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Social justice, activism and dentistry in the era of #BLM

Patricia Neville

Bristol Dental School, University of Bristol, UK

The #Black Lives Matter (BLM) movement thrust the dental profession into a period of critical reflection. Whilst there is enthusiasm for critical reflection and change now, we know from other social movements, like feminism, that this initial phase or 'wave' of activity will subside, hopefully to be replaced by a next 'wave'. How will we nurture this moment of activism and ensure that this initial energetic phase of activism and mobilisation transforms into more sustained and sustainable change? This article offers a sociological-ethical framework to ascertain if dentistry is the progressive and responsive profession it claims to be in the immediate aftermath of the #BLM movement. The dual theory of justice developed by Nancy Fraser (2001, 2004, 2005) and its distinction of the role played by redistribution and recognition in the pursuit of justice will be used to illuminate the challenges that dentistry and oral health face in this regard. It then plots the current efforts of the dental profession against the known trajectory of social movements to adjudicate what has been achieved and what work is yet to be done to ensure inclusion and race-based justice.

Keywords*: Ethics, organizations and administrations, justice*

The tragic killing of George Floyd on May 25th 2020, triggered a process of social change that continues to reverberate across all aspects of public and private life, catalysing personal and institutional reflection on the role and place of race and racism in society. The grammar of this discourse has been scripted by the #Black Lives Matter movement, an American black feminist, community activist group founded in 2013 in response to the acquittal of the police officer who shot and killed Trayvon Martin, a 14-year-old boy. It pronounces that the problem of racial inequality registers as a social justice and human rights issue (#Black Lives Matter, 2017). The ensuing awareness raising agenda has started to infiltrate the very institutions the #BLM movement critiques for producing and reproducing race-based inequalities. This includes paving the way for a much-needed conversation about race and race-based discrimination in healthcare. The recent publication of a special issue on Racism in Dentistry placed *Community Dental Health* at the vanguard of such discussions. This Special Issue and its five articles represent the journal's ongoing commitment to raising awareness of oral health inequalities and endorses the position that racism and ethnic related inequalities are appropriate and necessary subjects for the dental profession. These articles demonstrate that in a so-called "post-racial society" (e.g. Bhopal, 2018) the dental profession is racialised and that the provision of and access to oral health care is unequally distributed according to ethnicity. The collection is also a timely reminder that dental researchers can produce knowledge to challenge mindsets, inform and progress social change within and beyond the dental profession (Downs and Manion, 2004; Flood *et al*., 2013).

Politically aware and socially responsive research by dental academics on racism in oral health and the dental profession is welcome and warranted. Race-based inequalities are heavily inscribed onto the dental profession, from the 'leaky pipeline' that confronts ethnic minorities as they progress through the dental profession in the UK and US, and the 'whiteness' of dental academia, (e.g. Neville, 2018; Mertz *et al*., 2017a; 2017b; 2017c; Lala *et al.*, 2021) to the widely evidenced ethnic-related oral health inequalities and barriers to access (e.g. Krichauff *et al.*, 2020; Sabbah *et al*., 2019; Nalliah *et al*., 2019), a trend that has accelerated during COVID-19 (e.g. Public Health England, 2020; Raharja *et al.*, 2020; Sze *et al*., 2020). It would appear that dentistry and oral healthcare is ripe for the social justice and equality analyses called for by the #BLM movement. However, the question remains: as a self-regulated profession, is the dental profession doing enough to demonstrate to society that it can hold itself to account in relation to the issues raised by the #BLM movement (Holden, 2017, p.8)? Will dentistry use the #BLM social movement as an opportunity for a root –cause analysis of its institutionalised practices that facilitate and perpetuate racial injustices in the profession and the populations it serves, or will dentistry pay lip-service to this social movement? What tools can we use to assess the quality of the profession's engagement with the task at hand and critically evaluate or assess the progress it has made in this regard?

This article offers a sociological-ethical framework to ascertain if dentistry is the progressive and responsive profession it claims to be in the immediate aftermath of the #BLM movement. The dual theory of justice developed by Nancy Fraser (2001, 2004, 2005) and its distinction of the role played by redistribution and recognition in the pursuit of justice will be used to illuminate the challenges that dentistry and oral health face in this regard. I will then plot the current efforts of the dental profession

Correspondence to: Dr. Patricia Neville. Email: patricia.neville@bristol.ac.uk

against the known trajectory of social movements to adjudicate what has been achieved and what work is yet to be done to ensure inclusion and race-based justice.

