



# eJACD

The Official Journal of the American College of Dentists

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**Diversity & Inclusion**  
part 2

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

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It is the communication policy of the American College of Dentists to identify and place before the fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. The goal is to stimulate this community to remain informed, inquire actively, and participate in the formation of public policy and personal leadership to advance the purpose and objectives of the college. The college is not a political organization and does not intentionally promote specific views at the expense of others. The positions and opinions expressed in college publications do not necessarily represent those of the American College of Dentists or its fellows.

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- B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all, and to urge broad preparation for such a career at all educational levels;
- C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;
- D. To encourage, stimulate, and promote research;
- E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;
- F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
- G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;
- H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;
- I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potential for contributions to dental science, art, education, literature, human relations, or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.

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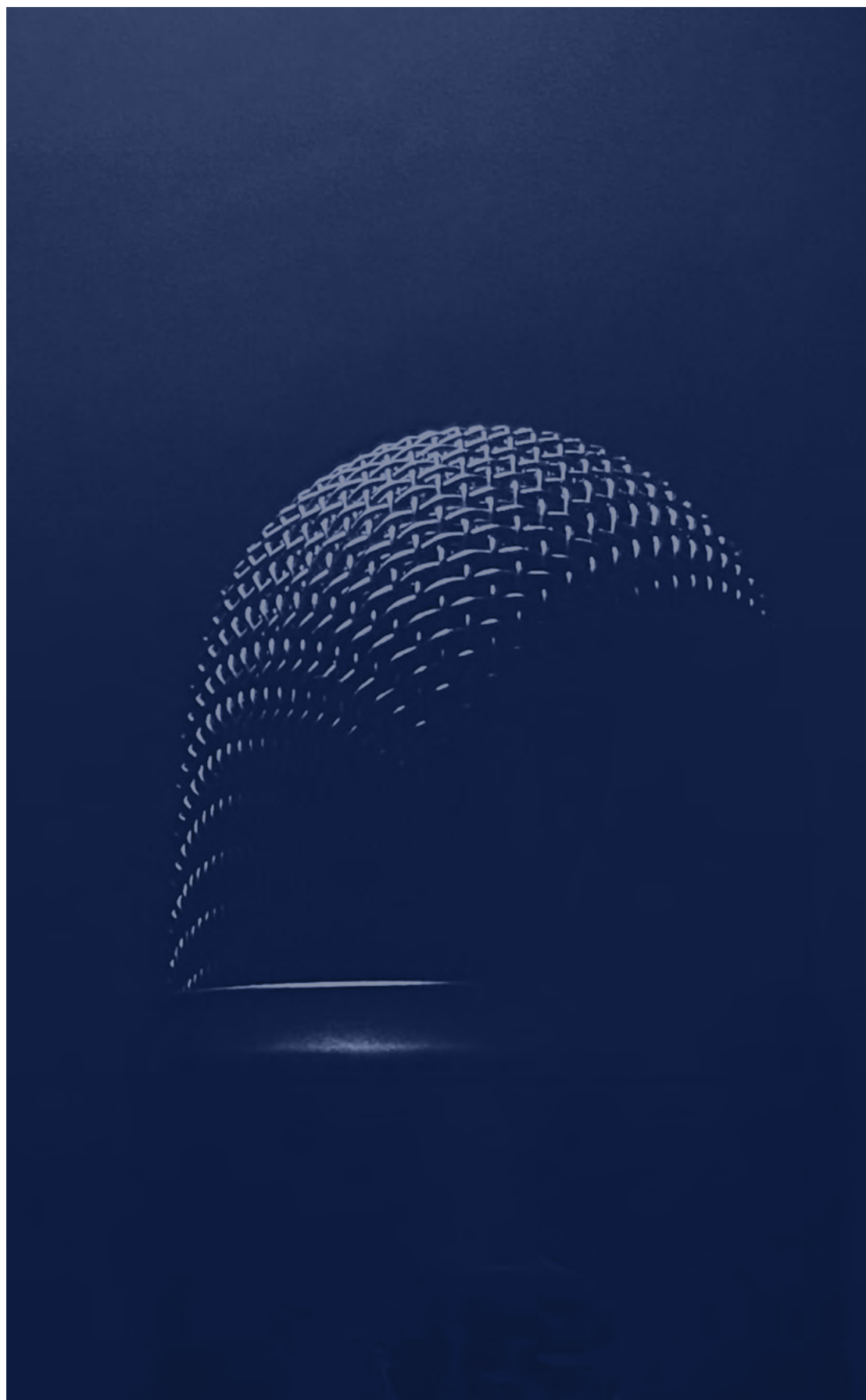
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## The Beauty of Many Voices

### Unlocking A Growth Mindset Towards Diversity and Inclusion

**D**iversity, in its simplest form, is an attempt to describe and value our collective differences. We intentionally use the word “attempt” here for a myriad of reasons, namely because our differences are so vast, rich and unfolding daily. Inclusion, while an interrelated concept, is distinct from diversity in that it focuses on how we leverage our collective differences for ultimate good.<sup>1</sup> Inherent within principles of diversity and inclusion is the valuing of what may be divergent perspectives, philosophies or schools of thought. As goes with most any topic—particularly those sometimes

skewed as controversial—there will be varied opinions, insights or conclusions drawn. In that spirit, we wish to thank those Fellows who have expressed pause and concern with our centering of diversity and inclusion for this current and our previous e-JACD issues. Upholding diversity in principle requires us to value all voices, even placing value on those voices and issues with which we may disagree. Furthermore, the American College of Dentist’s pillars of leadership, professionalism and ethics compel us to think about the opinions and thoughts of others—but to also consider the needs of others.

# Unlocking A Growth Mindset Towards Diversity and Inclusion

Carlos S. Smith, DDS, MDiv, FACD, Guest Editor and Nanette Elster, JD, MPH, FACD

Empathy, the ability to understand and share the feelings of another, is widely understood as a necessary lens for those engaged in patient care. However, empathy is also an appropriate ethical lens for how we engage with peers, colleagues and our profession as a whole. How does empathy shape our response to those with whom we respectfully disagree? Scholars define empathy as a cognitive attribute in which an individual is able to put themselves into another's position to share and understand the meaning and significance of one's behavior.<sup>2</sup> In many ways, empathy is a hallmark of the American College of Dentists. One, particularly those amongst a profession, cannot possibly consider the events of the last year and a half—and counting—without an empathic impulse. The unrelenting effects of the COVID-19 global pandemic, whose effects we continue to endure, have peeled away what was already a thinly veiled veneer of combating health inequities both globally and here within our own borders.<sup>3,4</sup> That one's zip code is still the best predictor of health outcomes cannot be our final resting point.<sup>5</sup> Nor can this be something we ignore as healthcare professionals. The American College of Dentists has been long regarded as the conscience of dentistry.<sup>6</sup> If we do not attempt to understand diversity and inclusion, and become practitioners of it—to ensure dentistry as a welcoming profession for all—patients, students and colleagues—must we then relinquish the conscience crown? Understanding principles of diversity and inclusion is not a mere can of worms we can sit idly by refusing to open. In many ways the ethical imperative presents our profession with a litmus test, in

which we must ask of ourselves—who are we really and . . . who do we want to be? Are we indeed the conscience of dentistry? Conscience is an inner feeling or voice viewed as acting as a guide to rightness or wrongness—a sense or consciousness of moral goodness—examining one's own conduct, intentions, or character together with a feeling of obligation to do right or be good.

To think of one's conscience is to also think of one's or a group's ability to change or evolve. Growth mindset, the belief that people can change, is

a growth (vs. fixed) mindset orients people toward learning about others and is key to comprehending diversity and inclusion.<sup>10</sup> A growth mindset can also increase engagement, particularly among women and minorities, in organizational settings.<sup>11,12</sup>

With that in mind, this second issue offers diversity and inclusion perspectives from organizational vantage points displaying the many voices of our esteemed dental profession. With historically marginalized groups in mind—we offer insights from the American Association of Women

*Understanding principles of diversity and inclusion is not a mere can of worms we can sit idly by refusing to open. In many ways the ethical imperative presents our profession with a litmus test, in which we must ask of ourselves—who are we really and . . . who do we want to be? Are we indeed the conscience of dentistry?*

a key psychological process for enhancing both individual and organizational effectiveness.<sup>7</sup> Research shows people fall along a continuum from believing that people are malleable and can develop over time, a growth mindset, to believing that people cannot change, a fixed mindset.<sup>8</sup> Mindsets shape our views on how people and the world work. Mindsets also drive our understanding of goals, perceptions, and reactions in group settings and environments.<sup>9</sup> Studies have shown that

Dentists, the Hispanic Dental Association, the National Dental Association and the Society of American Indian Dentists. We also garner insights from the American Dental Association, often regarded as the voice of organized dentistry. To be clear, there are many voices within our organized dentistry ranks, just as there are many and varied voices individually across our profession. The beauty is actually in the variety of these voices. This issue also sheds light on the often silent diversity factor - dis (ability) or

*“Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.”*

ableism as well as the understanding of intersectionality, the recognition of multiple interlocking identities.<sup>13</sup> With many of our readers and members being active in clinical practice, we offer a clinician’s corner within this issue—offering practical and applicable ways you can take up the diversity and inclusion mantle right within your practices with greater understanding of social determinants of health. We also offer an ethical framing of oral health policy. Again, our authorship is also intentionally diverse from a White midwestern female university provost armed with a law degree and a clinical background in dental hygiene to one of the few Black female oral surgeon’s ascending the ranks to chair an entire hospital dentistry that just so happens to have a PhD as well. We have also included a profile of past ACD President Dr. Stephen D. Chan as a true champion for inclusivity and his 2015 President-Elect ACD address, one of the most riveting in our storied history.

While race is certainly one aspect of diversity, it is not the only aspect of diversity. Particularly in the United States, where race has played a large role in lived experiences, it is understandable that many begin diversity and inclusion conversations on race. However, diversity at its richest, describes the full range of differences, the visible and non-visible, that make each and every individual unique.<sup>1</sup> While differences across culture, race, ethnicity,

language, age, sex, gender identity, and sexual orientation often come to mind—true diversity and inclusion also account for a communal spectrum across values, beliefs, nationality, military/veteran status, socioeconomic status, (dis)ability (both visible and invisible), religious commitment, life experiences, personality, learning styles, practice settings or other characteristics or ideologies unspecified or yet to be determined.

So where do we go from here? As teachers of ethics, we are often faced with dental and dental hygiene students, residents, faculty colleagues or practitioners in continuing education courses—all seeking answers, most aptly the “right” answers. Although it may seem frustrating at the onset, we are continually reminding these students, of every stage - life long learners—that the goal is not always the answer, but the most robust learning sometimes occurs along the journey. In offering a variety of voices—many contributing perspectives oft silenced or ignored—our aim is for the long way journey. Drawing from the words of Chinese philosopher Confucious, “roads were made for journeys not destinations.” Let us journey together. A journey where we remain the conscience of dentistry—through leadership, ethics and professionalism—advocating for a profession inclusive of all and providing optimal oral health care for all.

While most feedback on the first volume of the e-JACD devoted to ethical and professional issues of diversity, equity and inclusion (DEI) was positive, some readers have expressed concern that this focus embraces the views of one group and is inappropriately politically charged. A focus on DEI is really intended to be just that: diverse, equitable and inclusive. The focus is not intended to support or discredit one group over another nor is it intended to make a political statement. Instead, the intent is to prioritize some voices that have not been as prominent as others and to increase understanding of the many views, cultures, abilities, etc. that exist within the profession. Professionals hold such esteemed status because of the social contract. According to Wynia et al, the key function of professionalism in health care is “ensuring that health professionals are worthy of patient and public trust.”<sup>14</sup> Additionally, adherence to a code of ethics is one of many elements that helps to define a profession. Cruess, et. al. highlight this: “Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base,

# Unlocking A Growth Mindset Towards Diversity and Inclusion

Carlos S. Smith, DDS, MDiv, FACD, Guest Editor and Nanette Elster, JD, MPH, FACD

the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society.”<sup>15</sup> In dentistry as in other healthcare professions

(medicine, nursing, etc.) Justice is one of those foundational principles. Justice takes many forms (social, distributive, retributive, etc.) but can be summed up quite succinctly—Ethics is not about good people or

bad people, it is about actions. Not all will have the same beliefs, but as professionals there are actions and inactions that are expected and embraced.

## REFERENCES

1. eXtension Foundation Impact Collaborative (2021, May 20). Diversity, Equity, and Inclusion <https://dei.extension.org/>
2. Schattner A. Who cares for empathy? QJM 2012;105(3): 287–90.
3. Kim, E. J., Marrast, L., & Conigliaro, J. (2020). COVID-19: magnifying the effect of health disparities. *Journal of general internal medicine*, 35(8), 2441.
4. Phillips, N., Park, I. W., Robinson, J. R., & Jones, H. P. (2020). The perfect storm: COVID-19 health disparities in US Blacks. *Journal of racial and ethnic health disparities*, 1–8.
5. Graham, G. N. (2016). Why your ZIP code matters more than your genetic code: promoting healthy outcomes from mother to child. *Breastfeeding Medicine*, 11(8), 396–397.
6. Ralls SA. American College of Dentists: an overview. *J Am Coll Dent*. 2011 Spring;78(1):4–11. PMID: 21739864.
7. Rattan, A., & Dweck, C. (2018). What Happens After Prejudice Is Confronted in the Workplace? How Mindsets Affect Minorities' and Women's Outlook on Future Social Relations. *Journal of Applied Psychology*, 103, 676–687.
8. Rattan A., Georgeac O. (2017) Mindsets About Malleability and Intergroup Relations. In: Zedelius C., Müller B., Schooler J. (eds) *The Science of Lay Theories*. Springer, Cham. [https://doi.org/10.1007/978-3-319-57306-9\\_6](https://doi.org/10.1007/978-3-319-57306-9_6)
9. Carr, P. B., Dweck, C. S., & Pauker, K. (2012). “Prejudiced” behavior without prejudice? Beliefs about the malleability of prejudice affect interracial interactions. *Journal of Personality and Social Psychology*, 103, 452–71.
10. Carr, P.B., Rattan, A., & Dweck, C.S. (2012). Implicit Theories Shape Intergroup Relations. In P. Devine and A. Plant (Eds.) *Advances in Experimental Social Psychology*, 45, 127–165.
11. Emerson, K.T.U. & Murphy, M.C. (2015). A company I can trust? Organizational lay theories moderate stereotype threat for women. *Personality and Social Psychology Bulletin*, 41, 295–307.
12. Heslin, P.A., Vandewalle, D. & Latham, G. P. (2006). Keen to Help? Managers' Implicit Person Theories and their Subsequent Employee Coaching. *Personnel Psychology*, 59, 871–902.
13. Parent, M.C., DeBlaere, C. & Moradi, B. Approaches to Research on Intersectionality: Perspectives on Gender, LGBT, and Racial/Ethnic Identities. *Sex Roles* 68, 639–645 (2013). <https://doi.org/10.1007/s11199-013-0283-2>
14. Wynia, Matthew K. MD, MPH; Papadakis, Maxine A. MD; Sullivan, William M. PhD; Hafferty, Frederic W. PhD More Than a List of Values and Desired Behaviors, *Academic Medicine*: May 2014 - Volume 89 - Issue 5 - p 712–714 doi: 10.1097/ACM.0000000000000212
15. Sylvia R. Cruess, Sharon Johnston & Richard L. Cruess (2004) “Profession”: A Working Definition for Medical Educators, *Teaching and Learning in Medicine*, 16:1, 74–76, DOI: 10.1207/s15328015tlm1601\_15



## Dr. Steven D. Chan

# A Champion for Inclusivity

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

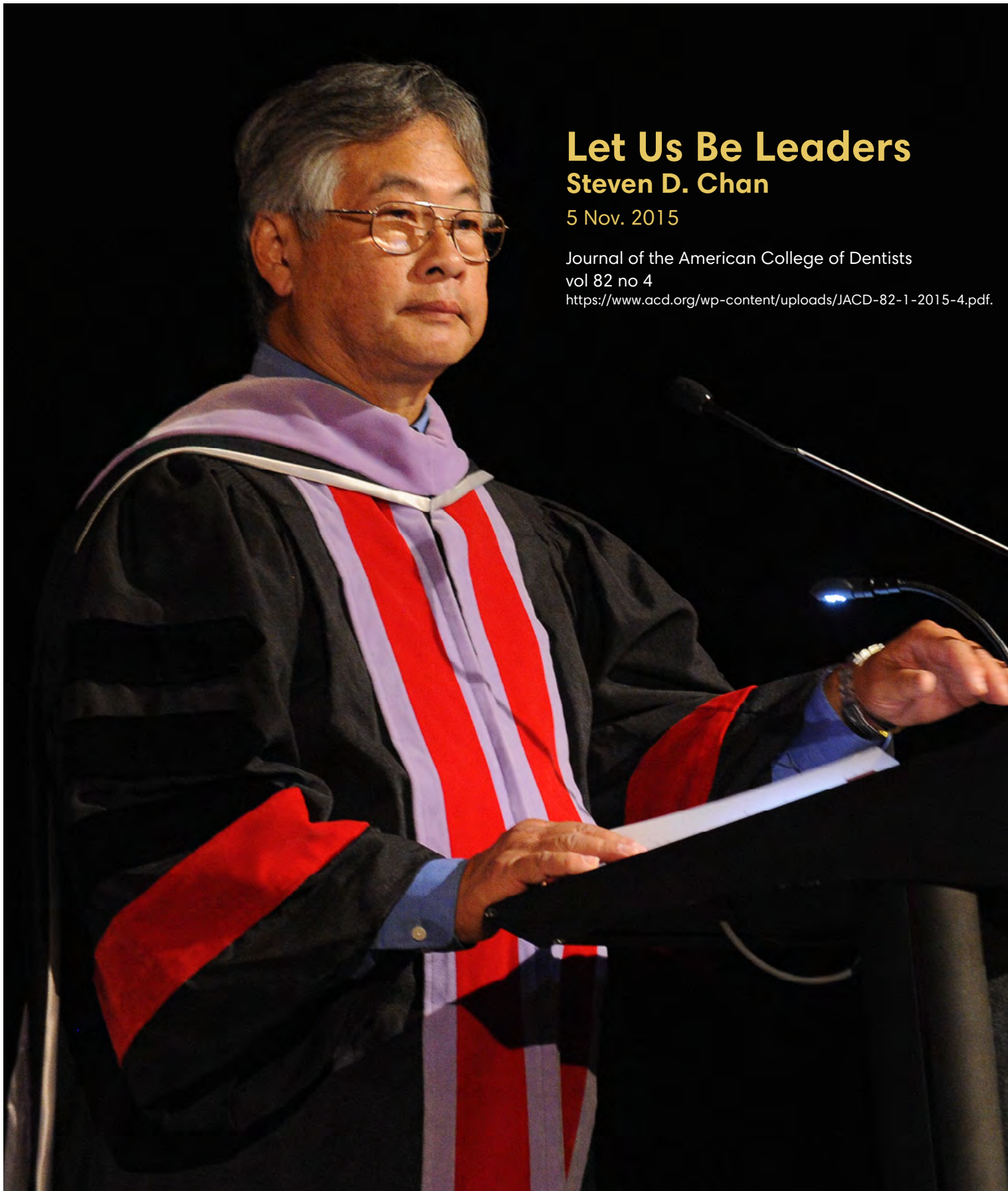
*Dr. Gonzales serves as the Executive Director of the American College of Dentists and is a Federal Health Care Executive.*

President-elect Steven D. Chan's 2015 speech was one of the most impactful and memorable in College history. The speech was delivered in Washington, DC, where he made an impassioned appeal for inclusivity. He held the audience spellbound with his utterly American story of his Chinese grandparents and their immigration to this country. It was the story of many families and their search for a better life in a new world. It was beautiful and distinctive in that many in the audience were moved to tears when he spoke of the passing of his 108-year-old grandmother.

