



# eJACD

The Official Journal of the American College of Dentists

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**Diversity & Inclusion**  
part 1

## **A publication advancing excellence, ethics, professionalism, and leadership in dentistry.**

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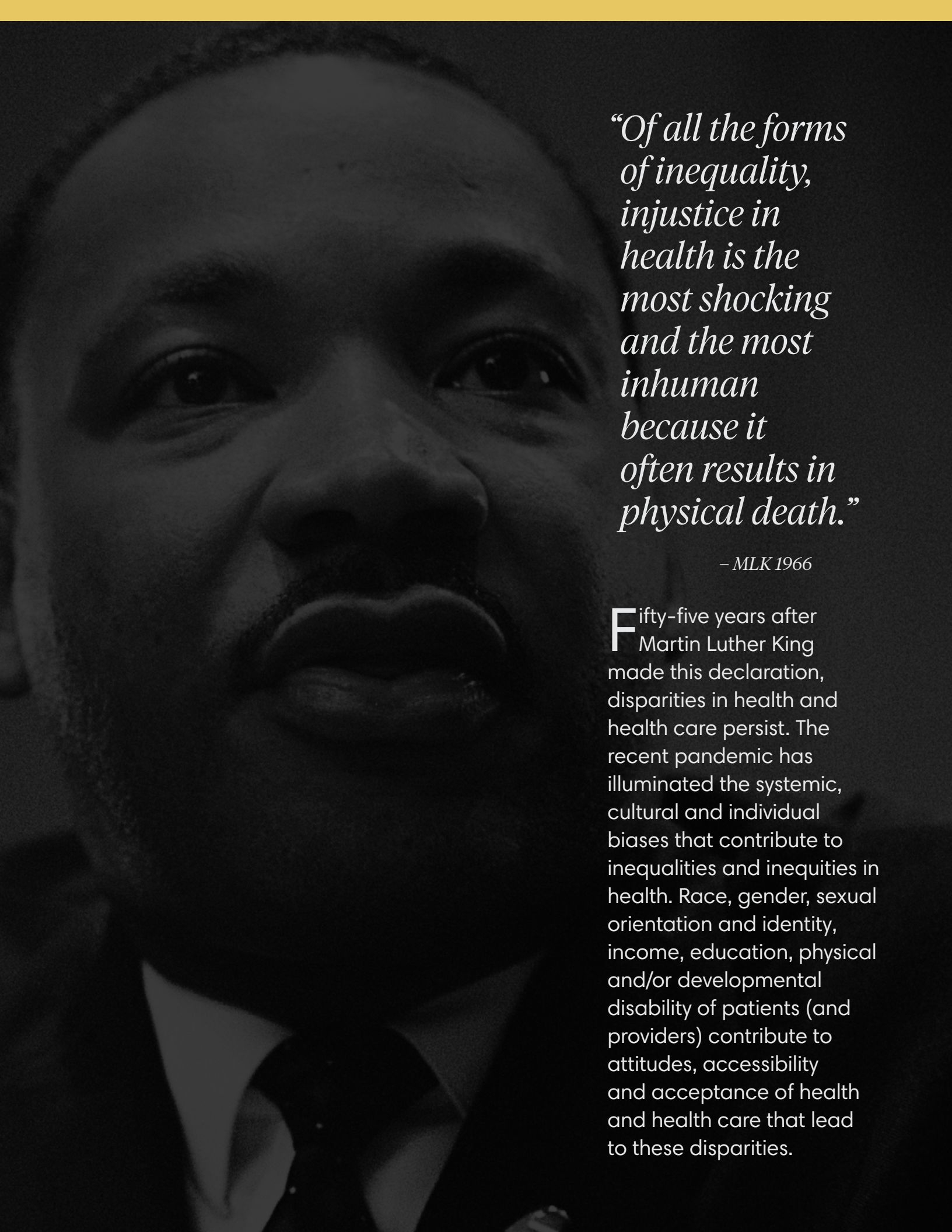
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*“Of all the forms  
of inequality,  
injustice in  
health is the  
most shocking  
and the most  
inhuman  
because it  
often results in  
physical death.”*

– MLK 1966

Fifty-five years after Martin Luther King made this declaration, disparities in health and health care persist. The recent pandemic has illuminated the systemic, cultural and individual biases that contribute to inequalities and inequities in health. Race, gender, sexual orientation and identity, income, education, physical and/or developmental disability of patients (and providers) contribute to attitudes, accessibility and acceptance of health and health care that lead to these disparities.



## Diversity, Equity & Inclusion

# An Ethical Imperative for the Dental Profession

Nanette R. Elster, JD, MPH, FACD  
Editor, eJACD

The ethical principle of justice which encompasses social justice, distributive justice, and restorative justice is a guidepost for many healthcare professions, including dentistry. In fact, the American Dental Association *Principles of Ethics & Code of Professional Responsibility* not only imposes a duty upon dentists to “treat people fairly . . .” but also urges dentists to “actively seek allies throughout society on specific activities that will help improve access for all.” Complimentary to that, the American College of Dentists adopts Justice as one of its core values stating that: “Issues of fairness are pervasive in dental practice and range from elemental procedural issues such as who shall receive treatment first, to complex questions of who shall receive treatment at all. The just dentist must be aware of these complexities when balancing the distribution of benefits and burdens in practice.”<sup>2</sup> Dental professionals have a clear ethical imperative and professional responsibility to strive for diversity, equity and inclusion (DEI) not only with patients, but with peers, students and the profession as a whole.

The breadth and depth of the topic are so vast that the next two

issues of the eJACD will address the role of dentists and organized dentistry in working toward greater diversity, equity and inclusion. This will not, however, mark the end of the eJACD’s coverage and in-depth exploration of the issues as we will continue to feature articles focused on DEI in upcoming issues as well. Dr. Carlos Smith, a fellow of the American College of Dentists brings his wealth of knowledge and expertise as the Director of Diversity, Equity and Inclusion and Director of Ethics Curriculum at Virginia Commonwealth University, School of Dentistry as the guest editor of the next two issues of the eJACD. He opens with his powerful editorial, *A Clarion Call – A Professionalism Ethic for Diversity, Equity, and Inclusion*.

The pieces that follow range from challenges facing women in the profession (*The Elephant in the Room: Combating Sexism – The Need for Real Inclusion in Dental Education* by Sophia Saeed and *President Juliann S. Bluitt-Foster – A Champion for Equity and Inclusion* by Theresa Gonzales), to the challenges of educating dental students about patients who may have a different lived experience from their own (*Incorporating Race*

*into Medical Education* by Keisha Ray). Additionally, Ethan Pansick shares his perspective on how the profession can continue to be more inclusive of the LGBTQ community in his piece, *Inclusion for ALL – LGBTQ+ Bettering the Profession and Patient Experiences*. Building on the concept of belonging, Sonya G. Smith, Kelli R. Johnson, Caroline Davis, and Pamela B. Banks, offer their perspective in their piece *Wired to Connect: Belonging as a Pathway to Diversity, Equity, and Inclusion*. To round out this first issue devoted to DEI, Brian Shue’s insightful commentary, *The Dis Ease of Microaggressions* is reprinted with permission from the California Dental Association and Vishruti Patel’s *Ethical Moment: Facts and Alternative Facts: Ethically Responding to Offensive Comments by Patients* is reprinted with permission from the *Journal of the American Dental Association*.

In keeping with the mission of the ACD, “to advance excellence, ethics, professionalism, and leadership in dentistry. . .” the hope is that the articles presented in this issue, as well as the next, will spark ongoing dialogue that will lead not only to personal reflection but reflection and dialogue as a profession.





*Carlos S. Smith, DDS, MDiv, FACD - Director, Diversity Equity and Inclusion, Director of Ethics Curriculum and Associate Professor, Virginia Commonwealth University School of Dentistry*

## **A Clarion Call to Leaders in Dentistry**

### Professionalism Ethic for Diversity, Equity, and Inclusion

Carlos S. Smith, DDS, MDiv, FACD  
Guest Editor

**T**he American College of Dentists and its leadership are no strangers to breaking barriers along the lines of diversity, equity and inclusion. The College has a place in the history of organized dentistry leadership with the ascension of the late Dr. Juliann Bluitt Foster to its presidency in 1994. Dr. Bluitt Foster broke the glass dental leadership ceiling as both a woman and African American. Nearly 30 years later, non-white females rank at the top of the list of the least likely candidate for dental organization presidencies.<sup>1</sup>

*The American College of Dentists defines ethics as studying systematically what is right and good with respect to character and conduct. In short, ethics is about choices. The choosing to act or to not act. Ethical issues faced by dentists and members of the dental team (dental hygienists, dental therapists, dental assistants and dental office administrative staff) are ever evolving, both increasing in number and in the complexity of factors needing to be reviewed, considered and addressed.*

The pages and electronic features of this two-issue *eJACD* strike another historic feat. No other major dental organization has dedicated a full issue of their respective journal to the ever relevant issues of diversity, equity and inclusion. Within its contents both issues may challenge you, and that is intentional and by design. As with most difficult conversations, remember the aim is improved outcomes for all and at times you may be triggered or even uncover stereotypes and prejudices you may carry, as we all do. Difficult roads often lead to beautiful destinations and that is the journey the American College of Dentists has courageously and appropriately embraced. Issues of race and racism, sexism and gender identity, sexual orientation, ableness and (dis)ability, organizational climate and culture, social determinants of health, dental and medical education, health policy and more are truly just the tip of the conceptual iceberg of eradicating oral health disparities and inequities.

Our goal is clear – to offer information, reframe these issues with ethi-

cal leadership practice at the center, and keep the conversation going. So why an ethical framing of diversity, equity and inclusion? A recent study by a team of Princeton University researchers has called for a new way of framing the diversity factor. While many organizations speak to diversity initiatives as providing compelling educational benefits and even bottom line increased corporate productivity and revenue; there remains a higher rationale – the moral one.<sup>2</sup> The responsibility of ensuring optimal oral health care for all rests on the shoulders of each and every one of us as dentists, professionals and leaders. There is much at stake – will we live up to our social contract inherent in our professional identity? Or will our biases, prejudices, and “othering” win out. We have a rare opportunity to chart a new course – in keeping with the new professionalism – to truly live up to all we purport to be and embrace. We can bring renewed hope to the title of Doctor while evoking a resurgence of trust in our profession, truly seeing the value in each and every person and advocating for optimal oral health for all.

The American College of Dentists has a long history of advocating for the advancement and understanding of ethics and leadership within the dental profession. As one who has always enjoyed the study, structure and meaning of words – let us look at the definitions of the concepts to which we ascribe. Ethics has long been defined as a branch of philosophy and theology that involves systematizing, defending, and recommending concepts of right and wrong behavior. The American College of Dentists defines ethics as studying systematically what is right and good with respect to character and conduct.<sup>3</sup> In short, ethics is about choices. The choosing to act or to not act. Ethical issues faced by dentists and members of the dental team (dental hygienists, dental therapists, dental assistants and dental office administrative staff) are ever evolving, both increasing in number and in the complexity of factors needing to be reviewed, considered and addressed.<sup>4</sup>

Leadership is the ability to influence others.<sup>5</sup> Similar to the practice of a profession such as dentistry, med-

## A Clarion Call to Leaders in Dentistry

Carlos S. Smith, DDS, MDiv, FACD, Guest Editor

icine, law or teaching - leadership is something one actually practices. Inherent within this is the notion that one may practice leadership well, or conversely one may practice leadership poorly (which some may denote as not true leadership at all). An area that begs greater emphasis is the need to clarify the actual practice of leadership from merely holding a leadership position. While positional leadership certainly has its place and is something most strive for, the reality is that one can assume a leadership position or role but not perform in or actually lead well in the role. A positive of leadership as not simply tethered to position is the fact that almost everyone, in nearly any role, has the capacity for practicing leadership well.<sup>6</sup> This is affirming in principal within both dentistry and dental education because there are so many players on the proverbial team: faculty (pre-clinical, clinical vs biomedical), staff (clinical, auxiliary, administrative, maintenance, technological), students (predoctoral, residents, PhD), prospective applicants, alumni, corporate partners, community stakeholders, donors and of course patients. Each of these individuals can practice leadership from their perspectives and roles.

