The Oppositional Social Justice-Oriented Dentist:

An emerging framework for dental professional education

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Abstract

A group of three administrators at McGill University's Faculty of Dentistry collaborated to mobilize an educational response to controversial and revelatory events which transpired at a faculty of dentistry in Atlantic Canada in the 2014-2015 academic year (Backhouse et al. 2015; CBC News, 2014, 2015). The author of this thesis, being one of those collaborators, relinquished their role as an administrator. They turned to their roots in popular education, and pursued a graduate degree in education to unearth possibilities for integrating a social justice course in McGill University's Doctor of Dental Medicine (DMD) program. A notable outcome of these events was the creation of a mandatory course on social justice, oral health, and professionalism in the fall of 2016 - DENT 206: Dentistry Social Justice Seminar. Through a qualitative paradigmatic case study, I conceived a conceptual educational tool grounded in a social justice reimagining of the humanistic aspects of dental professional education. This tool was then transposed to serve as: 1) a social justice-oriented conceptual guide for dental educators and curriculum writers, and 2) an analysis framework to assess the nascent course's attendance to a social justice-oriented professional development of McGill's dental students. Ultimately, this thesis endeavored to demonstrate the possibilities in merging two ostensibly diverging areas of education while generating concrete content development work for McGill's DENT 206.

Keywords: dental education, professional programs, social justice, critical education, case study, health inequality, healthcare.

Résumé

Trois administrateurs académiques à la Faculté de médecine dentaire de l'Université McGill ont collaboré pour répondre aux évènements controversés et révélateurs qui ont eu lieu à une autre faculté de médecine dentaire des Maritimes durant l'année scolaire 2015-2016 (Backhouse et al., 2015; CBC News, 2014, 2015). L'auteur de cette dissertation, étant l'un de ces collaborateurs, a cédé son rôle administratif. Il a décidé de retourner à ses racines en éducation populaire, et d'obtenir une maîtrise en éducation afin d'explorer l'intégration d'un cours en justice sociale dans le programme de Doctorat en médecine dentaire (DMD) à McGill. Ces évènements ont mené à la création d'un cours obligatoire sur la justice sociale, la santé buccale, et le professionnalisme débutant à l'automne 2016 – DENT 206 : Dentistry Social Justice Seminar. Basée sur une étude de cas qualitative et paradigmatique, j'ai conçu un outil pédagogique et conceptuel fondé sur une reconceptualisation de la formation humaniste des professionnels dentaires dans un cadre de justice sociale. Cet outil a été transposé afin de servir : 1) un guide conceptuel pour éducateurs et spécialistes en gestion de curriculum, et 2) de cadre analytique permettant d'évaluer la sensibilité de DENT 206 au développement professionnel des étudiants axé sur la justice sociale. En fin de compte, cette dissertation s'est efforcée de démontrer le potentiel que représente une fusion de deux domaines d'éducation ostensiblement divergents tout en générant des tâches concrètes pour développer le contenu de DENT 206 de McGill.

Mots clés: éducation dentaire, programmes professionnels, justice sociale, pédagogie critique, étude de cas, inégalités en santé, santé.

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Preface

As the primary author of this thesis, I, Emil Briones, performed the theorizing, research, and writing required for its completion. My supervisors, Drs. Philip S.S. Howard and Shaheen Shariff, provided feedback and guidance in the conceptualization and presentation of this thesis. My colleagues Chloe Garcia, Shannon Hutcheson, Sarah Lewington, and Ayesha Vemuri provided feedback for Chapters 5 and 6, and peer-checked my research findings and the assertions pursuant to them. Sarah Lewington and Jayne Malenfant provided copy-editing support for Chapters 1 through 4.

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Chapter 1: Introduction

A Rude Awakening

In 2014, a scandal was brought to public attention concerning an incident at Dalhousie University's Faculty of Dentistry in Halifax, Nova Scotia. Thirteen male-identified students were found culpable of posting sexually violent, misogynistic, and homophobic comments on a secret social media page titled *Class of DDS 2015 Gentlemen* (Backhouse et al., 2015; CBC News, 2014, 2015). One screenshotted post read: "*Penis, the tool used to wean and convert lesbians and virgins into useful, productive members of society*"; to which another student replied with the following comment: "*and by productive I'm assuming you mean it inspires them to become chefs, housekeepers, babysitters, etc.*" (Backhouse et al, 2015, p. 7; CBC News, 2014). Another notorious post contained a photo of a man standing behind four female dentists which included a caption suggesting that it was a depiction of a fellow male student masturbating to his colleagues (Backhouse et al., 2015, p. 8). Approximately fifty posts were leaked to the media and the administration - some of which were photos of the contributors' peers at Dalhousie accompanied by sexually violent commentary.

The controversy prompted emotionally charged debate within the oral health community, institutions of higher learning, and the general public. A notable outcome of this incident was the striking of the *Taskforce on Misogyny, Homophobia and Sexism in the Faculty of Dentistry* (or henceforth the *Taskforce*) at Dalhousie (Backhouse et al., 2015). Led by legal and human rights scholars Drs. Constance Backhouse, Don McRae, and Nitya Iyer, the *Taskforce* scrutinized the institutional culture at Dalhousie's Faculty of Dentistry through: a scoping review of its policies and practices; comparing these to other training institutions; uncovering how issues of harassment and discrimination are currently handled; and ultimately providing policy and

practice recommendations geared towards implementing mechanisms to address anonymous reports of misogyny, sexism, and homophobia (see *Taskforce* website landing page).

What the *Taskforce* unearthed was an unsettling truth – that an ecology of heterosexism, misogyny, and abuses of power thrived within (and beyond) the walls of Atlantic Canada's only dental professional training school. The investigation brought to light the existence of a graffiti wall installed in the Dalhousie dental students' lounge, *The Cavity* (Backhouse et al., 2015, p. 1). The wall was adorned with homophobic, misogynistic, and racist remarks, with a notable proportion of them containing sexually violent content. The *Taskforce* found that there have been a number of requests from students to have the wall painted over – requests which were either denied or ignored. A possible explanation for tolerating its existence was that the wall carried historical and cultural weight for some alumni. The *Taskforce* further reported that *The Cavity* served as a venue for alumni events and that attendees would "*regale listeners with stories of what they had written*" (p. 19; emphasis added). The graffiti was shown to have been in existence for many years and in the *Taskforce*'s interviews of faculty, none expressed chagrin nor a desire to remove it (p. 37). Tolerance of such behaviours and experiences were indicative of social conditions at Dalhousie's Faculty of Dentistry which sustain sexism, homophobia, and racism (p. 3). The scandal, and the subsequent outcomes and conclusions of Backhouse, McRae, and Iyer's (2015) systematic investigation served as a tragic and hopeful reminder that educators must interface with their moral duty: that we are in a position to challenge a history and a material reality of oppression. The *Taskforce* leads emphasize in their report that the Dalhousie incident is not detached from a larger cultural landscape of inequalities and tacit acceptance of abusing power (p. 2). Further inaction on our part as educators, administrators, and leaders is to be complicit with a troubling status quo (Briones, 2017, p. 64).

The Fruit of Collaboration

At the time the Dalhousie scandal broke out, I was working as an academic affairs administrator at McGill University's Faculty of Dentistry. I was part of the administrative team that coordinated academic logistics for the Doctor of Dental Medicine (DMD) program. My position was specifically responsible for managing curriculum development initiatives chaired by the Associate Dean of Academic Affairs, Dr. Shahrokh Esfandiari. When news of the Dalhousie *Class of DDS 2015 Gentlemen* controversy made its way through dental education and oral health professional channels, I, Dr. Esfandiari, and the administrative director of the academic affairs team, Ms. Nikoo Taghavi, felt compelled to act in light of these distressing events. Dr. Esfandiari and Ms. Taghavi knew of my prior experience in popular education and institutional equity work. With their blessing and encouragement, I took on a spearheading role in our shared desire to be proactive on these issues.

In consideration of the specificities of the Dalhousie scandal, Ms. Taghavi contacted Dr. Shaheen Shariff, an education and law scholar at McGill's Faculty of Education whom she had met at a cyberbullying workshop. Through this connection, I enrolled as a graduate student at McGill's Faculty of Education and was hired a researcher on Dr. Shariff's SSHRC Partnership Project *IMPACTS: Collaborations to Address Sexual Violence on Campus* (Shariff, 2016).