More than most, President-elect Chan understood the incalculable value of diversity and inclusivity in our society. He argued that inclusion empowers the concept and practice of diversity by fashioning an environment of involvement, respect, and connection. "We in the college exist for the common good for the greater whole of the profession, not just a part of it. No matter what you look like, no matter what manner of dress you wear, no matter what language you speak, no matter the model of practice. We believe in inclusiveness. America is built on the principal inclusiveness... American dentistry is shifting. I believe the greater whole of the profession will be in a better place by bringing us together under the tent of the American College of Dentists."

*Dr. Chan contends that  
"an inclusive team can  
take you places you never  
dreamed of and if you  
can build a sustainable  
culture of inclusivity—  
the rest will follow."*

He went on to advocate for the importance of developing leaders who reflect the population that we serve. "Our mission is to advance excellence, ethics, professionalism, and leadership. Ethics and professionalism are about the here and now. Excellence is what you can see before you. Yet leadership is seeing what can be. Build better leaders and we build better organizations. Build better leaders and we build a better profession. Build better leaders and we build better images of who we are in the communities we live in. Leadership is to touch the future. We can build the 'pipeline of hope' for the profession." He encouraged us to imagine the full potential of a diverse and inclusive world and to commit to an inventory of actions to realize this potential. In this way, he illuminated our imagination and catalyzed our resolve to continuously explore the richness of ideas and perspectives that inclusivity provides. Dr. Chan contends that "an inclusive team can take you places you never dreamed of and if you can build a sustainable culture of inclusivity— the rest will follow."



## Let Us Be Leaders Steven D. Chan

5 Nov. 2015

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<https://www.acd.org/wp-content/uploads/JACD-82-1-2015-4.pdf>

Good morning. My name is Steve Chan.  
I am the incoming president of the  
College, and I bring you greetings.

I can't believe I'm here. I used to be scared of those guys on the podium.

Now I am one of them.

This is a homecoming for me to be here in Washington, D.C. I graduated from Georgetown Dental School. It has since been closed, but Georgetown was a very traditional dental school. At Georgetown we wore white, high collar tunics, just like in the barber shops of old. But we also wore white pants, white shoes, and white lab coats. We looked like something out of the history books.

When I went back home to take the California licensure boards, I had to show them a copy of my diploma. They asked, "What country did you come from?" I firmly told them, "I am a third generation Californian." They persisted: "Did you go to school in this country?" Biting my tongue, I answered "Georgetown is one of the oldest universities (1789) in this country." But then it dawned on me why the questions. My diploma from Georgetown is very traditional. It's written in Latin! I had to find someone to translate my diploma!

#### **SOMEONE HELPED YOU GET HERE**

Let's begin this morning with a short tale. It's a story of discovery. My journey to this podium began with my

grandfather who sailed to this country in the 1880s. My grandmother followed by steamer ship 90 years ago. She came with only one suitcase and the clothes on her back. She didn't understand what people were saying to her. There were few who looked like her.

I did some research at the National Archives on her early immigration. She came aboard the USS Howard Taft in 1924. It was a month-long voyage on the high seas.

I found that she was likely on the last ship that allowed Asian women to come into this country. The Immigration Act of 1924 effectively barred Asian females from immigrating until 1943.

If she hadn't gotten on that ship, I wouldn't be here. So here today, some nine decades later after my grandmother touched these shores, her grandson has been given the honor of standing before you.

On behalf of the officers and regents of the American College of Dentists, I welcome you to the 2015 Annual Meeting of the oldest honorary organization for dentistry in America.



## Let Us Be Leaders

Steven D. Chan

The American College of Dentists is a mighty 95 years old!

When I was inducted, all I knew of the college were some initials behind the names of my dental school professors. At my convocation I was unprepared for the experience. I was in my 30s. I saw admirals and generals. There were deans of schools and famous scientists whom I had read about. The man who invented the high-speed handpiece was being recognized that day. I had a lump in my throat that wouldn't go away. After the ceremony, I ran downstairs to copy the certificate—just in case there was another Steve Chan.

I wrote a letter to the executive director to thank the college for the honor. I was awestruck. I was standing next to people who were legendary. But in my letter, I apologized. I was clearly out of my league. I wasn't even in the same class of people as those in that room. The executive director wrote back. What he said haunted me.

"Someone believed in you." That has been pretty hard to live up to.

And we see what many of you have done for the profession. So, it is our honor to thank you. But this is more than just a single celebration in time. For most of you your work is not yet done.

Something made you different. Someone saw something in you.

Someone saw something in you that could touch the lives of others.

Someone saw something in you that could move the profession.

It is said true leadership is tested and revealed in times of crisis. I

hope you'll come back next year to the 2016 Convocation in Denver. You will hear a story of leadership. The 2016 Convocation speaker will be the Honorable Norman Mineta. He was the United States Secretary of Transportation when 9-11 struck the heart of our country: when this country didn't understand what was happening to us, when the planes were crashing into the Twin Towers, when they were crashing into the Pentagon, and when they were crashing into that Pennsylvania countryside.

There were no "higher ups" to turn to or manuals to look up what to do next. Thousands were being killed. At that moment in time, history thrust a test of leadership in our faces. Our country was changed.

Incoming fellows: this year, you will cross that stage. You will be changed.

You have moved a bit of history to get here. The mountains you moved were formidable. Now the greater work begins. Those who follow you in their journeys are watching you. Move them. Teach them. Inspire them. They are your legacies.

### **THE COLLEGE HAS SOME WORK FOR LEADERS IN THE PROFESSION**

It is our custom for the incoming president to address "What's ahead for the College."

The college is known as "the conscience of the profession." In a way the college is to the profession what Walt Disney's character Jiminy Cricket was to Pinocchio. In times when Pinocchio's moral compass was dazzled and tempted, his companion, Jiminy Cricket, whispered into Pinocchio's ear "Let your conscience be your guide."

Among the drivers for the founders to create the college was to raise the dignity of the profession. That was an era of American dentistry where hucksters preyed on the unsuspecting. Dentistry was struggling. Were we just another street trade or were we an honorable profession?

Ninety years ago ACD Pioneer William Gies led a turning point in the profession. He managed the construction of a major treatise on education that transformed American dentistry.

Ninety years later this country has changed. The college recognizes that the challenge has returned. The regents have authorized a three-year ACD Gies Ethics Project that will lead to a major report on improving the ethical foundation vital to our profession. The college stands ready, side by side with the profession, to look at ourselves in the mirror. How does our profession "fit" with these new things we have yet to understand.

### **THE AFFORDABLE CARE ACT**

This initiative will change the landscape of dentistry in this country. No matter what your politics, it is supposed to be about care for those who do not have care. As the ACA unfolds, dentists on the front line are framing "This is what oral health care should look like." Meanwhile, non-dentists are telling us what we can or cannot do. The greatest test posed by the ACA will be: "How is dentistry valued by the American consumer?"

The marketplace will go through a period of discovery. It will learn from the good and from the bad. The marketplace can demand what it wants. We remember the first role



of the doctor is to teach what can be. The ACA will affect us on many levels. The ACA will affect what kind of care patients get. They will only remember whose hands delivered that care. How will dentistry “fit” in the Affordable Care Act?

### **CORPORATE DENTISTRY**

The business of American dentistry is evolving. Considering the national dental care expenditures in this country, dentistry is a \$111 billion industry. But also consider America is often driven for bigger is better.

Once upon a time you “hung out your shingle” and you were in business. And once upon a time cor-

porate dentistry meant a way for a doctor to protect his or her financial assets. But running a practice is getting more complicated. Competition surrounds us. Regulations are strangling us. Outsiders want control. Risk comes in many disguises.

There’s a signpost up ahead. In the drive to be leaner and more competitive and profitable—in the drive to be big—we must not forget that when we first came we professed to help a bit of humanity. But along the way we may lose our own humanity, and some will lose their souls.

We are given the power of the “laying on of hands.” We decide what our hands do to create one smile at

a time. How will corporate dentistry “fit” in the marketplace?

### **SOCIAL MEDIA**

We talk differently now. How will dentistry “fit” in the universe of social media?

The Internet is the new power tool. Yet, like any tool its impact depends on how it is used. A mallet can create and it can destroy.

Social media can create relationships. It can destroy relationships. A single online comment can crush a reputation that took a lifetime to build. The doctor may be the operator of the tool and he or she may

## Let Us Be Leaders

Steven D. Chan



sometimes be the target. In the goldfish bowl of social media, we only have control of our own conduct. A doctor must be a doctor 24/7. This new “word of mouth” will remember how you carried yourself.

It is about your good name.

### OUR NEW FACE

The faces of American dentistry are changing. We, the members of the college will have to work through some significant challenges here. The implications are far reaching. The effects are here and now. For whom does the college exist?

Consider: our bylaws require membership in the ADA to be nominated for the college. The measure of admission is demonstrated leadership. Yet in today's reality there are leaders

who are not members of the ADA. We cannot recognize them and bring them into the college. They share the same profession. They make their part of society better.

We struggle. The pool of leaders not found in the market share of the American Dental Association is expanding. The numbers may vary from year to year, but the trend line is clear. Depending on the report, market share may be dropping below 60%. As the ADA market share shrinks, the other wedges of the pie expand and occupy more of that marketplace.

In 2015 the face of dentistry in this country just looks different. And this is an additional demographic factor. The problem is the inability of the college to reach the other parts of

this profession. Where are the missed opportunities to influence the fabric of the profession?

What of those from different ethnic or racial backgrounds who speak the language of their people or who share common stories where we just don't understand?

What of those who are in the military and serve our country?

What of those in public health who treat those who otherwise have no care?

And then there are the young. Within the first five to ten years of graduation, it is the money. “How do I pay this monstrous debt from school? How do I make a living doing this thing called dentistry?” Some things are just more important at that time.

And what of those who choose not to join the ADA, but who one day will inherit parts of profession untouched by the college?

Let me clearly state we are not forsaking our core values. We are not sacrificing any of our standards. We must reach out and share them with more of our colleagues.

But in today's reality leadership exists not only within the sphere of the ADA.

We in the college exist for the common good for the greater whole of the profession, not just a part of it. No matter what you look like, no matter what manner of dress you wear, no matter what language you speak, no matter the model of practice.

We believe in inclusiveness. America is built on the principle of inclusiveness.

Several years ago, I was invited to a graduation at the University of Pacific, Arthur A. Dugoni School of Dentistry. At the graduation we heard the same stories. "It's time to get on with our lives. It's time to start our families." "We look forward to starting our residencies." "We look forward to making a living. We owe nearly half a million dollars in educational loans."

I met one of these new grads. He had the same debt. He had a new baby to care for. He proudly told me, "I am going back to the reservation. I am going back to be the dentist for the Cherokee Nation. I am going back to help my people." This is leadership.

A few years ago, I went to another graduation for a pilot program that helps students from underserved populations prepare for dental school. They weren't only Black or Hispanic. Some came from the war-torn Middle East or the broken Soviet Union. What about Latinos? El Salvador is not Cuba is not Guatemala

and certainly not Mexico. These immigrants are different—as different as the English and the Americans.

At this graduation the stories were the same. "I have to go back to help my people." Five years later, 100% remained in practice in federally identified shortage areas. Among their own people they are still healers. Do we still not have a place for them in the American College of Dentists?

The final story is about a Diversity Summit, an outreach by the ADA to ethnic and racial based organizations. Because of our own restrictions we could only invite three of those many leaders into the college. Consider: in their kingdoms, they are king, they are queen. Recognition of leadership begins with respect. We have chasms where we cannot reach. American dentistry is shifting. I believe the greater whole of the profession will be in a better place by bringing us together under the tent of the American College of Dentists.

### **HOW DO WE EXTEND THE HAND OF THE COLLEGE?**

Our mission is to advance excellence, ethics, professionalism, and leadership. Ethics and professionalism are about the here and now. Excellence is what you can see before you. Yet leadership is seeing what can be.

Leadership fascinates me. What makes a leader tick? How do they see possibilities we have yet to see? How do they inspire an audience? How do they send chills up our backs and move us on our own personal journeys long after they've left us?

I propose that the college build a Leadership Institute. Create a structured curriculum based on the social science of leadership. Study the skills. Study the art forms. Learn the

craft. Build better leaders and we build better organizations.

Build better leaders and we build a better profession. Build better leaders and we build better images of who we are in the communities we live in.

### **HOW DID WE COME TO BE HERE?**

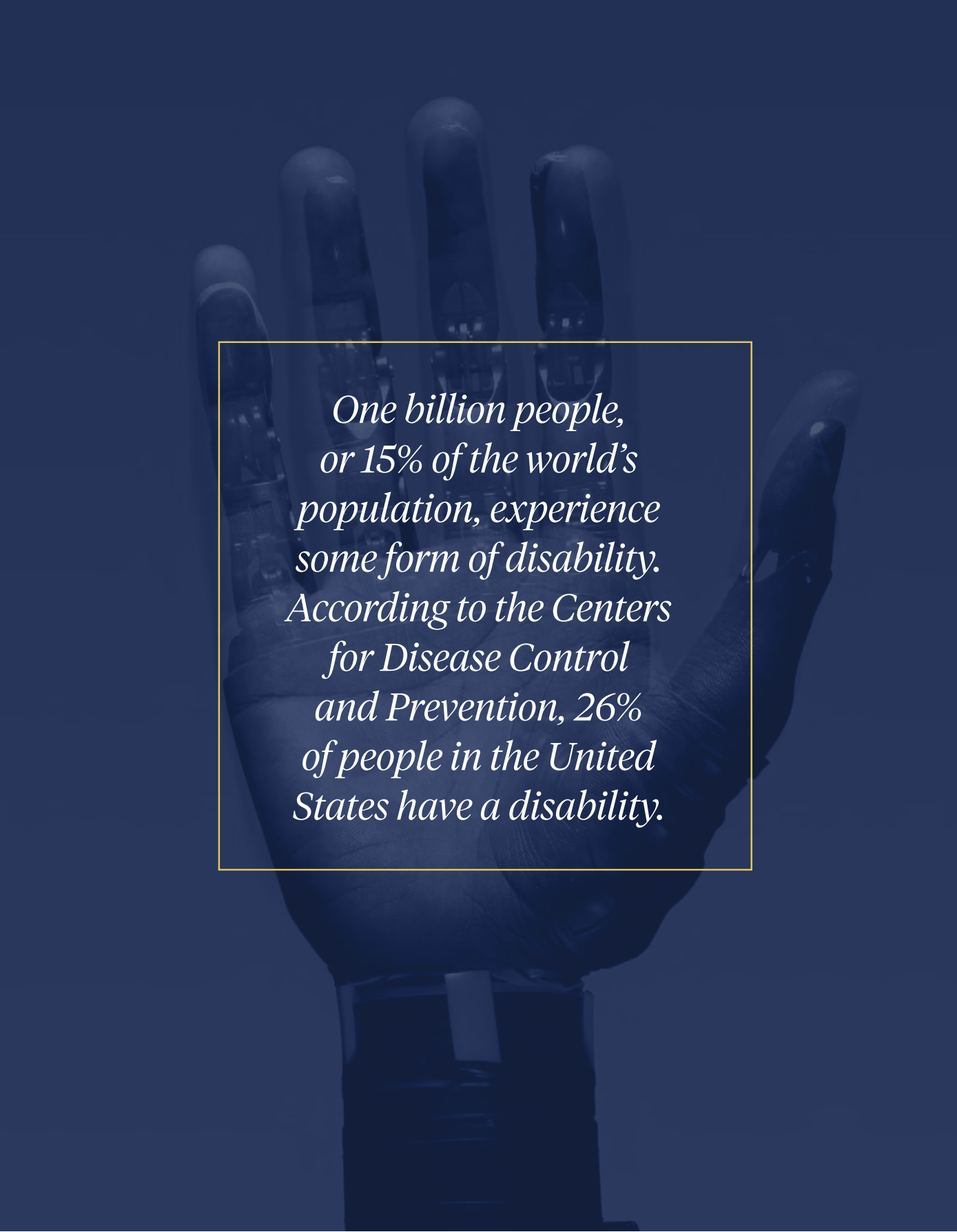
Leadership is to touch the lives of others. Leadership is to touch the future. We can build the "pipeline of hope" for the profession.

We began this morning with my grandmother. I lost her two years ago. She was 108. I see this tiny woman hunched over at the end of the day. She could barely stand. She was hurting. I saw her come home one late evening literally bleeding from her hands, a woman who came to this country, who couldn't speak English, who had no skills. All she wanted was honest work to feed and shelter her babies. She was a woman who taught me all I needed to know about faith and hard work by the simple eloquence of her example.

One hundred and thirty-five years ago my grandfather left a distant shore. He went to search for a place his countrymen called "Gold Mountain." One hundred and thirty-five years later, here at this podium, I believe I have found that Gold Mountain.

Gold Mountain is seated here before me. In my culture the Dragon is a noble creature. The dragons guard the heavens. I thank you for allowing me to fly with dragons.

May the gods of good fortune smile upon you and your families. May you live interesting lives. We are the American College of Dentists.



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population, experience  
some form of disability.  
According to the Centers  
for Disease Control  
and Prevention, 26%  
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States have a disability.*



## PERSPECTIVE

### DEI and dis(ability)

## The Often Forgotten Aspect of Diversity

Pamela Zarkowski, JD, MPH, FACD

*Provost and Vice President for Academic Affairs*

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**D**isability, Equity, and Inclusion (DEI) are increasingly cited as a priority across society's spectrum, including but not limited to higher education, the workplace, leadership, and politics. One billion people, or 15% of the world's population, experience some form of disability.<sup>1</sup> According to the Centers for Disease Control and Prevention, 26% of people in the United States have a disability.<sup>2</sup> That percentage includes visible disabilities, such as mobility impairments and hidden disabilities, such as psychosocial and emotional conditions and many autoimmune conditions. Some disabilities may be

temporary and others permanent. If asked to describe diversity and what it means, responses vary. Responses are influenced by one's personal and professional experiences, beliefs, and, in some circumstances, hopes and aspirations. Responses may include gender, gender expression, ethnicity, race, sexual identity, sexual orientation, migrant status, or socioeconomic status. Diversity is not limited solely to those descriptors and includes various unique attributes, experiences, and abilities. Diversity is complex. A significant percentage of the population is often forgotten in the diversity listing, persons with disabilities.

## The Often Forgotten Aspect of Diversity

Pamela Zarkowski, JD, MPH, FACD

The terminology surrounding diversity has broadened over time. A frequently missing component of diversity, or focused DEI priorities, is disability. However, the term disability is misunderstood as well. Contributing to its absence in DEI efforts is acknowledging that disability is often framed as a biomedical condition and a technical problem that has to be solved rather than as a group identity. Disability is viewed from the lens of legal obligations or providing support for accommodations in the educational or employment setting. Due to a mindset viewing disability as a condition or technical problem, DEI efforts, although intended to be inclusive, are largely either limited in or absent of an ability. Similarly, in an environment with multiple goals, such as education, which both employs individuals and serves a student population, disability may be viewed more narrowly because of the emphasis on addressing the needs of an individual with a disability vs. enhancing the participation of individuals with disabilities into the life of the organization as part of leadership or the educational workforce.