Each and every member of the dental team has the ability to ask of themselves - am I leading well? The correlations of leadership practice to professionalism and ethics is clear - leadership success (in the variable ways it may be measured) can ultimately be traced to the choices made by said individual or leader.<sup>7</sup> If leadership (good or bad) boils down to the quality of choices made, and it is widely understood that ethics is

grounded in one's choices, then how well one practices leadership is inextricably linked to one's ethical sensibilities and foundation. How do those who practice leadership well make the choices they do? Leaders make better choices when they are mindful about their own thought processes and actions.<sup>7</sup> Leadership requires a deliberate process of shifting perspectives to see situations in multiple ways and through different lenses. Leadership practiced well, requires moving beyond one's comfort zone and current preferences to embrace more complicated socioemotional, intellectual and ethical reasoning.<sup>7</sup> The habitual nature of being completely unaware or insensitive to varying perspectives and other viewpoints leaves many leaders blind to available alternatives or even gaps and biases in their own knowledge. Even more troublesome is that the unawareness, or at times downright refusal to see through the lens of others, leaves those leaders with "little incentive to question their interpretations or retrace any of their steps from data selection through action."<sup>7</sup>

The ability to see the perspective of others - moreover to see the value in a lens or viewpoint different from one's own requires two key elements - courage and emotional intelligence. Leadership practiced well - and practiced ethically - requires personal courage to break out of one's comfort zone and step away from crowds in seeking new options, proposing new explanations or even testing alternative responses.<sup>7</sup> Emotional intelligence brings together the fields of emotions and intelligence by viewing emotions as useful sources of information that help one to make

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sense of and navigate the social environment.<sup>8</sup> Studied widely for both personal development and organizational improvement, emotional intelligence is composed of five primary domains: self-awareness, self-management, social awareness and relationship management.<sup>9</sup> Emotional intelligence has been recommended as a critical tool to normalize the individual perceptions of difference.<sup>10</sup>



The need for greater understanding of our differences as well as the philosophical stance to actually value and leverage our differences is paramount to optimal oral health for all.

So what do we mean with the terms - diversity, equity and inclusion? Diversity describes the full range of differences, the visible and non-visible, that make each and every individual unique.<sup>11</sup> Diversity recognizes that each individual also has multiple dimensions of diversity that intersect and that there is a societal and communal benefit from the engagement of these differences.<sup>11</sup> When one

thinks of diversity, particularly in an American context, one often thinks about differences across culture, race, ethnicity, language, age, sex, gender identity, and sexual orientation. One must also center diversity of values, beliefs, nationality, military/veteran status, socioeconomic status, (dis)ability, religious commitment, life experiences, personality, learning styles or other characteristics or ideologies unspecified.

Equity is promoting justice, impartiality and fairness within the procedures, processes, and distribution of resources by institutions or systems.<sup>11</sup>

Tackling equity issues requires an understanding of the root causes of outcome disparities within our society. Many of these disparities are rooted in the historic oppression of groups that were viewed as other or different or not even fully human and worthy of basic dignity. The American Dental Association has articulated health equity as meaning each individual has a fair and just opportunity to be as healthy as possible.<sup>12</sup> Removing barriers to care is essential in ensuring that every community receives access to the quality and affordable health care they deserve.

## Acknowledgements

This historic double issue centered on diversity, equity and inclusion within the dental profession would not be possible without the sincere and thoughtful leadership of many within and outside the American College of Dentists. I want to personally acknowledge the following who have influenced my professional and academic journey and thus this double issue: the College Executive Committee, Board of Regents and staff, along with Drs. Leo Rouse & Theresa S. Gonzales, and Suzan Pitman and Nanette Elster; the American Society of Dental Ethics and Drs. Larry Garetto, Phyllis Beemsterboer, Frederick More, Toni Roucka and Odette Aguirre; mentors and faculty from the University of Michigan School of Dentistry Drs. Todd Ester, Marita Inglehart, George Taylor, Marilyn Woolfolk, Marilyn Lantz, Kenneth May and Ms. Pattie Katcher; colleagues and leaders at Virginia Commonwealth University Drs. J. Mark Barry, Ellen Byrne, Alfred Certosimo, Dave Sarrett and Clara Spatafore; Virginia Fellows Drs. Mayer Levy and Bill Bennett; past ADA Presidents Drs. Ray Gist and Ron Tankersley; the National Dental Association and Drs. Jeanne Sinkford, Leslie Grant, Winifred Booker, Sheila Armstrong, Sheila Brown and Ms. LaVette Henderson; the Peter B. Ramsey Dental Society of Richmond VA and mentors and friends Drs. Fred Sykes, Felicia Goins, Benetta Bell, Richard Boyd and Desiree T. Palmer; and our authors and contributors Drs. Keisha Ray, Sophia Saeed, Ethan Pansick, Sonya Smith, Pamela Banks, Brian Shue, Vishruti Patel, Tawana Lee Ware, Colonya C. Calhoun, Cherae Farmer-Dixon, Pamela Alston, Nate Armstrong, Daphne Ferguson-Young, Rosa Chaviano-Moran, Herminio Perez, Kevin Jenkins and Professor Pamela Zarkowski, Ms. Kelli R. Johnson, and Ms. Caroline Davis.

## A Clarion Call to Leaders in Dentistry

Carlos S. Smith, DDS, MDiv, FACD, Guest Editor

Inclusion is the practice of leveraging diversity to ensure all individuals can fully participate and perform at their best.<sup>11</sup> Inclusion is a shared responsibility of everyone within the community. An inclusive environment values differences rather than suppressing them; promotes respect, success and a sense of belonging; and fosters well-being through policies, programs, practices, learning and dialogue.<sup>11</sup> Inclusion actually values and highlights the lived experiences of others, even when one might disagree; inclusion allows for issues of diversity to be more than mere lip service or reactionary programmatic agendas to avoid

public disparaging. Inclusion compels oneself to not always be at the center, particularly if one has never found themselves among those historically marginalized, minoritized or maligned groups. The goal of inclusion is leveraging differences to drive results.

As you delve into the content of these two issues we hope you are challenged yet inspired to action. That we as a dental profession will make the individual and collective choice, to answer the call as a leader in dentistry to embrace and live out a professionalism ethic for diversity, equity and inclusion.

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## **Stories and Statistics**

# Creating Culturally Competent Dentists Using Integrative Race Education in Dental Schools

Keisha Ray, Ph.D.

**I**ntegrating race education into health sciences programs, such as undergraduate dental programs gives educators an opportunity to help students develop the social and behavioral skills necessary to provide culturally competent care, particularly for patients of color. Although the Commission on Dental Accreditation (CODA) requires dental schools to implement educational initiatives on cultural competency, for many dental educators this may be a daunting task.<sup>1</sup>



## Stories and Statistics

Keisha Ray, Ph.D.

To help educators meet this task I wrote about a pedagogical approach to race education that I often use in my own medical school courses—Experiential Race Testimonies, or ERT.<sup>2</sup> Although I have not performed scientific experimentation to prove its effectiveness, the ERT approach has allowed me to successfully facilitate class discussions on the experience of being Black and ill in America. The ERT approach 1) uses population data analysis to create a picture of Black health at the population level, including barriers to proper health; and 2) uses personal testimonies from Black people to better understand their health at the individual level, including Black people's thoughts and feelings about the relationship between their race, illness, and treatment. The ERT's success comes from this two-fold approach to integrating race education with a health sciences education.

Together, data analyses and testimonies provide students with a holistic understanding of their Black patients' health. To accomplish this the ERT approach centers Black patients and their experiences of illness rather than their illness alone or health care providers' experience of their illness. Secondly, the ERT approach also encourages students to understand Black patients within the context of racism and white supremacy, given its influence on Black people's health. Lastly, the ERT approach asks students to consider Black people's health without moralizing or declaring their health care decisions to be bad or good, but rather those often restrained by inequities in social determinants of health. Although there are fundamental differences between the ways that we concep-

*One prominent feature of the ERT approach is that it utilizes personal testimonies from Black patients to give students an understanding of the lived experiences of being Black and ill. Testimonies are short, personal stories that allow learners to listen, observe, and view illness from the patient's lens rather than interpret the patient's experience of illness through their own lens.*

tualize, govern, and practice medical care and dental care, both professions interact with patients from marginalized populations who are better treated by caregivers who are culturally informed. Therefore, the ERT approach can help develop any health sciences professional, including dentists.

Here, I continue to explore the benefits and limitations of the ERT approach to pedagogy by applying it to undergraduate dental education. First, I discuss different methods of using the ERT approach in established core curriculum courses and electives, dedicated humanities and ethics courses, and in clinical courses and simulations. Secondly, I discuss the benefits of using the ERT approach to pedagogy in dental programs. Specifically, it helps dental programs meet CODA standards by helping dental students become culturally competent dental professionals, it strengthens dental programs, and it helps mend the relationship between dentistry and Black people. Although the ERT approach specifically targets the needs of Black patients, it can be adapted to help educate dental students about any underserved population by humanizing patients and making them more than statistical data.

## ERT in the Classroom

One prominent feature of the ERT approach is that it utilizes personal testimonies from Black patients to give students an understanding of the lived experiences of being Black and ill. Testimonies are short, personal stories that allow learners to listen, observe, and view illness from the patient's lens rather than interpret the patient's experience of illness through their own lens. This is especially important for students whose life experiences may be very different from their Black patients. Because the ERT approach uses short testimonies, if educators have little space for new material in their curriculum, race education can be inserted into established curricula without creating new courses.

Patient testimonies can typically be found in academic journals, online blogs, or in articles in popular media. For instance, in Elizabeth Piatt's "Navigating Veronika: How Access, Knowledge, And Attitudes Shaped My Sister's Care"<sup>3</sup> a Black college professor tells the story of her Black sister's journey to pursuing dental care for an infected tooth using Medicaid services. Although this story is not a first-hand account, Piatt tells her sister's story with Veronika's

permission. In fact Veronika made sure that Piatt included her name in the story so people would know it is her story.

Veronika had a painful toothache. She eventually saw a dentist who tried to remove her infected tooth. After he could not remove it, Veronika was referred to one of the few oral surgeons in her area that accepted Medicaid. The surgeon, however, could not see her for another 8 weeks, but with few options, Veronika waited. When it came time for her appointment, Veronika thought she would be getting her tooth extracted but the appointment was only for a consultation; she would have to wait another 8 weeks to get the tooth extracted. While waiting for this appointment, Veronika lost her Medicaid coverage due to a lack of transportation. Eventually her Medicaid coverage was restored and after 4 months from her initial dentist visit she saw an oral surgeon for a tooth extraction.

Because of Veronika's many health problems, including a heart condition, the surgeon opted to use a "twilight" procedure to sedate her, but it did not work:

*During the initial stages of the procedure, Veronika kept asking when she was going to get numb. The surgeon ignored her questions, thinking that it was just the Valium that was confusing her. When he began cutting her gums, however, she screamed. At that moment, the surgeon realized she was alert and could feel everything he was doing. According to Veronika, he then grew angry and pushed back from the exam chair before slamming his instruments onto the tray beside him. In frustration, the surgeon threw up his hands and told his assistant, "I can't do her. Send her to Metro." At that very moment, I am sure my sister*

*was far from the perfect patient. But it's clear that, whatever his intentions, the oral surgeon's condescending response made her feel small.*<sup>3</sup>

Veronika's story includes economic, transportation, and dental literacy hurdles and how they made proper dental care difficult to attain. Any educational lesson that utilizes Veronika's story must also include a discussion of how a lack of social determinants of health can worsen access to dental care. But Piatt subtly mentions that something else influenced the kind of care that Veronika received. She notes that it is possible that her sister was not a star patient, but Veronika still deserved compassion and respect. But Veronika did not receive compassion nor respect. And because Veronika is Black we cannot ignore the likelihood that race influenced how the surgeon treated her.