Central to my duties as a graduate student and research assistant is to develop educational interventions to address social inequality and intersecting manifestations of oppression in the oral healthcare area. In the 2016-2017 academic year, I piloted a lecture-workshop series in collaboration with Shanice Yarde (Equity Education Advisor at the Social Equity and Diversity Education Office of McGill), Chloe Garcia, Shannon Hutcheson, Sarah Lewington, and Ayesha Vemuri (the latter three are fellow *IMPACTS* research assistants). In the Fall 2017 semester, the

lecture-workshop series became a stand-alone mandatory course in McGill's Doctor of Dental Medicine (DMD) program, *DENT 206: Dentistry Social Justice Seminar* (Briones, 2016). What started as a "reactionary" response to a public scandal is now part of a long-term initiative to educate future dental practitioners on social and health inequality. The course aims to provide dental students with the tools to be social justice-minded, to connect students with their power to instigate change social change, and to reclaim their roles in a larger movement for transforming healthcare and society (Briones, 2016; 2017).

Reorienting Towards Social Justice

Upon assuming the roles of emerging researcher and social justice educator at McGill's Faculty of Dentistry, I began to consider the interplay between oral health professional education, and health and social inequality within the Canadian and American oral healthcare arena. The American Dental Education Association (2016a) implored training institutions to take a proactive role in addressing oral health inequalities, as evidenced by dental public health research which indicates that these inequalities will worsen should no concrete action be taken (see also Albino et al., 2012; Dharamsi & MacEntee, 2002). Research demonstrates that oral health inequality is a glaring concern among historically and systemically disadvantaged social groups in Canada and the United States, namely racialized persons, Indigenous communities, persons living in poverty, gender and sexual minorities, persons with disabilities and so on (e.g. ADEA, 2016b; Albino et al., 2012; Behar-Horenstein et al., 2015; Dharamsi & MacEntee, 2002; Labby, 2017; Mays, 2016; Otto, 2017). Much of this research also critiques the predominantly privatized profit-driven nature of oral health services (Afrashtehfar & Chung, 2017; Dharamsi & MacEntee, 2002; Otto, 2017; Raja et al., 2015b, p. 1205).

My initial research activities, which included a scan of relevant news media, further revealed a selection of publications detailing other scandals implicating health care professionals (Bird, 2016; CBC News, 2015, 2017; Dhillon, 2016; Jaffe, 2017; Labby, 2017, Proctor, 2015). In 2015, a dentist and former senior administrator at a western Canada dental school underwent investigation for misappropriation of funds from a dental outreach project he led (Dhillon, 2016; Proctor, 2015). The investigation found that millions of dollars were unaccounted for in an audit of an oral health initiative for the Haida people in Haida Gwaii. In 2017, Mary Otto published a book detailing the history of oral health and inequality in the United States (Otto, 2017). A central narrative in her work was the story of Deamonte Driver, a 12-year-old Black child from an impoverished neighbourhood in the Washington DC area, who died from complications of an infected tooth. Deamonte's family struggled to find a dentist in their area willing to take a Medicaid patient, so much so that they had to extend their search to other states. The difference between life and death for the Deamonte could have been no more than 80.00 USD for a simple extraction. These stories call into question the ways in which healthcare professionals are taught to behave ethically and to navigate their role in socially responsible ways, further calling attention to Backhouse, McRae, and Iyer's (2015) assertion that the incident at Dalhousie should be viewed as entrenched in a broader social and material context. In line with the ADEA *Statement on the Roles and Responsibilities of Academic Dental Institutions* (2016a) and the CDA *Position on Access to Oral Health Care for Canadians* (2010), I argue that training institutions have a moral responsibility to respond to these social problems through their educational mandate – the status quo is unacceptable (Backhouse *et al.*, 2015, p. 2).

Turning to social justice education. Prior to my tenure as an academic affairs administrator at McGill's Faculty of Dentistry, I was involved in community-based anti-

oppression education (Clare et al., 2014; Student Housing and Hospitality Services, SACOMSS et al., 2011; see also Students of Colour Montreal, n.d.). Most of this work involved facilitating anti-racism, gender expansive, and anti-violence workshops and teach-ins for youth in universities and colleges in Montreal. When I was approached by McGill Dentistry's administration to create a social justice course, my practice was necessarily informed by these past experiences in popular education and activism. The first offering of *DENT 206: Dentistry Social Justice Seminar* in the 2016-2017 was a crystallization of my past experiences, my collaborative relationships with other anti-oppression educators, and a shared desire to address the issues raised by the Dalhousie incident in 2014 (Briones, 2017, pp. 64-65).

When my teaching and course development duties became the subject of my graduate work, I necessarily engaged with scholarly literature which informed the maturation of DENT 206. Encountering two key pieces of literature in the field of medical education (not dental education) were turning points in my lines of thinking about social justice education in a dental professional program. Cultural competency (which at times is used interchangeably with multicultural education) is a widely used model to educate on diversity at Canadian and American dental schools (Albino et al., 2012, p. 82; ADEA, 2015; ADEA, 2016a, p. 885; Behar-Horenstein *et al*., 2015, p. 1197; Isaac et al., 2015; McCann et al., 2014). Scholars of medical education Kumagai and Lypson (2009) problematize cultural competency through mobilizing the Freirian concept of critical consciousness. The authors argue that cultural competency sets up expectations for learners to achieve "static outcomes" – diversity checkboxes which can be ticked off – rather than encouraging an ongoing process of developing complex and sophisticated views of health disparities and society at large (p. 783). Metzl and Hansen (2014) likewise complicate and trouble cultural competency as a dominant educational model, citing its

unresponsiveness to larger social conditions. Their response is **structural competency**. Rather than fixating on "markers of difference", they argue for shifting a critical eye onto material and ideological structures which underpin what is ostensibly treated as social difference (p. 126). Though a structural competency framework, the authors advocate that service providers would be able to disentangle the physiological dimensions of illness with the socio-political and institutional forces which give rise to stigma and inequality (p. 128).

Given my own background in social justice education and community work, and my exploration of the literature, I inevitably questioned the absence and/or the lack of visibility of concepts such as structural inequality and critical consciousness in scholarly works on dental education (Briones, 2017). Oral health inequality manifests at the individual level (Bird, 2016; Dhillon, 2016; Jaffe, 2017; Labby, 2017; Proctor, 2015) to the institutional and systemic levels (ADEA, 2016a; Albino et al., 2012; Behar-Horenstein et al., 2015; Dharamsi & MacEntee, 2002; Labby, 2017; Mays, 2016; Otto, 2017). I argue that the educational status quo in Canadian and American dental professional programs have to be challenged. The work herein looks to possibilities in social justice education to directly engage with the synergy between historical trajectories, social structures, and individual actors that underlie social inequality and oppression.

Personally, unearthing these possibilities through an express investigation into the convergences and divergences between social justice education and dental professional education might facilitate the development of my own teaching practice. More broadly, I endeavor to also ensure that the findings and syntheses emerging from this thesis result in palpable take-aways for other educators, and perhaps curriculum specialists, in professional dental training programs. First, I must elaborate on the grounding tradition of education in this investigation and illustrate the contours of social justice education to dental educators who might not have an explicit

background in it. The following section will summarize relevant theories and seminal works to better explore what it is that social justice education (SJE), as defined by Adams and Bell (2016), can offer dental professional education. This framework will include scholarship on critical pedagogy (e.g. Freire, 1970, 2000; hooks, 2004; Orelus, 2015) and popular education (e.g. Choudry, 2015; Gordon & Ramdeholl, 2010; Rizvi, 2007) in recognition of SJE's genealogical ties to them.