There is evidence of change, such as industry-based efforts to diversify their employees, or as observed in higher education, to diversify the faculty and student bodies. Academic offerings are changing, as demonstrated by some colleges and universities that have created disabilities studies departments.<sup>3</sup> The number of college students with disabilities has steadily increased. Nearly 20% of undergraduates reported having a disability in 2016<sup>4</sup> and 90 percent of colleges and universities reported enrolling students with disabilities in 2011.<sup>5</sup> The increases are encouraging. The lat-

est data from 2004 suggest that only about 4 percent of faculty members in higher education have disabilities.<sup>6</sup> More work is necessary to recruit, retain and support faculty and students with disabilities in higher education.

Making DEI a priority allows for access, ensuring that individuals feel a sense of belonging and ensuring that processes and programs are fair and impartial. DEI efforts rely on the more traditional description of diversity and may not identify persons with disabilities within their priorities. RespectAbility, a group dedicated to fighting stigmas and advancing opportunities for people with disabilities, surveyed 969 participants to determine how the respondents successfully included persons with disabilities as part of their organizations. When asked to identify the top reasons why organizations were deficient in disability inclusion, the following is a summary of their findings:

- Overt and unconscious bias about people with disabilities
- No one specifically asked the organization to include people with disabilities or make it a priority
- Other more urgent concerns impact the organization
- Staff and leaders do not have the training, resources or contacts to make it successful
- Conversations and actions around diversity, equity and inclusion are complex and challenging
- Diversity efforts, while well intended, can cause conflict.

The study concluded that even when DEI is a priority, disability is not. The

themes presented in the responses noted in the survey apply to organizations, educational institutions, businesses, and industry, including oral health care providers.

Disability is not a monolith. Other characteristics impact how individuals experience a disability. The meeting of identities, such as gender, racial, ethnic, sexual or religious or

*Disability cannot be viewed as a unique, separate identity, just as other characteristics are not isolated to one checkbox on a form. Integrating disability within DEI activities is not adding another element or classification, but rather committing to its integration with other priorities.*

“intersectionality” creates complications for individuals with disabilities when seeking full inclusion. Individuals have more than one identity and experience systemic inequalities. Disability cannot be viewed as a unique, separate identity, just as other characteristics are not isolated to one checkbox on a form. Integrating disability within DEI activities is not adding another element or classifi-

*A caution. This essay is not supporting faux inclusivity. Faux inclusivity lacks authenticity in one's efforts and observable actions to enable, engage, employ, and empower a diverse workforce and create an inclusive climate. Faux inclusivity violates the ethical principles that guide the profession and inform ethical codes. Oral health professionals are committed to lifelong learning.*

cation, but rather committing to its integration with other priorities.

The absence of disability in DEI educational, recruitment, policy development and educational awareness efforts remains a critical problem that cannot be ignored.

Dental care settings and dental professional educational institutions can model efforts to create an inclusive educational and workplace environment that prioritizes diversity, equity and inclusion, including individuals with disabilities. Oral health professionals rely on the ethical principles of autonomy, justice, beneficence, non-maleficence and veracity to guide their interactions with their peers and their patients. Disability inclusion applies to dentistry including dental offices and clinics, community sites, professional associations and educational institutions. The ethical principles are integral to DEI activities and serve as a guiding framework in assessing, planning and implementing strategies to diversify.

What can dental professionals do to support efforts to be inclusive and demonstrate the profession's commitment to diversity?

- Acknowledge, understand and embrace the widespread nature of disability. Disability is found in every demographic category.
- Model leadership and leader commitment by requiring

accountability for improving diversity and inclusion.

- Include disability as part of the organization's vision, mission and stated values.
- Make disability inclusion an intentional consideration in developing policies and procedures:
- Integrate members of the disability population in your leadership, employees, associations, educational institutions, and advisory members.
- Incorporate appropriate recruitment strategies, including webpage accessibility, barrier-free application and interview formats, relevant information about the employment setting, and other applicant support.
- Provide employee education on inclusive practices. Topics can include appropriate language, civility and sensitivity, stereotyping, and invisible disabilities.
- Establish safety and wellness policies.
- Establish nondiscrimination and respect-based policies, including but not limited to social media, anti-bullying, and harassment.
- Incorporate inclusion in all website, social media, marketing, and advertising materials, including photographs,

infographics and other image-based media.

- Plan events, including meetings, personnel development opportunities and events that are inclusive and accessible.
- Create opportunities for employees to be heard with evidence of follow-up that suggestions and concerns are addressed.
- Engage members of the disability community when seeking input or advice about your workplace settings.

Reviewing the suggested list may trigger other considerations. Act on those ideas or seek input from others based on current practices or areas that need review and renewal.

A caution. This essay is not supporting faux inclusivity. Faux inclusivity lacks authenticity in one's efforts and observable actions to enable, engage, employ, and empower a diverse workforce and create an inclusive climate. Faux inclusivity violates the ethical principles that guide the profession and inform ethical codes. Oral health professionals are committed to lifelong learning. The profession must work to learn about the differences of others and how the differences can benefit the profession and the patients that are served. Disability inclusion must be a visible activity that is evident, consistent, reinforced and evaluated.

# The Often Forgotten Aspect of Diversity

Pamela Zarkowski, JD, MPH, FACD

The term disability is a term that should be viewed as disABILITY. This author once heard a speaker that greeted an audience by stating: "Welcome to all that are temporarily able." These words are memorable and true. The majority of society have or will develop some form of disability. Focusing on the skills and talents of employees, colleagues, and students with disabilities allows the oral

health profession to take the lead in supporting a population that is underrepresented, underutilized and marginalized. Whether recruiting and hiring an employee in a dental office, updating marketing materials, educating staff or modifying an office, small steps to diversity and recognize the value of including disability in DEI efforts is necessary.

Diversity expert Verna Myers coined the phrase "Diversity is being invited to the party. Inclusion is being asked to dance." Others have revised the statement and expanded its message to read "Diversity is being invited to the party. Inclusion is being asked to dance. Equality is being on the party planning committee." Every time this phrase is repeated, persons with disabilities cannot be forgotten.

## REFERENCES

1. Disability Inclusion. <https://www.worldbank.org/en/topic/disability#:~:text=Results-,One%20billion%20people%2C%20or%2015%25%20of%20the%20world's%20population%2C,million%20people%2C%20experience%20significant%20disabilities>. Accessed May 20, 2021
2. Disability impacts all of us <https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html> Accessed May 28, 2021
3. Connor, D. J., Gabel, S. L., Gallagher, D. J., & Morton, M. (2008). Disability studies and inclusive education—implications for theory, research, and practice. *International Journal of Inclusive Education*, 12(5-6), 441-457.
4. Students with disabilities. <https://nces.ed.gov/fastfacts/display.asp?id=60>. Accessed May 28, 2021
5. Students with Disabilities in Degree Granting Postsecondary Institutions. National Center for Education Statistics, June 2011 <https://nces.ed.gov/pubs2011/2011018.pdf>
6. A Difficult Pathway. <https://www.insidehighered.com/news/2021/05/12/faculty-disabilities-say-academe-can-present-barriers>. Accessed May 28, 2021
7. RespectAbility <https://www.respectability.org/> Accessed May 28, 2021

## RESOURCES

1. The National Center for College Students with Disabilities, (NCCSD) Clearinghouse and Resource Library <https://www.nccsdclearinghouse.org/intersectionality-of-identities.html> (Provides a list of resources highlighting disabilities and other characteristics)
2. How to include people with disabilities <https://www.respectability.org/inclusive-philanthropy/how-to-include-people-with-disabilities/>
3. The Employer Assistance and Resource Network on Disability Inclusion, (EARN) <https://askearn.org>



## Clinician's Corner

# A Pediatric Dentist's Perspective on Combating Social Determinants of Health

Tawana Lee-Ware, DDS, MSD, FACD

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Diplomate, American Board of Pediatric Dentists  
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The global COVID-19 pandemic revealed deficits in health equity experienced by vulnerable and underrepresented populations on both a global and national level. In the United States, marginalized and minority populations suffered disproportionately due to the inequities in society and healthcare.<sup>1</sup> The social determinants of health (SDoH) are increasingly recognized as a critical factor relating to health outcomes and general well-being. The practice of dentistry generally and the treatment of pediatric dental patients more specifically is greatly impacted by the SDoH. As a result, general and pediatric dentists are faced with working to identify, assess, and address the complex and multifaceted components of SDoH. While dental schools across the United States offer some dental public health content, the overall emphasis on public health and SDoH is limited.<sup>2</sup> With the global

*The central focus of this paper is to provide a means of identifying clinical implications of SDoH and strategies to address this dilemma for the underserved at-risk pediatric dental population. While the focus here is the pediatric patient population, these implications and strategies are applicable across our dental patient population spectrum (from pediatric to geriatric dentistry).*

pandemic “lifting the veil” and exposing the realities of health inequities inherent to our national healthcare system, it became common knowledge and consumed news organization headlines with such statistics as African Americans making-up 13% of the US population but accounting for 30% of COVID-19 deaths.<sup>1</sup> COVID-19 unlocked an opportunity to focus on health inequities and disparities to prompt dental school community and healthcare system conversations about professional and personal

challenges with systemic racism and challenges of healthcare systems.

The central focus of this paper is to provide a means of identifying clinical implications of SDoH and strategies to address this dilemma for the underserved, at-risk pediatric dental population. While the focus here is the pediatric patient population, these implications and strategies are applicable across our dental patient population spectrum (from pediatric to geriatric dentistry).

## SOCIAL DETERMINANTS OF HEALTH DEFINED

The Social Determinants of Health (SDoH) are increasingly recognized as critical to health outcomes and general well-being. The World Health Organization defines *social determinants of health* as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.”<sup>3</sup> More specific-

all people.<sup>5</sup> The Healthy People 2020 report places an emphasis on reducing health disparities and achieving health equity. “Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”<sup>6</sup> Understanding these principles is necessary for pediatric dentists to address social determinants of oral health.

these two ACA requirements provided millions of children financial access to dental health services, many for the first time.<sup>9</sup>

In 2017, the American Academy of Pediatric Dentistry (AAPD) adopted its Policy on Social Determinants of Children's Oral Health and Health Disparities. This AAPD policy “recognizes the influence of social factors on children's oral health including access to care, dental disease be-

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ly, social determinants of health are those structural determinants and conditions including income, race/ethnicity, education level, work opportunities, living in an urban or rural environment, social policy, and access to health care.<sup>2</sup> While SDoH are recognized as contributing to health inequities in academia, the message has not been as obvious in private practice.

## SDH-BASED DENTAL POLICIES AND INITIATIVES:

Twenty years ago, *Oral Health in America: A Report of the Surgeon General*, clearly illustrated the principle that oral health goes beyond healthy teeth and integral to every person's overall health and well-being.<sup>4</sup> The Healthy People 2020 report defines health equity as the “attainment of the highest level of health for

Congress advanced initiatives in support of oral healthcare. The body recognized dental insurance coverage as an important component of comprehensive care for children. As a result, two major policy changes were passed to improve dental coverage for children. First in 2009, Congress reauthorized the Children's Health Insurance Program (CHIP) which required states to provide dental coverage to enrolled children and gave states the option to provide dental benefits to certain children who do not qualify for full CHIP coverage.<sup>7</sup> In 2010, the Affordable Care Act (ACA) health reform bill required that all insurance plans offered through the health insurance exchanges include oral care for children.<sup>8</sup> Insurers were prohibited from charging out of pocket expenses for preventive pediatric oral health services. The result of

haviors, and oral health and inequalities.” Further the AAPD encourages oral health professionals and policy makers to “formally acknowledge the role that SDoH have in producing and perpetuating poor oral health and oral health inequities in children.”<sup>10</sup>

## CLINICAL CORRELATIONS AND IMPACTS OF SDH

The SDoH are not determined by a single factor but are impacted by a variety of factors which intersect based on the patient's social, environmental and economic conditions. Typically, SDoH are measured at the caregiver- or household-level. Acknowledging key indicators shaped by the distribution of money, power and resources may help pediatric dentists, and those general dentists treating underserved populations,



understand their practice population. The following categories represent essential SDoH and clinical impacts.

**Education:** The primary education indicators include grade level completed, literacy rates, vocational training opportunities, early childhood education, and ability to complete higher education. In fact, there is clinical evidence associating low educational levels with an increased risk for major disease, disability, and mortality due to poor health literacy, unhealthy behaviors, lower income, and lack of resources.<sup>11</sup>

**Household food insecurity:** Food insecurity is defined as disrupted eating patterns with or without reduced food intake.<sup>12</sup> The components of accessibility of food include access to healthy food options, use of subsidy programs like the Supplemental Nutrition Assistance program (SNAP), Women infants and children (WIC) programs, food deserts, and dietary choices.<sup>13</sup> Food insecurity is a vital SDH indicator because there is a strong linkage between food and adverse health issues. Children who are food insecure are at an increased risk of developing developmental health issues, including dental caries and tooth loss.<sup>8,9</sup>

**Socioeconomic Status and Income:** Income indicators include employment, public assistance, household income, and poverty data. There is a correlation between lower incomes and higher levels of mortality as well as specific chronic conditions like diabetes and dental caries.<sup>14-16</sup> A potential correlation between poverty and stress could influence child behaviors in dental settings, including

the ability to cooperate for dental procedures.<sup>17,18</sup>

**Neighborhood and Housing:** Housing indicators reflect both whether someone has a roof over their head and where that roof is located. In addition to housing status, other related indicators include access to parks, sidewalks, population density, crime, and safety. Not feeling safe to be outside or walk within the neighborhood impacts the ability to maintain adequate levels of exercise has a major effect on health outcomes. Higher levels of income inequality within a community are associated with poorer oral health outcomes.<sup>10-11,19-20</sup>

**Transportation:** Consistent access to transportation is a significant SDoH indicator. Limited public transportation options, inability to afford a car, lack of access to infrastructure like public sidewalks or bike lanes and lack of access to non-emergency transportation can impede positive health outcomes. This outcome may make it more difficult for families to attend routine preventive appointments based on the location of the pediatric dental office.<sup>11,20</sup>

## PEDIATRIC DENTISTS – WHAT ROLE DO YOU PLAY?

In February 2007 Deamonte Driver, a 12-year-old, seventh grader from Maryland, died after complications from an abscessed tooth. His mother, Alyce, worked low-paying jobs, faced housing insecurity, and had unreliable transportation.<sup>21</sup> She found it difficult to find a dentist who would accept Medicaid and perform the needed routine extraction. Deamonte's untreated tooth resulted in two neurosurgeries and six weeks

of hospital care prior to his death. In addition to the cost of losing his life, the \$80 tooth extraction eventually resulted in over \$250,000 in medical expenses.<sup>21</sup> This preventable tragedy is a case to study of SDH.

Pediatric dentists we are called to treat the disease not the symptoms. Restoring primary teeth back to form and function through dental restorations is only one component of a comprehensive approach to the most common chronic disease of childhood. For many patients, the SDoH serve as the indicators of what else must be addressed. To ignore the other risk factors is to provide inadequate disease management.

As a graduate of Meharry Medical College School of Dentistry, my professional guiding principles and core values were shaped by the school's motto: "Worship to God through service to mankind." Today, this translates into practice application as meaning: "meeting the people where they are." As we consider strategies for addressing SDoH, we must pause and ponder various factors that may lead to misunderstanding of treating the children as clinician versus serving children as a community advocate. Those factors include but may not be limited to: not having the time or interest, not seeing an underserved patient demographic (for dentists who make the conscious decision to not participate in such programs Medicaid or CHIP), stereotypes about patient no-show rates or tardiness or even an unappreciative attitude towards care providers.<sup>22,23</sup> Dentists can serve in a dual role providing clinical care and advocating for patients needs beyond the oral cavity.



## CREATIVE STRATEGIES TO ADDRESS SDoH FOR PEDIATRIC DENTIST:

As oral healthcare professionals, our goal is to provide high levels of evidence-based patient centered care. Dentists must provide an up-to-date, culturally competent clinical treatment addressing the effects of SDoH. Several frameworks can address the SDoH and serve to improve children's health outcomes. Suggested approaches reviewed will be divided into clinical practice, social influence/power, and volunteering efforts.

**Clinical Practice:** Pediatric dentists work in a variety of settings and are not limited to private practice, public health or academia. The clinical setting offers opportunities for the pediatric dentist to serve as a leader with their team with regards to SDoH-based efforts. The AAPD "encourages dentists and the oral health care team to provide anticipatory guidance that is sensitive to the SDoH, which involves collecting a social his-

tory from patients."<sup>10</sup> Clinicians can also expand our standardized Caries Risk Assessment (CRA) tool to incorporate SDH-based questions. For example, asking the primary caregiver and/or patient: "Is there a reason you don't brush twice a day?" may elicit responses around lacking oral hygiene tools in the home.

Increasing access to equitable care in the clinical setting could include creating convenient hours that would provide the patients greater access care. This effort may include extending business hours to include evenings and/or offering weekend appointments. Clinicians should also review pamphlets, leaflets, and fliers in the office to ensure materials are written in a manner to allow parents and caregivers to comprehend the information. Additionally, COVID-19 taught us about community resources that were made available such as providing transportation to and from the vaccine sites and home. A pediatric dental office staff should be familiar with transportation options for their area

and provide a list of these options.

**Social Influence/Power:** Utilizing social influence or power will provide an avenue towards advocacy for pediatric dentists. A first step with beginning to use one's social influence or power would be to communicate with the community members and solicit their voices to ensure the programming you cultivate is relevant and actually meeting expressed needs. Social influence allows the development of collaborations bridging partnerships with philanthropists, community organizations, community health centers, local public schools, and other key stakeholders to help address SDoH. An example of this approach would be working through the local public schools' superintendent's office to identify elementary schools with the highest rates of children on free and reduced lunch. Social influence opens the door to collaborative partnerships with schools and offers access to local grocery stores, farms, or restaurants to provide weekend bagged healthy meals. Another ex-

# A Pediatric Dentist's Perspective on Combating Social Determinants of Health

Tawana Lee-Ware, DDS, MSD, FACD

ample of leveraging social power for pediatric dentists is sponsoring a resource closet that could be filled with dental hygiene and other general hygiene products for a local disadvantaged school. These creative examples go beyond the school based public health model and allow real opportunity for many clinicians in private practice to foster collaborative, mutually beneficial relationships with schools and school systems.<sup>26</sup>

**Volunteering Efforts:** Volunteering with community service activities was a familiar practice for most pediatric dentists during dental school and residency. As practitioners, there are several opportunities to continue this community engagement. Often-

times, community-based programs offer preventive service and are in need of pediatric dentist volunteers to provide care. Pediatric dentists could explore methods to connect with their patients and other community stakeholders.

Pediatric dentists are more than clinicians. Pediatric dentists are health care and health policy advocates as well as community activists. As community activists who witness firsthand dental caries and tooth loss in low-income children, we can and should promote nutrition and access to affordable healthy choices. We can partner with businesses to address transportation challenges. We can be empathic health care profes-

*I leave you with a challenge to action: “What contributions will you make towards a more equitable, ethical practice of pediatric dentistry?”*

sionals. We can be the advocating voice for equitable healthcare policies. Pediatric dentists ought to be personally accountable for actively addressing SDoH. I leave you with a challenge to action: “What contributions will you make towards a more equitable, ethical practice of pediatric dentistry?”