The justice deficit

Justice is an integral pillar of the provision of healthcare. According to the WHO 'social justice begins by recognising that health is a fundamental human right and that gross inequalities in healthcare are politically, socially and economically unacceptable'(International Conference on Primary Care, WHO, UNICEF, 1978). David Nash, the noted dental ethicist, has written 'If oral health is a basic human need, as it is, then it is a basic human good. Therefore, all members of society should have equal opportunity to gain the benefits of this human good' (2015, p.8). According to the social contract theory of healthcare professions, dentistry has both a vocational and action-orientated focus, premised on the principles of mutual respect, trust, reciprocity, fairness and 'doing the right thing' by patients/the public and the members of its profession (Cruess and Cruess, 2008; Holden, 2017; Welie, 2012). While there is consensus that the principle of justice should infuse all aspects of the profession and delivery of care, there is less agreement on how to manifest or operationalise it. For philosopher Nancy Fraser justice is defined by the absence/presence of 'parity of participation' (Fraser 2005, p.73). To demonstrate this need for parity of participation, two conditions need to be secured: recognition and redistribution. Recognition hinges on the need for everyone to become 'full partners in social interaction' (Fraser *et al*., 2004, p.377) in peer/colleague, dentist-patient, dental team and other hierarchical workplace interactions. However, she also acknowledges that 'institutionalised hierarchies of cultural value (that) prevent some members of society from participating as peers in social interaction' (Fraser *et al*., 2004, p.377). For ethnic minority patients and professionals this can include, but is not limited to: everyday racism (Essed, 1991), ethnic/gender/social class stereotyping, the exercise of white privilege (e.g. McIntosh, 1984/1989), and the rhetoric of 'benevolence' when treating traditionally excluded ethnic minorities, e.g. First Nation or Indigenous groups (Bond *et al.*, 2021).

Redistribution refers to the process through which 'people can be impeded from full participation by economic structures that deny them the resources they need to interact with others as peers' (Fraser, 2005, p.73). The issue of redistribution has posed a longstanding moral and ethical quandary for the dental profession. Multiple and mutually reinforcing processes of economic and cultural exclusion ensure that access to dentistry has been historically limited to socially advantaged groups (White, middle class, western). Worldwide access to a dentist is skewed in favour of industrialised, Western economies. Even though 3.5 billion people suffer with oral diseases (Global Burden of Disease 2017 Disease and Injury Incidence and Prevalence Collaborators, 2018), 69% of the world's dentists live in developed countries and treat 27% of the population (Gallagher and Hutchinson, 2018). In 2020, 67% of World Health Organisations (WHO's) member states, including 40 members states from Africa and 25 from the WHO Americas region recorded less than 5 dentists per 10,000 population (World Health Organisation, 2021). These chronic global issues regarding access to dental services (Noushi *et al.*, 2020; Watt *et al*., 2019a) are exacerbated by local and national inequalities, especially for groups that have been traditionally excluded and marginalised in society, such as indigenous and First nations populations (Nath *et al*., 2021) and those with intellectual disabilities and other vulnerabilities (e.g. Watt *et al.*, 2019b). Furthermore, dentistry's association with commercialism (Welie, 2004; Nash, 2015; Ozar *et al.*, 2018; Holden, 2017) imposes a fundamental wedge between dentistry's claim to offer care for all. The predominance of cosmetic dentistry, as an elective treatment with the primary aim of aesthetic improvements (Holden, 2018), also calls into question whether this popular specialism of dentistry satisfies the 'care, cure, education, prevention or help' ethical parameters of healthcare (Pellegrino, 1999, p.247). These examples of redistributive injustices weaken dentistry's normative claim to be considered a just and inclusive healthcare (Holden and Quiñonez, 2021).

