Education – ended segregation in public schools

1955: Rosa Parks refused to give up her bus seat to a white passenger which initiated the Montgomery, Alabama, Bus Boycott

1957: Civil Rights Act, President Dwight D, Eisenhower

1960: Sit-ins start with student actions, Greensboro, North Carolina

1961: Freedom Riders in the South

1963: March on Washington, Martin Luther King delivered the "I Have a Dream" speech

1963: 16th Street Baptist Church bombing, four young girls killed, Birmingham, Alabama

1964: Civil Rights Bill, President Lyndon B. Johnson

1965: "Bloody Sunday" March from Selma to Montgomery, Alabama, and the confrontation on the Edmond Pettus Bridge

1965: Voting Rights Act, President Lyndon B. Johnson

1968: Assassination of Martin Luther King

1968: Civil Rights Act of 1968, known as the Fair Housing Act, created equal opportunity in housing

The recent deaths of Michael Brown (Ferguson, Missouri), Breonna Taylor (Louisville, Kentucky), George Floyd (Minneapolis, Minnesota), Eric Garner (New York City, New York), 12 year-old Tamir Rice (Cleveland, Ohio), and Walter Scott (Charleston, South Carolina), among others as a result of police disregard and abuse, has given birth to and energized the Black Lives Matter movement. That movement has also met with heated backlash. The now defeated, past-President of the United States distinguished himself by rhetoric that divided the public along the lines of color and ethnicity and brought to the surface hostilities and resentment that had been in remission, or at least were less visible.

Race and the US Census

Another matter in this history concerns the US Census, which has been conducted every decade over the past 230 years. For the first census, conducted in 1790, US Marshalls went to every known household to count its members. The classifications were: free white males, other free white persons, and slaves. Nearly four million people were enumerated in that census. By 1850 other descriptive categories had been added for people of color: free Blacks, mulattos (Black and any other "race"), Black and mulatto slaves, and quadroons (one-quarter Black), octoroons (one-eighth Black or any other trace of black) (Ladyzhets, 2020) (PRC, 2020). In the south, the route by which the categorized sub-populations of Black people emerged was a result of forced sexual encounters by slave owners and their minions upon slave women. Particularly after the abolishment of the slave trade, this form of sexual abuse was also a means to propagate new slaves. As the census and the country matured, and with the abolition of slavery, the slave category was dropped from the census and the term Colored emerged. The term Negro supplanted the Colored category starting with the 1900 census (Brown, 2020). Between 1790 and 1950 census takers used their personal judgement to classify people according to "racial" categories. Anyone with a suggestion of Black, or colored features was counted as colored. That process of judgement was formalized in 1930 with the "One Drop Rule." It conveyed that anyone with one drop of Black blood was to be categorized as Negro (Hollinger, 2005). After 1960 people used their own judgement to place themselves into demographic categories. The term African American emerged in the 2000 census, although Negro was still an option for identification. By a decision made in 2013, Negro was dropped from all future census taking. The term and category had become offensive to the Black population (Parker *et al*., 2015) (Prewitt, 2005).

Consider what we know from the Human Genome Project and the many genomic studies that have been conducted over the past 25 years. Data from those studies do not document predictable genetic sequences that define and support differences in people by race. No genetic code or sequence has been identified for race. Genetic markers have been identified that provide hints regarding geographic distribution of ancestry; but geography does not equate to racial identification (Harari, 2015). Again, this observation does not directly help answer questions about health, or oral health, but it is meaningful and relevant regardless.

Race and Racism

Today it is generally agreed that race has no determined genetic or scientific base. Even so, race as a social construct has served political, financial, social, and exploitive objectives for hundreds of years. The initiation of a method to define race is credited to Johann Friedrich Blumenbach (1782-1840), a German physician and anthropologist (Bhopal and Usher, 2007). He outlined a concept of race based on observations of physical differences, skull formations, observed behavioral characteristics, and estimates of intelligence. His work was explicated in three book editions. The first identified and highlighted differences among four groups: Europeans, Asians and north Africans, sub-Saharan Africans, and people in the Americas. His second volume added a fifth group, people in the Philippines. The third volume recategorized the groups into Caucasians, Mongoloids, Ethiopians, Americans, and Malays. Blumenbach's work stimulated the interest of others who produced analyses with outcomes resulting in the identification of up to eleven races. The categorization of superior and inferior "races" soon followed. In this manner the seeds were planted for exploitation and enslavement of people considered to be different and inferior.

Racism in the United States, directed towards the Black population, has been studied by social scientists as a means of understanding its origins and maintenance

over time. People, that is men, women and children, were brought to the US, sold in a marketplace environment, enslaved, worked without compensation, raped, poorly fed and clothed, denied education or any meaningful advancement, and blocked from all other advantages that society could provide. The people doing the purchasing and enslaving had families, most were church-going and prided themselves on the relative freedoms they had by being in the US. So how and why did the enslaved Black people become hated and despised? Were slaves lazy? They were forced to work hard; but doing more work and faster did not shorten their day. Did slaves steal? Given the leftover and marginal food they were provided, undoubtedly a loose egg or overly ripe fruit, or other food item was hidden away for future use. Were slave women raped? Were children of slaves sold and moved to distant places? Did slaves outnumber whites in many locations?

A plausible explanation of the hatred underscoring racism can be found in the concept of Cognitive Dissonance; the state in which attitudes and beliefs conflict and are inconsistent with behaviors (Davis, 2016). Slaves were dehumanized. Dehumanizing the despised is core to racism. Once the perception of dehumanization has taken root, bondage, mistreatment, rape, and full exploitation becomes a way of life and a forged belief structure. Maintenance of those beliefs is necessary to sustain biased attitudes and behaviors over generations. White privilege stems from that point. This background is fundamental to addressing questions about the effect of racism on oral health in the US.