## REFERENCES

1. Dyer O. Covid-19: Black people and other minorities are hardest hit in US BMJ 2020; 369 :m1483 doi:10.1136/bmj.m1483
2. Tiwari, T., A. Palatta, and J. Stewart. The value of social determinants of health in dental education. NAM Perspectives. Commentary, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202004a>
3. World Health Organization (WHO). (2016). *Social Determinants of Health*. Available at: [http://www.who.int/social\\_determinants/sdh\\_definition/en/](http://www.who.int/social_determinants/sdh_definition/en/) (accessed August 1, 2021)
4. United States. Public Health Service. Office of the Surgeon General, National Institute of Dental, & Craniofacial Research (US). (2000). Oral health in America: a report of the Surgeon General. US Public Health Service, Department of Health and Human Services.
5. U.S. Department of Health and Human Services. (2020). *The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020* [Internet]. Section IV: Advisory Committee findings and recommendations. Available at: [http://www.healthypeople.gov/sites/default/files/PhaseI\\_0.pdf](http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf). (accessed August 1, 2021)
6. U.S. Department of Health and Human Services, Office of Minority Health. (2010). *National Partnership for Action to End Health Disparities. The National Plan for Action Draft as of February 17, 2010* [Internet]. Chapter 1: Introduction. Available at: <http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?&lvl=2&lvlid=34> (accessed August 1, 2021)
7. Hakim, R. B., Babish, J. D., & Davis, A. C. (2012). State of dental care among Medicaid-enrolled children in the United States. *Pediatrics*, 130(1), 5-14.
8. Shane, D. M., & Ayyagari, P. (2015). Spillover effects of the Affordable Care Act? Exploring the impact on young adult dental insurance coverage. *Health services research*, 50(4), 1109-1124.

9. Collins, SR, & Lambrew, JM. (2019). *Federalism, the Affordable Care Act, and health reform in the 2020 election*. Retrieved from <https://www.commonwealthfund.org/publications/fund-reports/2019/jul/federalism-affordable-care-act-health-reform-2020-election>
10. The Reference Manual of Pediatric Dentistry. (2020-2021) Chicago, Ill.: American Academy of Pediatric Dentistry; 28-31.
11. Badland H, Pearce J. Liveable for whom? Prospects of urban liveability to address health inequities. *Soc Sci Med*. 2019 Jul;232:94-105. doi: 10.1016/j.socscimed.2019.05.001. Epub 2019 May 2. PMID: 31075753.
12. U.S. Department of Agriculture Economic Research Service.(2020) *Definition of Food Security*. Available at: "<https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx>". Accessed May 1, 2021.
13. Adler, N. E., Glymour, M. M., & Fielding, J. (2016). Addressing social determinants of health and health inequalities. *Jama*, 316(16), 1641-1642.
14. Snyder, S. E., & Evans, W. N. (2006). The effect of income on mortality: evidence from the social security notch. *The review of economics and statistics*, 88(3), 482-495.
15. Lysy, Z., Booth, G. L., Shah, B. R., Austin, P. C., Luo, J., & Lipscombe, L. L. (2013). The impact of income on the incidence of diabetes: a population-based study. *Diabetes research and clinical practice*, 99(3), 372-379.
16. Oliveira, L. B., Sheiham, A., & Bönecker, M. (2008). Exploring the association of dental caries with social factors and nutritional status in Brazilian preschool children. *European journal of oral sciences*, 116(1), 37-43.
17. da Fonseca MA. Eat or heat? The effects of poverty on children's behavior. *Pediatr Dent*. 2014 Mar-Apr;36(2):132-7. PMID: 24717751.
18. Fisher-Owens S. Broadening perspectives on pediatric oral health care provision: social determinants of health and behavioral management. *Pediatr Dent*. 2014 Mar-Apr;36(2):115-20. PMID: 24717748.
19. Gustafsson PE, San Sebastian M, Janlert U, Theorell T, Westerlund H, Hammarström A. Life-course accumulation of neighborhood disadvantage and allostatic load: empirical integration of three social determinants of health frameworks. *Am J Public Health*. 2014 May;104(5):904-10. doi: 10.2105/AJPH.2013.301707. Epub 2014 Mar 13. PMID: 24625161; PMCID: PMC3987591.
20. Kolak M, Bhatt J, Park YH, Padrón NA, Molefe A. (2020) *Quantification of Neighborhood-Level Social Determinants of Health in the Continental United States*. *JAMA Netw Open*. 3(1):e1919928.
21. Otto M.(2007). *For want of a dentist*. *The Washington Post*. [WWW document]. Available at: <http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116.html>[Accessed May1, 2021].
22. Mofidi, M., Rozier, R. G., & King, R. S. (2002). Problems with access to dental care for Medicaid-insured children: what caregivers think. *American Journal of Public Health*, 92(1), 53-58.
23. Behar-Horenstein, L. S., & Feng, X. (2017). Dental student, resident, and faculty attitudes toward treating Medicaid patients. *Journal of dental education*, 81(11), 1291-1300.
24. Community Relations Services Toolkit for Policing (2015) *Understanding Bias: A Resource Guide*. <https://www.justice.gov/crs/file/download>, Accessed May 2021
25. Jost, JT, Rudman, LA, Blair, IV, Carney, DR, Dasgupta, N, Glaser, J, Hardin, CD. (2009). *The existence of implicit bias is beyond reasonable doubt: A refutation of ideological and methodological objections and executive summary of ten studies that no manager should ignore*. *Research in Organizational Behavior*. 29:39-69
26. Dudovitz, R.N., Valiente, J.E., Espinosa, G., Yepes, C., Padilla, C., Puffer, M., Slavkin, H.C. and Chung, P.J. (2018), A school-based public health model to reduce oral health disparities. *Journal of Public Health Dentistry*, 78: 9-16. <https://doi.org/10.1111/jphd.12216>



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## Perspectives

# Intersectionality—Role Modeling Leadership Across Identities—A Black Female PhD Oral Surgeon Speaks

A young woman sat across the conference table from a colleague and me. She was a 4th year dental student interviewing for a position as a trainee in our Oral and Maxillofacial Surgery training program. As we worked through the typical interview questions many of her perspectives illustrated the difficulties she experienced as a black woman while matriculating through dental school. She expressed her delight when she discovered our program. Her enthusiasm originated from a desire to just be a trainee. Not a woman trainee. Not a black trainee. Not a black woman trainee. Just a trainee. She saw our program as an opportunity to learn as an equal. She saw this in our program because after doing her research she

found that our program was led by someone who looked like her. A black woman was not only the Program Director of the training program but also Chief of OMFS and Hospital Dentistry Division of the Surgery Department at our Hospital.

In all the years that I've interviewed and mentored students, I have never heard a response such as hers. Her statement made me reflect on my past experiences. I have wanted to be an Oral Surgeon since I was a child. Throughout my education I had very few black women role models in my desired profession. I felt the sting of that void many times. Especially when I would meet with my school counselor in junior high. As a high school student, I was told to reconsider my chosen class schedule consisting mostly of math and science. I was told that the schedule was too hard and that I should skip one year of math and add music. Although, I expressed my desire to become a dentist. I was told that this path was difficult, and that I should pursue a career as a singer. Did my counselor think that it was too hard for a woman to be a dentist? Did they think that all black people could do were sports and entertainment? Thankfully, I had a mother who encouraged and supported my aspirations making the attitudes of my counselor irrelevant.

## Intersectionality – Role Modeling Leadership Across Identities

Colonya C. Calhoun DDS, PhD and Ryan O. Grier DDS, MBA

More than 100 years ago black females set an example in dentistry. They illustrated what could be accomplished with hard work and opportunity. Ida Gray Rollins DDS, who graduated from the University of Michigan School of Dentistry in 1890 was the first black female dentist in the United States. She was a trailblazer in mentoring those in whom she saw potential. She was known for being a great role model as well as a gentle dental provider. She had such an impact on her patients that she motivated one of them, Olive M. Henderson, to become the second black female dentist in Chicago.<sup>1-5</sup> More recently, we have had several notable black female leaders in dental education who are also famous firsts in history. The first female dean of any dental school was Dean, Jeanne C. Sinkford, D.D.S., Ph.D. She was the Dean of Howard University College of Dentistry for almost 20 years. She served as Associate Executive Director of the American Dental Education Association and established its Center for Equity and Diversity in 1998.<sup>6-9</sup> Dr. Eugenia Mobley McGinnis, D.D.S., M.P.H., was first female Dean at Meharry Medical College and the first woman to become Vice President at Meharry Medical College.<sup>10-13</sup> When Juliann Bluitt Foster, D.D.S. became a dentist there were still very few African American women graduating from dental school. Her mission was to change that by becoming a mentor. She also led by example serving as the Associate Dean of Admissions as well as Student Affairs at Northwestern University Dental School. She was also the first woman to lead the American College of Dentists. We recognize these women for being first but, as Dr. Bluitt Foster has said, “first is not good enough; it is more important not to be the last.” Each of these black women serve as an inspiration to those who experience challenges from implicit bias due to their race, ethnicity, and/or gender.<sup>14-18</sup>

One of the most important needs in the longevity and resilience of any organization is the development of a talent pipeline. Furthermore, the necessity of empowering the perspective of people from diverse backgrounds is recognized as a valuable asset in many ways. In healthcare this proves to be an asset especially when considering health equity and implicit bias. These are historical problems in healthcare that unfortunately persist today. Perspective is necessary, empathy is required, and understanding has a major impact on compassion. Cultural competency is also a key component in providing an environment for our patients that acknowledges them holistically in order

to treat them appropriately. A goal should be to ensure that dental organizations, dentistry as a profession, and society as a whole receives the benefits that a diverse, equitable, and inclusive environment provides. We need to nurture diversity in talent at every level of academics both in leadership and in training in order to support a talent pipeline that will have the impact on society and dentistry that could only be derived from a diverse, equitable, and inclusive collective of perspectives.

Black female professionals play a significant role in the impact that diversity has on the evolution of our society. In every space their voice brings unique perspective and it is crucial that we continue to nurture, support, and develop the talent of black women in dentistry specifically. It is important that we recruit black female students at “majority institutions” as well as historically black institutions. For dental students and trainees to be successful, they need to know that there is strong representation, a peer group for support, and faculty who are culturally competent and relatable. Having faculty that looked like me was almost nonexistent during my training. When I was a second-year dental student in gross anatomy class my black female classmates and I all shared a cadaver. We noticed that it seemed to always be a little more difficult to keep our instructor engaged with us. He would inevitably float to groups of white students with whom he would spend more time per group than with us. We concluded that this was because we did not have anything in common to keep the professor engaged while he was helping us with our dissection. Therefore, I remember saying to my classmates, “the only way that we will be able to get the help we need is to find a topic that would peak our professor’s attention, so he would visit our dissection table when we needed help.” The essence of this story, the feelings evoked, and the rationalization used to cope with those feelings are neither unique among women nor those who identify as under-represented minorities in medicine or dentistry.

If women and racial or ethnic minorities remain underrepresented in senior faculty roles and academic leadership positions, we will never be able to sustain any appreciable increase in gender and racial diversification. Several studies have shown a decline in African Americans in academic medicine despite the advances made after the Civil Rights Movement. One study used a Census-derived statistical measure of diversity to quantify the degree of underrepresentation for racial minority and female facul-

*We all have a story full of challenges and success. We must acknowledge the positive and negative aspects of history and be inspired by those who blazed a trail for others who look like them and experience similar challenges. Our society is continuously evolving and smart leadership has recognized the need to nurture environments that support diversity, equity, and inclusion.*

ty by rank from 1990 to 2016. They found that African American females who held a Full Professor position were more underrepresented in 2016 than in 1990 for all specialties with the exception of OB/GYN. This specialty exhibited a significant trend toward representation on par with the Census. The categories of Associate Professor and Assistant Profes-

sor showed similar results. It seems that dental academia is having results similar to those seen in medicine. Furthermore, analysis has also shown that although, the percentage of females entering both medical and dental school is comparable; unfortunately, the percentage of black female dentists declined by 11.0% from 2010 to 2016 while black female physicians increased by 1.2% from 2013 to 2018.<sup>20-22</sup>

We need intentional, thoughtful, and sustainable ways to address the scarcity of African American females in dentistry and dental education. Institutions should first establish core values that guide the vision of promoting equitable representation of all groups. ADEA has developed the ADEA Access, Diversity, and Inclusion Framework 1-1 ([adea.org/diversity/framework](http://adea.org/diversity/framework)) to be used as a “visual checklist” ensuring that initiatives are fully inclusive.<sup>23</sup> The ADEA Faculty Diversity Toolkit is an evidenced based resource that takes a comprehensive approach to ameliorate diversity in our academic institutions.<sup>23</sup> This document reviews best practices for recruitment and retention which can be used to develop trained search committees and interviewing teams to address the needs of a diverse faculty. These are steps in the right direction.

Early initiatives to improve diversity, equity, and inclusion represent an acknowledgement of the problem, an understanding of the need for change, and an attempt at a solution. As our society evolves we understand the magnitude of the impact of diversity, equity, and inclusion. We all have a story full of challenges and success. We must acknowledge the positive and negative aspects of history and be inspired by those who blazed a trail for others who look like them and experience similar challenges. Our society is continuously evolving and smart leadership has recognized the need to nurture environments that support diversity, equity, and inclusion. However, data indicates that there is still work left to be done in supporting black female leadership in dentistry. We need initiatives on the national and the local level to support black women in dentistry and dental leadership. Black women dental providers and dental leaders occupy a unique space in which they are uniquely positioned to understand and empathize with the challenges and implicit biases faced by women as well as people who self-identify as minorities underrepresented within the overall dental workforce.

## REFERENCES

1. “Only Colored Woman Dentist”. Pittsburgh, Pennsylvania: Pittsburgh Dispatch. August 9, 1891. p. 15. Retrieved February 10, 2017 – via Newspapers.com. open access
2. Dykes Jr., De Witt S. (1996). “Ida Gray Nelson Rollins (1867-1953)”. In Smith, Jessie Carney (ed.). *Notable Black American Women*, Book (<https://books.google.com/books?id=ssMBzqrUpjwC&pg=PA496>). New York, New York: International Thomson Publishing Company, Gale Research, Inc. pp. 496-497. ISBN 978-0-8103-9177-2.
3. “Ida Gray Nelson (Rollins) (ca. 1866-1953) DDS 1890 University of Michigan College of
4. Dentistry” (<https://web.archive.org/web/20160622204557/http://www.dent.umich.edu/about-school/sindecuse-museum/ida-gray-nelson-rollins>). Dentistry University of Michigan. Ann Arbor, Michigan: University of Michigan School of Dentistry. 2014. Archived from the original (<http://dent.umich.edu/about-school/sindecuse-museum/ida-gray-nelson-rollins>) on June 22, 2016. Retrieved February 10, 2017.

## Intersectionality – Role Modeling Leadership Across Identities

Colonya C. Calhoun DDS, PhD and Ryan O. Grier DDS, MBA

5. "Only Colored Woman Dentist" ([https://www.newspapers.com/clip/8857499/only\\_colored\\_woman\\_dentist\\_pittsburgh/](https://www.newspapers.com/clip/8857499/only_colored_woman_dentist_pittsburgh/)). Pittsburgh, Pennsylvania: Pittsburgh Dispatch. August 9, 1891. p. 15. Retrieved February 10, 2017 – via Newspapers.com.
6. "Access, Diversity and Inclusion: American Dental Education Association". 2009. Retrieved July 3, 2016.
7. "ADA Distinguished Service Award: Dr. Jeanne Sinkford". American Dental Association. Retrieved January 5, 2016.
8. Smith, Jessie Carney (1996). *Notable Black American Women*, Book 2. VNR AG. pp. 598–601. ISBN 9780810391772. Retrieved January 5, 2016.
9. "Aetna: African American History Calendar: 2004: Jeanne C. Sinkford, D.D.S., Ph.D.: Profile". [www.aetna.com](http://www.aetna.com). Retrieved May 18, 2020.
10. <https://obits.tennessean.com/obituaries/tennessean/obituary.aspx?n=eugenia-mobley-mcginnis&pid=150822702>
11. [https://healthsciences.creighton.edu/sites/healthsciences.creighton.edu/files/aa\\_women\\_in\\_dentistry\\_draft.pdf](https://healthsciences.creighton.edu/sites/healthsciences.creighton.edu/files/aa_women_in_dentistry_draft.pdf)
12. <https://obits.tennessean.com/obituaries/tennessean/obituary.aspx?n=eugenia-mobley-mcginnis&pid=150822702>
13. <https://www.dentistryiq.com/dental-hygiene/student-hygiene/article/16352009/dentistry-in-the-african-american-community>
14. Weintraub, Karen (2019-06-03). "Juliann Bluitt Foster, Trailblazer in Dentistry, Is Dead at 80". *The New York Times*. ISSN 0362-4331. Retrieved 2020-06-25.
15. Smith, Jessie. *Notable Black African American Women*. Jessie Carney Smith. pp. 34–36.
16. Goldsborough, Bob. "Juliann Bluitt Foster, first female president of the Chicago Dental Society, dies at 80". [chicagotribune.com](http://chicagotribune.com). Retrieved 2020-06-25.
17. Versaci, M. (2019). "First woman to serve as Chicago Dental Society president inspired others to follow dreams".
18. Versaci, Mary Beth (2019-05-10). "First woman to serve as Chicago Dental Society president inspired others to follow dreams". [www.ada.org](http://www.ada.org). Retrieved 2020-06-26.
19. Lett LA, Orji WU, Sebro R (2018) Declining racial and ethnic representation in clinicalacademic medicine: A longitudinal study of 16 US medical specialties. *PLoS ONE* 13(11): e0207274. <https://doi.org/10.1371/journal.pone.0207274>
20. Surdu S, Langelier M, Liu Y, Goodwin N. *A National Study of the Practice Characteristics of Women in Dentistry and Potential Impacts on Access to Care for Underserved Communities*. Rensselaer, NY: Oral Health Workforce Research Center, Center for Health Workforce Studies, School of Public Health, SUNY Albany; June 2019.
21. Diana M. Lautenberger, MA, and Valerie M. Dandar, MA. *The State of Women in Academic Medicine 2018–2019: Exploring Pathways to Equity* updates the edition of the report published in 2014.
22. American Association of Medical Colleges. *U.S. Medical School Faculty*, 2018. <https://www.aamc.org/data/facultyroster/reports/494946/usmsf18.html>. Accessed May 6, 2019.great
23. Schwartz SB, Smith SG, Johnson KR. ADEA Faculty Diversity Toolkit: A Comprehensive Approach to Improving Diversity and Inclusion in Dental Education. *J Dent Educ*. 2020;84:279–282.



## Dentistry and the Principle of Justice

### How Ethics Informs Oral Health Policy

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One of the hallmarks of any profession is the requirement that its members adhere to strict ethical standards. This is the defining feature that truly distinguishes a profession from a trade or any other occupation. It grows out of an implied contract between society and that profession. It's hardly surprising that almost every profession's ethical code share most, if not all, of five common ethical principles. These include patient or client autonomy, nonmaleficence, beneficence, veracity and justice.