The ERT approach is helpful in instances when dental educators want to have conversations about race and dentistry because it focuses pedagogy on the patient's experience of being Black and ill. And since racial discrimination is a part of life for Black people, we must also include how racial discrimination can influence dental care, even when it is not explicit or conscious. Therefore, when discussing Veronika's story we also have to discuss how racism may have played a role in how much the surgeon disregarded her health and feelings. Additionally, we can situate Veronika's experience within the research that shows how dentists' unconscious racial biases can influence the way they treat patients.<sup>4</sup> We can also situate her experience within documented cases of racism such as when a Texas dentist referred to Black people using racial slurs on social media.<sup>5</sup> Veronika's story can

also be paired with studies like one conducted in 2019 that concluded when people experience the emotional impact of racial discrimination they are less likely to visit the dentist.<sup>6</sup> Treating Black patients, who already have a strained relationship with dentistry, in such a heartless manner can influence whether that relationship remains strained and Black people continue to have inferior oral health. Overall, educators can use the ERT approach to allow the data and stories to work together to give a complete picture of Black people's oral health and their experience with oral health care.

The ERT approach can also be used in dedicated ethics and humanities courses and electives. In these courses educators have more dedicated space in their curriculum and can demonstrate the link between racism, social determinants of health, and oral health in more depth. With more time, educators can discuss the many ways that racism and inequities infiltrate Black people's lives to affect their oral health and access to dental professionals. This can include the history and continued influence of segregated health care facilities, income and wealth inequities, and education, transportation and housing inequities. With more time, educators can demonstrate how a lack of social goods and institutional barriers do not lend themselves to oral health. For example, for people with a lack of resources, taking time off of work or finding child care to attend dental appointments can be difficult. With a lack of resources, preventive care also becomes less important than more immediate needs and affording expensive specialized care like oral surgeries is almost impossible. Additionally, navigating racism and microaggressions from dental professionals can be off-putting

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and discourage routine dentist visits. Dedicated ethics and humanities courses can draw links that may not be obvious for students but necessary for them to be culturally competent professionals.

Lastly, clinical courses or any kind of simulation where students observe and/or practice dentistry is another opportunity to incorporate race education using the ERT approach. Clinical courses offer educators an opportunity to model racially aware, anti-racist dental care for Black patients. Clinical courses also give students an opportunity to hear

tients so they can see real Black people in need of compassionate and competent dental care and not just see Black people as the data they read about in their courses.

Whether the ERT approach to pedagogy can successfully help students think about external influences on Black people's oral health such as personal, structural, and institutional racism depends on educators' willingness to have difficult conversations with our students. We have to be willing to embrace the discomfort and uneasiness that these kinds of conversations can elicit in ourselves

that specifically aim to ensure the quality of dental programs, thereby ensuring that competent students become competent dentists. CODA establishes standards by which to measure competency to professionally practice dentistry including skills and capacities like critical thinking, communication, problem-solving, and professionalism. Additionally, among other requirements and expectations CODA expects dental programs to 1) implement initiatives that create diversity among students and faculty, 2) educate students on cultural competency; and 3) educate students on effective communication

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Black patients' narratives about the ways their daily lives affect their oral health. Hearing firsthand accounts from Black people themselves is even better than written testimonies because students can witness the emotion and conviction behind patients' words in ways that they cannot with written testimonies. Interacting and observing Black patients also give students the chance to see representations of the data on Black people's oral health outcomes. Educators should make an effort to increase students' interactions with Black pa-

and in our students. We have to be willing to engage in the sometimes messy history of dentistry if we are going to graduate culturally competent dentists, even if we make some mistakes in the process.

### Benefits of a Race Education

Dental programs want to graduate dentists who have the skills needed to be high quality dentists. CODA also sets accreditation standards

with diverse populations.<sup>1</sup> With its focus on educating health sciences professionals on how to interact with and treat Black patients, the ERT approach to pedagogy helps educators meet CODA standards and graduate competent dentists.

Good communication skills is one skill set that all dental professionals ought to have. This includes being able to properly communicate with people from different backgrounds about their care. An ERT approach develops students' communica-





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tion skills with Black patients by engrossing them in a culture that may be different from their own and one they may never otherwise engage. The ERT approach equips students with knowledge about the cultural and societal issues that their Black patients may face that impede their oral health. This gives students the skills to participate in culturally informed communication with their Black patients. Proper communication skills can also help create rich, trusting relationships between dentists and Black patients, which can contribute to eliminating racial disparities in oral health.

The ERT approach can also help develop students' critical thinking and problem solving skills by encouraging a holistic view of Black patients. It helps them to see that their patients' dental problems are not just about what they see in front of them. For example, when treating a Black child with tooth decay dentists have to consider that their patient is a part of a larger problem of racial disparities in Black and White children's oral health. This patient's oral health has to be situated within factors that contribute to some Black children's poor oral health including structural, sociocultural, and familial factors such as access to quality care and access to healthy foods.<sup>7</sup> Therefore, when treating Black children, and making care recommendations dental professionals have to think about barriers that their patients may have to overcome and give thoughtful care recommendations that take into account their social and cultural experiences and limitations.

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can dentists were White, 20% were Asian, about 7.5% were Hispanic, and about 3.5% were Black.<sup>8</sup> In addition to benefiting individual dental students, the ERT approach also benefits the profession of dentistry by helping to change the racial make-up of the profession. Using the ERT approach to education shows potential students that dental programs are committed to developing and graduating culturally aware dental professionals who will participate in anti-racist dentistry. Using the ERT approach shows that dental programs want to better the relationship between Black people and dentistry and help eliminate their poor oral health outcomes. If more schools integrate the ERT approach with their dentistry curriculum it could change the public perception that dentistry is a White profession and encourage more students of color to enroll in dental programs.

Additionally, if more students from different racial backgrounds enroll in dentistry programs and eventually become dentists, more dentists of color would mean better health outcomes for patients of color.<sup>9</sup> Having more dental professionals of color available to treat patients of color will establish trust between people of color and dentistry. Seeing dental professionals that look like them puts

patients at ease and could encourage patients of color to routinely see their dentists.

## Conclusion

An ERT approach to race education combines both data to explain Black people's health at the population level but also testimonies from Black patients to explain health as it is experienced by individuals. Integrating race education with dental education helps dental programs accomplish their goals of creating well rounded, culturally competent professionals who are able to adequately meet the needs of their Black patients, while also helping to end racial disparities in oral health. Although I have used Black people and their experiences with oral health and dentistry as an example, an ERT approach to pedagogy can be applied to any marginalized population or any population of people made vulnerable by a lack of social determinants of health, disenfranchisement, or institutional and structural inequities such as Latinx and Indigenous people, immigrants, or economically poor people. What is important for students, who will one day be dentists is to be able to conceptualize and put into practice what it means to treat patients who are a part of marginalized groups and how this affects their oral health outcomes and access to dental facilities. A race education benefits dental programs and their dental students, but ultimately, the goal is to impart culturally competent and caring treatment upon their diverse patients.



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## The Elephant in the Room

# Combating Sexism—the Need for Real Inclusion in Dental Education

Sophia G. Saeed, DMD

*Statement of Responsibility: The aforementioned author is the sole author and contributor to this submission.*

A few years ago, I collaborated with colleagues to give a workshop on gender equity in academics at the American Dental Education Association Fall Meeting. We presented research outlining the challenges that women face in the workplace; the presentation was interspersed with small group discussions around defined, but uncomfortable, topics. The feedback from the faculty participants varied. A small handful of men felt it was hogwash. A large number of men thanked us for opening their eyes. They were entirely unaware of the challenges that their female students and colleagues put up with on a daily basis and throughout their careers, despite numerous publications on the topic.<sup>1-7</sup> Some of the more seasoned women in the audience felt that things were much worse when they were up-and-coming, so the younger women should be thankful, and just grin and bear it. But the younger women thanked us profusely for amplifying their experiences; they did not have a platform or the protection for speaking their minds. Many of them thought they were the only ones experiencing regular sexism, and they were suffering in silence.

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Though the number of women in dentistry and dental schools is growing, the culture of dental schools is still plagued with sexism.<sup>3-7</sup> Throughout my 13-year academic career, I have seen, heard, witnessed, or experienced misogyny on a daily basis. This may have been acceptable some decades ago, but society has evolved, and so have the expectations of women. Millennial women, born between 1980 and the mid-1990s, make up the largest proportion of women in dental schools today, as students and faculty. We expect our workplaces to comply with federal laws that are meant to prevent discrimination on the basis of sex, such as Title VII<sup>8</sup> and Title IX.<sup>9</sup> We expect to be treated as equals to our male counterparts, and we expect a culture that makes us feel included.

So, what does it mean to feel included? Let's first talk about what it feels like to be *excluded*. The stories below are real experiences shared with me by students and colleagues from across the US.

Imagine being a fourth-year female dental student working with a third-year male dental student to perform an extraction for a male patient. The female student is a few weeks shy of graduation—a few weeks away from being a doctor. Still, the patient is dismissive of her when she is speaking to him. She steps out of the operatory for a moment and the patient turns to the third-year

male student and says, “doc, does she really know what she's doing?” Scenarios like this happen routinely in dental schools, not only to female students, but also to female faculty. The perception by some patients that females are inadequate or cannot be real doctors persists in many parts of this country. Knowing this, how many dental schools provide female students the skills to professionally stand up for themselves in the moment? How many dental schools provide bystander training to male students so that they can intervene when their female classmates are being mistreated? How many faculty know what to do? What if the faculty member himself participates in, and promulgates, this type of behavior by calling female dental students “honey” or “dear”?

Let's look at another example. A male faculty member decides to have a pool party at his house and invites several male and female students. During the party, the faculty member takes photos of the students. The following week, one of the female students stops by the faculty member's office to review a treatment plan; she sees that he is using photos of her and her female classmates in their bikinis as the screensaver on his work computer. She politely asks him to remove the images because it makes her uncomfortable to have the photos displayed at work, but he brushes off her request. Later that week, she comes back to his office and sees

a few male faculty members hovering around the computer making comments about the bodies of the female students. There are a number of issues with this scenario, but ultimately, the female student feels sexually objectified in her learning environment.

Sometimes, it gets even more serious. Female students have reported being inappropriately touched by male faculty. Can such a student feel safe and supported? If advances are made by a male faculty and the student declines the advances, what impact will that have on her grade? If she reports it, will she be heard? Will she be taken seriously, or will her report be swept under the rug?<sup>3,10</sup>

Now, let's discuss what *inclusive* might feel like. Our first student would not be judged differently by her male patient because she is a female; perhaps she would be equipped to handle the situation with her patient, or perhaps her male classmate or faculty member would intervene as an ally. Over time, patients would learn that inappropriate comments about female students—whether ill-intentioned or not—are not acceptable in the school. But this requires proactive work by the school. Our second student would not be sexually objectified by her male faculty; in fact, the faculty members would be counseled on professional boundaries both at school and outside of school, and provided training on currently acceptable social

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norms with regard to the treatment of women. The faculty members would apologize to the student and promise not to engage in such actions again. Our third student would not be touched inappropriately and would not be in the ethical conundrum of going along with her faculty member's advances so that she can make it through her academic program, or stand up for herself, with the risk of retaliation. Witnesses to the advances would intercede in the moment, and also report the behavior without fear of retaliation.