Chapter 2: Conceptual Framework

Dr. Mary Bassett, Health Commissioner of the City of New York, used her experiences and meditations as a physician and activist to elaborate on *Why your doctor should care about social justice* in a 2015 TEDMed Talk. One of her key messages is as follows: "…inequities are embedded in the political and economic organizations of our social world often in ways that are invisible to those with privilege and power." In the previous chapter, I established the presence of both macro- (e.g. structural and systemic) and micro-scale (e.g. unethical behaviours) issues in oral healthcare – issues entangled in systemic oppression and social inequality (Albino et al., 2012, p. 83; ADEA, 2016a; Otto, 2017) which give rise to oppressive individual and institutional activities (Bird, 2016; CBC News, 2014, 2015; Dhillon, 2016; Jaffe, 2017; Labby, 2017; Proctor, 2015). To effectively formulate an educational framework that directly engages with the systemic underpinnings of these medico-social problems, I will ground this thesis in a social justice theoretical foundation. This theoretical framework was chosen accordingly with a central argument of this thesis: that Canadian and American dental professional programs are not adequately equipping oral healthcare providers with the necessary tools to: 1) foster social justice-oriented professional behaviours, and 2) gain a critical understanding of their roles in both perpetuating and disrupting systemic health and social inequality. This chapter will elaborate on social justice education and critical pedagogy – a tradition of oppositional pedagogy (Shick, 2000, p. 87) within the discursive field of social justice education rooted in social and popular movements.

I will first provide general contours of what this thesis understands as social justice education and critical pedagogy (e.g. Farahmandpur, 2009; Freire, 1970, 2000; hooks, 1994 etc.). To follow will be an overview of social justice education within the context of educating the

privileged in consideration of the elitism entangled with dental professional education. This conceptual anchor is significant in this thesis in accounting for the often problematized asymmetrical focus on marginalized and socially oppressed identities and experiences (see Potts & Brown, 2015, p. 19). After, I will elaborate on what it means to reverse the gaze via social justice and critical pedagogical practices, and to tap into learning through discomfort and emotions (e.g. Zembylas & McGlynn, 2012). This general concept further confronts the elitism with which social justice educators in dental education must contend, and provides openings (via learning through discomfort and emotionalities) to challenge the "privileged ways of knowing and doing" woven into the culture of the dental profession (see Howard, 2010, p. 89). Lastly, I will elucidate on an integral component of social justice – dreaming and working towards transformed socially just futures (e.g. Bleakney & Morrill, 2010, p. 140; Choudry, 2015, p. 90). Here, I will tease out concepts from scholarly work which have advocated for this foundational objective in learning for social justice.

Social Justice Education and Critical Pedagogy

Farahmandpur (2009) champions that critical pedagogy is a powerful educational tool which confronts contemporary conditions of inequality and oppression and opens up possibilities for transformative change:

> A critical reading of the world involves *denouncing* the existing oppression and injustices in the world. At the same time, it involves *announcing* the possibility of a more humane and just world… Denouncing the world is an act that involves criticizing, protesting, and struggling against domination and domestication. On the other hand, the act of announcing a new world entails hope, possibility, and envisioning a new democratic society. (p. 113)

The emergence of critical pedagogy and popular education theories can be attributed to the seminal works of Paulo Freire (1970, 2000) and bell hooks (1994). Freire, considered to be a

pioneering figure for critical pedagogy, first published *Pedagogy of the Oppressed* in 1968. In this seminal work, he documented and theorized on his experiences working with agrarian and working class peoples in mid-twentieth century Brazil. With the lens of learning for liberation and action, Freire coined the term "conscientize" which refers to the politicization of one's sense-making of their world. Kumagai and Lypson (2009), who deploy Freirean theories in their critique of mainstream views of critical thinking in medical education, advocate that to "conscientize" is to engage both "cognitive and affective" dimensions to create collaborative action-oriented discourse grounded in human relationships (Freire, 1993; as cited in p. 783).

Another seminal work in the tradition of critical pedagogy is *Teaching to Transgress* by bell hooks (1994), which takes a Black feminist approach to emancipatory learning. Consonant with Freire's ideas, hooks posits learners' lived experiences as sources of knowledge and understanding for the greater goals of liberatory practice. Freire (1970, 2000) advocated that through dialogue, facilitated by an educator who values student/participant voices (hooks, 1994, p. 15; see also Bofelo et al., 2013, p. 513 and Kumagai & Lypson, 2009, p. 784), there might be critical advances in the way individuals understand legacies and systems of oppression as they pertain to their own experiences. Orelus (2015), whose work draws from Freire and hooks, maintains that critical pedagogy affords learners "the ideological tools to question commonsensical knowledge", to challenge oppressive norms, and the impetus to do change-making work beyond the classroom (p. 1; see also Austin & Paré, 2009, p. 112).

Though the theories and practices which coalesce as critical pedagogy emerged out of capacity-building for those in marginalized social locations, this thesis taps into a particular branch of social justice education that is concerned with the education of the privileged. Potts and Brown (2015) term this as "reversing the gaze", a response to a trend whereby individuals of

the academy have disproportionately focused on marginalized individuals and groups, which the authors argue have created a gap in the ways social injustice is understood (p. 19). Therefore, I will draw from works which have mobilized social justice and critical pedagogy tailored to addressing those dominantly located (e.g. Gaztambide-Fernandez & Howard, 2010; Howard, 2010; Howard, 2006; Hsia, 2010; Schick, 2000 etc.). I forward that social justice education is a tradition that is not singularly *concerned* with those systematically oppressed, but also with opening up possibilities for the privileged and elite to understand their role in learning and acting for social justice and transformative change. Further, it must be clarified that the work herein does not argue that all dental students and professionals are uniformly privileged and powerful. McCann *et al.* (2014) and Tiwana *et al.* (2014) have documented the ways in which gender and racialized minority dental students experience alienation and discrimination during their training years. This thesis hones in on the power and privilege central to the identity of an elite healthcare practitioner (see ADEA, 2016b), and as Nash (2010) states:

> Professions are professions because of the power differential that exists between them and those seeking their help. Such power, based in the professionals' knowledge and skills, requires that those seeking their help trust that health professionals will always use the power they possess in their patients' best interest. (p. 573)

I endeavor to uncover the possibilities in social justice education and critical pedagogy in creating an emerging educational tradition in dental programs which will help students critically understand the power afforded to them as health professionals. The work here further argues that a social justice-oriented approach shines light on the ways a dentist qualitatively understands their professional power and social privilege as linked to: their positions in broader society, their ability to determine appropriate professional behaviours, and how these play out with regards to health inequality and systemic oppression.

Educating the privileged. Bearing in mind that educating future dental professionals for social justice inevitably means educating within an elite environment and individuals who will wield powers attached to an elite health profession (ADEA, 2016b; ACFD, 2016; Backhouse et al., 2015; see also Kumagai & Lypson, 2009, p. 785; Nash, 2010, p. 573), this thesis attends to social justice educational scholarship that speaks to such contexts. Social justice education for emerging dental professionals necessitates instilling an understanding of one's privileged social location and the powers afforded to one occupying such a location. Gaztambide-Fernandez and Howard (2010), in their examination of upper-class students engaged in social justice learning, assert that "challenging a culture of affluence" is foundational to teaching the privileged about social inequality and injustice (p. 2). They adhere to this objective, arguing that a general inattentiveness to the study of privilege and the privileged not only signals a gap in educational research, but also a void in the ways social injustice and inequality are understood (p. 1). In consideration of the powers and privileges granted to dentists, this thesis will move forward by disinterring the ways social privilege and elitism shape teaching for social justice within a healthcare professional training program.

Howard (2006) problematizes the ways in which racially privileged students often fail to acknowledge their embroilment and personal accountability within a racist society. He further calls attention to how obscuring the direct links between one's racial dominance and another's racial subjugation as a way to shed personal accountability in doing anti-racism work (p. 43). Smith (2016) echoes and extends this, in championing a social justice praxis which forms "alliances [both] based on shared victimization [and shared] complicity in the victimization of others" (p. 69). Dissociating oneself from systemic oppression and disclaiming one's entanglement might be a tool for socially advantaged individuals to preserve their (unearned)

dominant positions in society (Howard, 2006, p. 45; Weis, 2010, p. vii). McIntosh's (1988) seminal work, *The Invisible Knapsack of Privilege*, argues that concealing privileges afforded to those in favoured social locations functions to leave them unchallenged this perpetuating the legitimization an unequal status quo (as cited in Howard, 2010, p. 79).