Most of us are familiar with many of these principles. We understand patient autonomy as an ethical responsibility to respect the patient's rights to self-determination and confidentiality. Nonmaleficence and Beneficence refer to refraining from creating harm and the duty to protect the patient's welfare and place the primacy of their welfare above all else. You could substitute the words "client" or "customer," for "patient" and easily see how these same

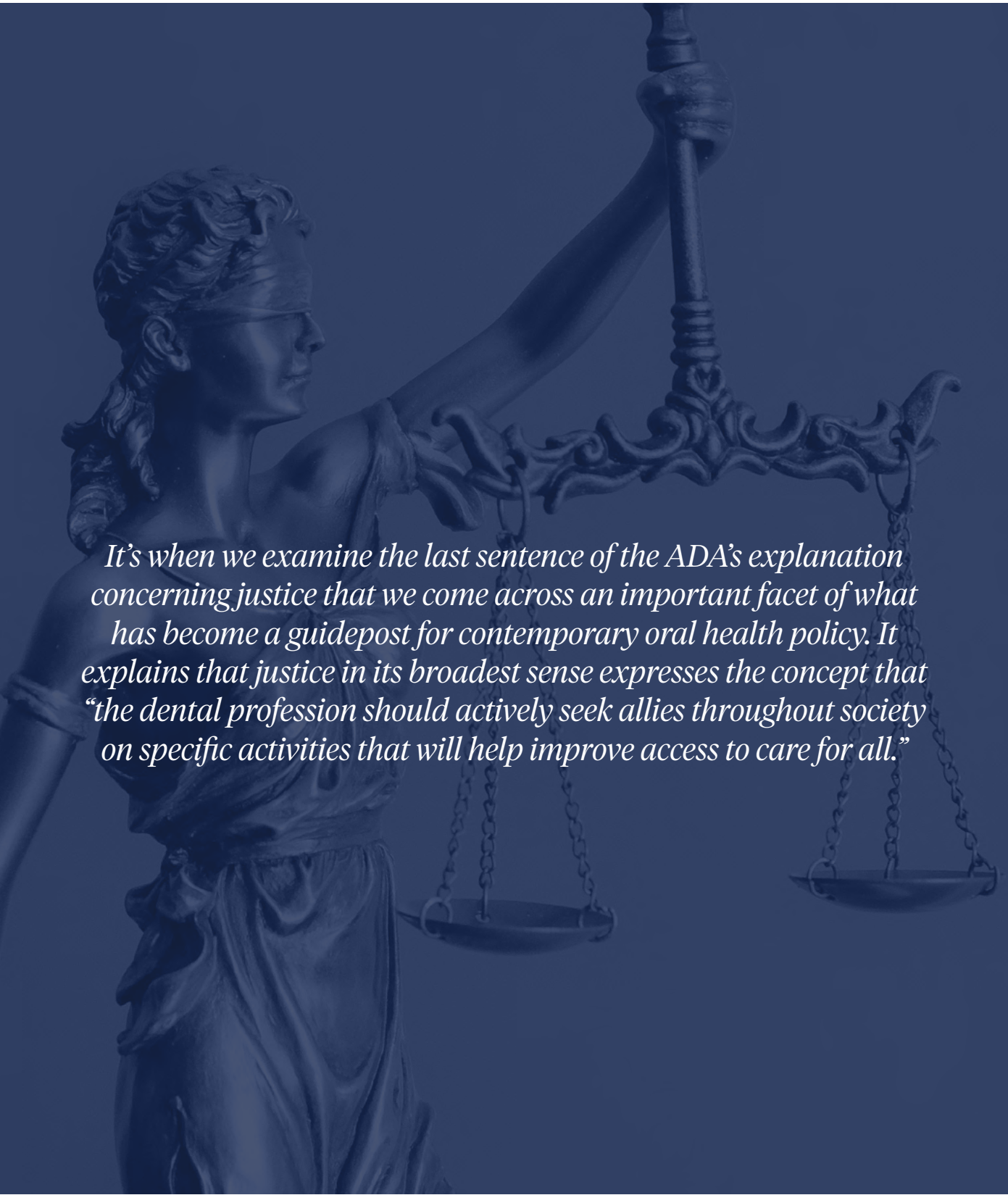
ethical principles might be applicable across all professions. Likewise, another principle, that of Veracity or truthfulness, has always been a universal guiding principle that lends trust and credibility to any profession.

Perhaps the ethical principle which has received the most attention in recent years is that of Justice. It may also be the one ethical principle that has been least examined and understood. By definition, the principle of justice addresses the dentist's duty to treat people fairly. The American Dental Association's Code further elaborates on this ethical obligation as follows; *This principle expresses the concept that professionals have a duty to be fair in their dealings with patients, colleagues and society. Under this principle, the dentist's primary obligations include dealing with people justly and delivering dental care without prejudice. In its broadest sense, this principle expresses the concept that the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all.* It might be informative to pick this principle apart to better understand its relevance and importance to both clinical practice, dental education and emerging oral health policy.

The first question that comes to mind is, "What does it mean to treat people fairly?" The dictionary defines the word fair as "impartial, frank, open, sincere, honest, unbiased, blameless, uncorrupted, equitable, objective, unprejudiced, evenhanded." And while those are great

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*It's when we examine the last sentence of the ADA's explanation concerning justice that we come across an important facet of what has become a guidepost for contemporary oral health policy. It explains that justice in its broadest sense expresses the concept that "the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all."*

*But how fair is it to establish tier levels of access and care based solely on social determinants? Do the poor and underserved deserve a lower level of care than the rest of us? Can a profession that is ethically committed to beneficence, non-maleficence and justice support such an approach?*

descriptive synonyms, how do they inform our ethical obligation when it comes to dental treatment? Is it possible to always be objective and unprejudiced when treating all patients? The ideal would be to answer in the affirmative, but the reality may be a bit more complicated.<sup>1-2</sup> Certainly, we all want to do our best and do what's right in meeting all of our patient's oral health needs. But there may be times that we come up short. There may be times that we let our prejudices and unconscious biases interfere with our obligation to be fair.

Perhaps a patient's physical appearance, ethnic background, sexual orientation, financial circumstances or personal demeanor might create a barrier to our acting in an objective manner. As oral health professionals, we are ethically obligated to recognize and overcome these biases that may impede our ability to treat our patients equitably.

It's when we examine the last sentence of the ADA's explanation concerning justice that we come across an important facet of what has become a guidepost for contemporary oral health policy. It explains that justice in its broadest sense expresses the concept that "*the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all.*" This now ties in the ethical concept of justice with dentistry's mission of advancing the profession and promoting the health of the pub-

lic. This is where dentistry's ethical code now veers into the realm of social justice. For some this presents a problem. They have a hard time reconciling the idea that dentistry would play a role in social justice. They worry dentistry might be veering into the world of politics which, in the past, has traditionally been the main arbitrator of social issues. And, because of the current polarized political environment, it might appear to some as though dentistry is taking sides or aligning itself with a particular political party, which is in distinct contrast to its traditional non-partisan political stance.

But a closer examination would reveal that this is not the case. It's simply a positioning of the principle of justice into the mission and strategic plan of the profession. It reflects dentistry's ethical commitment to promote a sense of fairness in the access and delivery of oral health care to the public. We know that oral health care disparities or differences in the incidence, prevalence, mortality, and burden of oral diseases, as well as the use of health care services, are prevalent throughout our country and predicted to exacerbate in the future.<sup>3-5</sup> We also know that reducing these oral health disparities is central to the overall goal of improving population health and dentistry's expressed mission of advocating for the oral health of the public. The question now becomes; What approach is fair or just when it comes to addressing these?

One approach to addressing oral health care disparities has come through state legislatures. Some states have adopted legislation that provides for legalization of minimally educated, low level, oral healthcare providers in order to address the oral health needs of both underserved and poor populations. In many cases these *Dental Therapists* are that state's alternative to addressing existing underfunded state Medicaid programs. But how fair is it to establish tier levels of access and care based solely on social determinants? Do the poor and underserved deserve a lower level of care than the rest of us? Can a profession that is ethically committed to beneficence, nonmaleficence and justice support such an approach?

Dentistry and dental education have taken a different approach. They've engaged and embraced the ethical concept of justice that "*the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all.*" They've begun by adopting strong policies on diversity, equity and inclusion. Because it only makes sense that as our population and all of society changes and becomes more diverse that this would and should be reflected in our profession that serves that society. In fact, it is society that determines and defines what can be called a profession. And in granting professional status, society always has the expectation that the profession will continue to reflect that society. So, as an evidenced

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based profession, dentistry looked at the literature. A number of studies suggest that fostering a diverse and inclusive workforce is critical to increasing access to care and improving aspects of health care quality among underserved populations.<sup>6-9</sup> These studies have demonstrated that dentists from underrepresented minority groups are more likely to practice in high-need specialties and in underserved communities.<sup>10-11</sup> This definitively supports health equity because, for there to be equity in our oral healthcare system, the people

who provide care should reflect the population that they serve. Anything that aids access to, and utilization of health care is vital to good and equitable health. In fact, some studies have suggested that a diverse workforce may improve health care professionals' cultural competence and better prepare them to respond to the needs of the entire population.<sup>12</sup>

So, when it comes to "seeking allies throughout society on specific activities that will help improve access to care for all," dentistry's work contin-

ues to evolve. It's obvious though that, advocating and supporting initiatives like, dental school pipeline programs that attempt to recruit qualified students from underrepresented backgrounds, encouraging more federal and state loan repayment programs for practicing in underserved areas, lobbying for more adequate financial reimbursement from Medicaid and creating pathways to leadership for underrepresented dentists, are all compatible with dentistry's mission and ethical obligation to the principle of justice.

## REFERENCES

1. Patel N, Patel S: Unconscious Racial Bias May Affect Dentists' Clinical Decisions on Tooth Restorability: A Randomized Clinical Trial. *Clin Trans Res*. 2019 Jan;4(1):19-28.
2. FitzGerald C, Hurst S, Implicit bias in healthcare professionals: a systematic review. *BMC Medical Ethics* 2017; 18: 19.
3. Edelstein BL, Chinn MH: Update on Disparities in Oral Health and Access to Dental Care for America's Children. *Academic Pediatrics*. Nov-Dec 2009, 9 (6):415-419
4. Mouradian WE, Wehr E, Crall JJ: Disparities in Children's Oral Health and Access to Dental Care. *JAMA*. Nov.22/29 2000, 284 (20): 2625-2631
5. Patrick DL, Shuk Yin Lee R, Nucci M, Grembowski D: Reducing Oral Health Disparities: A Focus on Social and Cultural Determinants. *BMC Oral Health*. 2006, 6 (4)
6. MarrastLM,ZallmanL,WoolhandlerS,BorDH,McCormickD.: Minority physicians' role in the care of underserved patients: diversifying the physician workforce may be key in addressing health disparities. *JAMA Intern Med*. 2014;174(2):289-291. doi:10.1001/jamainternmed.2013.12756
7. WilburK,SnyderC,EssaryAC,ReddyS,WillKK,SaxonM: Developing workforce diversity int the health professions: a social justice perspective. *Health Prof Educ*. 2020;6(2):222-229. doi:10.1016/j.hpe.2020.01.002
8. CantorJC,MilesEL,BakerLC,BarkerDC: Physician service to the underserved: implications for affirmative action in medical education. *Inquiry*. 1996;33(2):167-180.
9. GrumbachK,MendozaR: Disparities in human resources: addressing the lack of diversity in the health professions. *Health Aff (Millwood)*. 2008;27(2):413-422. doi:10.1377/hlthaff.27.2.413
10. GoodfellowA,UlloaJG,DowlingPT,etal: Predictors of primary care physician practice location in underserved urban or rural areas in the United States: a systematic literature review. *Acad Med*. 2016;91(9):1313-1321. doi:10.1097/ACM.0000000000001203
11. Mertz EA, Wides CD, Kottek AM, Calvo JM, Gates PE: Underrepresented minority dentists: quantifying their numbers and characterizing the communities they serve. *Health Aff (Millwood)*. 2016;35(12):2190-2199. doi:10.1377/hlthaff.2016.1122
12. GurinP,DeyE,HurtadoS,GurinG: Diversity and higher education: theory and impact on educational outcomes. *Harvard Educ Rev*. 2002;72(3):330-367. doi:10.17763/haer.72.3.01151786u134n051



## An Historical Reflection

# The Unique Relevancy of HBCU Dental Schools

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**T**hought provoking conversations and questions over the years have centered around the importance of Historically Black Colleges and Universities (HBCUs), their relevance and necessity for existing. These institutions are as important today as they were at their inception. It has been proven that comfortable students perform better when they make emotional connections that make them feel that they are understood and supported. HBCUs offer students a safe harbor when it is imperative that they feel safe and respected.

HBCUs have and continue to train their students for future careers to be well-equipped, highly educated professionals. These institutions provide formal training and have also created liberation from societal limitations, as well as financial elevation. They have created leaders, improved communities, and served to address and help eliminate health disparities. Howard University and Meharry Medi-

cal College School of Dentistry, both premium HBCUs, are among the best in the country with climates of equity, diversity, and inclusion. They have validated their purpose and relevance as schools that have trained the majority of the African American physicians and dentists in the United States for over a century.

## HBCU EVOLUTION

With so many institutions of higher learning, the relevance of HBCUs may be questioned. However, historically no institutions of higher learning for African Americans existed. HBCUs were established in the 1800's for the sole purpose of training African American men and women. They have played a key role in higher education since the days of Reconstruction. HBCU institutions have played a crucial role in transforming how America was to understand and envision what it meant to be black following the Civil War.<sup>1</sup>

The majority of HBCUs originated from 1865-1900, with the greatest number of HBCUs started in 1867, two years after the Emancipation Proclamation: Alabama State University, Barber-Scotia College, Fayetteville State University, Howard University, Johnson C. Smith University, Morehouse College, Morgan State University, Saint Augustine's University and Talladega College. Over a century later, HBCUs were still being established with J.F. Drake State Technical College (1961), University of the Virgin Islands (1962), Southern University at Shreveport (1967) and Morehouse School of Medicine (1975). Technically,

# The Unique Relevancy of HBCU Dental Schools

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HBCUs are those Institutes of Higher Education (IHEs) established prior to 1964, to educate persons of African descent. Those founded after 1964 are known as predominantly Black institutions (PBIs), but are considered a part of the 101 HBCUs. The technical definition of a PBI, as established in the Higher Education Act of 2008, includes the following criteria: at least 40% African-American students, minimum of 1,000 undergraduates, have at least 50% low-income or first-generation degree seeking undergraduate students, and have a low per full-time undergraduate student expenditure in comparison with other institutions offering similar instruction. These qualifications reflect conditions in which HBCUs operate, and indicate that since their founding, HBCUs have continued to serve their core constituencies: students who are of African descent, and/or first-generation, and/or low-income.<sup>2</sup>

Howard University was founded in 1867 in Washington, DC and named for General Oliver Otis Howard, head of the post-Civil War Freedman's Bureau. The institution firmly stood behind a special obligation to provide advanced studies for Blacks. The College of Dentistry at Howard University was established in 1881. It is the fifth oldest dental school in the United States.

Meharry Medical College was founded in 1876, just 11 years after the end of the Civil War with the mission of teaching former slaves in the healing arts. The college, rooted within the United Methodist Church, is named after Samuel Meharry. History states that while traveling, his wagon became stuck in the mud and snow. He

went to a log cabin in the distance that was home to a freed slave family. They gave him food and shelter for the night and the next day, helped him to move his wagon. Mr. Meharry promised them that he would one day repay their act of kindness by doing something for their people. Their act of kindness and his gracious donation led to Meharry Medical College. The School of Dentistry was established ten years later in 1886.

Howard University in Washington, D.C. and Meharry Medical College in Nashville, Tennessee were the only private HBCUs with medical schools that expanded to establish dental schools. This created opportunities to continue to advance the training of African Americans and increase the availability of health care professionals who could and would provide care to their communities. For more than a century, these two institutions have trained health care professionals who practiced throughout the country. While their existence began post-Civil War and pre-segregation, their significance to exist is as relevant today as it was in the 1800s. They have increased the diversity of the healthcare workforce while addressing racial and ethnic health disparities among patients. In addition, these HBCU dental institutions like so many other HBCUs, have created leaders who enhance their communities and organizations throughout the country.


## HBCU DENTAL SCHOOLS' ROLE IN INCREASING DIVERSITY

With the recognition of the need for better health equity, the relevance of HBCUs and HBCU dental schools is more important than ever. They serve

a significant role of increasing diversity within the dental community and the nation.

HBCUs, in general, continue to have a positive impact on the production of college-educated African Americans. HBCUs constitute approximately three percent of all colleges and universities. However, an estimated twenty percent of college trained African Americans are graduates of HBCUs.<sup>2</sup> HBCUs have been and continue to be essential for increasing the number of African Americans in the oral healthcare workforce space. Meharry and Howard's dental schools are the only HBCUs that continue to serve as preeminent institutions that have trained the majority of the practicing African American dentists in the United States. An estimated 41% of the current practicing African American dentists in the United States are graduates of Meharry Medical College as reported by the college's Office of Institutional Research. More importantly, many of these health care professionals serve in underserved areas, providing treatment to indigent patients.

During the last several years, the number of dental schools has increased. While this expansion is potentially increasing the dental workforce, many schools still have few, or no African American dental students enrolled. Currently, there are sixty-nine (69) dental schools, and it is projected that there will be a total of seventy-two (72) within the next few years.<sup>3</sup> The expansion of the number of dental schools has been constant in recent years; however, the number of African American students who enroll and graduate from dental school



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has not kept pace. Over the years, Meharry and Howard have increased diversity and demonstrated an increase in the number of white students and those of other races/ethnicities.<sup>4</sup> However, similar increases in African American student enrollment have not occurred in other dental

schools. More importantly, were it not for the existence of Meharry and Howard, the percentage of African American practicing dentists would be substantially lower.<sup>5</sup>

The racial mix of the dentist workforce does not reflect the US popu-

lation, with black and Hispanic dentists significantly underrepresented in the profession. In 2020, white dentists made up 70.2 % of the dentist workforce; 18% were Asian; 5.9% were Hispanic; and 3.8% were black.<sup>6</sup> African Americans comprise an estimated 13% of the U.S. population and ap-

# The Unique Relevancy of HBCU Dental Schools

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proximately 4% of practicing dentists in the United States. As the country continues to become more diverse, expansion of diversity in oral and all aspects of healthcare workspace is necessary. This will require collective and intentional efforts.

## HBCU DENTAL SCHOOLS ADDRESSING HEALTH CARE DISPARITIES

The educational training at Meharry and Howard dental schools encompasses not only the didactic and educational training but places an emphasis on individuals who will serve the underserved. They create a large percentage of health care professionals who practice in underserved areas and add value to addressing and eliminating health care disparities,<sup>5</sup> which inadvertently disproportionately impact people of color at a greater level.<sup>7,8</sup> African Americans are disproportionately affected by health disparities such as cardiovascular disease and diabetes. Furthermore, oral health disparities such as caries, periodontal disease, and tooth loss are also higher among African Americans.<sup>9-11</sup> Various reports have noted the impact that increased diversity in healthcare can have on reducing racial and ethnic health care disparities.<sup>12-14</sup> More importantly, diversity can improve access to health care for underserved communities while also improving communication and increasing innovation. A large percentage of the medical and dental graduates of Meharry and Howard serve minorities and underserved communities.<sup>5</sup>

In medicine, African-American, Hispanic, and Native-American physicians are much more likely than are

white physicians to practice in underserved communities and to treat larger numbers of minority patients, irrespective of income.<sup>15</sup> African-American and Hispanic physicians, as well as women, are more likely to provide care to the poor and those on Medicaid.<sup>16</sup> These same findings transcend in the dental profession. Black dentists treat 61.8 % of Black patients, White dentists only treat 10.5 %, Hispanics treat 9.8 and Asian dentists only treat 11.5 %.<sup>17</sup> In addition, racial and ethnic minority patients who have a choice are more likely to select health care professionals of their own racial or ethnic background.<sup>18</sup> Racial and ethnic minority patients are generally more satisfied with their care and are more likely to report receiving higher-quality care when treated by a health professional of their own racial or ethnic background.<sup>19,20</sup> With the absence of Meharry and Howard, there would be fewer African American dental graduates and fewer individuals to serve the African American community and other people of color, thus limiting diverse racial and ethnic options for the community.<sup>21</sup> Meharry and Howard are relevant institutions that significantly diversify the dental workforce and help to address health disparities.

