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The mouth as a site of structural inequalities; an introduction

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A key premise of sociology is to promote fairness, justice and equity. These goals are synonymous with those of dental public health organisations throughout the world. However, an additional purpose of sociology is to reveal invisible points of observation, particularly those related to power. In the five papers that follow, we seek to contribute to the discourse around oral health-related inequalities through the lens of power and human agency. Based on the seminal work of Davis in the 1970s, Lukes' three-dimensional power framework and Goodley's work on dis/ability, we present a range of papers from the United Kingdom, Australia and New Zealand that give examples of structural power and disadvantage as they relate to the oral health experiences of Aboriginal Australians, dental school curricula and encounters in the dental practice. The papers formed the basis of a symposium entitled *'A sociological/ anthropological perspective on oral health inequalities'* at the 94th General Session of the International Association of Dental Research held June 2016 in Seoul, Korea. This symposium was a product of many requests over the years for there to be a specific research session focussing on the role of sociology and anthropology in oral health inequalities, especially as they relate to disadvantaged populations, dental service provision and dental school curricula.

Throughout the papers, we argue that the focus of dental care over the last century has shifted away from treatment which ensures functionality – to eat, speak and swallow – to treatments which position the mouth as important to ableist norms of cultural attractiveness (the ultra-white, ultra-straight smile). The hidden message is that we must take care of our teeth, because their condition not only impacts on how we are perceived by others, but reveals clues as to our age, health, wellness, wealth and success. Part of this dental care includes having resources and access to expensive and increasingly privatised forms of treatment. Paradoxically, those who in objective terms require the most dental care are those who are less likely to receive it; representing disadvantaged populations to whom dental service providers feel no desire, or obligation, to provide services. The roots of social inequalities in the provision of dental care clearly lie as deep as the inequalities existing in society itself; the evidence of which is strongly demonstrated by views of dental students in New Zealand. When culture is oriented towards an individual as opposed to collective perspective, and invisibly supports power differences between the 'haves' and 'have nots', it is no surprise that dentists choose mainly middle class areas in which to work over locations that are more socially disadvantaged.

We present evidence that the mouth is also a bodily site where structured inequalities are played out. Examples from contemporary literature include Mexican American farmworkers and their children being judged as either fit or not to be American citizens on the basis of their ability to look after their teeth, and patients from rural Brazil encountering dental professionals who violate the rhythms and sentiments of patients' daily lives, with the argument that dental treatment becomes a form of 'symbolic aggression'. There are additional issues involving social accountability in dental curricula. We suggest that these findings warrant deeper analysis and a revisiting of the sociology of embodiment, including examination of how ideas of super normality that are so widespread in dentistry are in fact probably not good for us. In each of the papers we assert that different groups are '*othered*" in dental discourse and provide examples of how such groups are treated by dental care systems, and are constantly being treated differently because they are different. We propose that the mouth is a cultural site for disabling and ableist practices, which includes but is not limited to the social organisation of dental work relevant to delivering care in disadvantaged communities. We describe a novel approach to understanding the relationships between the work of dentistry and these groups that do not fit the '*norm*', where 'normal' is an arbitrarily defined ideal that is impossible to attain. While wide in remit, the papers offer an alternative perspective to understanding oral health inequalities through a sociological lens. In this regard, they offer a refreshing, and fascinating, viewpoint that might serve as a platform on which further analyses on structural oral health inequalities might be based.

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