This thesis thusly hopes to accomplish a "reversal of the gaze" (Potts & Brown, 2015, p. 19) to bring to light the power and privilege fundamental to the identity of oral healthcare professionals, and discuss how such a task is essential to the development of a social justice educational framework. A critical look into the social and material clout of the dental professional is contingent on creating educational conditions that nourish a socially-just awareness of service-provider behaviours and an understanding of one's role in reproducing inequalities. Hsia (2010) illustrates the aspirational idea of professionals, academics, or anyone in society with particular access and power to affect others' lives with the heuristic of the "conscious wolfman" (p. 116). This prompts an exploration of how social justice education can be operationalized in dental education to make conscious wolfpersons out of oral health professionals. How could a social justice-oriented professional training program for dental care providers provide avenues to "step outside privileged ways of knowing and doing" (Howard, 2010, p. 89)? A social justice-oriented framework for dental education is founded on students gaining a critical understanding of the powers and privileges attached to donning the role of a respected elite healthcare professional. Further, to be grounded in such a framework would facilitate a critical understanding of one's social and professional position can contribute to the advancement of health and social justice.

Reversing the gaze through SJE. Adams and Bell (2016) define social justice education as follows:

> [A]n interdisciplinary conceptual framework for analyzing multiple forms of oppression and a set of interactive, experiential pedagogical principles to help learners understand the meaning of social difference and oppression, both in social systems and in their personal lives. (p. ix)

The authors further describe social justice education as an explicit call to address both past and present power structures which determine social positions of dominance and subordination, wherein individuals and groups are categorized according to hegemonic constructions of identity informed by both historical and ongoing processes (p. xiii). Social justice education is likewise mired in a commitment to: 1) situating oneself in an interlocking array of social, material, and political forces (see Bannerji, 1995, p. 55), and 2) "recognizing the existence of multiple locations along the spectra of both privilege and politics" (Howard, 2006, p. 47). Operationalizing social justice within the educational mandate of a dental professional program then entails "locating oneself" (Absolon and Willett, 2005; as cited in Brown & Strega, 2015, p. 10). More specifically, the learner requires tools to situate oneself within systems of social relations and material entities that either privilege or oppress depending on the various axes of identity and experience comprising one's social location. For the purposes of this inquiry, I wish to call explicit attention to the "two-sidedness of oppression" (Howard, 2006, p. 47) and subvert the asymmetrical focus on the marginalized, underserved, or systematically oppressed individuals and groups (Tuck, 2009, pp. 409-412). In prioritizing the acquisition of a critical awareness of a dentist's privileged social and professional status, I will also explore the ways in which a social justice-oriented educational framework might critically unpack how privilege functions symbolically, materially, and ideologically, how it is rendered obscure, and how healthcare professionals construe health and social inequality (see McIntosh, 1988; as cited in Howard, 2010, p. 79). Therefore, social justice education for a socially elite and privileged audience could benefit from unpacking one's complicity to (or direct participation in) the

continued subjugation of those in oppressed social locations (Brown & Strega, 2010, p. 10; Gaztambide-Fernandez & Howard, 2010, p. 2; Potts & Brown, 2015, p. 19; Weis, 2010, p. vii).

Howard (2006) brings up the challenges posed by those in privileged social locations who either are unaware, deny personal accountability, or legitimize the ways in which they benefit from unequal social systems and norms (p. 43). Gaztambide-Fernandez and Howard (2010) caution that characteristic of social justice teaching within a privileged environment are "complicated conversations" and challenging emotional requirements for both the educator and the learner to come to an "understanding [of] how the success of some relates to the failure of many" (p. 10). Resistance to social justice learning, as Shick (2000) puts, might be further entangled in identity formation processes for the dominantly located learner (p. 86). Her work calls attention to the ways in which an emerging dental professional might be invested in constructing the self as benevolent purveyors of healthcare, innocent of benefiting from and contributing to the ongoing subordination of the "other" (p. 91). Schick's study concluded that privileged learners might resist "oppositional pedagogies," such as those in the traditions of social justice and critical education, as a means to preserve dominance and an identity of the "benevolent self" (p. 84). A claim to innocence from complicity to social injustice serves as method by which individuals with social privilege to protect one's entitlement to their advantaged position. Techniques that accomplish this outcome might also include proclaiming inculpability from oppressive behaviours and systems (p. 85), thus constructing the self as a respectable productive citizen and reinforcing the "otherness" of the socially marginalized (pp. 87-90). The mechanisms by which advantaged individuals and groups legitimize their positionalities may also be imbricated in meritocratic rationales – that their privileged status is the result of earning their advantages through hard work or an endogenous superiority (Howard,

2010, p. 89). A social justice framework would necessarily confront and interrogate this assumed benevolence - an inherent challenge in teaching for social justice in a health professional program (Schick, 2000, p. 98). An operative goal would then be reshaping a dental professional identity that is politically aware, self-critical, and (re)claims a professional duty to actively learn and work towards social justice ends, rather than the maintenance of respectability (Howard, 2010, p. 94; Schick, 2000, p. 96; Zembylas & McGlynn, 2012, p. 55). Works in the field of social justice and critical pedagogy have contended with learner resistance and have offered guiding theories and techniques.

Berry (2010) advocates for the necessity of "mutual vulnerability" (p. 21) between learner and educator in social justice spaces (p. 21). Informed by hooks' Black feminist approach to critical pedagogy, the author argues that it is necessary for a teacher of social justice to lean into challenging and emotionally conflicting learning experiences when politically engaging learners (see also Lugg & Shoho, 2006, p. 205). For these honest and difficult conversations to occur, the teacher/facilitator must foster a learning environment where students have the space and time to process their implication in systemic oppression (see Zembylas & McGlynn, 2012, p. 41). Brown and Strega (2015) relatedly describe the phenomenon of "uncomfortable reflexivity" which is when learning spaces "allow explanations to be messy, confessional, and tentative… sharing not only personal struggles experienced… but also... the political struggles that [one has] not necessarily resolved" (p. 10). It is not uncommon for privileged learners to experience cognitive dissonance when learning about social injustice. Gaztambide-Fernandez and Howard (2010) note that learning activities that task privileged students to complicate their views of their own social location challenge constitutive elements of their sense of self (p. 4). For one, the authors found that socially affluent students use an "imagined Other" as a relational tool for

identity formation (p. 4; see also Butler, 1992; as cited in Shick, 2000, p. 87). Of concern is how imagining the other can accompany negative beliefs such as attributing impoverished persons' circumstances to laziness or unwillingness to do hard work. Participants in Brantlinger's (1993) study on adolescents in elite schools discovered that these students accept the notion that their advantaged life situation is made possible through merit and hard work, rather than prosperous systemic realities and unearned privileges (as cited in Gaztambide-Howard, 2010, p. 3; see also Howard, 2006, p. 50). To disrupt one's understanding of their social world, one defined by deficit rationales of meritocracy (Fine & Ruglis, 2009, p. 20; Carpenter, 2016, p. 2) may be a process riddled with cognitive dissonance and discomfort (Brown & Strega, 2015, p. 10). Consequently, Zembylas and McGlynn (2012) identified these "discomforting" emotions can be tools for learning about justice and injustice. They coined the term "pedagogies of discomfort" to emphasize "the need for educators and students alike to move outside their 'comfort zones'" (p. 41). The authors put forward that reflecting through and on the emotions associated with a certain learning experience can provide openings for the educator and learner to critique normalized status quo ideologies, practices, and norms that prop up social injustices (pp. 41-42). They further posit that through stirring critical self-reflection, pedagogical exercises that interrogate the affective aspects of one's understanding of their position within a landscape of social inequity can provide opportunities to learn for social justice (p. 55). In agreement with the position of Lugg and Shoho (2006), I further contend that those dominantly located in society are well positioned to take part in the "risky" work of social justice (p. 205). Educating individuals who might ascend to power and privileged social locations, namely oral health care professionals, must come with the understanding that social responsibility might involve risk-taking, learning hard truths, and participating in the potentially daunting work of transformative

social change. In spite of the challenging realizations that social justice education might uncover, "willful ignorance" to the social hierarchies and material realities that delineate dominance and exclusion will perpetuate the very social relations of oppression embedded in oral health inequality (see Howard, 2006, pp. 45, 53).