## HBCU DENTAL SCHOOLS AS A LEADERSHIP FOOTPRINT

HBCUs such as Meharry and Howard have not only served to increase the number of African American dentists, but have proven to create leaders within communities, academia, corporations, and organizations. The character of these two HBCU dental schools have influenced the lives of future leaders and promoted forward

paths to higher socialization skills, intellectual freedom, and economic prosperity for many who would not have those opportunities. The current deans of Meharry's dental school and Howard's College of Dentistry are both women and graduates of these institutions, respectively. In addition, current and past leaders of organizations such as the American College of Dentists, the American Dental Education Association, the National Dental Association, Heartland Dental, and other professional organizations and companies have been graduates of these two institutions.

HBCU dental schools are more relevant than ever. These institutions help African Americans increase their awareness and self-esteem while pursuing professional careers in inclusive and diverse learning environments ensuring every student of an opportunity to be successful. Dental school is a journey and is central to personal identity formation.

There must continue to be a cultivation and advocacy for higher education diversity. HBCUs will always be a pedestal of the American college and university system representing educational equality. HBCU dental schools undoubtedly exemplify the American ideal of life, liberty, and the pursuit of happiness. Their relevance was essential after the Civil War and centuries later, their existence is even more critical and necessary today. HBCU dental schools have and will continue to maintain a footprint and relevance as institutions of higher education, healthcare, and racial and ethnic health disparities.

## REFERENCES

1. Wooten, M. (2019, November 28). The importance of historically black colleges and universities. Retrieved from <https://newsone.com/3895119/the-importance-of-historically-black-colleges-and-universities/>.
2. History of HBCUs. (2019). Retrieved from [www.tmcf.org/hisotry-of-hbcus/](http://www.tmcf.org/hisotry-of-hbcus/).
3. ADEA Snapshot of Dental Education, 2019–20. American Dental Education Association Web site. [https://www.adea.org/uploadedFiles/ADEA/Content\\_Conversion\\_Final/deansbriefing/2019-20\\_ADEA\\_Snapshot\\_of\\_Dental\\_Education.pdf](https://www.adea.org/uploadedFiles/ADEA/Content_Conversion_Final/deansbriefing/2019-20_ADEA_Snapshot_of_Dental_Education.pdf) Accessed September 1, 2021
4. Henley, G. L., Lawrence, W., Mitchell, C., Henley-Jackson, D., & Feimster, T. (2012). Measuring Diversity at a Historically Black College of Dentistry. In *Cases on Institutional Research Systems* (pp. 212–227). IGI Global.
5. Mertz, E., Calvo, J., Wides, C., & Gates, P. (2017). The Black dentist workforce in the United States. *Journal of public health dentistry*, 77(2), 136–147.
6. Findings into racial disparities in oral health. (2021, April 19). Retrieved from <https://www.ada.org/en/publications/ada-news/2021-archive/april/hpi-publishes-findings-into-racial-disparities-in-oral-health>.
7. Gillispie-Bell, V. The Contrast of Color: Why the Black Community Continues to Suffer Health Disparities, *Obstetrics & Gynecology*: February 2021 - Volume 137 - Issue 2 - p 220–224 doi: 10.1097/AOG.0000000000004226
8. Walker, B., Mays, V. M., & Warren, R. (2004). The changing landscape for the elimination of racial/ethnic health status disparities. *Journal of Health Care for the Poor and Underserved*, 15(4), 506.
9. Satcher, D., & Nottingham, J. H. (2017). Revisiting oral health in America: A report of the surgeon general.
10. Chattopadhyay, A. (2008). Oral health disparities in the United States. *Dental Clinics of North America*, 52(2), 297–318.
11. Wu, B., Liang, J., Plassman, B. L., Remle, R. C., & Bai, L. (2011). Oral health among white, black, and Mexican-American elders: an examination of edentulism and dental caries. *Journal of public health dentistry*, 71(4), 308–317.
12. Noonan, A. S., & Evans, C. A. (2003). The need for diversity in the health professions. *Journal of Dental Education*, 67(9), 1030–1033.
13. Mitchell, D. A., & Lassiter, S. L. (2006). Addressing health care disparities and increasing workforce diversity: the next step for the dental, medical, and public health professions. *American Journal of Public Health*, 96(12), 2093–2097.
14. Smith, C. S., Ester, T. V., & Inglehart, M. R. (2006). Dental education and care for underserved patients: an analysis of students' intentions and alumni behavior. *Journal of dental education*, 70(4), 398–408.
15. Kington R, Tisnado D, Carlisle DM. Increasing racial and ethnic diversity among physicians: an intervention to address health disparities? In Smedley BD, Stith AY, Colburn L, Evans CH, (eds.). *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions*. Washington, DC: National Academy Press, 2001.
16. Cantor JC, Miles EL, Baker LC, Barker DC. Physician service to the underserved: implications for affirmative action in medical education. *Inquiry*. 1996; 33: 167–180.
17. Muhammad, NI, (2013, April 13). Shortage of Black dentists means more than just fewer smiles. Retrieved from [https://www.finalcall.com/artman/publish/Health\\_amp\\_Fitness\\_11/article\\_9773.shtml](https://www.finalcall.com/artman/publish/Health_amp_Fitness_11/article_9773.shtml).
18. Saha S, Taggart SH, Komaromy M, Bindman AB. Do patients choose physicians of their own race? *Health Affairs*. 2000; 19: 76–83.
19. Cooper-Patrick L, Gallo JJ, Gonzales JJ, Vu HT, Powe NR, Nelson C, Ford DE. Race, gender, and partnership in the patient–physician relationship. *JAMA*. 1999; 282: 583–589.
20. Cooper, L. A., & Powe, N. R. (2004). Disparities in patient experiences, health care processes, and outcomes: The role of patient–provider racial, ethnic, and language concordance (pp. 1–29). New York, NY: Commonwealth Fund.
21. Rodríguez, J.E., López, I.A., Campbell, K.M., & Dutton, M. (2017). The Role of Historically Black College and University Medical Schools in Academic Medicine. *Journal of Health Care for the Poor and Underserved* 28(1), 266–278. doi:10.1353/hpu.2017.0022.



## A Case for Inclusion

### The AAWD Perspective

Daphne Ferguson-Young, DDS, MSPH, FACD

**T**he American Association of Women Dentists (AAWD) was formally organized in 1921 in Milwaukee, Wisconsin with a delegation of twelve (12) women dentists. The organization was not focused on separating themselves from the male dentists but focused on building a network of women who could discuss the issues which are/were important to and for women dentists.

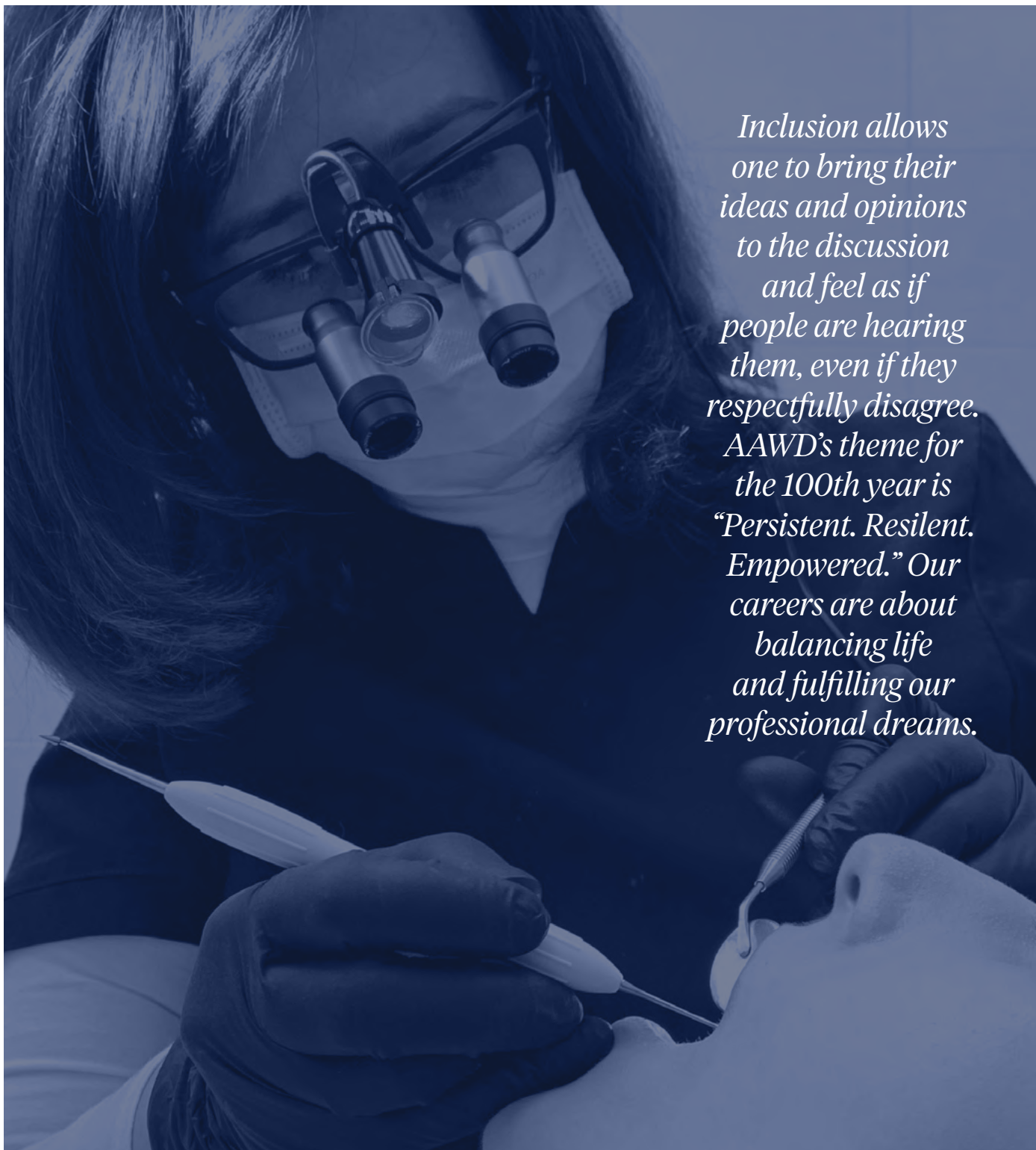
This year as AAWD celebrates the organization's 100th year, we will sponsor an interdisciplinary workshop on September 18 and October 23 from 10 am – 2 pm (EDT). The workshop will discuss not only dental topics but will include workshops on business management and women's health.

Dentistry has evolved greatly over the last one hundred years. The practice of dentistry includes more technology and business savvy. Women are being accepted into dental schools where classes are now close to, if not 50% women. An organization which started out with 12 dedicated dentists now includes dental students, dental faculty, practicing dentists, armed services dentists, and retired dentists. With the multigenerational groups actively involved in AAWD, there is a wealth of experience and knowledge as well as a source for mentoring. The foundational principles which were present in 1921 are the foundation which still supports AAWD as it expands globally.

Worldwide, professional women are still challenged in their prospective careers. Not only are we dentists, but we are also business owners, spouses, parents (pets or children), caregivers, community volunteers as well as engaged in family activities. We are a diverse group of professionals. All are included in the AAWD as the

organization reflects the diversity of our country. Inclusion is about empowering and involving our members to ensure that everyone feels valued. Inclusion allows one to bring their ideas and opinions to the discussion and feel as if people are hearing them, even if they respectfully disagree. AAWD's theme for the 100th year is "Persistent. Resilient. Empowered." Our careers are about balancing life and fulfilling our professional dreams. It is about the support of sister dentists that we can depend on as we network and share ideas, skills and knowledge.

As profound as AAWD is with a diverse membership, which includes but is not limited to, the factors of race, gender, sexual orientation, cultural background, and age, the organization realizes that the other important part to add to diversity is inclusion. AAWD realizes that diversity + inclusion = organizational success. When an organization is 100 years old, AAWD knows that members have different skills, knowledge and interest.



*Inclusion allows one to bring their ideas and opinions to the discussion and feel as if people are hearing them, even if they respectfully disagree. AAWD's theme for the 100th year is "Persistent. Resilient. Empowered." Our careers are about balancing life and fulfilling our professional dreams.*

Our Board of Directors is designed to address every aspect of our membership. We have a director for each of these areas: Corporate Relations, Membership and Chapters, Federal Services, Member Benefits, Academ-

ic Affairs and a Student Representative. It is important that everyone has a representative.

As AAWD starts the next 100 years, we are committed to our mission and

vision of the organization. We will continue to be the leading resource advancing, connecting and enriching the lives for women dentists.



## A Case for Inclusion

# The Hispanic Dental Association Perspective

Rosa Chaviano-Moran, DMD and Herminio Perez, DMD, MBA

Inclusion is the required core element to successfully “integrate” everyone and allow their differences to coexist in a mutually beneficial way. When talking about “inclusion,” clarifying the distinction between diversity and inclusion is important. Sometimes these terms are used interchangeably. Diversity, as a core value, embodies inclusiveness and includes all aspects of human differences (socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability, and age). Inclusion is the core element in achieving diversity to create an environment that fosters belonging, respect, and value for all.

### **HISPANIC DENTAL ASSOCIATION: A HISTORICAL PERSPECTIVE**

In 1990, the founding members of the Hispanic Dental Association (HDA) shared a joint commitment to improve

the oral health of Hispanics and other underserved communities. Incorporated in Texas with a national scope, our history is one of inclusivity driven by our mission.

As the leading voice for Hispanic Oral Health, we provide Service, Education, Advocacy, and Leadership for promotion of overall health of the Hispanic and other underserved communities.<sup>1</sup>

Furthermore, HDA's vision is to “Eliminate Oral Health disparities in Hispanic and other underserved communities.”

With Hispanics being the nation's fastest-growing minority group and its largest,<sup>2</sup> the HDA priorities are improving the oral health of the Hispanic/Latinx\* (H/L) communities while supporting the oral health providers, the interprofessional team, and the prospective students representing the future of dentistry.

### **HISPANIC/LATINX DEFINITIONS**

*Latinos in the U.S. describe their identity in many ways, reflecting the diversity of origins in the Latino community, the immigrant experience and geography.<sup>3</sup> Broadly, some Latinos use pan-ethnic terms such as “Hispanic” or “Latino” to describe their identity; some prefer their family's Hispanic origin group; others use “American”. When describing their identity, more than half (54%) of Hispanics say they most often use the name of their ancestors' Hispanic origin (such as Mexican, Dominican, Salvadoran or Cuban).<sup>3</sup>*

*An additional 23% say they describe themselves most often as “American.” And one-in-five (20%) most often use the pan-ethnic terms of “Hispanic” or “Latino” to describe their identity.<sup>3</sup>*

*Latinx is a new, gender-neutral, pan-ethnic label that has emerged that is used by some news and entertainment outlets, corporations, local governments, and universities to describe the nation’s Hispanic population.<sup>4</sup> However, for the population it is meant to describe, only 23% of U.S. adults who self-identify as Hispanic or Latino have heard of the term Latinx, and just 3% say they use it to describe themselves.<sup>4</sup>*

HDA wants to be intentional, focus on education, develop and implement interventions and programs that hold the most promise for first-generation students, low-income students, and students from groups that continuously face barriers in higher education. HDA aspires to increase the number of accepted H/L students while promoting an inclusive and thriving environment to build educational excellence at our dental institutions.

In an effort to encourage and support H/L candidates, HDA has been advocating for the development of policies and guidelines to assist H/L students with the burden of the dental school loan debt. Recent studies show that H/L dentists report higher than an average educational debt, with the debt of African Americans being the only demographic with even higher debt loads.<sup>5</sup>

Approximately 7 percent of clinical H/L dentists report working in safety-net settings, with 40 percent primarily treating underserved populations, with 42 percent of their patient population being H/L.<sup>6</sup> Safety-net is a fragmented and heterogeneous network of public hospitals, clinics, community health centers (CHCs), and

other healthcare organizations defined only by their shared mission—to provide care to individuals regardless of ability to pay.<sup>7</sup> The workforce landscape of dental providers must be enhanced and diversified as a strategy to address the oral needs of H/L patients who face a lack of access.<sup>6</sup> H/L dental providers are underrepresented in the dentist population, and those in practice shoulder a disproportionate share of dental care for minority and underserved communities.<sup>6</sup> Improving the workforce diversity of dental providers is a critical part of a strategy to address the high burden of dental disease in the H/L population.<sup>6</sup>

## THE CASE FOR INCLUSION

Eighteen percent of the U.S. population is H/L making it the largest minority and racial or ethnic group.<sup>8</sup> According to the 2017 Race and Ethnicity in Higher Education Status Report, all racial and ethnic adult groups in the United States, ages 35 to 44, had higher levels of educational attainment than other younger age 25–34 groups in 2017.<sup>9</sup> However, H/L followed a different pattern than the other racial and ethnic groups. All other age cohorts had higher college graduation rates than their Hispanic counterparts did. These numbers and those of the other underrepresented groups are still well below the Asian (highest level) and White populations that hold such degrees.<sup>9</sup> This becomes particularly important when considering the health professions pipeline and the collective responsibility of dental educational institutions and the dental profession to mentor the next generation. If a needed demographic, H/L, lags behind in college degree attainment, the pipeline or pathway must begin earlier. Research has shown the middle school years a pivotal entry point.<sup>10,11</sup>

Earlier this year, ADEA published the *Snapshot in Dental Education*, an annual report intended to collect data on topics of interest to the dental community. The data represents findings that help dental community members understand the academic dental profession and its role in health and healthcare.<sup>12</sup> Between 2014 and 2019, an increase in the number of the predoctoral applicant pool and first-year class was noted. The increase consisted of Hispanics, African Americans, two or more races, and nonresident alien individuals. Despite the report indicating a noticeable increase of Asian, Hispanic, and African American dental students, the reality is that the numbers do not adequately reflect the diverse population of the U.S. Other historically underrepresented groups such as Alaskan Native, Asian/Pacific Islander, and Native Americans were not included.<sup>5</sup>

A study conducted by the U.S. Census in 2019 estimated the population percentage of Hispanics and African Americans as 18.5% and 13.4%, respectively.<sup>6</sup> The number of students currently in dental schools does not reflect the underrepresented population of Hispanics and African Americans in the U.S.<sup>12</sup> Studies have shown that U.S. dental schools compete over a small pool of eligible applicants from underrepresented racial/ethnic populations.<sup>13</sup> True progress involves enlarging the dental applicant pool as well as incentivizing the practice of diversity and inclusion principles across the dental landscape.

The current U.S. dental workforce is 5.9% H/L, 3.8% African American vs. 70.2% white.<sup>14</sup> How then do we attempt to make up the gap? Many dental organizations have recently joined the long-stated chorus from historically marginalized and underrepresented dental groups, calling for

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Rosa Chaviano-Moran, DMD and Herminio Perez, DMD, MBA

a more diverse oral health workforce. The benefits of having diversity in the dental profession workforce and leadership are many, including helping address racial and ethnic health care disparities, improving patient and community-centered care, and enriching the pool of policy-makers.<sup>15</sup>

Increasing racial and ethnic diversity in the healthcare workforce will provide patients with choices and better experiences that will translate into positive patient satisfaction, adherence, and better participation in care. To support the importance of increasing the diversity of dental professions from various races and ethnicities in dental practice settings, studies have found linkages of patient-physician race and ethnic concordance with higher patient satisfaction and better healthcare processes.<sup>17</sup>

A growing demographic within the oral health workforce is the internationally-trained dentist.<sup>18</sup> It has been shown that the life experiences of internationally trained dental students differ from regular four-year dental students in terms of cultural values and previous life experiences, both professionally and personally, and that most of them are older with families.<sup>19</sup> While much research has focused on the ability and need for internationally-trained dental students to cope and acclimate to life here in the U.S.,<sup>19,20</sup> one must also consider the rich ways these students and dentists contribute to the oral health workforce. An optimal patient experience is also enhanced for those internationally-trained dentists that share cultural norms, countries of origin, and language with our increasingly diverse population.

