


## BRIEF COMMUNICATIONS

# Stronger together. Diverse dentists weigh in on racism and its impact on oral health in our communities

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## Abstract

**Objectives:** 1) To detail how racism and its intersection with the social determinants of health affect the oral health of Blacks or African Americans (B/AA), Hispanics or LatinX (H/L), and American Indians and Alaska Natives (AI/AN) as well as their ability to thrive and succeed in dental academic and professional settings; 2) to describe how the Diverse Dental Society is addressing the oral health of these ethnic/racial populations

**Methods:** The processes in which 1) structural (systemic) and cultural racism operate in the living and working environments of B/AA, H/L, and AI/AN to impact oral health outcomes and 2) B/AA, HL, and AI/AN oral health organizational leaders are collectively addressing the oral health effects of racism are examined

**Results:** Structural racism and cultural racism and their intersection with the social determinants of health adversely affect the oral health of B/AA, H/L, and AI/AN as well as their ability to thrive and succeed in dental academic and professional settings.

**Conclusions:** The leaders of the Hispanic Dental Association, National Dental Association, and the Society of American Indian Dentists realize that it will take collective action under the auspices of the Diverse Dental Society to synergize their organizations' individual efforts to create systemic change to address racial and health inequities and improve oral health outcomes.

## INTRODUCTION

Racism operates on cultural and systemic levels. On a cultural level, racism manifests as implicit bias and discrimination against others based upon race and ethnicity [1]. On a systemic level, it manifests as ideologies and institutional practices that confer advantages to some groups of individuals and disadvantages to other groups of individuals based upon their race or ethnicity [2]. State and local health leaders have elevated racism to the level of a serious public health threat because racism deprives ethnic/racial groups of access to key drivers of health equity, that is, to the social determinants of health. The result is harmful health disparities and racial inequities among ethnic/racial groups.

The authors examine systemic and cultural racism to which African Americans (B/AA), Hispanics/LatinX

(H/L), and American Indians/Alaska Natives (AI/AN) are subjected and how it impacts their oral health. They demonstrate how the current low-socioeconomic status and mistreatment of large segments of the B/AA, H/L, and AI/AN populations are the legacy of systemic and cultural racism that perpetuates inequities and places them at greater risk to poor oral health outcomes. Redlining, discriminatory employment policies, an inadequate research portfolio examining ethnic/racial oral health disparities, immigration policies, racial profiling during dental schools' admissions processes, forced relocation to Federal reservations, poor community infrastructure on reservations, limited oral health resources, and limited oral health care access are given as examples of structural racism. Employment practices, discriminatory patient treatment, and providers' implicit bias are given as examples of cultural racism.

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## THE IMPACT OF SYSTEMIC AND CULTURAL RACISM ON THE B/AA POPULATION

Historic systemic racism that has led to high rates of homelessness, poverty, and under-resourced communities perpetuates multiple barriers to oral health for B/AA today. For example, until 1968 redlining was a system practiced by banks and realtors to segregate B/AA in neighborhoods and prevent home ownership. Redlining led to divestment in B/AA communities that adversely impacted educational and job opportunities. It also led to access barriers to quality health care [3]. Today, the under-resourced communities in which impoverished B/AA are concentrated and the missed opportunities by B/AA to build and maintain wealth from home ownership are a legacy from the redlining period. According to the US 2020 Census, the poverty rate among Blacks and African Americans is 19.5% [4]. Past inner city redevelopment programs, the destruction of thriving B/AA communities, and gentrification have displaced B/AA and caused homelessness today. In 2020, B/AA comprised nearly half of the homeless population according to a HUD report [5].

Even B/AA who achieves the traditional measures of success does not escape systemic and cultural racism. The Pew Research Center reported that 67 percent of educated B/AA stated that they have been treated like they lacked intelligence and 52 percent stated they were treated unfairly in hiring, pay or promotion [6]. As patients, the discriminatory treatment to which BAA at all socioeconomic levels are subjected creates mistrust and reduces the likelihood of establishing routine oral health care which affects oral health [7]. A study found that African American adults were fearful of visiting dentists because they were concerned about the poor quality of care they might receive [8].

Systemic racism impacts oral health research. The National Dental Association Research Committee cites significant research gaps related to health disparities and inequities including: genetic markers for stress linked to oral diseases, trauma-informed health outcomes, oral biomarkers of stress linked to systemic disease in B/AA communities; implicit bias and racism among dental providers/other healthcare providers; and understanding and mitigating bias in educational environments, and student mistreatment grounded in systemic racism [9].