Bodies which govern the educational standards and missions of Canadian and American training programs uphold that a good dentist is one who espouses an ethic of responsibly using one's professional power and privilege, demonstrates a commitment to being a purveyor of a democratic health service, and endeavors to challenge a status quo of health inequality (ACFD, 2016, p. 20; ADEA, 2016b, pp. 867-870). This thesis allies with these stances and advocates for a shift grounded in learning for equity and transformative change from the dental educational status quo. Developing a critical awareness and self-reflexive engagement as per status quo conditions of one's ideological, social, and material world, as Adams and Bell (2016, p. ix) stated, are fundamental to the mission of social justice education. Ahmed (2007, p. 594), Howard (2010, p. 80) and Choudry (2015, p. 88) likewise have explicitly supported this assertion. Scholars of dental and medical education have similarly affirmed this stance (Behar-Horenstein et al., 2015, p. 1189-1190; Isaac et al., 2015, p. 313; Koole et al., 2016; p. 1213; Metzl & Hansen, 2014, p. 128; Raja et al., 2015a, p. 47; Tiwana et al., 2014, p. 403). I moreover seek to couple the development of a critical social justice-oriented awareness with the fostering of a "culture of action and agency" (Choudry, 2015, p. 89). In order to fully explore the opportunities that social justice education can provide dental education, I will further unpack critical pedagogy (e.g. Berry, 2010, Freire, 1970, 2000; hooks, 2004; Orelus, 2015) and popular education (e.g. Austin & Paré, 2009; Choudry, 2015; Rizvi, 2007) due to the explicit calls to direct material action embedded in these traditions.

Hope and possibility. To echo the previously stated notion that educating elites, namely future dental care providers, on social justice involves a cognitively and emotionally challenging process (Brown & Strega, 2015, p. 10; Gaztambide-Fernandez & Howard, 2010, p. 3; Howard, 2006, p. 50), critical and popular education accepts that learning for freedom and justice necessarily means some form of struggle. To disrupt and confront one's accepted norms of one's social and material world, and to further critically deconstruct it, can be emotionally and cognitively demanding (Carter, 2013, p. 507; see also Choudry, 2015, p. 513; Gordon & Ramdeholl, 2010, p. 35; Kumagai & Lypson, 2009, p. 783). The educational traditions in this conceptual framework first and foremost are "grounded on the concern for human suffering," having the moral courage to oppose the systems and practices that give rise to such suffering, and building individual and community capacity to resist (Orelus, 2015, p. 2; see also hooks, 1994). Learning through struggle and resistance is a primary component of popular education – a tenet couched in the belief that suffering can be a source of knowledge (Bofelo et al., 2013, p. 513). Simultaneously unraveling a society wrought by unequal histories and unjust contemporary conditions, realizing one's complicity to injustice, and immersing the learning experience in the anguish of oneself and others, are difficulties inextricable from the undertaking that is learning (and acting) for social justice. Inherent in the practices of critical pedagogy however is a belief in hopeful possibilities and that justice is attainable in spite of the struggles and suffering in processes of social change (Farahmandpur, 2009, p. 114).

Critical education, though wary of the pitfalls of hopelessness in social justice education contexts, is sensitive to the delicate balance between speaking to truth and fostering the conditions for hope and action. Hope is integral to the practice of critical pedagogy and popular education and scholars of this field contend that a pedagogy of hope is indispensable when social

change is at the core of the educational mission (Bleakney & Morrill, 2010, p. 140; Choudry, 2015, p. 90). Bofelo et al. (2013) avow that "education must be seen in the broad context of bringing about change in intellectual understanding....and responding creatively to the conditions and realities of society" (p. 517). Moreover, hope and possibilities are only achievable with the formation of solidarities and democratic communities with shared goals of challenging and dismantling practices, institutions, and systems that perpetuate oppression and domination (Farahmandpur, 2009, p. 110; Gordon & Ramdeholl, 2010, p. 32; Smith, 2016, p. 66). Choudry (2015) further advocates that collective learning and action depend on "building collective spaces and movements in which…people can see themselves as...agents of change" (p. 88). Though critical pedagogy and popular education arose from the struggles of the socially oppressed (Freire, 1970, 2000), reversing the gaze onto those dominantly located also means that these individuals are vitally involved in working for socially-just change. Thus, the work herein is to develop an educational framework which teaches emerging elite healthcare professionals to repurpose their powers and advantages for social justice.

My goal in doing this work is not only to develop an educational praxis couched in hope and compassion, but also one that is contemplative of transformative socially-just possibilities in oral health care. In view of this, this conceptual framework acknowledges the position of Potts and Brown (2015) who suggest that doing change-making work for social justice can also be done in "dominant institutions", such as institutions of higher learning (p. 18). Gordon and Ramdeholl (2010) assert the importance locating "the cracks in which to work" (p. 34). Social justice, critical, and popular education challenge the imaginary lines between educational institutions and broader social and cultural landscape (Austin & Paré, 2009, p. 113). These are further contingent on a political engagement with the ideological and material entities in a given

learning context – recognizing the interconnectedness of all forms of systemic oppression (Bleakney & Morrill, 2010, p. 143; Wilson, 2008, as cited in Brown & Strega, 2015; p. 10; see also Smith, 2016). This thesis, in adherence to the tenets embodied in the fields of social justice and critical education, treats the dental student as not only a learner, but also an agent of social justice and social change (see Freire, 1970, 2000; hooks, 1994, p. 15).

Thesis Overview

This thesis will proceed with a literature review (Chapter 3) summarizing the predominant traditions of teaching the "humanistic", rather than the technical, aspects of oral health provision in dental professional programs in Canada and the United States (e.g. Brondani, 2012; Connor et al., 2011; Dharamsi & MacEntee, 2002; Loignon et al., 2012; Major et al., 2016; Nash, 2010). Within each summary of the various components of dental "humanistic" education, I will also offer a complimentary social justice-oriented critique and reconceptualization given this thesis' conceptual framework. The operative research questions will be stated at the end of the literature review. Immediately following this, I will outline the two-pronged qualitative case study methodological approach this thesis will be taking (Chapter 4; see Flyvbjerg, 2006; Yin, 1981).

I will report the results of the first methodological component in Chapter 5. There, I will present a social justice-oriented assessment-conceptual tool tailored to Canadian/American dental education. The tool will be refined via a critical juxtaposition and analysis of the convergences and divergences between SJE and dental education for social responsibility. Further, it will serve as the building blocks for an emerging social justice educational framework for dental education. Inspired by a tool published by the Association of Faculties of Medicine of Canada (AFMC) Equity, Diversity, and Gender Committee (2011), this theoretical work will be

repurposed as a conceptual tool to evaluate the degree to which DENT 206 complies to this context-specific SJE-oriented framework. This will lead to the second part of the study method, Chapter 6, wherein I will detail a social justice-oriented audit of my course, DENT 206: Dentistry Social Justice Seminar, via a deductive thematic analysis to gauge how the course content measures up to the proposed educational framework. The goal will be to illustrate how a SJE framework, tailored to dental professional education, could be operationalized at the course level and to provide an exemplar for other dental professional training programs who might endeavor to evaluate their own curricula as per a social justice lens. The final chapter (Chapter 7) will discuss the ways in which the investigation addressed the research objectives, the study's limitations, and potentials for future research on educational institutions adopting social justice-oriented approach in the ethical training of healthcare professionals.

Chapter 3: Literature Review

An overview of the landscape of dental education is necessary to creating a social justice-oriented educational framework sensitive to the context and needs of oral health professional training programs. This thesis critically looks at areas of dental education wherein the "humanistic" (see Kumagai & Lypson, 2009, p. 784) aspects of oral healthcare provision, rather than the technical and "hard sciences," constitute their primary educational mandate. This review is organized into three broad categories: 1) **Ethics and Professionalism**, 2) **Diversity Education and Public Health**, and 3) **Community-based Education and Service Learning**.

