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# Power in Dentistry: A Foucauldian Shift in South Korea

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The established method of understanding power in dentistry is based on the early Foucauldian discourse that dentistry enforces oral health discipline to the people on behalf of state power. This exhibits the hierarchy between dentists and patients, which clearly appears in clinical dentistry and effectively explains the responsibility of oral care assigned to patients. However, there presents no way to becoming free from the framework in the discourse as a resistance. Beyond the political aspect of the medico-sociological framework, this paper seeks a different way to understand power in dentistry through 'care of the self', a late Foucauldian concept. First, based on the current discussion of the dentist-patient relationship (DPR), the paper examines two trends of clinical dental treatments in South Korea. The high prevalence of dental implant and orthognathic surgery indicates that traditional prejudices including ableism and pursuit of Western beauty still remain in South Korea albeit with the society overcoming paternalism in DPRs. These dental phenomena, however, contain excesses that cannot be explained only by traditional prejudice, and this paper attempts to interpret them as the pursuit of care of the self that appears in the dentist's professionalism and the patient's self-determination. In dentistry, care of the self can be introduced in the form of empowerment, which is implemented through the improvement of oral health literacy and shared decision-making. This paper argues that this interpretation helps surmount the traditional dyadic model of the DPR and revise the understanding of power in dentistry.

**Keywords**: *Power, Dentist-Patient Relations, Empowerment, Health Literacy, Shared Decision Making*

## Introduction

In *Power, Pain and Dentistry* (Nettleton, 1992), which set the direction of medical sociology in the 1990s, Nettleton reviewed dentistry through Michel Foucault's theory of power. She argued that "the mouth became an object of surveillance, a subject of the mechanisms of discipline which were inherent in the twentieth century public health movement" (Nettleton, 1998). This work examined the process of translating medical knowledge, which can be understood as pursuing knowledge of the body in the network of micro-power, and influenced the understanding of how dentistry became a modern profession (Kitchener *et al.*, 2012; Holden, 2018).

This understanding of the way in which dentistry shapes oral power clearly shows the limitations of the dental healthcare system. That is, "the duty of the dentist was not just to invade the mouth but to monitor and regulate and thus to contribute to the policing of bodies" (Nettleton, 1994). In other words, dental knowledge created by dentistry provides a window for the state to investigate the oral cavity of the people, and through this, the state inscribes an internal monitoring process. In addition, the formation of the dental profession cannot be understood apart from the institutionalisation of oral power, where the profession is depicted as a group that strengthens their exclusive power by setting oral health as a norm (Macdonald, 1995; McKeown *et al.*, 2003; Holden 2020).

The problem is that even if this analysis can help understand a specific part of dentistry, especially the process of governing the oral cavity of the patient, we cannot find a way to resist this process from anywhere. This is not only a feature that appears in dental analysis, but also a limitation placed on early Foucauldian discourse, which medical sociology adopts as a theoretical basis (Sato *et al.*, 2007). Foucault's disciplinary power not only talks about the oppression of the subject by the ruler but argues that the subjects themselves are formed through power. As in the case of dentistry, oral discipline creates a norm of oral cavity that needs tooth-brushing every day and undergoes regular dental check-ups periodically (Nettleton, 1992). As a result, individual oral health is defined as being equipped with a 'white, regular, and flawless' dentition. This leads to the public welfare by reducing oral diseases and securing socioeconomic resources, and eventually through this, increasing 'state power'.

In the process of setting this norm, individuals are given the benefit of reduction in pain caused by oral disease. In addition, Foucauldian power already presumes individual resistance in the process. "By definition, resistance exists only in the strategic field of power relations" (Foucault, 2006). Resistance naturally occurs as an opposition to power and the power structure already

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subsumes resistance of individuals (i.e., social discipline inherently appears in individuals and individuals only express minor resistance, being unable to change this structure). Therefore, under such a power structure, it is difficult to resist oral discipline. The rules for oral health implemented by the state to the people—as aforementioned for being Western, white, and able-bodied—are set as the only method of oral management, and other alternatives are excluded from the normative framework outside state-approved oral knowledge.