While laws and policies are in place that encourage, or even mandate, the reporting of sexual harassment and discrimination on the basis of sex,<sup>8,9</sup> if a woman reports this behavior, it is her career that takes the hit.<sup>10,11</sup> This is true for female students and female faculty. The oppressor is often protected by the system; the reporter gets shamed, retaliated against, gaslighted, or pushed out.<sup>3,10,11</sup> The long-term consequences on a woman's career for standing up for herself are costly. It is precisely because of this structural silencing that sexism in dental education is not discussed as openly or candidly as might be expected for such a pervasive problem.

In addition to the risks a woman takes if she does report inappropriate behavior, there is also an emotional cost if a woman chooses to tolerate misogyny, whether overt or understated. Microaggressions are words or actions that are insulting to the recipient; they are often unconscious, subtle, and not ill-intentioned. Microaggressions are like microtrauma that teeth experience

from a parafunctional habit. It is hard to see the damage from one night of tooth-grinding, but years of repeated microtrauma will lead to weakened tooth structure, cracks, or even a broken tooth. When a woman is repeatedly subjected to

en are interrupted, mansplained, or belittled; women are addressed by their first names while males are addressed as "doctor"; and women are paid less than their male counterparts.<sup>16,17</sup> Women's concerns about misogyny are dismissed

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microaggressions, it can impact her academic performance and self-esteem.<sup>12,13</sup> If we want our female dental students to perform their best, we must take action. But the impact of sexist environments does not only impact female students<sup>14</sup>; it also weighs on female faculty.<sup>15</sup>

What is it like to be a woman dental educator? There is an entrenched "boys club" culture in dental education.<sup>16</sup> For rank-and-file faculty, women are assigned more clerical tasks, such as taking minutes during meetings; women are appointed to committees that have less influence or importance toward promotion while their male counterparts are given the opportunity to shine on influential committees; wom-

en are interrupted, mansplained, or belittled; women are addressed by their first names while males are addressed as "doctor"; and women are paid less than their male counterparts.<sup>16,17</sup> Women's concerns about misogyny are dismissed

and invalidated. In addition, female faculty are rated more harshly by students on their teaching evaluations,<sup>18-26</sup> which impacts their ability to be promoted<sup>27</sup>; they are also bullied more frequently<sup>28</sup> by students and their peers. Adding even more inequity to all of this, social circles among male leaders in higher education often exclude women.<sup>29</sup> It is often based on these social networks that opportunities to serve on high profile committees or projects are discussed, and it is also through these networks that introductions are made to other people in positions of influence.

As women faculty advance in their careers and enter leadership roles—despite the odds against them—they are under a microscope. They



are judged differently than their male peers. For example, males may get away with being rude, aggressive, or unprofessional. Or they may be grossly unqualified but “look the part,” so they get promoted. In the US, we are deeply socialized to believe that tall, white men are leaders. This phenomenon, called the Harding Error, makes it challenging for us to see women, people of color, and short people as leaders. Women who do make it into leadership positions may be expected to behave and speak in ways that comply with outdated societal expectations of women—submissive, docile, and obedient. In some places, women are even expected to dress a certain way. Throughout my career, I have been advised to “wear more pink,” “act stupid” because my intelligence intimidates men, or speak with more “honey” in my voice. I have yet to find a male colleague who has experienced the same.

Sadly, dental education is no stranger to woman-on-woman sabotage. When seasoned women in dental education see a promising young female faculty, they tell her that they can’t wait to see her career flourish. Yet, when the young woman’s career flourishes more quickly than they would have expected, and she is now a candidate for those same leadership positions, she is a threat and she is held down. Sometimes, she is even sabotaged. Men participate in this, too, but it is especially discouraging when women hurt each other.

Female students see how their female faculty, department chairs, associate deans, and deans are treated. They see women holding other women down. They watch with horror as women leaders are dismissed by their male counterparts when they speak in public settings. There is a shortage of faculty in den-

tal education and with more women among our students, and a desire to encourage more women to consider academic careers, female students legitimately ask, “why would I want to be treated like you’re being treated?” The landscape and culture of dental education must evolve with the times if we have any hope of making women in dental schools feel welcome, supported, and included.<sup>3</sup> It is time for women in dental education—whether students or faculty—to thrive.

Formal steps, such as diversifying candidate pools for executive searches, is a step that many universities are taking.<sup>29</sup> This is a well-intentioned initiative if the desire is truly to recruit someone who comes from an underrepresented group. However, if the intention of diversifying the candidate pool is simply to meet the university’s policies, with no intention of considering those candidates, the practice is harmful. It is misleading to women who are asked to apply, and it compromises their career if confidentiality of their application is breached.

Mentorship and sponsorship programs that allow women to gain access to influential males and their networks are another good step. For example, perhaps you are a man who knows of an opening on an influential committee, whether in a dental school or in organized dentistry. Mentorship is informing a female mentee that the position is opening up and she may want to consider throwing her hat in the ring. Sponsorship is talking to the decision-makers and using your social capital to vouch for your female mentee and thrust her into the spotlight, of course after checking if she is actually interested in the position. It may also require convincing her that she is, indeed, good enough for the position

since so many women experience imposter syndrome.

But ultimately, the hardest and most important work that must be done to address sexism in dental education starts with ourselves. We have to assess our own biases against women. Americans are socialized to believe that women are supposed to behave, speak, and dress a certain way. This is so deeply rooted that even *women* are socialized against women leaders.<sup>30</sup> An easy way to assess where you stand is to take a confidential online assessment of your biases, for example the Implicit Association Test.<sup>31</sup> If you are anything like me, you will struggle to accept your results. There are two ways to deal with this: one is to deny the results and continue to live with your current world view; another is to have the humility to reflect, read, learn, and change.

Another step we can take is to listen to the stories of our female students and faculty with open hearts and minds. Listen without judging. Listen without dismissing. Listen without invalidating. Listen to hear and understand, just as you would with your patients.<sup>32</sup> There is a caveat here. If you are employed by a school and are a mandated reporter for alleged discrimination or harassment on the basis of sex, this must be disclosed at the start of any conversation on this topic. Some women, then, will choose to continue suffering in silence because the repercussions they could face by being honest may be too risky. Try reaching out to women at other schools. They will have more flexibility to speak openly with you.

Other than self-reflection and personal growth, there are additional steps you can take. If you serve on the advisory board for your local dental school, are in organized dentistry, or are involved with your school’s

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alumni association, encourage the school's leadership to conduct a well-designed, anonymous climate survey that specifically asks about witnessed or experienced sexism. Assure that there is a plan for transparent and timely sharing of the results, not only with the school, but also with your dental society or alumni association. Use your influence to assure that there is a commitment from the school's leadership to identify action plans based on the results, as well as ongoing assessment of the climate after interventions are made. When climate surveys are conducted without transparency and defined action plans, they do more harm than good.

Dental school deans have a number of different stakeholders whom they must hear and satisfy. It is possible that the local dental society, state board, donors, or alumni do not want to hear about diversity, equity, and inclusion. They may even deny the existence of sexism within dental education and dentistry. While this is unquestionably a challenge, dental schools will lose relevance to their students and faculty if they are not firmly committed to improving the culture for historically minoritized groups, including women. Improving the culture will allow

female students and faculty to perform their best, be engaged, and feel supported. There are two more reasons why dental schools should care about creating an inclusive environment.

First, the bottom line. Students who are in a psychologically safe learning environment and faculty who are in an inclusive workplace will be more confident in their work, and ultimately more productive.<sup>33</sup> Productivity can be measured by clinical revenue,

relative value units, research grants, quantity and quality of teaching, involvement with organized dentistry or other professional organizations, publications, or service. All of these are important to the business and reputation of dental schools. Especially as we emerge from the COVID-19 pandemic, many dental schools are facing historic financial challenges. Compelling research from the private sector shows that a positive workplace culture can impact up to a third of an organization's productivity.<sup>34</sup>

Second, the Commission on Dental Accreditation (CODA) states that dental schools need to create a humanistic environment; that is, one that is "characterized by respectful professional relationships between and among faculty and students."<sup>35</sup> CODA also emphasizes the importance of diversity, as informal interactions with different people "stimulate one another to reexamine even their most deeply held assumptions about themselves and their world."<sup>35</sup> CODA goes on to say that "programs must create an environment that ensures in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural and socioeconomic lines."<sup>35</sup> These minimum standards must be met or exceeded, and deficiencies can be reported. Reports lead to investigations which take time and resources away from other activities, so it is to the school's financial benefit to demonstrate an authentic commitment to a humanistic environment where people feel respected, valued, and included.

Dentistry has made some valiant changes in recent decades. The shift away from drilling and filling and toward health promotion and disease

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prevention has taken time and serious re-evaluation of our philosophy of care. Instead of being reactive and addressing symptoms and sequelae of disease, we are now proactive in identifying modifiable risk factors, and providing targeted interventions to prevent disease. Let's apply this same framework to inclusion in dentistry and dental education. Instead of being reactive to complaints and concerns, let's do the difficult work of critical self-reflection and identify what actions and behaviors we can change within ourselves, and what actions and behaviors we can influence from our positions of authority. I dream of a day "that everyone has a voice, that no one gets away with things just because of their wealth, power, race, or gender."<sup>36</sup> As leaders in our field, it is our duty and moral imperative to invest in uncomfortable conversations now to assure the long-term sustainability of our profession. Together, we can.

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## The Elephant in the Room

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### Wired to Connect

# Belonging as a Pathway to Diversity, Equity, and Inclusion

Sonya G. Smith, EdD, JD; Kelli R. Johnson, JD;  
Caroline Davis, MPP; Pamela B. Banks, DHA

**B**elonging is often described as a “sense of feeling respected and treated fairly” and is frequently included in current discussions of diversity, equity, and inclusion (DEI).<sup>i</sup> Belonging embodies both the cognitive and affective assessments of our relationships.<sup>1</sup> Embedded within the concept of belonging is the critical concept of psychological safety. Edmondson describes psychological safety as:

*“the confidence that the team will not embarrass, reject, or punish someone for speaking up with ideas, questions, concerns, or mistakes. It is a shared belief that the team is safe for interpersonal risk-taking. It describes a team climate characterized by interpersonal trust and mutual respect in which people are comfortable being themselves.”<sup>2</sup>*



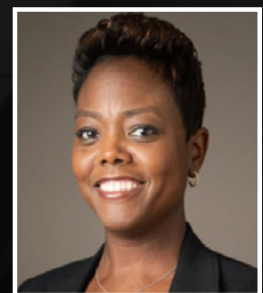
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## Wired to Connect

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The concept of belonging is tied closely to the human ability to connect. Research shows that our brains are hardwired, and our bodies are designed to “engage in satisfying emotional connections with others”<sup>3</sup> and not to live or function in isolation.<sup>4</sup> Prehistorically, these social connections have not only helped us survive but collectively build and innovate.<sup>4</sup> In Maslow’s hierarchy of needs, belonging is the third rung in the pyramid, representing friendship, intimacy, family, and sense of connection.<sup>5</sup>

When we experience strong and healthy relationships, the part of the brain that regulates the stress response calms us and keeps the stress response from taking over.<sup>4</sup> This calming, regulated response allows us to think clearly and creatively instead of defaulting to the flight (run away) or fight (angry/defensiveness) response.<sup>5</sup> The more we participate in what we perceive to be good relationships, the more the brain creates feedback loops that reinforce and strengthen relationships, thus, making them more rewarding.<sup>5</sup>

When we do not feel like we belong, our brain sends out stress signals, and we enter “flight or fight” mode.<sup>4</sup> During this period of stress, when we experience social isolation, exclusion, and lack a sense of belonging, the more primitive part of the brain kicks-in and controls our responses.<sup>5</sup> The stress mechanism within our brains is triggered and it calls the shots, which can lead to poor decisions and relationship problems.<sup>5</sup> The long-term result of exclusion is emotional distress, exhaustion, reduced effectiveness, anxiety, depression, and the potential onset of chronic

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diseases.<sup>5</sup> Research also shows that our bodies experience psychological (social) pain and exclusion the same way that we experience physical injury or illness.<sup>5</sup> The fact that our bodies’ stress response and alarm system is activated for both physical and social pain is a strong measure of the importance of perceived belonging.<sup>5</sup>

Daily, oral health clinicians, dental educators, and student doctors are engaged in a web of interactions with one another, patients, the community, family, and friends. These relationships have the potential to strengthen our sense of belonging and overall wellness or deny us the

connections we need for cognitive growth, optimal performance, and self-actualization.