Within each section, I will detail policies, guidelines, and position statements issued by the main Canadian and American dental education governing bodies, namely: The Association of Canadian Faculties of Dentistry (ACFD, 2016), and the American Dental Education Association (ADEA, 2015, 2016a, 2016b). They textualize the educational and medico-social mission to which professional orders and training institutions adhere. These organizations inform, coordinate, and regulate what is operationalized in Doctor of Dental Medicine (DMD) or Doctor of Dental Surgery (DDS) training programs (see also Canadian Dental Association, 2010; Ordre des dentistes du Québec, n.d.; Royal College of Dentists of Canada, n.d.). Further, the ACFD and the ADEA are directly involved in defining and evaluating the standards by which training institutions are officially accredited. The Commission on Dental Accreditation of Canada (CDAC, 2013) recognizes the role of the ACFD in mediating between the accreditation body and educational institutions (p. 4), as is the case between the Commission on Dental Accreditation (US) and the ADEA (CODA, 2018, p. 7). I will accordingly describe what is manifested in the McGill Faculty of Dentistry Doctor of Dental Medicine (DMD) as per each relevant section, excluding DENT 206: Dentistry Social Justice Seminar, the social justice course that I teach and

one of the main subjects of inquiry in this thesis. This is to ensure attentiveness to the educational landscape in which DENT 206 operates and to understand the ways in which this course relates to others in the McGill DMD curriculum.

Closing each section will be a critical appraisal offering a social justice-oriented framework wherein each constituent component of the humanistic aspects of dental education is reimagined. The conceptual framework in Chapter 2 will serve as the framework with which these subsections will be critiqued and re-oriented. I will also draw on other critical texts to build my theorization (e.g. Ahmed, 2007, 2012; Ferguson, 2007; Kumagai & Lypson, 2009; Metzl & Hansen, 2014). These subsections are titled and listed as follows respective to their corresponding section: 1) **Politicizing the Self and the Profession**, 2) **From Systems to Structures: Complicating diversity and cultural competency**, 3) **Nurturing Hope and Socially-Just Possibilities through Dental Education**. The chapter will end with the research objectives with which this thesis pursued its inquiry.

Ethics and Professionalism

The Competent Beginning General Dentist (CBGD) is the primary outcome resulting from the work of a taskforce comprised of academic senior administrators across Canada's ten faculties of dentistry. The CBGD serves as a guiding conceptual tool for dental education institutions across the country (ACFD, 2016). This document delineates five core competencies which serve as the basis of the educational mandate of Doctor of Dental Medicine (DMD) and Doctor of Dental Surgery (DDS) programs in the Canada. These general competency categories, to which the document refers to as "core competencies" are: Patient-centered Care, Professionalism, Communication and Collaboration, Practice and Information Management, and Health Promotion (p. 14). Within each core competency are sub-competencies, a number of

which are based on a predecessor of the CBGD called *Competencies for the Beginning Dental Practitioner* (CBDP, 2005; from ACFD, 2016).

With respect to the core competency of *Professionalism*, the ACFD defines it as marked by a commitment to: the care of patients, the maintenance of the profession's integrity, and the adherence to ethical standards and professional regulations (p. 14). Some salient sub-competencies are as follows:

1. "Recognize signs of abuse and/or neglect and make appropriate reports" (p. 18)
2. "Apply accepted principles of ethics and jurisprudence to maintain standards and advance knowledge and skills" (p. 20)
3. "Demonstrate professional behaviour that is ethical, supersedes self-interest, strives for excellence, is committed to continued professional development and is accountable to individual patients, society and the profession" (p. 20)

The American Dental Education Association (ADEA), the ACFD's counterpart in the United States, published two key position statements in 2016 titled: *Statement on the Roles and Responsibilities of Academic Dental Institutions in Improving the Oral Health Status of All Americans* (2016a) and *ADEA Statement on Professionalism in Dental Education* (2016b). The former declares that oral health professionals are to be instructed on the tenets of a "moral community" (ADEA, 2007; as cited in ADEA, 2016a) which demands the consideration of moral issues when making patient-care decisions and when using privileged medical knowledge. It also calls for "moral complicity", which here means that the care provider is a guardian of the patient's oral health, well-being, and safety (p. 885). The latter position statement advocates that professionalism consequently involves that the care provider "[protect] students, patients, and society from harm" (ADEA, 2016b, p. 868). A host of discursive constituent components

additionally make up the working definition of *professionalism* as per this document, which notably include:

1. A commitment to fairness (p. 867)
2. Integrity, which here means "honesty and truthfulness", thus necessitating an engagement with reflective practices, "willingness to suffer personal discomfort, or harm for the sake of a moral good", and admitting when "improvements need to be made" to one's practice (p. 868)
3. Beneficence, i.e. service to the public (p. 870)

The development of self-reflection skills is a prominent theme in these governing documents (e.g. ACFD, 2016; ADEA, 2016a, 2016b) as well as scholarly literature on dental education (e.g. Brondani, 2012; Isaac et al., 2015; Koole et al., 2016; Whitney et al., 2016). Koole *et al.* (2016) argue that dental training programs should not solely invest in developing the clinical and technical aspects of their teaching mandate. They suggest that the role of dental education is also to help students become "reflective practitioners" (p. 1212). Brondani (2012) concludes in his study of dentistry students' self-reflection exercises that these activities bolster students' consciousness of the social and ethical dimensions of their duties. His study further revealed that these activities have a formative role in the development of students' construal of their social responsibilities as furture healthcare providers (p. 610).

Koole *et al.* (2016) offers the following deconstruction of self-reflection: 1) the process of self-reflection and, 2) the contents of the reflection (p. 1212). The authors describe self-reflection as a "metacognitive" process which seeks to augment students' scope of awareness thus providing cognitive space for new ideas and understandings (p. 1212) where the contents of reflection are grounded in real-life experiences with a variety of patient populations and care

provision contexts (p. 1217). Brondani and Rossoff's (2010) research on the effectiveness of the "hot seat" model of ethics teaching supports the claim that such teaching methods are most effective when reflective practices are used in conjunction with them (p. 1224). Their "hot seat" method involves students role-playing real-life clinical ethical dilemmas and debriefing via facilitated open discussions and self-evaluation activities.

Nash's (2010) philosophical writings endorse the necessity of developing empathy and empathetic patient-care skills, which they contend to be provisional on reflective practices that account for their "intellectual and affective aspects" (p. 575). Empathy, and the reflective practices that nurture it, play a key role in detecting indicators of violence, neglect, and trauma – especially among patients from vulnerable contexts (Raja et al., 2015a; Raja et al. 2015b; see also ACFD, 2016, p. 18). A study by Raja *et al.* (2015b) found that patients are especially concerned with a dental practitioner's perceived ability to communicate and practice empathetically. The researchers observed that patients who have experienced traumatizing life experiences and/or who come from underserved communities are less likely to access essential oral healthcare services when they have been treated by a dental professional who has been perceived to dehumanize their patients (p. 1205). Participants reported dehumanizing experiences with dentists who: used overly technical terms (i.e. misuse of medical knowledge) (p. 1204, see also ADEA, 2016a, p. 885), donned an intimidating and/or condescending tone or body language (p. 1204), and were perceived to be more concerned about the financial aspects, rather than the therapeutic, of the doctor-patient relationship (p. 1205). Fostering empathy for the patient and an acute sense of their suffering then necessitates an educational response which requires methods beyond classroom-based didactic teaching, which Raja *et al.* (2015a) argue in their research on teaching trauma-informed care in dental schools (p. 53). Their study found that

students who were provided with interactive modules, and opportunities to reflect and discuss, exhibited increased understandings of how trauma and violence inform the ways in which patients access and navigate oral healthcare. In line with one of the components of the ACFD's (2016) *professionalism* core competency, a dentist must be able to identify characteristics of a patient who has been through traumatic experiences (p. 18). Empathy for patient suffering, therefore, can be viewed as embedded in the aims of teaching for reflectiveness.

Self-reflection might not only invoke a surface awareness of a patient's suffering and pain, but also the myriad of social factors that inform their experiences with oral disease and care-seeking. A study by Whitney *et al.* (2016), where the researchers administered critical thinking tests to dental students to measure critical thinking disposition, supported past assertions that well-developed critical thinking skills are strong indicators of professional performance (Scott & Markert, 1994; Sebok et al., 2014; Tsai, 2014; as cited in p. 949). This is additionally supported by Raja *et al.* (2015b) who have found that dentists who account for non-clinical and non-biological elements – such as social, institutional, and environmental – are more likely to provide care in underprivileged settings (p. 1021). A Montreal-based study of dental professionals by Loignon *et al.* (2012, p. 548) found that dentists who are critically aware of social and structural factors linked to higher rates of oral disease (e.g. poverty, racial oppression etc.) were more likely to perform service in those communities in their professional career. The research summarized above might propose to dental educators to consider the ways self-reflection and opportunities for critical thinking are woven into their teaching activities. The ADEA (2015) contends that critical thinking provides openings for students to absorb information in ways conducive to identifying their gaps in knowledge and understandings and conceiving creative solutions (as cited in Whitney et al., 2016, p. 948).