#BLM in dentistry

The next question is, how does the profession redress these injustices and moral failures? It is common at the beginning of a social movement to be inundated by a litany of recognition and redistribution-based issues (Fraser *et al*., 2004, p.375). The challenge begins when the movement enters a 'less expansive phase' (Fraser *et al*., 2004, p.375), and some issues continue to gather support and interest, while others fall by the wayside. How can we ensure that dentistry does not fall into the same trap? One way to do this is to map the current efforts of dentistry using a social movement model. Understanding the life cycle of social movements may be helpful in lending clarity to a '#BLM in dentistry' movement and steer the profession along a transformative agenda.

Social movements typically move through four stages of growth; emergence, coalescence, formalisation and institutionalisation (Blumer, 1951). The emergence stage refers to the period when people first become aware of an issue, or when a sense of grievance or discontent is first articulated (Tyler and Smith, 1998). This period is often hallmarked by a flurry of activity or 'social ferment' (Blumer, 1951). This is followed by the coalescence stage when people come together and begin to organise themselves to raise further awareness and politicise the issue. In the formalisation stage, the seeds of activism become more established resulting in the creation of a clear platform for action and acknowledged practices for change. The final stage, institutionalisation, occurs when the calls for change are accepted as part and parcel of how the institution works (Blumer, 1951).

When we map this social movements blueprint onto the current debate about racism in dentistry, we can say that the emergence stage is firmly established, with dentists from ethnic minority backgrounds going online to lend their voices in support of #BLM movement and sharing their experiences of discrimination (e.g. Bissett, 2020). This 'online activism' has been matched by the establishment of several networks, such as the Melanin Medics (https://www.melaninmedics.com/), Black Budding Dentists

(https://www.instagram.com/buddingblackdentists/) and the African Caribbean Dental Association (https://acda-uk.org/), in addition to other newly formed associations for dental students from ethnic minority backgrounds. These grassroot developments offer the opportunity for the establishment of ethnically aligned affinity groups within dentistry. As informal or formal groups they provide support, mentoring and networking opportunities for its members. Their very existence also helps initiate dialogues about discrimination and prejudice experienced by dentists within the profession. Such #BLM activism has also contributed to change at an institutional level; various dental professional associations have issued statements of support, recognising the values of the #BLM movement (respect and social justice) (#Black Lives Matter, 2017) and committing to a process of organisational change (e.g. Lawda, 2020; Moyes, 2020; Faculty of Dental General Practice, 2021, Canadian Association of Public Health Dentistry, 2020). The #BLM movement has also spurred the establishment of anti-racism steering committees and the commissioning of reports. The recent publication in the Diversity in Dentistry Action Group (UK) report (2021) and the White paper by the American Association of Public Health Dentistry (2020) is further evidence of a commitment to profession-wide, institutional level response to the issue of institutional racism with clear targets and strategy for change.

Dovetailing the #BLM movement is the 'decolonising the curriculum' initiative. Started in 2015 in response to student calls to remove a statue of Cecil Rhodes from the University of Cape Town, this African movement has transformed into an educational movement popular among US and UK universities critiquing existing bodies of knowledge for its colonial and Eurocentric assumptions and biases and the underrepresentation of Black and other ethnic minority scholars in the canon and academy more generally (Gill, 2018). For dentistry this has resulted in the recognition that dental knowledge is premised on colonial, Western epistemologies (Bastos *et al*., 2018; 2020) with white patients (in the use of clinical images, diagnostic skills, case studies in textbooks) assuming the default setting for clinical teaching (Ali *et al*., 2020). There is now a rise in calls to decolonise the dental curriculum (e.g. Ali *et al*., 2020; Kayido and Mellish, 2021) and make dental education more socially aware and politically oriented (e.g. Palmer, 2007).

This range of responses can be interpreted as signs that the #BLM in dentistry movement in the UK, Canada and US is edging closer to the coalescence stage. However, social movement theory reminds us that for momentum to be maintained there needs to be continued support for the cause from the wider collective, not just from among the activist contingent. Three key ingredients are needed for the continued success of any social movement- legitimacy, strategy and resources (Walker and McCarthy, 2010). Legitimacy can be defined as "a generalised perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions" (Suchman, 1995, p.574). How can we secure legitimacy for #BLM movement in dentistry? Fraser et al. (2004) and Fraser (2005) reminds us that not all responses to injustice are equal. Some are affirmative or ameliorative in effect, and others are transformative. While there is room for both responses (e.g. Having Western dentists volunteer with a dental charity in Africa (an affirmative response to the maldistribution of dentists globally) and ringfencing national investment to target the training of local/African dentists (a transformative response to the global maldistribution of dentists)), each action reveals a different level of understanding about and commitment to the process of change. If individuals and organisations only support affirmative actions, then the potential for lasting structural change will be impeded and the sense of legitimacy achieved will be based on a less politicised engagement with the movement.