## Historical and Contemporary Implications

Despite being wired to connect, belonging has not been without its historical challenges. For persons of color, women, individuals with disabilities, and the LGBTQIA+ community, belonging has often been a luxury and not a reality. These challenges are rooted in power differentials and elements of privilege in which historically underrepresented and marginalized (HURM) persons have been denied equal access to schools, housing, hiring and promotion, safe neighborhoods, and health care in comparison to their white peers.<sup>6</sup> Some of the most egregious examples of exclusionary practices are the WWII extermination of Jews, the enslavement of African Americans, the internment of Japanese Americans during WWII, the forced removal of Indigenous people, and denial of universal suffrage for women.<sup>7</sup> These exclusionary laws represent only a few of society’s practices “signaling difference,” disavowing a group’s humanity, and signifying that HURM people are unwelcome, unsafe, and do not belong.

Historically, within the healthcare system, not belonging has manifested as “othering.” Othering is seeing people as “fundamentally different, even to the point of ultimately denying their humanity.”<sup>8</sup> Through eugenics laws, people deemed undesirable, including imprisoned women and





individuals with psychiatric illnesses, were forcibly sterilized and “othered.”<sup>9</sup> The Tuskegee Syphilis experiment and the coercion of gay and lesbian teens into conversion therapy are also examples of “othering” and dehumanization in the name of “us vs. them.”<sup>10</sup>

Current headlines reveal the continuing consequences and societal impact of exclusion and perceptions that marginalized groups do not belong. The murders of Ahmaud Arbery while jogging, and Trayvon Martin while walking through his own neighborhood, are recent, dangerous, and unfortunate consequences of living in spaces where people are perceived as “outsiders,” “suspicious,” and not the “right fit.”<sup>11</sup> Additional implications for perceived belonging can be seen in the case of Dr. Susan Moore, an Indianapolis physician, who received subpar treatment for COVID-19 by a white physician,<sup>12</sup>

and in the “The Silence Breakers,” who graced the cover of *Time* for courageously exposing some of Hollywood’s most powerful sexual predators.<sup>13</sup> The result has been a rise in a series of new movements. MeToo, Stop AA/PI Hate, Neurodiversity, and the Black Lives Matter/Anti-racism movements are a modern evolution of groups defying their “outgroup status” and responding to the subsequent violence, inhumane treatment, harassment, and hate.

## The Business Case for Belonging

Creating a workplace culture with a strong sense of belonging is good for business. Research shows that strong belonging increases job performance by 56%, reduces turnover risk by 50%, and decreases sick days taken by employees by 75% with the

potential to save a large corporation \$52 million annually.<sup>14</sup> Additionally, individuals with higher workplace belonging receive double the raises and are promoted 18 times more.<sup>14</sup>

One survey revealed that people feel the greatest sense of belonging at home (62%), followed by the workplace (34%).<sup>15</sup> Individuals feel their greatest sense of belonging at work when they feel trusted, respected,<sup>14</sup> can speak freely, and voice their opinions. Consistently, individuals across all generations report feeling the greatest sense of belonging when colleagues check-in to see how they are, both personally and professionally.<sup>15</sup> As it relates to creating a sense of workplace belonging, a check-in at work ranked higher than invitations to after hour events, participation in meetings with senior leaders, receiving emails from senior leaders, and public recognition.<sup>15</sup>

## Wired to Connect

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Despite ranking second to home as the place where individuals feel the greatest sense of belonging, workplace isolation is still a major concern. Of those surveyed and spanning across generations and gender identity, more than 40% stated that they feel physically and emotionally isolated in the workplace.<sup>15</sup> Although

we live in a technologically connected world, Dr. Vivek Murthy, the U.S. Surgeon General, has declared loneliness an epidemic.<sup>1vi</sup> Loneliness is “the subjective feeling of having inadequate social connections”<sup>16</sup> and decreases the life span at the same rate as smoking fifteen (15) cigarettes a day or obesity across a lifetime.<sup>16</sup> Iso-

lation and loneliness both have consequences. For example, persistent loneliness creates stress and impairs higher-order thinking skills, abstract cognition, and the control of emotions. Lasting loneliness is also linked to inflammation, which can cause chronic diseases like diabetes, obesity, and depression.<sup>16</sup>





## Belonging and the COVID-19 Pandemic

The COVID-19 pandemic has further contributed to the stress associated with isolation and exclusion. During the pandemic, remote work, the blurring of work and home boundaries, and lockdown orders have increased isolation and prevented normal restoration processes such as interpersonal connections, networking, and exercising.

Research shows that women in the Science, Technology, Engineering, Mathematics and Medicine (STEMM) fields have experienced greater isolation and adverse impacts during the COVID-19 pandemic than men.<sup>17</sup> Since women are considerably underrepresented in most STEMM fields, particularly in senior leadership roles, their chances of professional isolation and access to sponsors and mentors with shared racial/ethnic and gender identities is less.<sup>17</sup> This isolation has been magnified by mandated public health closings, which have restricted much needed community networking and disproportionately resulted in women taking on caregiver roles.<sup>17</sup>

Throughout the pandemic, health care workers have reported increased feelings of isolation and physical and mental exhaustion. This isolation and exhaustion are linked to extra work shifts, witnessing unprecedented loss of life, and extended periods without personal family contact.<sup>18</sup> The pandemic also increased anxiety and concerns of COVID-19 transmission among patients and oral health care professionals.<sup>19</sup> Safety protocols resulting in the increased use of personal protective equipment (PPE) have been a necessary outcome, but not without unintended consequences. Dr. Kate FitzPatrick, chief nurse executive officer of Jefferson Health, describes the

loss of connection and emotional impact of full PPE:

*“Some of those emotions were lost because we lost key parts of our body in how we emote. The basic emotion of happiness, smiling or showing warmth — you can’t do it in ways you normally would. It is hidden by the PPE we are still wearing.”<sup>20</sup>*

The toll of the COVID-19 virus has also disproportionately affected poor people and communities of color.<sup>21</sup> The result has been a sense of helplessness, frustration, and anger on the part of healthcare professionals. Seeing the impact of entrenched upstream factors (e.g., racism, poverty, and other social determinants of health) has resulted in the stress of “moral injury.”<sup>20</sup> Dr. Kelly Cawcutt, associate medical director of infection control and epidemiology at the University of Nebraska Medical Center, observed:

*“ But there perhaps may be more moral injury being faced by working in a system that is broken, has not been equitable, has not been inclusive, hasn’t necessarily maintained the level of fairness and justice and the attributes you’re taught when you go to medical school about what it means to be a physician and to care for everyone and provide that best level of care you can.”<sup>21</sup>*

Additionally, due to pandemic disruption, dental school faculty and student doctors have reported difficulties developing close profession-

al relationships and lack of support systems from family and peers due to social distancing.<sup>22</sup> In dental education, students already report a high degree of chronic depression and stress associated with workload, student debt, difficult patients, and inconsistent clinical feedback.<sup>23</sup> From what we know of trauma and extreme psychological pain and distress, the post-pandemic health and well-being of our healthcare professionals, faculty, students, and oral health clinicians is a major concern. We are yet to gauge the long-term effects of more than a year of chronic stress and isolation on first responders, the higher education community, and health care providers.

## The Case for Belonging in Dental Education

Faculty and student belonging are tied to satisfaction, retention, and persistence.<sup>24</sup> One study related to belonging examined dental faculty perceptions regarding feeling welcome within the dental community, feelings of support, comfort level raising issues, and inclusion and exclusion within informal networks.<sup>25</sup> Results revealed that when comparing women and men faculty, women dental faculty reported access to fewer resources such as office space, administrative support, protected research time, and lab space. When compared to men, women dental faculty also expressed feeling less welcome and perceived the environment as being less inclusive of women. Women dental faculty participating in the study also reported greater gender bias and sexual harassment than their men counterparts.<sup>25</sup>

Closed faculty networks can create stress and adversely impact the ability of women faculty to maximize



*Additionally, research shows that perceived “fairness and equity” are building blocks for belonging. Inequities in protected research time, lab space, and office space bring on exclusionary stressors and provide unnecessary hurdles for women.<sup>27</sup> The goal is fair and equitable distribution of resources for all persons. When people perceive that they are valued and treated fairly, brain pathways support higher-order cognition and improve innovative thinking.<sup>4</sup> Therefore, removing these barriers and fostering belonging has the potential to not only improve the productivity of women in academic dentistry but also others experiencing similar roadblocks.*

time and efforts toward tenure and promotion.<sup>26</sup> Additionally, research shows that perceived “fairness and equity” are building blocks for belonging. Inequities in protected research time, lab space, and office space bring on exclusionary stressors and provide unnecessary hurdles for women.<sup>27</sup> The goal is fair and equitable distribution of resources for all persons. When people perceive that they are valued and treated fairly, brain pathways support higher-order cognition and improve innovative thinking.<sup>4</sup> Therefore, removing these barriers and fostering belonging has the potential to not only improve the productivity of women in academic dentistry but also others experiencing similar roadblocks.

Similarly, a recent survey on student belonging and persistence shows the significant impact that belonging has on dental students.<sup>28</sup> Results revealed variations in sense of belonging based on race. White dental students reported much higher levels of belonging than their HURM peers.<sup>28</sup> When controlling for gender and GPA, sense of belonging was strongly predictive of dental students’ intention to continue in

school.<sup>28</sup> Interestingly, the influence of sense of belonging on dental student persistence was almost three times greater than the influence of grades.<sup>28</sup> This study is particularly informative because it revealed significantly lower sense of belonging rates for HURM students, and thus, less likelihood of continued persistence.<sup>28</sup> Additionally, this research reminds us of the need for ongoing assessment related to key factors driving student belonging: 1) learning experiences; 2) social networks; 3) digital and physical spaces; 4) extra-curricular activities, and 5) student services.<sup>29</sup>

### Barriers to Belonging

*HURM oral health professionals, patients, dental educators, and student doctors often report barriers associated with “chilly campus climates” that lack support and openness.<sup>30</sup> Shared stories and reports of harassment, isolation, exclusion, and bias are detrimental to the physical and psychological safety of the oral health community.<sup>31</sup> One significant barrier contributing to a chilly climate is implicit bias. Implicit bias refers to “the attitudes or stereotypes that affect our understanding,*

*actions, and decisions in an unconscious manner.”<sup>32</sup> The media has a profound influence on biases. Not all bias is bad. However, images seen in the media can reinforce stereotypes that we must intentionally unlearn and dismantle.<sup>3</sup>*

Implicit bias can manifest itself in different ways, such as through microaggressions. Examples of microaggressions include:

- An Asian American dentist, born and raised in the United States, is complimented for speaking “good English” by a white colleague. (Hidden message: You are not a true American. You are a perpetual foreigner in your own country.)<sup>33</sup>
- A woman oral and maxillofacial surgeon is called to assist in repairing the jaw of a trauma patient and upon entering the operating room, the anesthesiologist, who is a man, assumes she is a nurse and begins giving her instructions to help him prepare the equipment. (Hidden message: Women do not have the skills, intelligence, and stamina to be surgeons. Women are less capable than men.)<sup>33</sup>

Microaggressions have been described as “death by a thousand paper cuts.” When experienced almost daily, the cumulative effect of these “verbal and nonverbal environmental slights, snubs, insults, and derogatory messages” is mental anguish and pain.<sup>34</sup> Because of the destructive effects of bias and exclusion on our communities and our health, we must take individual responsibility for learning to identify microaggressions and recognize our own biases. Doing so will not only allow us to self-correct but to productively address biases that we observe and may experience.

