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Power, dentistry and oral health inequities; an introduction

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Oral health inequities at a global level persist. This is despite marked advancements in technology, service delivery, training, research and population-level initiatives such as water fluoridation. Although the social determinants of health are frequently cited in the framing, analysis and description of oral health inequities, the explicit role of power is usually omitted. Lukes described power as the capacity of actors to make change, as well as to receive and resist change. An analysis of power thus provides a better understanding of how diverse and conflicting interests of multiple actors can lead to differential oral health norms within communities. An analysis of power also demonstrates the intersectional forms of oral inequities experienced among the socially marginalised; it is not rooted in economic deprivation alone. The training and practice of dentistry itself creates intersectional forms of inequalities through race, gender and class. Dental academic spaces are overwhelmingly White, with the knowledge created thus embedded with Eurocentric values. This needs to be challenged. We aim, in this special issue, to provide an overview of the pluralist and diverse nature of contemporary global society, and to show how attempting to impose singular forms of behaviours, values and knowledge that suppress the cultures of socially marginalised communities enhances oral health inequities. Specifically, this special issue will: (1) present an overview of how power operates generally, using implicit bias examples, with a strong underpinning from the literature; (2) describe what this means for power in dentistry, drawing upon sociological literature with a specific lens on dental organisations; (3) expand understanding of post-colonial theory and how this reinforces power structures in dentistry that further enable the privileged and; (4) examine the power relationship between dentists and patients, using theoretical underpinnings and elaborating on different power paradigms in the Australian vs Asian/Korean context.

The papers formed the basis of a symposium entitled *'Power, dentistry and oral health inequities'* at the virtual 100th General Session of the International Association of Dental Research held July 2022. Speakers from the United States, United Kingdom, Fiji and Korea provided an engaging forum in both elucidating the far-reaching influence of power in global oral health inequities, from sociological, epidemiological and political perspectives, and the multi-faceted impacts on oral health policy this has.

Reese describes how groups with greater power have capacity to both accumulate resources and influence key structural elements of both all societal systems, including healthcare. He argues that dismantling these inequities requires changes to both political, programmatic and interpersonal initiatives. Explicit and implicit bias in workplaces, teaching institutions, families and community groups need to be understood and addressed, with a move away from "diversity leaders" being responsible for change. An example is given whereby dental schools not only teach about inequities in oral health, but require students to demonstrate recognition of systems that reinforce inequities in dental practice/research and broader society. Kearns and colleagues provide a compelling synopsis of the issues of caste in the US and what implications this has on oral health inequities. They suggest that organised dentistry wields a power over contemporary dental service models that are, in essence, ineffective. And that these dental service provision models are steeped in casteist concepts. For example, the authors argue that saving patients from harm and having a profitable business margin are key motivators for many dental providers, but there are deeper biases around beliefs that patients/other providers are inferior. This is reflected back by broader society across almost all countries. A caste-based conceptual framework provides an important lens through which to better understand oral health inequities, with its related theoretical constructs of decoloniality, conflict theories and Marxist feminist scholarship.

Lala further expands decolonising theory in her paper, with a specific focus on dental school curricula. She describes how dental knowledge is neither objective nor neutral, and how colonialism has created persisting patterns of power that are embedded in almost all Western epistemic models. She argues that, with widening racial inequities, the dental discipline has emphasised diversity as opposed to addressing the wider, more far-reaching impacts of colonialism. If dental schools are sincere in their aim to dismantle inequities, a courageous transformation of their hierarchical knowledge practices is required.

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In an example from Korea, Junhewk and colleagues explore the impacts of power on dental implants and two-jaw surgery. They concluded that the social desire for such practices appear to be in excess of usual clinical norms, and that this is intrinsically shaped by the power imbalance of the dentist-patient relationship. Drawing on Foucault's theory of power, the authors conclude that, whether by a dentist provider's position of power or pursuit of aesthetics as derived from social norms, the patient typically has little choice but to submit to 'white, neatly arranged, Western, and flawless' teeth in anterior dental prosthesis.

In conclusion, the papers inform researchers, clinicians and policy makers of the intractable role of power relationships in population oral health inequities over the past century and how these might be identified, articulated and minimised. There are clear implications for addressing power dynamics in population oral health at an international level, including the role of advocacy and engaging with the wider political body to both identify and increase comprehension of the far-reaching impacts, and many guises, of power in dentistry that may lead to misinformed policy.