Another response playing out around the misrecognition of the role played by ethnic minorities within the profession, evidenced by the everyday (Essed, 1991) and institutional racism (e.g. NHS, 2021) they experience in healthcare settings, is the move to create 'white allies'. "An ally is someone from a nonmarginalised group who uses their privilege to advocate for a marginalised group. They transfer the benefits of their privilege to those who lack it" (Phillips, 2020). However, becoming an ally is not easy. The focus of allyship is three-fold; 1) to challenge mindsets that are closed to the existence of everyday, structural and institutional racism and its social, psychological, economic and cultural impacts; 2) to encourage 'white' people to take responsibility for the explicit and implicit way(s) they discriminate against non-white groups and 3) to empower everyone to show solidarity with those who are racially discriminated against, calling out racist treatment and role-modelling anti-racist practice (The Anti-oppression network, 2011). While initiatives like implicit bias tests, unconscious bias training and bystander training are designed to facilitate the reallocation of privilege, some commentators lament that such a strategy is often reduced to an exercise in critical self- reflection, rather than collective action (Smith, 2013). If allyship has the potential to individualise and moralise (Pedersen-Smith and Bean, 2013) rather than politicise race-based activism, other structural efforts regarding the working conditions of ethnic minority healthcare workers, such as equal pay, effective and robust complaints investigations, ethnicity quotas for recruitments and representation at executive boards and positions of leadership need to be considered, in addition to, and not instead of allyship (NHS, 2021).

This critical analysis of dentistry through a justice lens presents a sobering moment of reflection for the profession. While such an exposition is being undertaken to facilitate a new phase of development for the profession and oral health care, there is also the risk that it will lead to feelings of despondency or resignation. Worse still it could serve to reinforce long standing biases and exclusionary practices, resulting in ethnic minorities and others who are engaged in calling out racialised injustices to be branded as 'troublesome' (Ahmed 2021). How can we mitigate this type of defensive posturing? According to social movement theory, people will only connect to a movement if its ideas are framed in a way that everyone can relate to (Van Stekelenburg and Klandermans, 2009). Stressing commonalities helps build solidarity with the movement and its goal. One way that this can be achieved is if we re-articulate the ethical/normative values that are shared by the #BLM movement and dentistry as a commitment

to addressing the moral and social determinants of oral health (Berwick 2020; Tellez *et al*., 2014; Watt, 2007). Framing the purpose of '#BLM in dentistry' as such will also achieve 'consensus mobilisation' (Van Stekelenburg and Klandermans, 2009). Giving people this shared vision of the movement will allow all members of the profession to build a meaningful connection with #BLM goals and ideals, recognising that dentistry and oral health should be available to all. Such a strategy serves not only to 'rediscover' the activist roots of dentistry but also validates and lends legitimacy to the argument that the endeavours of '#BLM in dentistry' is a rightful concern of the profession.

Conclusions

In this commentary we posed the question "How has dentistry engaged with the #BLM movement?" Like many other institutions, dentistry responded to its call for race-based justice with an initial 'fervent' phase of activity. However, when analysed through a social justice lens, we find that much of this activity was affirmative in focus (e.g. institutional statements of support, allyship, unconscious bias training) rather than transformative (e.g. targeted recruitment drives and selection quotas for under-represented ethnic minorities). Granted, efforts to address the structural/redistributive injustices of dentistry and oral health care will take substantial commitment of resources, including time and involve a strategic end-to-end action plan, incorporating grassroots, national and international collaborations. However, because of the justice deficit that defines dentistry and oral healthcare, concern was raised about the profession's legitimacy to pursue such a change agenda. Dentistry needs to reaffirm its moral and ethical purpose; failure to do so will continue to place the profession in a weakened principled position when and if it continues to pursue an anti-racist agenda of dismantling ethnicity related barriers to oral health and the profession and decolonising the dental curriculum.

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