Another barrier to belonging is the inability to bring your “whole authentic-self” to a work or learning environment for fear of exclusion, judgment, or discrimination.<sup>35</sup> The need for state laws and corporate policies forbidding discrimination based on hairstyles of African Americans and people of color is an example of why employees, faculty, and students are often afraid to share their culture or true selves.<sup>36</sup> A study revealed that 61% of the workers surveyed had received overt or implicit pressure to “cover up” some form of their identity, with HURM people experiencing the most pressure.<sup>37</sup> One woman stated she was coached not to discuss family responsibilities to avoid incurring the “motherhood penalty.”<sup>37</sup>

Additionally, code switching can signal exclusion and be a barrier to belonging. Code switching is when individuals adjust their style of speech, appearance, behavior, and expression in ways to ensure the comfort of others.<sup>38</sup> For example, persons identifying as non-binary and genderqueer describe code switching in spaces dominated by men such as auto shops or hardware stores for perceived safety reasons.<sup>39</sup> HURM persons have explained code switching as exhausting but some-

times necessary to avoid harm.<sup>40</sup> Thus, we see the mental fatigue and potentially unhealthy impact that code switching can have by activating unhealthy stress responses.

The task of eradicating belonging barriers experienced by all persons, including marginalized groups, is an individual and collective responsibility of the dental education community and the entire oral health profession. Below are 10 suggested strategies for supporting social connections and belonging:

1. **develop more inclusive intake procedures for patients;**
2. **participate in continuing education to progress through the culturally competent continuum and learn about structural competency;**
3. **select diverse representatives from different backgrounds to serve on committees and build teams;**
4. **support resources for affinity groups and commit to being an ally;**
5. **create messaging connecting your staff’s talent to your organizational mission and purpose;**
6. **replace emails and texts with in-person or virtual one-on-one check-ins;**
7. **adopt flexible schedules to reduce fatigue and accommodate caregiver responsibilities;**
8. **create safe spaces to share stories and concerns to help facilitate resource referrals;**
9. **implement well-being groups that empower stakeholders to co-create and co-own structures that promote community engagement; and**
10. **participate in inclusive leadership opportunities that teach:**

- **cultural due diligence, including how to assess the impact of culture on relationships, and**
- **how to identify and intervene in social dynamics and interactions that exclude persons within teams and communities.**<sup>41</sup>

Additional information on barriers to DEI, including belonging, and strategies to address them is available in the *ADEA Faculty Diversity Toolkit*.<sup>33</sup>

## Conclusion

We are wired to connect – to develop deep social bonds. History and current events remind us of the dire consequences of not belonging or being labelled an outsider and the grave importance of creating social connections. Additionally, as a result of the COVID-19 pandemic, we are even more familiar with the individual and combined mental and physical costs of isolation, exclusion, and loneliness.

Addressing issues of bias and creating humanistic environments in which our dental education and oral health communities experience high levels of belonging requires each of us. It is a collective journey. In our quest, we must be courageous and embrace the risks associated with vulnerability and connecting deeply with people who may be different from us. We must also take intentional, sometimes scary steps to climb outside of our comfort zones to experience the rewards and bonds which have the greatest potential to change our world.

# Wired to Connect

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## Perspective

# Inclusive for ALL – LGBTQ+ Bettering the Profession and Patient Experience

Ethan A. Pansick, DDS, MS, FACD, FICD

*Ethan A. Pansick,  
Prosthodontist in  
private practice in  
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For most of the population, a visit to the dental office is anticipated with a mixture of emotions ranging from anxious anticipation to tacit acceptance. Typical reasons for this range from the perception that dental procedures are associated with pain to the expense often associated with dental treatment. However, for many members of the Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) community, other issues also need to be considered. It is important to keep in mind that many members of the LGBTQ community have routinely experienced health disparities and frequently mistrust the health care system.<sup>1</sup>

The initial contact with the dental office is often a registration form that asks a variety of personal and health oriented questions. Questions that ask the patient to check a box to identify themselves as male or female are common on these forms. If the patient does not identify as either of these choices or has a birth gender that does not match

their physical appearance, what should they do? Checking a box marked “other” or writing in another choice such as “trans” might spark discussion with the dentist or the dental team with which the patient may not be comfortable, depending upon how welcoming the environment in the office is.

Patients are often concerned with how the dentist and the team providing their care will feel about their answers to these questions.<sup>2</sup> Will they be met with giggles or sideways glances? Or worse, will they be dismissed from the practice by a practitioner with a different belief system than that of the patient?

As the registration form continues, health related questions are posed along with a space to list medications that the patient is taking. Questions related to sexually transmitted diseases and HIV status may also be a source of anxiety for members of the LGBTQ community. Patients that choose to indicate that they are HIV positive may fear that they will not be treated by the dentist in some practices because of their status, despite explicit provisions in the *American Dental Association's Principles of Ethics & Code of Professional Conduct*<sup>3</sup> as well as federal and state laws. Other patients may be concerned that the dentist will judge them based on the type of sexually transmitted diseases that they indicate that they have. Patients may not list all of their prescription medications for fear that the medications will make their medical conditions apparent to the dentist.

*Patients are often concerned with how the dentist and the team providing their care will feel about their answers to these questions. Will they be met with giggles or sideways glances? Or worse, will they be dismissed from the practice by a practitioner with a different belief system than that of the patient?*

Patients that answer health questionnaires inaccurately for fear of how they may be treated may be at risk when being treated. For example, medication and anesthesia interactions may result if the information provided is not accurate. Additionally, the ability of the dentist to treat or diagnose may be impacted.<sup>4</sup>

The question of how to address these barriers to care is complex. Dentists are the de facto leaders of the dental team and they set the tone for how the office operates on a day-to-day basis. The dentist is also the person who will determine how team members are educated to be sensitive to the wide variety of patients that will be treated in their practice. In addition, it is the dentist who will determine how to address discrimination issues that arise in their practice in real time.

Dentists and their teams should be made aware of the wide spectrum of gender identities that exist. Asking the patient how they identify rather than asking them to check a box may reduce anxiety for patients and

create a more comfortable environment for treatment. This may entail a more detailed form and/or direct communication with the dentist and/or staff on intake.

There is still stigma attached to HIV status relative to medical and dental care. The team should, of course, be following universal precautions for bloodborne pathogens on all patients for everyone's safety and peace of mind. It is also important that dentists are educated and aware of the complications that HIV and the medications used to treat HIV can have in the oral cavity.

Dentists should be prepared to examine their patients for the oral manifestations of sexually transmitted diseases and be ready to discuss their findings and answer patient questions regarding these diseases. The dentist should have appropriate referrals ready should they be necessary. The dental office should be a safe environment for patients to voice their healthcare concerns without fear of judgment or mistreatment.<sup>5</sup>

While this perspective has focused on the issues of LGBTQ patients and their interaction with the dental office, the relationship between the dentist, members of the dental team, and each other should also be considered. Many dentists and team members are afraid to reveal their sexual orientation or gender identities to each other for fear of discrimination, harassment or even employment termination, despite local, state and/or federal laws that might offer protection.

It is imperative that dentists, provide a safe and accepting environment for those with whom they work and their patients. By so doing, patients and team members will feel safe, protected and free to be the people that they are without worrying about retribution or reprisal. This is embodied in the principles of ethics as well as the standards of professionalism. "The dentist has a duty to treat people fairly."<sup>3</sup>

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## The Dis Ease of Microaggression

Brian Shue, DDS, CDE

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A person of color walks down a quiet street in a suburb. A passing car slows down to a crawl. The driver glares, shouts something unintelligible, then drives off. Was it a racial slur?

Or how about this? A person reads an article about COVID-19 in a professional journal, which begins with the words: “The Chinese Coronavirus COVID-19. . .” Was that appropriate?

Those are true stories. Unfortunately, examples like those are becoming more common in the U.S. because of heightened racial tensions. After a white police officer killed a Black man named George Floyd, our country's beliefs and actions have been challenged. Yet some types of racism are subtle. As the impact of the coronavirus is felt by our country, there are increased incidences of anger blaming Americans of Asian descent for causing COVID-19.<sup>1</sup>

The World Health Organization created best practices on naming new diseases to avoid stigma and any possible

negative impact to any groups or areas of society. Disease names such as Swine Flu or even Legionnaires Disease would not be permitted today.

So, it is inexcusable when a news commentator or even a leader of a country refers to the COVID-19 disease as “Kung Flu.” Additionally, COVID-19 is caused by the coronavirus SARS-CoV-2, not “China virus” or “Chinese coronavirus.” That is racially insensitive. And it personally insults me.

The use of racially insensitive words is a form of “racial microaggression.” Microaggressions have been defined as commonplace verbal indignities. They are intentional or unintentional, hostile, derogatory insults that target a person.<sup>2</sup>

Microaggressions reduce inclusion. They increase divisiveness. They reinforce bias and prejudices. They decrease empathy. And they are deceptive and insidious. Microaggressions are more than just feeling slighted. It has been shown to lead to exhaustion and decreased mental, emotional and physical well-being. Microaggression can be directed at any marginalized group, based on color, sex, religion or other characteristics. It's not just about race. It's about all of us.

Microaggressions are detrimental to providing health care. And they are pervasive. One study found microaggressions

## *Microaggressions of a dentist can basically undermine the trust inherent in the doctor-patient relationship.*

were seen or experienced by a majority of first-year medical and dental students. Picture this scenario: A female dentist walks into an operator. The patient declares, “You’re too young to be a doctor. I want a real doctor who knows what they’re doing. I want a doctor — who can speak English.” That is an example of an intentional microaggression.

Microaggressions can affect our dental practices. A study showed that patients who experienced microaggressions from their medical provider had poorer compliance, more missed appointments and poorer health outcomes.

In treatment planning, microaggressions of a dentist could lead to different diagnoses for two patients with identical clinical presentation. It could influence treatment plan options provided and even the type of prescriptions written. It can basically undermine the trust inherent in the doctor-patient relationship. The patient may believe the dentist did not treat them like they would have treated someone else. As a result of a perceived microaggression, the patient may even seek care elsewhere. It could lead to negative reviews in social media. One’s reputation in the community could be damaged. Un- toward consequences could spring

from a simple remark or action that was an unintentional microaggression. Not only is that patient gone, but their future referrals are gone as well.

Back on June 2, ADA President Chad P. Gehani, DDS, addressed racial violence. He courageously said this:

**“This is the moment to unravel from whatever personal biases we may harbor. To become allies. To have the hard conversations. To listen to voices that have long gone unheard. To speak up for those who have been disenfranchised. To commit to empathy and understanding. To be forces for change. To be agents of harmony. To call out wrong when we see it. And to do what’s right when we can.”**

We most likely won’t see or be exposed to racial violence in our profession. But microaggressions are more likely to happen. And we can do something about it.

We must do our best to send the right messages in our practices and in our professional lives to our patients. And to our peers. It is our responsibility to treat all our patients respectfully. We must communicate with our patients without judgement or our own negative personal bias. Sue et al. states it is important to first understand one’s own racial identity in our soci-

ety, then look at one’s opinions about other racial groups. That can lead to recognizing one’s own prejudices and bias. One needs to recognize microaggressions exist, then look at how these can impact patients. And then do what is possible to correct one’s own actions.<sup>2</sup>

Full disclosure: I am Chinese American. And the true stories mentioned above? Those involved me. I was that person walking in my neighborhood. Did I confront that driver? No. And the person that read the offensive editorial? That was also me. I contacted the writer who used the racially insensitive wording. We had an open and honest discussion. The writer said there was no intention to offend and would have removed it if the writer knew it was hurtful. That is a signature characteristic of a microaggression. The organization immediately retracted the article from the publication. Writing about this subject even made me recall events that I have not thought about for decades.

