Oral Health Equity Must Address Oppression: On the BSSOH Consensus Statement

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Abstract

The Consensus Statement on Future Directions for the Behavioral and Social Sciences in Oral Health (Consensus Statement) is a transformational contribution to oral health research synthesizing a wide array of conceptual, methodological, and disciplinary concerns and offering strategies to improve scientific inquiry. The Consensus Statement explicates global oral health equity as a foundational concern of our field. Given this context, a key concern is missing from the statement: oppression!

Keywords: racism, research design, social sciences, behavioral sciences, social justice, social determinants of health

The Consensus Statement on Future Directions for the Behavioral and Social Sciences in Oral Health (Consensus Statement; McNeil et al. 2022) is a transformational contribution to oral health research synthesizing a wide array of conceptual, methodological, and disciplinary concerns and offering strategies to improve scientific inquiry. The Consensus Statement explicates global oral health equity as a foundational concern of our field. Given this context, a key concern is missing from the statement: oppression!

The omission of oppression is striking given recent global events, particularly minoritized groups' disproportionate impacts of COVID-19 and ongoing freedom struggles, including ethnoracial justice, antiauthoritarianism, and sovereignty rights. Equity-oriented agendas urgently need to address oppression.

We understand oppression as how institutionalized power and privilege categorizes groups of people hierarchically based on otherwise value-neutral characteristics (Bowleg 2012; Feagin 2013). People are conditioned to see themselves and others as superior or inferior and are selectively subjected to benefits and harms. As a US-born-and-raised anthropologist (SER) and political scientist (EF), we are particularly familiar with how oppression manifests as anti-Black racism. We also appreciate that histories and practices of oppression—colonialism, capitalism, caste, colorism, citizenship, religiocentrism, misogyny, gender binarism, heteronormativity, and normative able-ness—are neither unique to the United States nor limited to racism. While in this editorial, we consider structural racism and institutional white supremacy as *foundational* oppression, we advocate an intersectional understanding of global oppression (Jamieson 2021; Kelly et al. 2021) in how we conduct research.

Emerging work in oral health research holds promise to advance equity and address racism—its forms, measurement, and effects in population health, workforce development, and scientific inquiry. Scientific fields, including our own (Bastos et al. 2020; Ioannidou and Feine 2020; Evans and Smith 2021; Jamieson 2021; Fleming, Bastos, et al. unpublished), are interrogating their legacies of racism and oppression. The omission from the Consensus Statement[1] simultaneously reflects the dominant intellectual history of the field, at least in the United States,[2] *and* left us wondering: where is our accounting for racial justice epistemologically and ethically?

We propose grounding behavioral and social sciences of oral health in an antioppression understanding of equity. Any future for oral health research that *does not* situate itself as such is obsolete. We need frameworks that compel us to interrogate critically how structural racism and institutional white supremacy affect our field's approach to inquiry. Inspired by James Baldwin, we critique our field because we love it enough to hold it accountable and inspire liberation.

The Consensus Statement correctly argues that operationalizations of social determinants of oral health "frequently ignore social and political theories of power and inequalities" (McNeil et al. 2022). However, it perpetuates a conceptual and methodological error: naming *race* as a social determinant rather than the more valid construct *racism*. Race is a scientifically unjustifiable marker rooted in the transatlantic moment of African captives and inconsistently applied and manipulated across history (Braveman and Parker Dominguez 2021). A proxy variable,

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race offers little explanatory power for the causes or distribution of disease. Conversely, racism encapsulates self-perception and interpersonal relationships as well systems and institutions (Bailey et al. 2017). Racism underlies health conditions across the life course: oral health outcomes, comorbid conditions, and mediating circumstances (American Association of Public Health Dentistry 2021; Braveman and Parker Dominguez 2021; Jameson 2021). Oral health scholars who quantify population health should consider how peers in public health, medicine, and other fields operationalize structural racism as a construct for statistical analysis (see Bailey et al. 2017 and citations in Braveman and Parker Dominguez 2021 and Kelly et al. 2021).

Addressing structural racism requires vigilantly and humbly assessing potential *impacts* of our intentions, which may reflect tacit—or willfully ignored—manifestations of oppression such as hegemonic ideas about what constitutes expertise. Health interventionists have long fretted "motivating" research participants, characterized as "ambivalent about change, or unaware that change is needed" (McNeil et al. 2022). Such pronouncements overlook ontological hierarchies and how oppression shapes individual "choices" predisposing to disease, including epigenetic expression. We need epistemologically and methodologically diverse research *and researchers*—to *trust* research participants' logics within their sociopolitical and historical contexts, in particular oppression (Bastos et al. 2020; Muirhead et al. 2020; Jamieson 2021; Kelly et al. 2021).

The authors' wise advocacy for "high-quality research that is both theoretically sound and clinically and socially relevant, with subsequent translation into practice" (McNeil et al. 2022) can be strengthened through grounding in antiracist praxis. Statistical methods used to evaluate interventions have, historically, too often derived from Western positivist traditions that fail to theorize or operationalize oppression in the causal pathway. We can enrich research rigor and relevance by introducing oral health interventions that target institutional and structural racism, as well as internalized and interpersonal[3] (see Brown et al. 2019), and evaluating them using validated measures (see Fleming, Brody, et al. in press), diverse empirical lineages (e.g., body mapping or interpretive self-narration), and community-engaged approaches.