McGill dentistry students must successfully complete a set of academic and clinical requirements in order to be granted the degree of Doctor of Dental Medicine (DMD). The majority of these requirements are housed in the Faculty of Dentistry and approximately 85% of the credit requirements in the first four semesters of the program are done within the Fundamentals of Medicine and Dentistry (FMD) curriculum at the Faculty of Medicine (McGill University, 2017a, 2017b). A considerable portion of the students' ethics and professionalism training occurs within two courses: DENT 306 and 406 (Ethics and Jurisprudence 1 and 2) (Hovey, 2017). Both courses explore the philosophical aspects of deontological ethics and the legal aspects of working as a dental professional in Quebec (see also ODQ, n.d.). Self-reflectiveness also operates in courses not explicitly dealing with ethics and professionalism. Activities which build non-technical professional skills (e.g. communication skills, internal bias identification etc.) can be found in a first-year foundational course called INDS 119: Clinical Method (Andermann, 2017), as well as in the four-year spanned service-learning curriculum, DENT 113, 213, 313, 413: Community Oral Health Services (Power, 2017).

The literature demonstrates the effectiveness of reflective educational practices in nourishing empathy and critical thinking skills, thus suggesting that such approaches are necessary to the ethics and professionalism training of dental students. Ethics and professionalism education, in line with educational governing bodies' stances, appears to be concerned with developing dental students' sense of duty to society (Brondani, 2012, p. 610; see also ACFD. 2016, p. 20; ADEA, 2016b, p. 870). Nonetheless, in recalling the conceptual framework in the previous chapter, the qualitative nature of self-reflection as an educational technique in dental education is complicated by a social justice and critical education perspective. To what degree do current dental education practices politicize self-reflection for its

students and weave in systemic social and health injustice into these metacognitive activities (see Koole et al., 2016, p. 1212 and Freire, 1993; as cited in Kumagai & Lypson, 2009, p. 783)? How could a social justice-oriented and politicized understanding of the self and self-reflection help develop a social justice-oriented professional ethic?

Politicizing Dental Ed: Orienting the self and the profession towards social justice

The section to follow will consist of a social justice-oriented reimagining of professionalism education as well as proposals for bridging humanistic dental education with social justice and critical education. A US-based study by Hersh and Goldenberg (2017), which revealed distinct patterns between right-wing and left-wing physicians' patient-care practices, calls attention to the necessity of a politicized training program for health professionals. Their research found that doctors who self-identified as right-leaning/conservative were more likely to advise patients in sex work to think on the legal implications of their occupation, in contrast with their left-leaning/liberal counterparts who tended to provide harm-reductive counsel on safer sex practices and regular STI testing. The conclusions in Hersh and Goldenberg's study challenges political neutrality in professionalism education and confronts the co-constructive relationship between a care provider's political attitudes and beliefs and their professional behaviours. These findings raise a particular concern in Canadian and American dental education, wherein I argue that the socio-political aspects of oral health, care provision, and professional ethics are not adequately prioritized in their teaching missions. The ACFD (2016) and the ADEA (2016a, 2016b) for example, in their educational governing documents, recognize the role of dental professionals in addressing health inequalities and patient care in a culturally pluralistic society, but not explicitly call attention to the political and historical factors which undergird structural forces that give rise to health inequality (Briones, 2017, pp. 69-70).

A politicized training program for future dental professionals is of further consideration given the political activities which have led to the privatization of oral healthcare and the subsequent attrition of socialized dental care. Dental professionals themselves were key players in these historical events. The Royal Commission on Health Service, which ran from 1961 to 1964, found that oral disease was one of the most commonly reported illnesses in Canada (Afrashtehfar & Chung, 2017). In light of this, a number of dentists lobbied for a fee-for-service model and capitalized on the government's hesitation over backing a financially costly response to the widespread problem of oral disease. In the United States, policy reforms and austerity measures in the Medicaid system have been criticized for its role in the prevalence of oral disease among low socioeconomic communities, much of which are populated by people of colour (Otto, 2017, pp. 223-245). These historical events harken to Hersh and Goldenberg's (2017) overture to interrogate the relationship between a care provider's professional behaviours and political values. The market-drive overlying oral healthcare and the profession of dentistry has been a central point of critique in the broader campaign against oral health disparities (ADEA, 2016a, p. 884; Afrashtehfar & Chung, 2017; Dharamsi & MacEntee, 2002, p. 324; Otto, 2017). Further troubling are the ways in which educational governing bodies articulate a commitment to a democratic health service (ACFD, 2016, p. 20; ADEA, 2015; ADEA, 2016a, p. 884; ADEA, 2016b, pp. 868-870), while cognizant that dental students must be prepared to be practitioners of a primarily privatized health service. The ACFD (2016) states that students must be competent in "present[ing] and discuss[ing]... estimated fees, payment arrangements**,** time requirements and the patient's responsibilities for treatment" (p. 18). Relatedly, the Commission on Dental Accreditation (United States) (2018) requires dental training institutions to train its graduates to be adept at managing a private practice – a professional role tied to monetary gain

(p. 28). The interplay between political ideology and political movement, institutional arrangements around care delivery, and individual professional behaviors thus warrants training programs to contemplate the ways in which it politicizes students' sense of themselves, their profession, and their ideologies concerning social responsibility (see Dharamsi et al., 2007).

As described in this chapter as well as the previous one, self-reflection is well-represented in both the educational traditions of dental professional and social justice education. In dental education, self-reflection is deployed as a way to gain an *awareness* of the self (e.g. biases, preconceptions), of health inequalities (Brondani, 2012; Koole et al., 2016; Whitney et al., 2016), and of patient suffering (Raja et al, 2015a; Raja et al., 2015b). Ahmed's (2007) work however calls attention to the ways in which "awareness" might be taken up superficially and uncritically. Through a material look at higher education institutions, she observed how "being aware" is often taken as the "end-point" rather than the first step in a complex process of doing equity work (p. 594). Social justice and critical education fundamentally orient the goals of self-reflection towards critical consciousness rather than a surface awareness (see Freire, 1970, 2000). Kumagai and Lypson's (2009) theorization on the operationalization of critical consciousness in medical education presents an opportunity for dental education. They advocate that critical self-awareness, in concert with politico-critical engagement with histories, contemporary realities, and structures of oppression, develop an active fluency in the social aspects of health provision (p. 783; see also Freire, 1970, 2000). The qualitative and ideological properties of self-reflection in dental education (see Koole et al., 2016, p. 1212) must therefore be assessed to determine if reflectiveness unfolds in dental training in social justice-oriented ways. Social justice and critical education posit the learner as an active political agent within an array of political activities and structures defined and coordinated by histories and norms of

inequality and oppression (see Bannerji, 1995, p. 65). A politico-critical uptake of self-awareness and reflectiveness would bring to light the inherently contradictory relationship between a dentist's financial obligations within a largely for-profit professional landscape and a social justice-oriented professional ethic. Moreover, self-reflection within a social justice-oriented framework would serve as a mechanism by which the learner personalizes their involvement in social injustice while creating spaces for working towards resistance and change.

In the previous chapter, I unpacked the particularities of social justice and critical education which concern those in privileged social locations. Attentive to the context of educating prospective elite healthcare professionals, this social justice-oriented reimagining of ethics, professionalism, and self-reflection education will further theorize on such proposals. The following subsections will elucidate on an emerging politicized social justice-oriented professional ethic and reflectiveness framework.

Interfacing with privilege and power. Anti-oppression researchers Potts and Brown (2015) state:

> Most of us recognize oppression when it occurs 'out there' or when we are being oppressed ourselves, but can we also recognize how we are implicated in sustaining systems on inequality? This is often harder, especially if we are well-meaning people. (p. 18)

Governing bodies of dental education communicate an imperative for training institutions to teach students so that they have an ethical understanding of their professional powers, privileges, and skills (see ACFD, 2016, p. 20; ADEA, 2016a, p. 866). Nash (2010) describes the power gradient between carer and caree as rooted in the privileged knowledge and skills of the care provider, thus responsibilizing dentists with the trust placed onto them. Using their power and agency in the best interest of patients and broader society grounds this trust between practitioner and patient (p. 573; see also Raja 2015b). This thesis however looks not only at the doctor-

patient level, but also to expanded treatments of dental professional (social) power and privilege (Briones, 2017, p. 76).