Microaggressions, especially noticeable during this pandemic, can have negative effects. We need to be self-aware of our personal biases. They should not be allowed to affect our ability to provide the best dental care possible to vulnerable populations. This can greatly affect our standing in our communities and the success of our practices. Understanding microaggressions and recognizing they exist in our everyday interactions is a first step.

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## Facts and Alternative Facts

# Ethically Responding to Offensive Comments by Patients

Vishruti Patel, DDS

*Reprinted from the Journal of the American Dental Association, Vol 150, issue 4, Pages 321-322., Copyright 2019, with permission from Elsevier.*

**Q:** Plain old truth is just that, or so I thought. We enjoyed fun-filled holidays with family and friends and successfully avoided politics and religion. Although disagreements and, sometimes, shouting matches allow us to learn about each other's beliefs and values, they are better left out of a family dinner table or in a dental practice.

In the words of the late senator John McCain, "A fight not joined is a fight not enjoyed." But are all fights enjoyed when joined? Do some fights go beyond disagreements and result in mistrust? Could a "fight" with a patient who says before receiving an injection with local anesthetic that she is going to a Bible study after the appointment to pray for "people like

me" ever be enjoyable? Is any argument with a patient who offends my staff by saying "the Sandy Hook massacre and the Las Vegas shootings were staged with actors" ever just a disagreement?

Religion and politics have taken center stage in our everyday lives. This has become the "small talk" with patients who often bring in the news and "alternative facts" to their appointment. So what are my ethical obligations to a patient who offends me because of my religion or offends my staff (who knows someone affected by the tragedies) with their conspiracy theories?

**A:** As a leader of the dental team, dentists hold themselves to a high professional standard. American Dental Association (ADA) member dentists agree to abide by the American Dental Association Principles of Ethics and Code of Professional Conduct (ADA Code) when dealing with anything in their dental practices, especially when facing an ethical dilemma.

When treating an offensive patient in your practice, you have 3 options. First, ignore the offensive comments and continue treating the patient as usual. Second, counter and respond to the patient's comments, and let the patient decide if he or she would like to continue being a patient at your practice. And lastly, dismiss the patient from the practice. Applying each of the ADA Code's ethical principles—Section 1, Patient Autonomy ("self-governance"); Section 2, Non-maleficence ("do no harm"); Section 3, Beneficence ("do good"); Section 4, Justice ("fairness"); and Section 5, Veracity ("truthfulness")—to the 3 options can help you make your decision about which approach to take.

The first option of not reacting to the patient's comments and continuing to treat the patient preserves patient autonomy. It enables the patient to continue receiving care with his or her chosen provider. The patient may never realize the offensive nature of his or her comments. No harm is done to the

patient, and it is also beneficial and fair to the patient as it prevents any delays and lapses in his or her care. Thus, principles 1 through 4 are being adhered to; however, the principle of Veracity, which imposes a duty for dentists “to be honest ... in their dealings with people,”<sup>1</sup> may not be.

The second option is to counter or respond to the patient’s offensive comments but offer to continue the care. Although the patient has a choice to continue receiving care with the dental practice where he or she feels comfortable, the patient may be forced to leave the practice if he or she feels reprimanded, shamed, or even angry. This may affect patient autonomy indirectly and may be harmful to the patient, who would need to seek the services of a new provider, causing anxiety and delays in treatment; however, you would be required to furnish copies of the patient’s records to the new dentist.<sup>1</sup> You may also need to make a referral to another dentist if you are in the midst of care so as not to abandon the patient. Section 2.F, Patient Abandonment, of the ADA Code requires that if you have “undertaken a course of treatment, [you] should not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist.”<sup>1</sup> Although your communication with the patient is truthful, as the principle of Veracity requires, you must balance this against the principles of Justice, Beneficence, and Nonmaleficence.

The third option, to dismiss the patient as a result of the offensive comments, may be the most aggressive approach. On the one hand, you take away the patient’s autonomy by not allowing him or her to choose to continue care with you knowing your differing viewpoints. On the other hand, this might promote autonomy if you feel that you may now treat the patient differently because of unconscious or

implicit bias. According to Chapman and colleagues,<sup>2</sup> “Research suggests that implicit bias may contribute to health care disparities by shaping physician behavior and producing differences in medical treatment... ” The patient would be forced to start the treatment again with a new provider, which may create a lapse in the care. This also may create long-term mistrust with dental providers and a negative opinion of the profession as a whole. Be sure to adhere to your state requirements for dismissal and avoid patient abandonment as discussed under the second option.

When dentists are faced with an ethical dilemma, whether in a personal setting or a professional setting, several factors affect responses to the incident. Individual principles play an important role in decision making. Some may see a need to correct and educate at every opportunity, whereas others may choose to forgive and forget. Upbringing and core values can serve as a guide, as can professional codes of ethics.

The number of years in practice may also influence a dentist’s approach to practice matters. Building a patient base may be the top priority for a new dentist, as opposed to protecting the practice values for a more seasoned practitioner. Whether the dentist is male or female and the patient is male or female may also influence a dentist’s response and course of action to an offensive comment. In a group practice, there may be policies to address offensive patients, but a solo practitioner may make decisions on an individual basis. In any event, having a policy for responding to offensive patients can be helpful so as not to respond in an arbitrary or ad hoc way.

All dentists have patients whom they love to see in the schedule and look forward to “catching up” with and

others with whom they try to minimize any personal communication. Past experiences influence perception of interactions with others. Whether a comment is offensive may depend on a history of being subjected to such behaviors. The patient’s comments of praying for “people like me” may be perceived as genuinely caring by some. However, for others who have gone through childhood and beyond subjected to prejudice against them, such comments may be viewed as the next attack. Patterns and parallels may force unconscious or implicit bias. If implicit bias may compromise your ability to provide good care, then ethically, it may be warranted to refer the patient to another dentist.

Dentists are leaders of the dental team. Dentists take an oath to put the welfare of the patient first. They hold themselves to a high professional standard and let the ADA Code guide their practices. This means that dentists must often put personal feelings and their egos aside in caring for every patient. Each interaction and ethical moment must be weighed to “do no harm” and “do good” in the most “truthful” and “just” manner. So my response to offensive patients is to “rise above” and treat them with the utmost care and professionalism.

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# A Champion for Equity and Inclusion

President Juliann S. Bluitt-Foster

Theresa S. Gonzales, DMD, MS, MSS, FACD

Interactive Audio Feature

**Juliann Bluitt understood the bigotry of low expectations and she was determined not to let anything hold her back. As a child, she charted a path that led her to the heights of professional achievement and along the way she secured a place for others to do the same. She was a champion for equity and inclusion long before the benefits of a diverse workforce were largely known. While I think that she would be disappointed in the slow pace of the diversification of the dental workforce community; she would be pleased with the efforts of her colleagues who work tirelessly to seek ways to advance the initiative and create opportunities for those who have endured all forms of prejudice. She was masterful at creating opportunities for others.**

Juliann Stephanie Bluitt was born on June 14, 1938, the only child of Marion Eugenia Hughes, a first-grade teacher, and Stephen Bernard Bluitt Jr., a government payroll clerk. Growing up in segregated

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*“As the first female and African-American female president of the Chicago Dental Society, Juliann Bluitt inspired me and countless others to pursue our dreams without limitation. She not only served as a role model to so many of us but was also a pioneer in multiple arenas.”*

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Washington, she attended a private school through the fourth grade, then switched to public schools, graduating from high school before enrolling at Howard. Along the way she took lessons in art, drama, piano and ballet.

She earned her bachelor's degree at Howard University in zoology and decided to pursue dentistry there so that she could remain close to home. After earning her dental degree, she taught at Howard's College of Dentistry for a year before moving to Chi-



## A Champion for Equity and Inclusion

President Juliann S. Bluitt-Foster

cago. Dr. Bluitt went to dental school at a time when fewer than two percent of the students were women and the number of women of color in professional school was appalling low. Dr. Bluitt Foster made it her goal to change that. She would become a leader in the field, mentoring students and using her own career path as an example of what they could achieve, first as director of the dental hygiene department at Northwestern University's Dental School in 1967, then as assistant dean, associate dean of admissions and associate dean of student affairs.

As previously mentioned, women did not enter dentistry in appreciable numbers until the 1970s and have only recently outnumbered men in dental schools. It was not until 1967, that the American College of Dentists began welcoming women and minorities into fellowship. Notably, Dr. Jeanne Sinkford was inducted that year, followed by former ACD President Juliann Bluitt-Foster in 1974 and Dr. Cecilia Dows in 1985. In 1994, Dr. Foster served with distinction as the first female president of the American College of Dentists and over the course of the next three decades, she continued to advocate audaciously for ethics and professionalism in health-care. Her tenure as president was characterized by meticulous preparations for the 75th anniversary of the founding of the college and her intense desire to enhance the myriad missions of the college.

"Dr. Juliann Bluitt was an amazingly accomplished professional. She dedicated her adult life to the education of others in the dental profession," said Chicago Dental Society President Cheryl Watson-Lowry, the society's second female African-American president, in an obituary published in the CDS Review. "As the first female and African-American female president of the Chicago Dental Society, Juliann Bluitt inspired me and countless others to pursue our dreams without limitation. She not only served as a role model to so many of us but was also a pioneer in multiple arenas." Dr. Bluitt-Foster was elected as the first female president of the Chicago Dental Society in 1992. She guided its 127th annual convention to a move into a major convention center in Chicago,



McCormick Place. This catapulted the meeting attendance of dental personnel to over 23,000 from the US, Canada and several countries of the world.

Dr. Bluitt-Foster's well-known expertise and myriad experiences led many national level organizations to pursue her participation and her guidance. She served on the National Advisory Council for Health Manpower Legislation, on the Federal Drug Administration Committee, and the Advisory Council to the Director of the National Institutes of Health in Bethesda, Maryland, and as a member of the American Dental Association's, Council on Ethics, Bylaws and Judicial Affairs. As a committee member for a number of years in each of these capacities, she was known for her outspokenness and diligence. Her proudest accomplishments were serving on the committees which authorized mapping of the Human Genome and the investigative study for this newly emerging disease, Acquired Immune Deficiency Syndrome or AIDS.

Dr. Bluitt-Foster died at her home on Hilton Head Island. Her commitment to the college continues through a generous gift from her estate. Dr. Bluitt-Foster's philanthropy was widely known and her legacy lives on through the establishment of the Dr. Juliann Bluitt-Foster and the Dr. Roscoe Foster Fund for emerging leaders.



## FEATURE

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# Ethics in Action: *Profiles in Leadership*

Spotlight on Dr. Amy Martin, Chair, Department of Stomatology, The Medical University of South Carolina, James B. Edwards College of Dental Medicine.

**A**s integral members of the health care team delivering oral health care while battling a pandemic, we have been called upon to operate under extraordinary circumstances. Our capacity has been forged in the crucible of uncertainty and powerful alliances have been reimagined. Not surprisingly, the dental workforce has risen to the task and made adjustments to the delivery of care as the situation continues to evolve. Emerging data suggests that the COVID-19 pandemic has disproportionately affected many minority and marginalized populations in the United States and beyond. This is evidenced in disparate infection rates, poorer clinical outcomes and higher mortality rates among disenfranchised communities.