## THE IMPACT OF SYSTEMIC AND CULTURAL RACISM ON THE H/L POPULATION

Social, medical, and human rights activists have identified ethnic and racial inequities that H/L people continue to face in the US. H/L immigrants face numerous

challenges as they navigate for health services. There are systemic inequities in the delivery of oral healthcare for this population, driven by factors such as implicit and explicit bias, and/or discrimination. Cultural explanations for immigrant health outcomes obscure the impact of systemic factors on immigrant health [10]. A stronger emphasis on how location, racialization processes, and immigration policies affects immigrant health, including oral health, is necessary.

Discrimination against and ethnic profiling of H/L people is real. H/L are a mix of different races and roots; a multicultural ethnicity that speaks several languages and dialects. H/L experience discrimination at private dental offices and other healthcare facilities through being doubled booked for appointments, not being offered the same dental treatment options as others, and linguistic barriers. This toxic environment leads to poor oral health outcomes including periodontal disease and specifically tooth loss. Racism has the strongest association with tooth loss in H/L communities [11].

Systemic racism also impacts the selection of H/L into oral health professions by racial profiling during the admissions process with the assumptions that H/L applicants “won’t or can’t make it” through school. Admission committees focus on the H/L candidate’s cognitive abilities (standardized tests and metrics), losing sight of noncognitive attributes, thus missing an opportunity to increase a diverse oral health workforce of H/L providers. The fastest growing ethnic group in the United States, H/L represents about 20% of the US population but, only 6% of US dentists [12].

## THE IMPACT OF SYSTEMIC AND CULTURAL RACISM ON THE AI/AN POPULATION

As the original inhabitants of this country, today’s Indigenous peoples have a long and traumatic history with colonialism. Genocide inflicted on AI/AN peoples created a foundation for structural racism in today’s healthcare services. Health care for Native peoples was first provided as an offshoot of the US war department in the 1800s to tend to confined peoples while their lands were stolen [13]. This care was provided in a context of distrust and evolved with the clashing of western and traditional medicine. Dental care accessed by AI/AN today at Indian Health Service facilities stems from a federal mandate [13]. Racism exists in the stereotype that AI/AN get “free” health care and must abuse or not use it, making them responsible for their poor health. The reality proves that the provision of this health care is limited through government appropriation and remains underfunded so that it cannot truly meet the needs of all AI/AN peoples.

Although multifactorial, the myriad of health problems AI/ANs suffer from can be examined at one angle and understood in the context that diet was

dramatically changed from subsistence as hunter-gatherers and farmers, to being forced into federal reservations where natural food sources were limited and people had to subsist on government rations of highly processed carbohydrates to survive. Structural racism creates poor community infrastructure on reservations, resulting in a present day environment of food deserts where infants are exposed to sweetened beverages in a bottle, and highly processed junk foods soon follow. Today's AI/AN peoples have the nation's highest rates of caries [14] tooth loss [14] and diabetes [15]. Contemporary dental providers in AI/AN communities can acknowledge how the history of racism and subsequent structural racism of providing limited health resources results in poor oral health outcomes. Providers can use this knowledge to improve their oral health education delivery to AI/AN patients. It requires a culturally sensitive public health approach to combat oral health disparities in AI/AN communities.

## STRONGER TOGETHER FACING RACISM

B/AA, H/L, and AI/AN oral health leaders are committed to addressing racism in healthcare through leadership development, mentoring, improving the representation of their ethnic/racial groups in dentistry, improving health equity, increasing access to and utilization of quality oral health care, and improving oral health outcomes. The Hispanic Dental Association, the National Dental Association, and the Society of American Indian Dentists came together as the Diverse Dental Society (D.D.S.) in 2020 to employ joint strategies to close the oral health disparities gap and to advance oral care access among historically underrepresented ethnic/racial populations in a culturally sensitive manner. The D.D.S. is working to move the oral health care system away from one that perpetuates historical systemic racism into one that roots out the cause of oral health inequities and addresses them. The D.D.S. is poised to address the social determinants of oral health, workforce pathways, and the environment of oral health care delivery. Recognizing our shared challenges provides the impetus to create systemic change to address racial and health inequities and improve oral health outcomes.

## CONCLUSION

Racism is pervasive. Systemic and cultural racism is embedded in the fabric of society including our healthcare system. Systemic racism impacts B/AA, HL, and AI/AN populations' access to the social determinants of health including housing, healthful food, employment, and health including oral health care. Research has shown that even after adjusting for educational and income levels, racial

differences in health persist [16]. Racism is acknowledged as a fundamental cause of poor health outcomes and health inequities for historically under-represented ethnic/racial minorities [17]. The D.D.S. is a model for collectively addressing racism and improving the oral health status of B/AA, HL, and AI/AN populations.

## CONFLICT OF INTEREST

This article is representative of the authors' personal experiences and thoughts. In this capacity, they do not represent any organization other than the Diverse Dental Society.

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