Therefore, HDA is interested in providing and sharing educational resources and best practices with other oral health care professionals in the United States and globally. Sharing knowledge will enhance the interest in and the diversification of the profession in academia, clinical methods, evidence-based research, scientific research, and many other opportunities that a career in oral healthcare can offer. Furthermore, by sharing our knowledge and resources, we open the possibilities better to understand the global health needs of all underserved communities.

Exchange of knowledge not only serves the one who receives it but also the one that provides that information. From a racial, ethnic, cultural, and linguistic perspective, the new generation of oral healthcare providers should be equipped to navigate the challenges of a diverse population, which will translate into a more culturally sensitive dental care practice.

It is well documented that the H/L population is underrepresented in the medical, dental, and allied health professions and academia.<sup>21</sup> Considering those factors, HDA is committed to setting high standards for providing access and opportunities to all segments of our communities and empowering the underrepresented and underserved by promoting professional development, education, policy, and practice. In addition, HDA acknowledges the impact that Hispanics/Latinx can have as providers and consumers of oral healthcare services and as participants in higher learning institutions. Therefore, the HDA platform is a service-oriented one where individuals must provide

culturally competent oral health care and equitable access to all patients.

Our aim is to grow and support our members and communities that mirror the population growth of Hispanics/Latinx in the general population. We are one of the few dental organizations that include the entire oral health team as members—dentists, hygienists, dental assistants, administrators, dental technicians—and are inclusive of all students in these categories.

The Hispanic Dental Association is now 31 years young and growing. HDA's quest for inclusivity aims to empower a diverse workforce of oral health professionals to achieve oral health equity. Now more than ever, the dream of HDA is to celebrate our races and cultures while embracing other ethnic, racial, and marginalized groups that share similar challenges, as well as those from non-marginalized groups who stand as allies and advocates for our mission.

Hispanic/Latinx are not one race or one culture, but an amalgamation of several races, languages, and rich cultures, all of which can influence or affect our health outcomes. Many of us are a subset of the races genetically represented in many other ethnic groups. We can be of Caribbean/Latin America descent (several combinations of Taino, African and European DNA) and/or descent from Central, South, and even North America (i.e., African Americans, Native Americans, or Aztec or Mayan DNA). This fusion of genetic traits makes our communities unique, and HDA stands as a literal embodiment of diversity and inclusion. May we continue to fulfill the needs of our growing diverse populations. "We Are HDA." "Somos HDA."

## REFERENCES

1. Hispanic Dental Association. Hispanic Dental Association - About HDA. <https://www.hdassoc.org/about-hda> . Published 2021.
2. Ramos-Gomez, F., Cruz, G. D., Watson, M. R., Canto, M. T., & Boneta, A. E. (2005). Latino oral health: a research agenda toward eliminating oral health disparities. *The Journal of the American Dental Association*, 136(9), 1231-1240.
3. Lopez, MH Three-Fourths of Hispanics Say Their Community Needs a Leader - Most Latinos Cannot Name One. (2013). Pew Research Center. <https://www.pewresearch.org/hispanic/2013/10/22/3-hispanic-identity/> Accessed September 1, 2021
4. Noe-Bustamante L, Mora L, Lopez MH About One-in-Four U.S. Hispanics Have Heard of Latinx, but Just 3% Use It. (2020). Pew Research Center. <https://www.pewresearch.org/hispanic/2020/08/11/about-one-in-four-u-s-hispanics-have-heard-of-latinx-but-just-3-use-it/> Accessed September 1, 2021
5. Health Policy Institute: Racial mix of workforce does not reflect population. ADA. 2021. <https://www.ada.org/en/publications/ada-news/2021-archive/april/hpi-publishes-findings-into-racial-disparities-in-oral-health> Accessed September 1, 2021.
6. Mertz E, Wides C, Calvo J, Gates P. The Hispanic and Latino dentist workforce in the United States. *J Public Health Dent*. 2017;77(2):163-173. doi:10.1111/jphd.12194
7. Nguyen OK, Makam AN, Halm EA (2016) National Use of Safety-Net Clinics for Primary Care among Adults with Non-Medicaid Insurance in the United States. *PLoS ONE* 11(3): e0151610. doi:10.1371/journal.pone.0151610
8. Pew Research Center. A View of the Nation's Future Through Kindergarten Demographics. <https://www.livingfacts.org/facts/demographics/2019/11/18-percent-of-the-us-population-is-hispanic-making-it-largest-minority-group>. Published 2019.
9. Espinosa LL, M. J, Turk T, Chessman M, M. H. *Race and Ethnicity in Higher Education: A Status Report*. Washington, DC; 2019. <https://1xfsu31b52d33idlp13twos-wpengine.netdna-ssl.com/wp-content/uploads/2019/02/Race-and-Ethnicity-in-Higher-Education.pdf>.
10. Smith CS, Ester TV, Inglehart MR. Recruiting minority middle school students into dentistry - feeding the pipeline. *J Dent Res*. 2006;85(A):#0224.
11. Mayberry ME, Young DD, Sawilowsky S, Hoelscher D. Exposure of seventh and eighth grade urban youth to dentistry and oral health careers. *J Dent Educ*. 2018;82(1):29-38.
12. ADEA Snapshot of Dental Education, 2019-20. American Dental Education Association. [https://www.adea.org/uploadedFiles/ADEA/Content\\_Conversion\\_Final/deansbriefing/2019-20\\_ADEA\\_Snapshot\\_of\\_Dental\\_Education.pdf](https://www.adea.org/uploadedFiles/ADEA/Content_Conversion_Final/deansbriefing/2019-20_ADEA_Snapshot_of_Dental_Education.pdf) Accessed September 1, 2021
13. Nalliah, R. P., Timoth  , P., & Reddy, M. S. (2021). Diversity, equity, and inclusion interventions to support admissions have had little benefit to Black students over past 20 years. *Journal of Dental Education*, 85(4), 448-455.
14. United States Census Bureau. Census Quick Facts: United States. Population Estimates 2019. census.gov. <https://www.census.gov/quickfacts/fact/table/US/PST045219>. Published 2020. Accessed November 3, 2020.
15. Wright, J. T., Vujicic, M., & Frazier-Bowers, S. (2021). Elevating dentistry through diversity. *The Journal of the American Dental Association*, 152(4), 253-255.
16. ADA. ADA Health Policy Institute: Racial and Ethnic Mix of the Dentist Workforce in the U.S. American Dental Association. [https://www.ada.org/~/media/ADA/Science and Research/HPI/Files/HPIgraphic\\_0421\\_1.pdf?la=en](https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0421_1.pdf?la=en).
17. Cooper, L. A., & Powe, N. R. (2004). Disparities in patient experiences, health care processes, and outcomes: The role of patient-provider racial, ethnic, and language concordance (pp. 1-29). New York, NY: Commonwealth Fund. <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.129.86&rep=rep1&type=pdf>.
18. Boorberg, N. B., Sch  nwetter, D. J., & Swain, V. L. (2009). Advanced placement, qualifying, and degree completion programs for internationally trained dentists in Canada and the United States: an overview. *Journal of Dental Education*, 73(3), 399-415.
19. Lopez N, Berthold P. Transnational licensure: foreign dentists in America reclaim their profession through the Program for Advanced Standing Students (PASS). *J Am Coll Dent* 2003; 70 (1): 15- 7.
20. Bender DJ. Patient Preference for a Racially or Gender-Concordant Student Dentist. *J Dent Educ*. 2007;71(6):726-745. doi:10.1002/j.0022-0337.2007.71.6.tb04330.x
21. Grumbach K, Mendoza R. Disparities in human resources: Addressing the lack of diversity in the health professions. *Health Aff*. 2008;27(2):413-422. doi:10.1377/hlthaff.27.2.413



## A Case for Inclusion

# The National Dental Association's Perspective

Pamela Alston, DDS, MPP, FACD, *President, National Dental Association*

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This paper examines the value of inclusion in organized dentistry from the perspective of the National Dental Association (NDA). It is significant that the NDA is making the case for inclusion because the NDA was excluded for generations from joining majority dental organizations. Even after membership was extended to join such organizations, the NDA had to fight to participate. There is a “big picture” to inclusion. Dentistry is at a critical juncture. It cannot meet its social contract to promote health equity, tackle oral health disparities and improve oral health outcomes among those with the greatest needs without the meaningful inclusion of minority dental organizations. Failure to include them weakens dentistry as a profession.

### THE NDA'S PURSUIT OF MEMBERSHIP IN ORGANIZED DENTISTRY

Historians Dr. Clifton O. and Lois Doyle Dummett observed at the beginning of the twentieth century, “Regardless of race, American dentists looked to the future of their profession with earnest determination to foster the art and science of dentistry, to support dental research, to elevate dental professional education, and to cultivate dental journalism. Organized dentistry was the instrument of choice to achieve laudable objectives.” Yet African American dentists were barred from membership in organized dentistry solely due to skin color for many generations. The National Dental Association (NDA) was formed to give African American dentists our own organization for continuing professional development as well as for fighting for oral health, racial and educational equity.

The leaders of the NDA continued to challenge the racially based membership restrictions of the American Dental Association and its component organizations until they were removed. Dr. Clifton O. Dummett wrote, “...the inability to attend professional meetings and gain scientific knowledge therefrom, the failure to see and discuss cases of scientific interest with large numbers of colleagues of varied experience, the restraints upon free intellectual intercourse, the inability to hold professional discourse with research scientists and highly trained scientific persons, the taboos against mutual inter-racial referral—these are

*The NDA has grappled with racial and oral health inequities since its founding. As an organization committed to social justice and health equity, the NDA amplifies the voices of African Americans and other historically marginalized peoples including but not limited to ethnic/racial minorities, the impoverished, the vulnerable, and those living in dental health professional shortage areas.*

among the more obvious restrictions which have served silently, but most effectively, to limit the horizons of the majority of the members of professional minorities.” The NDA leaders recognized that they could not fight effectively to end discrimination in the delivery of oral health care to African Americans if they were excluded from participating in the deliberations of majority dental organizations. During segregation, the number of African American dentists was not large enough to meet the needs of the African American population and the majority of dentists refused to treat African American patients. The under-representation of African American dentists continues to this day.<sup>3,4</sup>

#### **THE NDA’S PURSUIT OF INCLUSION IN ORGANIZED DENTISTRY**

Eventually, the American Dental Association (ADA) eased its membership restrictions.<sup>5</sup> Subsequently, the ADA changed its policies as well to urge its member groups and affiliates to cease discrimination based on race, ethnicity and creed. The NDA retained its strong, loyal membership base as African American dentists integrated into other dental organizations. The integration of organized dentistry improved diversity but it did not promote inclusion. The NDA leaders pressed not only for membership but also for inclusion in the largest dental organization, the ADA. In 1969, NDA Speaker (later NDA President) Eddie Smith addressed

the ADA House of Delegates clarifying the NDA’s position. He said, “Whereas the discriminatory membership problems had largely been solved, black dentists are not involved in every facet of the mainstream of the profession. However, it must be clear that due to persistent difficulties encountered, we are not fighting so much for the privilege to belong—rather the right to join and to participate fully...The object of the NDA is to work towards the elimination of every vestige of discrimination in the profession anywhere.”<sup>1</sup> The ADA had a history of taking positions that thwarted the NDA’s efforts to improve access to quality care for African Americans. After Dr. Eddie Smith’s speech, the ADA House of Delegates added two paragraphs to the ADA Principles of Ethics prohibiting the denial of treatment by the dental profession solely because of a patient’s race, creed, color, or national origin.

The NDA has grappled with racial and oral health inequities since its founding. As an organization committed to social justice and health equity, the NDA amplifies the voices of African Americans and other historically marginalized peoples including but not limited to ethnic/racial minorities, the impoverished, the vulnerable, and those living in dental health professional shortage areas. For all that it has accomplished, however, the NDA is cognizant that it cannot remedy oral health disparities and inequities alone. Racism in dentistry, in

the healthcare system, and in dental education is structural and requires a concerted, inclusive effort by the entirety of the dental profession to address it.<sup>3,6</sup>

#### **THE MEANING AND SIGNIFICANCE OF INCLUSION**

Diversity in dentistry has grown over the years. But inclusion is not a natural outgrowth of diversity. Diversity is about counting the numbers. Inclusion is about making the numbers count. The numbers count when members, whether they are individuals or organizations, feel welcomed, their perspectives are valued, and they have a meaningful opportunity to contribute.

Minority dental organizations have not always been respected by mainstream organized dentistry because our missions promoting equity and access to care were not deemed as worthy by other dental organizations. Implicit bias played a role. Implicit bias includes unconscious beliefs and assumptions that shape people’s perceptions, attitudes, stereotypes, and behaviors. Implicit bias interferes at an unconscious level with people’s ability to support full equity and inclusion for those organizations that they marginalize. These mindsets have enabled structural racism to thrive in organized dentistry and dental practice.<sup>7</sup>

If the NDA and other historic minority organizations are to feel included,

organized dentistry must stop tolerating implicit bias. NDA leaders have first-hand experience regarding how racism affects people of color. We are experienced in how racism has affected our African American population, our dental health professional students, our dental colleagues, and ourselves. We are a people who live with promised equality yet regularly encounter the realities of racism's oppression. The leaders of other historic minority dental organizations, ethnic/racial and otherwise, live with the same realities. In order to feel included, our perspectives must be welcomed so that they may be espoused and reflected in decisions, policies and practices. When organized dentistry is totally inclusive, it will propel the work of each organization to keep dentistry strong as a profession.

### **WHY INCLUSION IN DENTISTRY IS ESSENTIAL**

Keeping dentistry strong as a profession should be the common ground that incentivizes dental organizations to work inclusively. Dentistry is a profession because of its social contract. Society trusts and expects that the dental profession will show concern for the public by addressing oral health inequities and access to oral health care among the marginalized, vulnerable, low-income, and historically mistreated people of color. Historic minority dental organizations were founded out of a need to promote health equity, access to care and oral health outcomes in their constituencies. Today, we continue to amplify the voices of the marginalized and disenfranchised.<sup>8</sup>

Years ago, William John Gies shined a light on racial inequities with

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scathing remarks in his 1926 landmark report. He wrote, The general indifference of the white population to the welfare of the colored citizens not only violates the sentiments of fair play, decency and humanity, but also expresses a form of racial selfishness that fails to see the ends of enlightened self-interest, for every Negro having a communicable disease is a menace to the health of all with whom he may be associated, and particularly to the well-being of those he may serve personally and intimately. Where his ailment is traceable to denial of the benefits of instruction in hygiene, or where its continuance results from lack of the remedial care that is available to all white persons the ensuing danger to the whole community is retributive in its threat of disease and death.<sup>9</sup>

### **ORGANIZED DENTISTRY PAID NO ATTENTION.**

The light on racial inequities is being shined again. The COVID-19 pandemic has laid bare the health disparities that have negatively affected

African Americans, Native Americans, and Hispanic people for generations.<sup>10-13</sup> The pandemic has further exposed weaknesses in our nation's health care system as well as underlying structures that perpetuate health inequities, including oral health inequities.<sup>10-13</sup> The oral health care system is unjust, and it is failing to meet the basic needs of the marginalized, the impoverished, vulnerable, and people of color.

Social determinants of health contribute greatly to oral health status.<sup>14</sup> Thus it requires the collective strength of the dental profession working through its dental organizations to address those structural determinants, structural inequities and systemic racism that spans across the oral healthcare system, profession and educational institutions.<sup>15,16</sup> Dental organizations must advocate inter-professionally, across sectors, and with decision-makers.<sup>15,16</sup> The profession must have a united voice in championing the collective social justice considerations as leaders in our communities.

This time, if dentistry does not pay adequate attention and assume collective responsibility to address oral health inequities, other entities will step in. The weakening of dentistry as a profession is truly at risk. The professional status of dentistry is a privilege that is granted by society. Society expects that the dental profession will meet the oral health needs of the most vulnerable. It is not acceptable that there are large segments of the population that are unserved. According to the latest statistics, 61,062,691 people live in 6,553 Dental Health Professional Shortage Areas.<sup>17</sup>

Traditionally, those organizations with missions to promote health equity, oral health outcomes, and access to care have amplified the voices of those who are disadvantaged, marginalized and vulnerable. The COVID-19 pandemic has demonstrated how crucial it is for the dental profession to seize the moment now to add more voices to form a collective voice amplifying the voices of its many disparate parts. A collective voice does not mean one voice. By definition, a collective voice means all dental organizations embracing the collective message that the dental profession values oral health equity and is earnest in moving its needle.

Dental organizations must come together to unite our voices as we work towards oral health equity together. Dental organizations coming together can work towards ensuring oral health care access to everyone. When organized dentistry is inclusive, it has the knowledge base in key areas such as population-based dentistry, policy development, research, community-based oral health promotion, oral disease prevention, cultural competency, and maintenance of our dental safety net. When organized dentistry is inclusive, dental or-

ganizations whose members come from disenfranchised backgrounds and/or are serving these populations add to the collective knowledge base.

An inclusive organized dentistry can be a powerful change agent. Now is a pivotal time for dental organizations to be inclusive. It is a decision backed by action. The Biden-Harris administration is now uniquely positioned to address our nation's structural health care barriers and health disparities, including oral health. Organized dentistry needs the full inclusion of dental organizations working together to influence key decision-makers to advance public policy ensuring oral healthcare is available and accessible to everyone. And organized dentistry must be open to changes in the profession that will necessarily result.

There are promising inclusive collaborations drawing in and drawing together traditionally marginalized dental organizations. Public-private partnerships such as the Public Private Partner Dental Coordination Group that Rear Admiral Tim Ricks, Assistant Surgeon General convenes regularly is an excellent example of inclusion. Government agencies and dental organizations meet regularly to educate, share information and support each other. The Diversity Summit Presidents Group is composed of the executive directors and presidents of the ADA, NDA, Hispanic Dental Association (HDA), Society of American Indian Dentists (SAID) and the American Association of Women Dentists. The Group has found common ground, shares information, and works collectively to support all the organizations' missions. The Diverse Dental Society (DDS), formed by the NDA, HDA, and SAID leaders, is focused on working collaboratively to address the unmet oral and health care needs of underserved populations through service, education, out-

reach, advocacy, and measures to reform health policy.

## CONCLUSIONS

Organized dentistry's common ground is the contract that the dental profession has with society. Organized dentistry must take it seriously and work inclusively inside the profession, also including supporting team organizations, and collaboratively outside the profession for dentistry to remain sustainable as a profession. It is imperative that organized dentistry, through its leadership and membership, work collaboratively and accept responsibility for improving access to oral health care for all, promoting health equity, addressing oral health disparities, and improving oral health outcomes. Otherwise, dentistry will weaken as a profession. Our status as a profession hinges on our ability to govern ourselves and keep the public trust.

Jamie Moeller and Carlos Quiñonez remind us of the expectations for dentistry as a profession, "The values underlying dentistry as a profession...are fostering human prosperity and flourishing, cooperation among stakeholders, maximizing social good, justice, and equality."<sup>18</sup> If dental organizations do not come together inclusively to promote health equity, improve oral health outcomes, and improve oral health care, "the general public may increasingly view dentistry as something other than a profession, nullifying the need for a social contract and ultimately leading to the loss of dentistry's status as a regulated health profession."<sup>18</sup> An inclusive organized dentistry meeting the social contract will keep the dental profession strong.