As a regular feature, we have elected to highlight “ethics in action” and have chosen the contributions of Dr. Amy Brock Martin and her colleagues at the Medical University of South Carolina for this issue of the eJACD. Dr. Martin and her team of professionals have championed access and health equity for many years and they have prioritized this effort in the age of COVID. Dr. Martin contends that health care systems must prioritize respectfully assessing and addressing social determinants of health including economic stability, physical environment, education and access to healthy food that might limit an affected community’s ability to comply with public health guidance, follow through with recommended treatments and influence the health care outcomes.

## Ethics in Action: *Profiles in Leadership*

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### What was the ethical issue that you were trying to reconcile?

Rural children experience persistent inequities when it comes to dental care access and oral health status. In the middle of the pandemic, we fully expected their disparities to become exacerbated as schools moved to remote learning. For many children, rural especially, this meant they were also separated from essential services such as school-based oral health and nutritional assistance programs.

As the health system enterprise of the Medical University South Carolina (MUSC) acquired a network of four rural hospitals and affiliated physician practices, our Board of Trustees and executive leadership appealed to our College to become more integrated with the healthcare delivery system. Marion County was home to one such acquisition. At more than 450



*The Dynamic Duo:*

*Amy Martin, DrPH, MSPH, Director of the Division of Population Oral Health and Joni Nelson, PhD, MS, Deputy Director*

square miles with approximately 31,000 residents, Marion County's rurality is evident in its fabric of agricultural acreage. At one

point in its history, it was home to the largest tobacco market in the state. As such there are complex health inequities that are generational. Marion County is more than 130 miles from Charleston, home to MUSC.

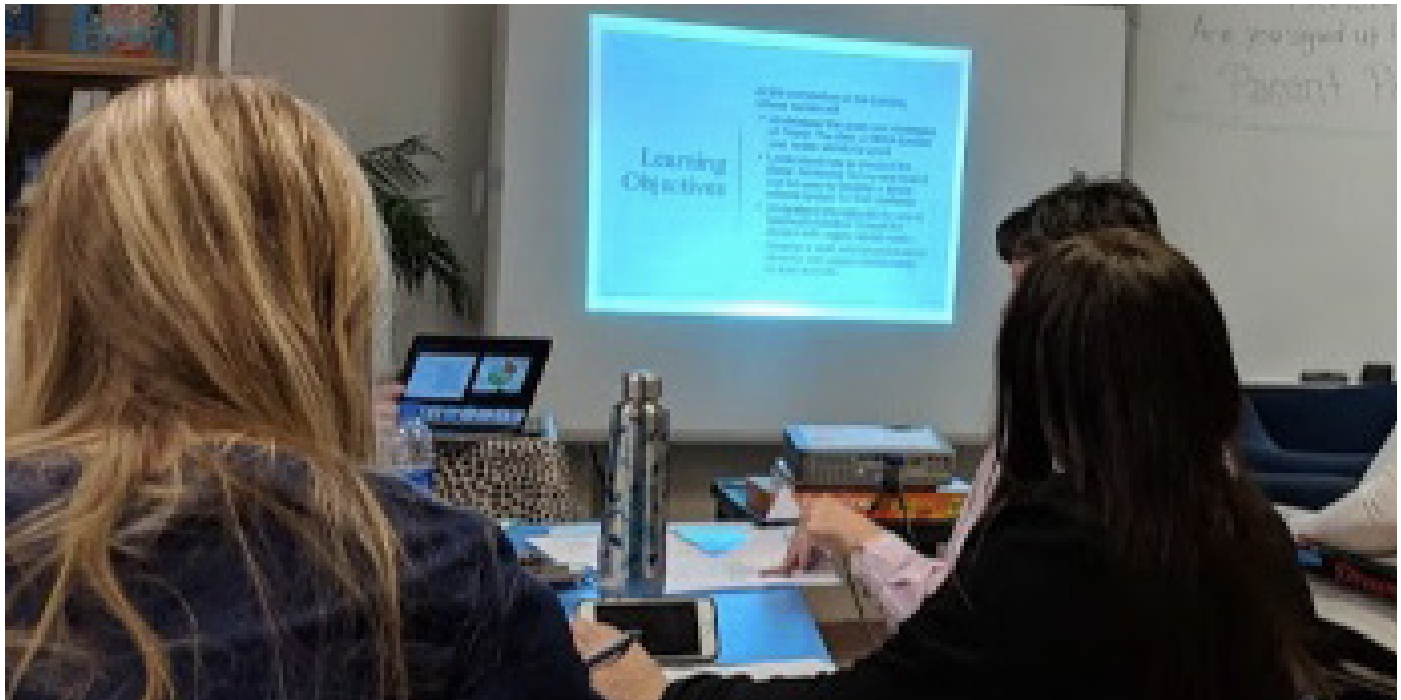
### How did you and/or your organization champion the effort?

We were already engaged in supporting the expansion of school-based programs in rural North and South Carolina so that was an obvious first step for Marion County. In conducting an environmental scan of the region, we discovered reasonable infrastructure already existed with a Federally Qualified Health Center (FQHC) and a non-profit organization bringing dental care into public schools in the area. Rather than disrupting existing programs and partnerships, we made the



*Marion County- South Carolina*





*Formalized training of community liaisons is crucial to improving access and equity to populations at risk.*

strategic decision to develop a pediatric oral health system to support providers in the area while ensuring rural children had access to a full suite of service options.

Working with area oral health providers and human service partners, a system was designed. Children were already finding their way into care through existing school-based programs and community dentists. It was clear from claims data too many were disconnected from regular dental care. We secured funding from the Health Resources and Services Administration and philanthropic partners to increase the number of entrances into care. These additions included oral health interprofessional practice in pediatrician and family medicine practices. We are currently implementing a strategy that co-located dental hygienists in rural health clinics, a configuration supported by the state's practice act. We are also designing rotations

of some of our residency programs to offer surgical services at the hospital. Periodicity schedules for pediatric dentistry, oral surgery, and periodontics are being planned. The network of engaged partners (primary care, community dentists, and the College's dental specialty teams) will enjoy facilitated referral management through a system-level care coordinator and telehealth technology. We have also received funding to develop predoctoral dental student rotations in this system, specifically the FQHC. This rotation will augment an existing Safety Net Dental Practice Certificate Program for which we received the Gies Award for Innovation in Education in 2020.

Maintaining the existing dental workforce is essential to the success of the system. We have repurposed the Certificate Program for continuing education so as to calibrate and equip rural dentists with emerging models in collaborative referral management

and interprofessional practice. CE is augmented with a small grants programs so that rural practices can purchase capital equipment (i.e., 3D printers, electronic health record system, laser technology) so that have greater success in recruiting new graduates.

Finally, this system is made possible by the tireless efforts of our state dental public health program, who has been conducting extensive outreach and education with Head Start programs, daycare centers, and public schools. They are also convening community meetings to address the oral health of children.

## **What was your timeline?**

We did not have a predetermined timeline for designing the new system. As we continued in-person meetings, the plans that emerged were organic, dynamic and obvious. It was important to us

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as a college to make value-added contributions and not compete or disrupt existing health service markets. We were certain our vision was ill-timed for extramural funding given the need for COVID-related resources. We were wrong. We had secured funding for our hygiene co-location model in January 2020 but everything else was secured only within the first five months of 2021. Our system design wasn't just good grantsmanship. It was the right thing to do for rural children.

### What was the result of the effort?

With funding secured, we are moving forward expeditiously to implement the essential components of the system. We naively underestimated the amount of project management necessary, given the speed with which our funding came together. As a result, we are hiring an Oral Health Integration Officer. This person will provide administratively leadership to all aspects of system development. This person will also develop

and lead a quality improvement agenda in the primary care, dental practices, enabling services, and hospital settings. This agenda is essential to ensuring our system design can be easily replicated in other rural communities with comparable infrastructure.

### What were the lessons learned?

Our vision for a new system came together because we had both grass roots and grass tops advocacy. Our grass roots advocates were the rural providers and constituents in Marion County. Our grass tops were the institutional and executive level leadership at MUSC. Our work would not have been successful without if not for both advocacy domains supporting it. Oral health system redesign is more than just improving care and outcomes. Its an expression of social justice for communities that have been forgotten by the urbanization of our society. Our focus on children has been deliberate. Improving rural children's oral health can



*Dr. Nelson advocating for safety net dental education causes.*

contribute to their successful aging out of poverty, a statistical improbability without it. To learn more about this effort please visit <https://onlinelibrary.wiley.com/doi/epdf/10.1111/jphd.12444>

### Is this expanded institutional capacity scalable at other academic healthcare institutions?

The short answer is absolutely, so long as the organizational culture values health equity for all, including those whose population numbers are small, insurance is public or non-existent, and social determinants of health are complex.



*Oral health is a critical component of a young child's overall health, development, and ability to learn.*



## The Pulse

# Are We Truly Meeting the Oral Health and Total Health Care Needs of the Most Vulnerable Citizens in All Our Communities?

Leo E. Rouse, DDS, FACD  
President of the American College of Dentists

Sir Winston Churchill famously opined that “no matter how grand the strategy—we must occasionally look at the results.” Throughout my career, we, as an oral health care workforce, have developed many policies and programs to improve oral health and oral health care delivery for the general population and that is laudable. But what about populations at risk? Are we truly meeting the oral health and total health care needs of the most vulnerable citizens in all our communities? To answer this question, we must “pulse” the community and get the input from those most affected by the decisions that are made. As a general measure of health, the pulse is important and although there’s a wide range of normal, an unusually high or low pulse or an erratic rate may indicate an underlying problem. Early recognition of the problem portends a more favorable outcome and regular pulse checks are necessary.

Recently, the National Coalition of Dentists for Health Equity (NCDHE) released a statement on oral healthcare disparities that greatly and negatively impact those most vulnerable. They also remind us that we cannot forget Dr. Martin Luther King, Jr.’s 1966 statement:

“Of all forms of inequality, injustice in health care is the most shocking and inhumane.”

As the conscience of dentistry, the American College of Dentists is committed to the professional responsibility of striving for diversity, equity, and inclusion (DEI). This commitment

is inherent in our mission to advance excellence, ethics, professionalism, and leadership. That commitment must be manifest in our professional practice, and not simply theoretical.

I submit to you that the missions of the American College of Dentists have been inordinately stressed during the pandemic, and we have resolved to remain steadfast in our commitment to ethical leadership at the Regency and Section components of our College. Our local leaders and Fellows, unsurprisingly, have met that challenge directly, regularly, and remarkably.

I have witnessed a reframing of the College’s commitment to diversity, equity, and inclusion at all levels through my virtual visits to Regency meetings, leadership summits, and specific programs related to DEI. I am especially proud of our SPEA chapters and their leadership; supported by our outstanding Regents and Section Chairs with their commitment to ethical discussions related to social and racial justice.

As health care providers and leaders, we fully understand the importance of taking the pulse of our patients, a key vital sign; but let us not forget how biases can contribute to the inequities and inequalities in health care delivery. The Centers for Medicare & Medicaid Services (CMS) has indicated that social determinants of health (SDoH) are not just an adjunct element to our health care ecosystem, but increasingly drive the definition of health care.

*“We are called at this moment in history to take our own collective, professional pulse to ensure better healthcare outcomes for all. The American College of Dentists will continue to look for opportunities to collaborate with other national organizations focused on dental education, research, oral health equity, diversity, inclusion, and social justice.”*

We are called at this moment in history to take our own collective, professional pulse to ensure better healthcare outcomes for all. The American College of Dentists will continue to look for opportunities to collaborate with other national organizations focused on dental education, research, oral health equity, diversity, inclusion, and social justice. Fellows, stay tuned for more conversation as we continue to lead as the conscience of dentistry.

The complete statement issued by NCDHE may be found at <https://www.dentistsfortheequity.org>. The eJACD may be found at <https://www.acd.org/publications-2/publications/jacd/>.

A stylized, handwritten signature in black ink, appearing to read 'Leo Rouse'.