This understanding of power makes it difficult to interpret individuals' practices of resistance in today's world (or subsumes it into the way of power operation). In fact, understanding dentistry through disciplinary power helped identify issues of paternalism in dentistry but failed to suggest an alternative and stopped short of insisting on consumerism (Holden, 2020). Here, we understand that both paternalism and consumerism act power in dentistry in the same way (Shutzberg, 2021). Both are the same in that the rules of the state are instilled in people through the unidirectional implementation of power from dentists to patients in paternalism, and the other way around in consumerism. Whether it is by a dentist's paternalistic decision or a patient's pursuit of aesthetics, for example, the patient has no choice but to choose 'white, neatly arranged, Western, and flawless' teeth in anterior dental prosthesis.

We will examine two cases of dental practice in Korea: dental implant and two-jaw surgery in consideration of the dentist-patient relationship. Korea has been utilising dentistry as a method of enforcing state norms in establishing a state-led healthcare system. Widespread ableism, ageism, and Western-White centrism in society have influenced the way of defining dental practice and explained the high prevalence of dental implant and orthognathic surgeries in Korea. However, using these practices, dentists and patients simultaneously pursue their own purposes that may be different from the state norms. For the matter, this paper attempts to understand and suggest a different perspective on power in dentistry through the concept of 'care of the self' (Foucault, 2012).

## Background: Dentist-patient relationships

Clinical encounters are a key element of healthcare services particularly for dentistry, considering the inherent nature of surgical procedures in most dental practice. Of core value is the dentist-patient relationship (DPR) established in dental encounters (Yamalik, 2005; Song *et al*., 2020). Models illustrating DPR have been extrapolated from the medical equivalent mainly consisting of paternalistic, informative, interpretive, and deliberative models (Emanuel *et al*., 1992; Song, 2020). In these models, power is considered to be a substance or property to occupy in dental encounters between two adversaries, dentists and patients as a dyad. The dichotomy of the power game has dominated and prescribed the transition of DPR hitherto. For example, the Parsonian model presumes that the physician-patient relationship is inevitably asymmetrical, assigning the power dominance to physicians and the 'sick role' to patients (Weiss *et al*., 2017). This understanding has led to the adverse outcome of victim blaming (Watt, 2007) as a result of disease-centred care and the biomedical model of health. Critics of the Parsonian model have introduced patients' more active role in healthcare encounters from being mere subjects of paternalism via contracting parties to autonomic participants. The power imbalance leaning towards dentists in the DPR seems to strike a balance for more equitable mutuality thanks to the consumer rights movement, enforcement of regulation, information and technology revolution, and institutional change. The ostensibly successful achievement, however, may simply mean the shift or sharing of the 'final say' in DPR for the pursuit of 'white, straight, and complete set' of dentition with no change in underlying social norms of oral health. As such, patients, not dentists, become the ones asking for a cosmetic dental veneer rather than accepting slightly mottled teeth from water fluoridation for aesthetic concerns. Furthermore, although paternalism in dental decision-making in the past may have faded, the top-down unidirectional implementation of power from the state to the people remains unchanged. This is more pronounced in the context of Korea, which quickly and successfully established a post-war state-led healthcare system (DiMoia 2013).

## Case studies: Power in dentistry in South Korea

South Korea has a national health insurance system that includes dental health services, mainly for urgent/essential care, along with some elective prosthodontics such as dental implants for some conditions (Kim *et al*., 2021). Now that a brief understanding of power in DPR has been established, we will explore two up-to-date yet over-indicated dental practices in Korea about how power is reflected in dentistry and the possibility of applying 'care of the self' on the matter.