Race and Oral Health

In the US, oral health data are commonly reported by "race". Inequities among groups categorized by race reveal that Black populations consistently experience higher levels of untreated tooth decay, periodontal disease, and tooth loss (Henshaw *et al*., 2018). Additionally, Black men experience the lowest 5-year survival from oral and pharyngeal cancers (Henshaw *et al*., 2018). The mechanisms by which racial categories associate with oral health are not completely understood. Studies of Black children have revealed that contributions to oral health inequities include education levels, oral health literacy, self- efficacy of oral health promoting behaviors, and attitudes and beliefs about oral health (Como *et al*., 2019). Additionally, many Black populations lack sufficient access to dental care due to limited affordability, inadequate insurance coverage, and fewer dental providers, including Black dentists, available and willing to treat them (Voinea-Griffin and Solomon, 2016) (Mertz *et al*., 2017).

The reporting of individual or population oral health status by racial categories may be regarded as a constant and reliable descriptor of differences based on genetic phenotype. However, race as a social construct presents an undertone in data reporting that is proximal to social disadvantage due to the disproportionate distribution of socioeconomic resources among racial groups (Braveman *et al*., 2011). Assari and Hani (2018) have challenged scholars to look further than socioeconomic status by way of the Diminished Return Theory, which suggests that inequities still exists among Black and White populations even when there are no socioeconomic differences.

Racism and Oral Health

Racism is described in the health literature as the intentional or unintentional belief or acceptance of race as a valid social construct that guides decision-making about health resource distribution and interpersonal interactions (Jones, 2000). The unfortunate health outcomes of racism are inequities (Bailey *et al*., 2017). The effects of any particular form of racism on oral health have not been studied broadly enough to identify the mechanisms or degrees to which racism has an affect. Sabbah and colleagues (2019) reported that individuals who reported the emotional impact of discrimination, rather than the act of discrimination itself, were less likely to utilize dental care services in the previous 12 months. Additionally, some social and economic conditions that are commonly associated with racism also have strong associations with poor oral health. For example, underemployment, low income, poor neighborhood conditions, lack of education, and incarceration can increase risks for oral diseases while reducing access to and utilization of dental care (Smith, 2019). Access to care among Black populations is also hindered in states where significant numbers of Black people live at or below the poverty line. This effect is partially due to high costs of dental care and limited adult dental coverage through government sponsored insurance programs. Additionally, too few dentists participate in those insurance programs, limiting access even further (ADA, 2020).

The attempt to racially categorize groups of people requires exploration of the historical social, political, and economic environments that they experience. Beyond being descriptive, racial categories, have a role to play in oral health status reporting, research designs, and interventions if the intent is to address the inequities that are consistently revealed. Hence, if research intends to generalize data based on racial categories, sampling should reflect their diverse experiences. All Black populations do not experience race the same way. The common threads that some Black populations may identify with as 'cultural' are likely influenced by their common social and environmental experiences. Attempting to confuse race with culture or ethnicity is inappropriate and could be considered, in itself, an act of racism. The implications of reporting oral health data by race without context retains the potential to perpetuate stereotypes, incite biases, or reinforce implicit and/or explicit biases that are associated with some racial categories.

Another issue with oral health and racism among Black populations is the lack of prioritization in targeted approaches to address the etiology of the problems. If race is the issue or a significant mediator of oral diseases, then race should be a centralized part of the solution. However, approaches to address problems that are described as 'racial' are often addressed in ways that benefit all parties, rather than utilize limited resources to target the most affected groups. An illustration of this is when people counter the phrase 'Black Lives Matter' in favor of 'All Lives Matter'. It is also evident when attempts to address underrepresentation of Black healthcare providers are coined 'diversity initiatives' that improve overall diversity, but do not significantly increase the number of Black healthcare providers. If excessive

morbidity and mortality from disease were affecting all lives, that approach seems appropriate. However, if the burden of morbidity and mortality is heavily weighted to Black populations, the lack of prioritization to reduce those effects could be considered racist. Whether it is implicit or explicit, for some people, Black populations experiencing poor health outcomes is not alarming or concerning. That perspective can validate the well health status of non-Black population groups while reinforcing notions that Black populations are unhealthy because of their racial identity, and not because of racism within the environmental conditions and milieus that they experience.

Addressing racism and oral health in the US can begin with oral health professionals learning about and acknowledging the history of race in the US while confronting misconceptions and misunderstandings about race. There is also a need for a broader understanding of how race is experienced among various populations, along with how racism impacts social, political, and behavioral determinants that affect oral health outcomes. Without adequate research up to this point, the contributions of race and racism to oral health are merely speculative. Hence, more research and assessment of interventions that address the influence of racism on oral health may benefit prevention of oral diseases and improve dental practice. Finally, there is a need to improve racial equity within the oral health workforce, which can improve racial concordance in the provision of dental care. It can also guide research and advocacy efforts aimed towards addressing oral health inequities among Black populations.

Conclusion

The impact of racism on oral health in the US is rooted in the historical contexts of race and the evolution of racism in society. The common experiences of people in racial groups with morbidity and mortality from oral diseases align with historical interpersonal, institutional, and structural inequities. Additionally, the lack of effort to contextualize race and address racism in oral health minimizes its impact. It also does not allow empirical validation of racism as a determinant of poor oral health. Moving forward, there are opportunities to address racism through research, education, and dental practice. The legacy of struggle towards social progress of marginalized population groups in the US is reason to remain cautiously optimistic that eventually, the contributions of racism to poor oral health will be addressed. However, it should be a matter of pragmatism if overall health is valued as the foundation of life, liberty, and the pursuit of happiness.

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