The Consensus Statement lightly acknowledges power. We implore our fellow social and behavioral scientists, dental researchers, clinicians, educators, and policy makers to turn the mirror on ourselves. We must consider how we

- hold, share, or cede power in developing research and funding agendas;
- formulate research questions, as well as design and implement studies;
- review funding applications and journal articles;
- work with diverse community partners whose expertise, knowledge, and lived experiences complement, constructively challenge, and strengthen our own;
- mentor research team members, particularly minoritized and marginalized students; and
- hold society's power centers (professional associations, research institutions, academic centers, funders, payors, and dental practitioners) accountable for their social obligations to advance reparative oral health equity and universal basic care.

Approaches rooted in cultural humility and structural competency hold promise in training current and future researchers, clinicians, and other stakeholders (Kelly et al. 2021; see also Bastos et al. 2020; Muirhead et al. 2020). Oral health scholars must also adopt antiracist publishing standards in journals and expand funding opportunities to support these efforts.

On May 27, 2021, the World Health Assembly passed a watershed resolution on oral health. Work remains in the broader field of oral health research and practice to deepen our analyses of—and actions on—racism, oppression, and institutional white supremacy. We take heart and inspiration in recent developments, including literature from Consensus Statement authors, work from other disciplines, and the Consensus Statement's lead authors' invitation that we contribute this editorial. We look forward to collaborating in the words of the Reverend Dr. Martin Luther King Jr. to bend the arc of oral health's moral universe toward justice, however long it takes. Onward, together.

Author Contributions

S.E. Raskin, contributed to conception, design, data acquisition, analysis, and interpretation, drafted and critically revised the manuscript; E. Fleming, contributed to conception, design, data acquisition and interpretation, drafted and critically revised the manuscript. All authors gave final approval and agree to be accountable for all aspects of the work.

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Notes

1. Table 1 in McNeil et al. (2022) rightly enumerates some of these research areas. We applaud its development after oral health researchers and institutions endorsed the original statement and during the lead authors' initial review of this commentary.
2. By dominant, we mean a field that, like many others, originated and matured in institutional white supremacy. Scholars from minoritized backgrounds have produced more expansive and diverse social, clinical, and historical research for many decades, for example Dummett (1974, 1996).
3. Bailey et al. (2017) define structural racism as an overarching societal force in which discriminatory systems in both the material sense (e.g., housing, policing) and the nonmaterial sense (e.g., media) reinforce each other and deepen discriminatory values and resource distribution. This reinforcement happens in both institutional spheres (e.g., policies and procedures in public and private settings, for example, courts of law and private employers) as well as interpersonal spheres (e.g., implicit bias).

References

American Association of Public Health Dentistry. 2021. Anti-racism in dental public health: a call to action. Springfield (IL): American Association of Public Health Dentistry [accessed 2021 Nov 14]. https://www.aaphd.org/assets/Webinars/White%20paper%20FINAL%20July%202021.pdf.

Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. 2017. Structural racism and health inequities in the USA: evidence and interventions. Lancet. 389(10077):1453–1463.

Bastos JL, Constante HM, Celeste RK, Haag DG, Jamieson LM. 2020. Advancing racial equity in oral health (research): more of the same is not enough. Eur J Oral Sci. 128(6):459–466.

Bowleg L. 2012. The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. Am J Public Health Res. 102(7):1267–1273.

Braveman P, Parker Dominguez T. 2021. Abandon "race." Focus on racism. Front Public Health. 9:689462.

Brown AF, Ma GX, Miranda J, Eng E, Castille D, Brockie T, Jones P, Airhihenbuwa CO, Farhat T, Zhu L, et al. 2019. Structural interventions to reduce and eliminate health disparities. Am J Public Health. 109(S1):S72–S78.

Dummett CO. 1974. Dentistry's beginnings among Blacks in the United States. J Natl Med Assoc. 66(4):321–327.

Dummett CO. 1996. Dismantling discrimination in dental education. J Natl Med Assoc. 88(7):454–459.

Evans CA, Smith PD. 2021. Effects of racism on oral health in the United States. Community Dent Health. 38(2):138–141.

Feagin J. 2013. Systemic racism: a theory of oppression. New York (NY): Routledge.

Fleming E, Brody E, Raskin SE. In press. From describing disparities to understanding why disparities exist: anti-racist methods to support dental public health research. J Public Health Dent.

Ioannidou E, Feine JS. 2020. Black Lives Matter is about more than police behavior. JDR Clin Trans Res. 5(4):288–289.

Jamieson L, editor. 2021. Racism and oral health inequities. International Association for Dental Research symposium [Special issue]. Community Dent Health. 38(2):131–155.

Kelly C, Kasperavicius D, Duncan D, Etherington C, Giangregorio L, Presseau J, Sibley KM, Straus S. 2021. 'Doing' or 'using intersectionality? Opportunities and challenges in incorporating intersectionality into knowledge translation theory and practice. Int J Equity Health. 20(1):187.

McNeil DW, Randall CL, Baker S, Borrelli B, Burgette JM, Gibson B, Heaton LJ, Kitsaras G, McGrath C, Newton JT. 2022. Consensus statement on future directions for the behavioral and social sciences in oral health. J Dent Res. 101(6):619–622.

Muirhead EV, Milner A, Freeman R, Doughty J, Macdonald ME. 2020. What is intersectionality and why is it important in oral health research? Community Dent Oral Epidemiol. 48(6):464–470.