### *Dental Implant*

Although implant-supported prosthodontics is a recognised treatment in most developed countries, only 15-20% of dentists worldwide perform dental implant surgery on a regular basis. There is a global consensus that general dentists refer their dental implant patients to more experienced and skilful specialists, whereas in Korea, more than 70% of active general dentists practice implant surgery. According to the 2017 annual report of Straumann (Strauman Group, 2017), a major implant manufacturer, Korea is one of the countries with the highest numbers of dental implant surgeries performed, at 632 per 10,000 people. This is four to five times the number in Germany, Europe's largest economy, or the US, the world's largest economy. The prevalence of dental implant treatment in Korea can be partly because the national health insurance system has gradually introduced reimbursement for the practice in the elderly since 2014 (Lee *et al*., 2017). Most of all, however, a culture prevails in the country whereby Koreans tend to feel ashamed to live with missing teeth.

Data from the 7th Korea National Health and Nutrition Examination Survey (KNHANES) were analysed to explore the status of dental implant treatment in a representative Korean population (KDCPA, 2021). The KNHANES is a statutory periodic national survey on health behaviours, chronic disease prevalence, food

and nutrition intake to provide baseline data for public health policies and healthcare system. Since 2007, the KNHANES has included items on whether respondents had dental implants. The proportion of the population with dental implants among those with more than one missing tooth and those with only a single tooth loss was calculated respectively. According to the analysis, 31.0% of Koreans with more than one missing tooth had dental implants. The prevalence of dental implants gradually increased with age, except among those aged 65 years and older. By age, 17.0% of the 20 to 34-year-old population, 29.3% of the 35 to 49, 38.6% of the 50 to 64, and 28.7% of the 65-year-olds or older population had implants.

In contrast, the percentage of dental implant treatment for a single missing tooth decreased with age. Among those with one missing tooth, 23.0% of the 20 to 34-year-old group had a single dental implant placed, while 22.1% of the 35 to 49, 21.9% of the 50 to 64, and 17.1% of the 65-year-olds or older group appeared with the treatment. For the former pattern, the greater prevalence of dental implants among the older population, except for those aged over 65 years with more than one missing tooth, may indicate that they opt for the treatment to rehabilitate their masticatory function considering the proportional relationships between tooth loss, ageing, and difficulty of biting/chewing ability. Whereas, for the latter pattern, the declining prevalence of dental implants in accordance with age among those with a single missing tooth suggests that younger people are more likely to improve their dental semblance of 'normality' as the first loss of a tooth is considered a symbol of social incompetence and can potentially cause appearance discrimination.

### *'Two-jaw' Surgery*

Statistics on cosmetic surgery in Korea are limited because, unlike other areas of medical treatment covered by the national health insurance system, cosmetic surgery is regarded as elective or unessential medical procedure solely left to the private sector. According to a 2014 report by the National Evidence-based Healthcare Collaborating Agency (NECA, 2013), Korea showed the highest number of cosmetic procedures performed (131 per 10,000 people) in 2011 ahead of the second and third ranks, Italy (116/10,000) and the United States (100/10,000).

Furthermore, in a 2008 survey from orthodontists in Korea, 11.0% of patients aged 19 years or older underwent orthognathic surgery (Jung, 2012). Data were collected in a survey from a total of 11,340 patients by 28 orthodontists, and on average per orthodontist, 22.3 patients over the age of 19 years opted for the surgery. Meanwhile, in a similar survey in the United States from 2009 to 2013, orthodontists treated an average of 3.7 patients for orthognathic surgery (Ford *et al.*, 2014). For reference, a major textbook in orthodontics estimates that 5.3% of patients with dental malocclusion need orthognathic surgery (5% of patients with class II jaw relations, 33% of patients with class III, and 25% of patients with anterior open bite) (Musich *et al.*, 2017). Thus, the prevalence of orthognathic surgery in Korea is quite high compared to that in the United States and the estimation on a textbook.

This difference can be partially explained by the fact that the prevalence of class III jaw relations is higher in Korean orthodontic patient population with 36.1~36.7% as compared to 31.3% in a North American white counterpart (Piao *et al*., 2016; Kook *et al*., 2004). Despite the higher prevalence of class III malocclusion, many of the extra surgery cases are not simply explained considering its financial burden and potential adverse effects from relatively massive procedures. Rather, it seems more plausible to postulate that the preference for Western beauty standards in Korean culture (Leem 2017) and aggressive attitudes towards the surgery by maxillofacial surgeons in Korea (Lee *et al*., 2011) may account for the high prevalence of orthognathic surgery.