# The National Dental Association's Perspective

Pamela Alston, DDS, MPP, FACD and Nathan Fletcher, DDS, FACD

## References

1. Dummett CO, Dummett LD. (2000) NDA II: The Story of America's Second National Dental Association, Washington, DC: National Dental Association Foundation, Washington DC)
2. Dummett CO, Reflections on a Passing Era: Compilation of Editorials—National Dental Association 1953-1975, published in the National Dental Association Bulletin
3. Nalliah, R. P., Timothé, P., & Reddy, M. S. (2021). Diversity, equity, and inclusion interventions to support admissions have had little benefit to Black students over past 20 years. *Journal of Dental Education*, 85(4), 448-455.
4. Wright, J. T., Vujicic, M., & Frazier-Bowers, S. (2021). Elevating dentistry through diversity. *The Journal of the American Dental Association*, 152(4), 253-255.
5. Dummett, C. O. (2002). NDA II: summary documentation of a health professional organization. National Dental Association. *Journal of the National Medical Association*, 94(5), 376.
6. Asmussen, N. On the fight against racism in dentistry.
7. Patel N, Patel S, Cotti E, Bardini G, Mannocci F. Unconscious Racial Bias May Affect Dentists' Clinical Decisions on Tooth Restorability: A Randomized Clinical Trial. *JDR Clin Trans Res*. 2019;4(1):19-28. doi:10.1177/2380084418812886
8. Mertz E, Calvo J, Wides C, Gates P. The Black dentist workforce in the United States. *J Public Health Dent*. 2017;77(2):136-147. doi:10.1111/jphd.12187
9. Gies WJ (1926), *Dental Education in the United States and Canada*, New York: The Carnegie Foundation, Chapter 5
10. Dyer O. Covid-19: Black people and other minorities are hardest hit in US *BMJ* 2020; 369 :m1483 doi:10.1136/bmj.m1483
11. Cheng, K. J. G., Sun, Y., & Monnat, S. M. (2020). COVID-19 death rates are higher in rural counties with larger shares of Blacks and Hispanics. *The Journal of Rural Health*, 36(4), 602-608.
12. Van Dorn, A., Cooney, R. E., & Sabin, M. L. (2020). COVID-19 exacerbating inequalities in the US. *Lancet* (London, England), 395(10232), 1243.
13. Smith, T. M. (2020). Why COVID-19 Is Decimating Some Native American Communities. *American Medical Association*, 13.
14. Tiwari, T., A. Palatta, and J. Stewart. The value of social determinants of health in dental education. *NAM Perspectives*. Commentary, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202004a>
15. Wolff, T., Minkler, M., Wolfe, S. M., Berkowitz, B., Bowen, L., Butterfoss, F. D., & Lee, K. S. (2017). Collaborating for equity and justice: Moving beyond collective impact. *Nonprofit quarterly*, 9, 42-53.
16. Franks, N. M., Gipson, K., Kaltiso, S. A., Osborne, A., & Heron, S. L. (2021). The Time Is Now: Racism and the Responsibility of Emergency Medicine to Be Antiracist. *Annals of Emergency Medicine*.
17. Shortage areas accessed on May 15, 2021 at: <https://data.hrsa.gov/>
18. Moeller J, Quiñonez CR, Dentistry's social contract is at risk, *Journal of the ADA*, 151(5), (May 2020)



## A Case for Inclusion

### The Society of American Indian Dentists

Felicia Fontenot, DMD, SAID President, and Cristin Haase, DMD, MPH, SAID Vice President, with Contributions by Student Dentist Tommie Chavis II, MS, SAID Student Board Member



*Disclaimer: This article is representative of our personal experiences and thoughts, and in this capacity, we do not represent any organization other than the Society of American Indian Dentists.*

Today's Indigenous peoples of what is now the United States of America are a proud and strong surviving people. In writing this article from our perspective as "Native Dentists," we have the solemn awareness that our ancestors were decimated by the early U.S. government under the banner of "Manifest Destiny".<sup>1</sup> Our perspective also includes the belief that no one can be as uniquely qualified to treat our peoples as we are. It remains of utmost importance for Native American people to gain equal representation as providers in the field of dentistry in order for our people to achieve oral health parity. American Indians and Alaskan Natives (AI/AN) (also referred to as Native Americans) currently suffer from the worst oral health outcomes in comparison to any racial or ethnic group within the United States.<sup>2,3</sup> Our organization, The Society of American Indian Dentists (SAID), is a national non-profit organization for dentists and dental students dedicated to promoting and improving the oral health of the American Indian/Alaskan Native (AI/AN) community and advocating for the American Indian/Alaskan Native dental professionals across the US.

## The Society of American Indian Dentists

Felicia Fontenot, DMD and Cristin Haase, DMD, MPH

Diversity in the classroom has been linked to improved learning environments for all students.<sup>4</sup> This is also true for the profession of dentistry as a whole.<sup>5-8</sup> Our youth have a lot to offer to the field of dentistry. As we celebrate those who succeed in obtaining a DDS/DMD degree, we also see many well qualified candidates denied entry to the dental profession. These qualified candidates have encountered barriers early within the grade school to college educational system and constructs within the dental school application process that place our Native American pre-dental students at a disadvantage.

Dr. Fontenot grew up on the reservation and excelled in academics, attending K-12th grade in the same small town public school. She believed she would naturally find her way to academic success at Stanford University. Once arriving there, she found herself intimidated by peers, and the intensive preparatory programs they had the privilege of participating in prior to Stanford. Undergraduate was difficult as she was not used to asking for help and she struggled to maintain a GPA competitive enough for dental school. Her path to dental school was not direct. She fortified her GPA by attending a graduate program at the Johns Hopkins School of Public Health. Despite being successful in her own right, she still felt like an imposter in dental school as the only Native student in her class and Native faculty seemed unheard of.<sup>9</sup> Sometimes the environment that glamorized cosmetic cases and expensive private practices made her feel that working towards a career in public health dentistry was considered a second class pro-

fession. This story is similar to many of our members' journeys through dental schools. Despite the many difficulties our AI/AN students face on their admission to dental school, our graduates positively impact their communities as role-models when bringing their unique understanding of health disparities and thus changing the way their patients view oral health. Today, Dr. Fontenot serves her fellow tribal members as the first Mescalero Apache dentist, treating patients in the same clinic where she had her first dental visit. Through the challenges and uncertainty of feeling that she did not belong in this profession, she now feels her most authentic self when healing the community she grew up in.

In addition to acknowledging that our AI/AN students are at a disadvantage academically, we also believe that the profession of dentistry is held back when historically underrepresented populations are missing from the conversation. We, the President and Vice President of SAID, understand what it feels like to be the first Native American dentists who our colleagues have encountered. We have also felt the weight of the dual responsibility of bringing something to the table while also educating our peers about the communities we are from. The current infrastructure of the profession of dentistry has failed our people, and we, the Society of American Indian Dentists, although small in membership, will work towards increasing our numbers to change the profession.

Due to the limited number of AI/AN dentists in the U.S., it can be challenging for our voices to be heard. Unlike other dental organizations, it

can be difficult to find a voice that is able to deliver our concerns to those in power. We are often left out of data sets and research in the dental profession through misclassification and erasure. As we aim to improve the oral health outcomes of our people, exclusion from data sets signifies to larger ethnic groups that our people are non-existent.<sup>10</sup> During the 2020 election polls, CNN classified AI/AN voters as "something else," a blatant and modern example of misclassification and erasure. This erasure is not limited to politics as demonstrated in last year's data from the American Dental Association Health Policy Institute. The in-depth research on race and ethnicity in dentistry specifically excluded AI/AN data, as seen in the link here: <https://www.ada.org/en/science-research/health-policy-institute/publications/infographics>.<sup>11</sup> Exclusion from data sets leads to loss of recognition of public health needs in AI/AN communities, loss of funding, and further exacerbates disparities in healthcare.

Today, AI/ANs represent a diverse group of peoples with 574 federally recognized tribes in 37 states. Additionally, there exist 63 state recognized tribes as well as people who have AI/AN ancestry but do not possess documentation to become an enrolled member of their tribe. The decimation of tribal peoples continues to have ramifications in modern AI/AN identity and manifests in not qualifying for dental health benefits through Indian Health Service, an agency within the Department of Health and Human Services that provides federally funded and operated health care, including dental.<sup>12</sup>

*Today, AI/ANs represent a diverse group of peoples with 574 federally recognized tribes in 37 states. Additionally, there exist 63 state recognized tribes as well as people who have AI/AN ancestry but do not possess documentation to become an enrolled member of their tribe.*

The health care for Native peoples was not a consideration in establishing the United States. The War Department in the 1800s created Federal Indian policy that focused on military confinement of tribes while ancestral lands were taken.<sup>12</sup> In 1921, over a century after treaty rights were established, the Snyder Act provided a clear mandate for healthcare rights and improved healthcare to the AI/AN community.<sup>13</sup> Since then, care provided continues to be underfunded and under delivered. Currently, the prevalence of untreated caries in AI/AN adults is twice that of an average American adult, and our people have the highest rate of caries of any ethnic group in the United States.<sup>14</sup> AI/AN adults compared to the general U.S. population are more likely to have severe periodontal disease, more missing teeth, and are more likely to report poor state of oral health, higher prevalence of oral pain, and avoidance of certain foods due to the status of their oral health.<sup>14</sup> The oral health of AI/AN children is also of concern as the likelihood that they have untreated dental caries in primary teeth is twice that of an average American child in addition to having a five-fold likelihood to have permanent teeth with untreated dental caries.<sup>15</sup> Consider the violent history of

colonization as part of the context of why Native Americans currently suffer from the worst oral health outcomes in comparison to any racial or ethnic group within the United States. Consider, additionally, how AI/AN providers can uniquely address these traumas through shared experiences and working towards elevating fellow tribal members into our profession.

The Society of American Indian Dentists was founded by the first American Indian dentist, George Blue Spruce, Jr. (DDS, MPH) and colleagues in 1990. Although SAID has been working towards the inclusion of AI/ANs in dentistry for over thirty years, there has been very little improvement in the representation of AI/AN people in the profession of dentistry. According to the American Dental Education Association the number of AI/AN students applying to dental school has actually decreased significantly over the past decade with a record high of applicants, 92 in 2006, and a record low of AI/AN over the past 20 years of 16 AI/AN dental school applicants in 2019.<sup>16</sup> The AI/AN students also see a lower matriculation rate in comparison to other minority groups. For example in 2019, 31% of AI/AN applicants who applied were accepted,

while Black or African American students matriculated at a rate of 50%, and Hispanic or Latino students matriculated at a rate of 52%. This is in comparison to white students matriculated at 59%.<sup>16</sup> This is unacceptable. The Society of American Indian Dentists needs additional support from allies in our mission. With a current membership just shy of 100 members, it is challenging to reach our growth rate goal of 20% per year. We cannot reach this goal without the help of the gatekeepers to the profession of dentistry. SAID wants to recruit more youth to consider dentistry as an attainable profession for our communities. The Society of American Indian Dentists calls to action leaders in our tribal communities, grade school educators, and current American Indian Dentists to mentor young people as they consider pursuing a dental education. We call for the support of leaders in higher education to be aware of Native issues and guide those indigenous youth that have already begun the process of attaining the coursework and grades needed to gain acceptance into dental school. We implore support from college pre-dental advisors, our dental peers and colleagues, dental school deans and admissions committees, and leadership from majority dental organizations. Diverse organizations like ours play a key role in advocating for and providing resources to indigenous students throughout their pre-dental career as well as once they start dental school, and other dental organizations can help us in our goal to increase our numbers. Our perspective and our presence provides hope for the next generation—that they may see structural changes within the dental profession to include and hear Indigenous voices.

To learn more about us, visit our website at: <http://www.thesaidonline.org/>

## REFERENCES

1. Dunbar-Ortiz, R. (2015). *An Indigenous Peoples' History of the United States*. Boston: Beacon Press.
2. Patrick, D. L., Lee, R. S. Y., Nucci, M., Grembowski, D., Jolles, C. Z., & Milgrom, P. (2006, June). Reducing oral health disparities: a focus on social and cultural determinants. In *BMC oral health* (Vol. 6, No. 1, pp. 1-17). BioMed Central.
3. Heaton, B., Crawford, A., Garcia, R. I., Henshaw, M., Riedy, C. A., Barker, J. C., ... & Native Oral Health Project. (2017). Oral health beliefs, knowledge, and behaviors in Northern California American Indian and Alaska Native mothers regarding early childhood caries. *Journal of public health dentistry*, 77(4), 350-359.
4. Adrienne Nishina, Jakeem Amir Lewis, Amy Bellmore & Melissa R. Witkow (2019) Ethnic Diversity and Inclusive School Environments, *Educational Psychologist*, 54:4, 306-321, DOI: 10.1080/00461520.2019.1633923
5. Formicola, A. J. (2017). Current state of dental education: executive summary. *Journal of dental education*, 81(8), 1008-1014.
6. Murdoch-Kinch, C. A., Duff, R. E., Ramaswamy, V., Ester, T. V., Sponseller, S. A., & Seeley, J. A. (2017). Climate study of the learning environment for faculty, staff, and students at a US dental school: Foundation for culture change. *Journal of dental education*, 81(10), 1153-1163.
7. Ester, T. V., Tucker-Lively, F. L., Smith, C., Taylor, G. W., Ware, T. K., & Inglehart, M. R. (2021). The status of climate studies in the United States and Canadian dental schools: Deans' perspectives. *Journal of Dental Education*.
8. McCann, A. L., Lacy, E. S., & Miller, B. H. (2014). Underrepresented minority students' experiences at Baylor College of Dentistry: perceptions of cultural climate and reasons for choosing to attend. *Journal of Dental Education*, 78(3), 411-422.
9. Rivera, N., Feldman, E. A., Augustin, D. A., Caceres, W., Gans, H. A., & Blankenburg, R. (2021). Do I Belong Here? Confronting Imposter Syndrome at an Individual, Peer, and Institutional Level in Health Professionals. *MedEdPORTAL*, 17, 11166.
10. 10) Gampa V, Bernard K, Oldani MJ. Racialization as a barrier to achieving health equity for native Americans. *AMA J Ethics*. (2020) 22:874-81. doi: 10.1001/amajethics.2020.874
11. American Dental Association Health Policy Institute. <https://www.ada.org/en/science-research/health-policy-institute/publications/infographics>, 2021. Accessed September 1, 2021
12. Indian Health Service. (n.d.). About IHS. Indian Health Service. Retrieved September 9, 2021 from [www.ihs.gov/aboutihs/](http://www.ihs.gov/aboutihs/) Accessed September 1, 2021.
13. Trout L, Kramer C, Fischer L. Social Medicine in Practice: Realizing the American Indian and Alaska Native Right to Health. *Health Hum Rights*. 2018 Dec;20(2):19-30. [PMC free article: PMC6293359] [PubMed:30568399]
14. Phipps K.R. & Ricks T.L. (2016, March). The oral health of American Indian and Alaska Native adult dental patients: results of the 2015 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service.
15. Phipps K.R. & Ricks T.L. (2017, April). The oral health of American Indian and Alaska Native children aged 6-9 years: results of the 2016-2017 IHS oral health survey. Indian Health Service data brief. Rockville, MD: Indian Health Service.
16. American Dental Education Association. U.S. Dental School Applicants by Race and Ethnicity, 2021



## A Case for Inclusion

# The ADA Perspective: Embracing Diversity, Equity, and Inclusion

Cesar R. Sabates  
President-elect, American Dental Association

In everything we do, the American Dental Association strives to fulfill its mission—to help all dentists succeed and support the advancement of public health—and to be led by its vision of achieving optimal health for all.

As the president-elect of the ADA, I recognize that the elements of how we succeed are multifaceted. But I also believe that by adhering to our values—two of which are diversity and inclusion—we will succeed in driving dentistry forward.

Taking a stand on health equity is one way to bring these principles to life.

Although the COVID-19 pandemic is a once-in-a-lifetime phenomenon, it has shed light on blatant inequities that have plagued our health care system for decades. The data are clear—communities of color have been disproportionately more affected by COVID-19. But the

*Although the COVID-19 pandemic is a once-in-a-lifetime phenomenon, it has shed light on blatant inequities that have plagued our health care system for decades. The data are clear—communities of color have been disproportionately more affected by COVID-19. But the issue is bigger than this pandemic alone, and the topic of health equity has come to greater prominence throughout all of health care.*

issue is bigger than this pandemic alone, and the topic of health equity has come to greater prominence throughout all of health care.

The ADA's Health Policy Institute published infographics highlighting racial disparities in oral health, indicating that Black and Hispanic people across all age groups are most likely to face cost barriers to dental care. The data also find that racial disparities in cost barriers have widened for adults and senior citizens.

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Economic opportunity, education level, prejudice, as well as care quality and access are among the social factors that can determine the extent of a person's sickness or health. Generally, populations in poverty-stricken and remote rural communities have higher rates of dental disease but are less likely to have a dental home.

Oral health is an important part of overall health. As leaders in dentistry,

ADA would fall woefully short of its vision to achieve optimal health for all. Call it ambitious, call it difficult—but with the careful planning and stakeholder collaboration, oral health equity is possible.

The ADA is also imagining what's possible for its members in the spaces of diversity, equity, and inclusion. The ADA, through the work of its Diversity and Inclusion Committee, has made considerable strides toward

yet, in my opinion, many of them still face the unfairness of a gender pay gap and unjust treatment by their male colleagues as they juggle their professional passions with personal responsibilities.

Racial and gender diversity within the dentist workforce have implications on health access and equity—nearly half of female dentists participate in programs like Medicaid or CHIP, compared to 41 percent

*Embracing diversity, equity, and inclusion ensures that we stay in alignment with dentistry's foremost obligation to help and heal. It also helps us keep the ADA's fundamental promise to serve and support the talented thousands who comprise our Association and drive dentistry forward each day.*

the ADA has a responsibility to shape the discourse on oral health equity and influence future policy on this issue. We have already taken steps in that direction, with efforts like the Emergency Department Referral and Community Dental Health Coordinator programs under the Action for Dental Health Initiative. This fall, a resolution on health equity proposed by the ADA Council on Access, Advocacy, and Prevention will be voted on by the House of Delegates.

There are also thousands of dentists in our nation who dedicate their time and talents to serve vulnerable communities every day. The ADA wants to continue bolstering their efforts.

I believe that it would be unconscionable not to lend our strength to meeting the national challenge of health equity. If we don't, the

embracing the diverse segments of its membership. Programs such as the Institute for Diversity in Leadership, the Accelerator Series, and Amplifying Voices are magnifying the valuable perspectives and experiences of dentists from traditionally underrepresented backgrounds.

Racial diversity in dentistry has not kept pace with that of the overall U.S. population. Although Asian dentists account for much of the workforce's diversity, the share of Hispanic dentists has gone up only slightly and the share of Black dentists has not changed at all.

Conversely, the percentage of female dentists and female dental school graduates has increased in the last ten years. Female dentists are expected to account for 50 percent of all U.S. dentists by 2039. And

of male dentists. Black, Hispanic, and Asian dentists are more likely than White dentists to participate in Medicaid or CHIP.

We want to build an Association that provides members an equitable opportunities to thrive in their careers and at the ADA, including within leadership positions. We want to build an Association where all members feel seen, heard, valued, validated, and cared for.

Embracing diversity, equity, and inclusion ensures that we stay in alignment with dentistry's foremost obligation to help and heal. It also helps us keep the ADA's fundamental promise to serve and support the talented thousands who comprise our Association and drive dentistry forward each day.

## INTERACTIVE FEATURE

### Earl Sewell Interviews Dr. Carlos Smith About Leadership and Ethics



*Listen to the interview*

The background of the image is a dark blue gradient. In the center, there is a faint, stylized outline of a tooth. Radiating from the top of the tooth are numerous thin, light blue lines that spread outwards, creating a sunburst or starburst effect across the entire background.

# ACD

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American College of Dentists