Trauma from the Korean War, be it physical, mental, or social, was treated and reconstructed by medical intervention with aid from the United States (DiMoia 2013). This resulted in normalisation of the reconstruction of the body along with commercialisation of elective plastic surgery even at the cost of out-of-pocket 'investment'. Consequently, Korea was even dubbed 'Plastic Surgery Nation' and 'Plastic Surgery Powerhouse' from a dubious endorsement with the highest number of cosmetic procedures performed per 10,000 people (Leem 2016a; ISAPS 2011). In particular, the prevalence of plastic surgery, including orthognathic surgery, can be ascribed to pathologizing the body of a non-white race (Leem 2017).

In other words, the operation of power in medicine and dentistry sets Western-White people's facial beauty as a norm in histo-cultural context. During the Cold War, Korean fantasies about Western-White once served as an ideal for plastic surgery, orthodontics, and jaw surgery, defining Koreans' pursuit of beauty. In particular, plastic surgery (the same goes for orthodontics and jaw surgery) was recognized as feminine and linked to the invigouration of the beauty industry (Leem, 2016b), which shows that gendered norms are working in plastic surgery. Ageism also has a strong influence (Morgan 1991; Suissa, 2008), which leads to the prevalence of anti-ageing practices (Chung, 2017). Dentistry would be no exception since orthodontics is commonly regarded as a way to look younger and smiley in the lower third of the face. However, as can be seen in the case of double eyelid surgery (Edmonds and Leem, 2020), the pursuit of Western beauty is gradually transitioning into a different phase in Korea. We will examine below that such changes are occurring in dentistry also.

## Discussion: Care of the self in dentistry

We have explored how power in dentistry has played in Korea with the background of DPR and two common treatments. Dentistry and oral health in Korea have swayed between the traditional paternalism and the modern consumerism under the influence of ableism, reconstructivism, and the pursuit of Western beauty.

Both dental implant and two-jaw surgery are reconstructive procedures. Based on historical analysis (DiMoia, 2013) showing that medicine and dentistry in Korea were influenced by American reconstructive surgery around the Korean War, we can determine the role of two dental practices played in the clinical context in Korea. As a technique for rebuilding broken body parts, the two

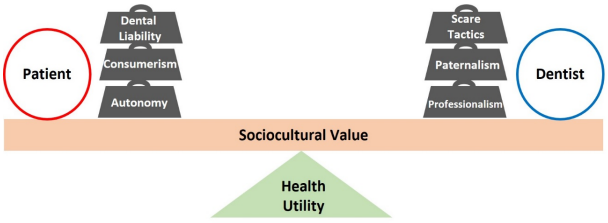
treatments come to work by reinscribing existing social norms on how to normalize the body. As is seen above, missing teeth should be quickly 'filled in' to camouflage an empty space. A distorted jaw should be 'relocated' for optimal health as much as possible.

Both patients and dentists, however, bring into the process an excess that cannot be explained simply by social norms. Dentists emphasise the establishment or improvement of physical functions in the two treatments which are substantially concerned with aesthetics needs. Through this cause, they try to reaffirm and solidify their role as experts in oral health. Likewise, patients seek better quality of life by undergoing dental implant or two-jaw surgery even at the cost of significant financial burden. The patients' decision-making cannot be simply accounted for by economic rationality (Lee *et al*., 2012). In other words, the high frequency of the two surgeries may indicate that patients try to improve their health irrespective of the state-prescribed standards and dentists also pursue their professional goals distinct from traditional prejudice.

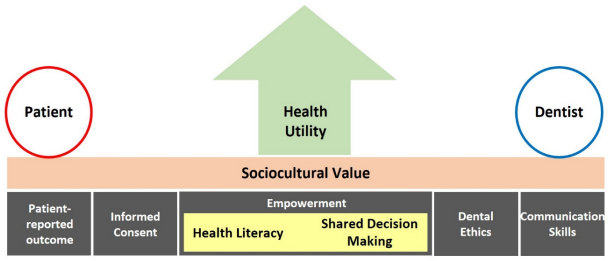
Power as a complex group of forces (Foucault, 2019), has primarily been objectified to restructure/reassign force relations between two players of a dyad in DPR. While focusing on 'who' to hold the power of making a clinical decision, the attention on 'what' underlies the power might have been overlooked. The discourse on power in DPR is not only about pursuing equitable relationships by quantitatively redistributing the decision-making force, but also putting the patient's value and preference at the centre of dental healthcare. For example, the transition of power in DPR necessitates informed consent from the patient, and informed consent can be valid only if the patient's best interests from the dental practice are explicitly delineated and agreed on for the self-directed care, not state-driven intervention. To determine the patient's best interests, improving oral health literacy through health information, and the healthcare and education systems (Horowitz *et al*., 2008) is imperative for shared decision-making. In addition, health outcomes should be redefined to reflect individual preferences over social norms from other people's perspectives. For that matter, patient-reported oral health outcomes including oral health-related quality of life (Fayers *et al*., 2002) in the biopsychosocial model of health are encouraged to be the raison d'être of dental practice. Trust in DPR is also advised for the translation of power, considering the vulnerability of the patient and fragility of the relationship in dental encounters (Yamalik, 2005).

Starting from DPR, we identified two factors in the process of analysing the power effect of treatment practice. First, the relationship between dentists and patients in dental encounters is incorporated into the existing dominant unidirectional model of power. Second, nevertheless, the relationship has excess areas that are not explained in the existing power model, and this excess, which we conceptualise this through care of the self, provides a clue to the formation of alternative forms of relationships. 'Care of the self' refers to "an attitude and a quest that individualized his action, modulated it, and perhaps even gave him a special brilliance by virtue of the rational and deliberate structure his action manifested" (Foucault, 1990), or, in other words, an individual's ethical subjectivation process that is not reduced to the norms of the community.

In dentistry, care of the self can manifest as the empowerment of patients. The aim of dental healthcare should be the best interests of individual patients, based on patient-centred care for oral health promotion rather than clinical dental outcomes as a social norm set by the implicit power in dentistry. In this regard, not only dentists but also patients and the general public should be empowered in dental healthcare to achieve the aim. Dental professionals should play the roles of advocates, champions, counsellors, companions or guardians, providing support and guidance to patients on care of the self so that they can actively participate in shared decision-making based on oral health literacy and trustful DPR (Figure 1).




(a) Dyadic 'Power Imbalance' model




(b) 'Care of the Self' model

*Figure 1. Traditional understanding of power in DPR and 'care of the self' model*

## Conclusion

Based on a review of the DPR, this study explored two treatments in Korea, dental implant and two-jaw surgery. Through these examples, we examined the excess and desire for such practices that appear beyond the ostensible cause in the framework of traditional DPR and social norms. Foucault's later works emphasised practicing how to manage oneself instead of monitoring of power so as to identify novel styles of subjectivation deviating from the logic of state and capitalism. Accordingly, we tried to reposition dentistry as a mechanism that supports a dual role newly found from the excess. Dentistry is a channel where monitoring the oral cavity traditionally stipulates oral health and forms dental knowledge by the disciplinary power of state or profession. However, the knowledge can also serve as a source for care of the self to surmount the projection of dominant power. When it emerges as an active pursuit of the aim for both dentists and patients through empowerment, power in dentistry can benefit both parties in a different way from the existing framework.

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## Data Sharing Statements

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## Author Contributions

J Kim contributed to the conception of the article, and drafted and critically revised the manuscript. DH Han contributed to conception of the article and drafted the manuscript. Y Song contributed to the conception of the article, and drafted and critically revised the manuscript. All authors gave final approval and agreed to be accountable for all aspects of the work.

## Disclosure

The authors have no conflicts of interest to declare.

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