I further assert that social justice and critical education possess the tools to engage with the complexities of the problems I reported on in the opening chapter of this thesis. I recounted evidence that the power available to dental professionals has been misused and/or underutilized for the sake of socially just ends. Dentists were directly involved in political activities that pushed for the for-profit model of oral healthcare delivery in Canada and the United States (Afrashtehfar & Chung, 2017; Otto, 2017, pp. 223-245). My overture detailing Backhouse, McRae, and Iyer's (2015, p. 2) systemic investigation of Dalhousie University's Faculty of Dentistry gave an example of how clinical and professorial staff reinforce a culture of abuses, misogyny, and racism. A key recommendation stemming from the investigation further emphasized the role of education in enacting necessary systemic reforms to not only address isolated incidences, but also to shift the professional culture towards that of equality and justice (p. 3). In order to push for this proposed shift, I suggest a coupling of dental education and social justice education.

The infusion of critical pedagogy (i.e. Freire, 1970, 2000; hooks, 1994, Orelus, 2015) into reflective practice is of consideration given the tradition's roots in social change and activism (Briones, 2017, p. 69). A paper by Kumagai and Lypson (2009) explores and advocates for critical pedagogy's potential in medical education. Educating care providers on donning socially just professional behaviours and on interfacing with their agency as change makers necessarily involves a critical engagement with broader systems of oppression and inequality, the ways in which they define social difference, and their impact on care delivery (Adams & Bell, 2016, p. ix; see also Farahmandpur, 2009, p. 113). Moreover, critical pedagogy and social justice

education fundamentally require that learners are continuously contemplative of the ways in which one is either (or both) personally impacted by, and complicit in systemic oppression (Absolon and Willett, 2005; as cited in Brown & Strega, 2015, p. 10; Potts & Brown, 2015, p. 19). Thereto, critical pedagogy frames one's lived experiences as entry points for engaging learners in palpable and personalized ways in analyzing and understanding themselves within a matrix of social systems (Berry, 2010, p. 21; Kumagai & Lypson, 2009, p. 784; Orelus, 2015, p. 23). Depersonalized and depoliticized "neutral" engagements of oral health inequality and one's professional ethic obscure the larger social factors and injustices at play, thus perpetuating a "(willful) ignorance" to them (see King, 1991; as cited in Howard, 2006, pp. 45). Therefore, dental students must understand themselves as political actors within their profession and critically interface with their responsibility in challenging unethical professional behaviours and an unjust status quo (Bleakney & Morrill, 2010, p. 146). Social justice and critical education do not absolve the learner from their implication in oppression and injustice (Howard, 2006, p. 53; Schick, 2000, p. 86). This thesis aspires for dental education to be a platform wherein future healthcare providers don a personal responsibility in resisting oppression and working towards socially-just outcomes.

Ahmed (2012) offers the following: "if we start with complicity, we recognize our proximity to the problems we are addressing" (p. 18). A fundamental commitment to reduce and eradicate human suffering (see ACFD, 2016; ADEA, 2016b; Orelus, 2015, p. 2) ineludibly calls for those dominantly located to identify and be discerning of one's power, question one's privilege, and critically link them to the oppression of those on the "other side" (Gaztambide-Fernandez, 2010, p. 10; Howard, 2006, p. 43; Howard, 2010, p. 79). Medical sociologist Armstrong (1995) theorized on physicians going from spatially locating disease on a physical

site to abstracting it in external artefacts. With the rise of new medical technologies, activities, and bureaucracies, he described the ways in which disease and illness are "spatialized" in medical records, in laboratories, and in public health statistics. In line with Armstrong, I similarly observe the ways in which inequality and injustice in the medico-social context has undergone a parallel process of abstraction – disembodied from individuals' actions, "in a nebulous 'out there'… [with] no connections to themselves," (Howard, 2006, p. 45). A critical awareness of the operationalization of privilege as ideological, symbolic, and material power might spur dental students to interrogate structures and systems of dominance and oppression – both in their roles as healthcare providers, and privately as individuals (Howard, 2010, pp. 79-80). More than cultivating a personal "social conscience" that relinquishes economic individualism (Dharamsi et al., 2007, p. 1591), a social justice-oriented training program would provide students the space to critically explore the "bigger picture" and how one is a political and professional actor therein (Briones, 2017, p. 72).

Extant literature on dental education attends to the specificities of the oral healthcare provider's role (e.g. Nash, 2010; Raja, 2015b) while social justice education pushes beyond "awareness" towards a critical professional consciousness (see Hsia, 2010, p 116; Kumagai & Lypson, 2009, pp. 786-787). The goal is to not only educate dental students on the potential negative outcomes of misusing their professional powers and privileges, but also on the ways in which they might be agents for social justice and health equity. Beyond developing a surface awareness of cultural sensitivity and health inequality, this thesis seeks to create a framework wherein dental students are provided tools to critically question status quo conditions, identify the "cracks in which to work" (Gordon & Ramdeholl, 2010, p. 34), and conceive a social justice imaginary for dentistry and the dental profession.

Learning through discomfort. Chapter 2 (Conceptual Framework) illustrated the affective challenges in learning for social justice for the privileged learner in attendance to the professional status and elitism inherent in the dental professional identity. Brown and Strega (2015, p. 10) term these learning experiences as "uncomfortable reflexivity". Carter (2013, p. 507) similarly acknowledges the emotional and cognitive tax of considering one's personal implication in oppression and inequality. This is of special concern when deficit normalizations of meritocracy function to reason away one's social privilege and advantaged position in society (Gaztambide-Howard, 2010, p. 3; Fine & Ruglis, 2009, p. 20; Carpenter, 2016, p. 2; see also Loignon et al., 2012, p. 545). Notwithstanding the challenges leveraged by privileged learners' resistance and the discomforting emotions involved in social justice learning, I argue that "leading an examined life" (ADEA, 2016b, p. 868) concomitantly implicates the social privilege enjoyed by those dominantly located with the oppression of those at the margins (see Howard, 2006, p. 47 Potts & Brown, 2015, p. 19; Tuck, 2009).

The ADEA (2016b) expresses the following in its professionalism statement: the dental professional should demonstrate a "willingness to suffer personal discomfort, or harm for the sake of a moral good" (p. 868). In the same vein, Zembylas and McGlynn (2012) lean into emotionally "discomforting" reflexive practices and subsequently propose them as tools for social justice learning. Emotional experiences are part and parcel of critically reading the self, the world, and the conditions which give rise to inequality and injustice in its discursive forms (Kumagai & Lypson, 2009, p. 783; Zembylas, 2010, p. 611). Interrogating students' conceptualization of, and relationship with status quo conditions as they pertain to their roles as healthcare professionals, provides opportunities for identifying invisible privileges and the ways in which one may (un)intentionally perpetuate oppressive norms (Boler & Zembylas, 2009, as

cited in Zembylas & McGlynn, 2012, p. 44; see also Howard, 2010, pp. 79, 89). Though there are risks involved in using emotions in a classroom, an experienced teacher/facilitator capable of fostering a supportive environment open to productive disagreements might open up pathways towards transforming the ways in which students, 1) think of themselves within a larger social context, and 2) understand their role in perpetuating or disrupting inequities (Kumagai & Lypson, 2009, pp. 784-786). Social justice work for those in privileged locations requires a denouncing of one's unearned advantages and understanding them in relation to another's deprivation (Howard, 2006, p. 43). Grounding students' learnings within their personal contexts and lived experiences, in concert with their peers', in a dialogic environment, might inhibit abstracting oneself from health inequality and social (in)justice. Personalizing, not only complicity, but also one's personal responsibility provides the basis for acting for health and social justice (see Howard, 2006, p. 45; Potts & Brown, 2015, p. 18).

Thus far, I have unpacked dental education and a social justice-oriented reimagining of dental education from the vantage point of ethics, professionalism, and reflectiveness. I conceptualized dental education as a potential site wherein students could gain a social justice understanding of the (professional) self through identifying one's location and agency in a political medico-social matrix. Characteristic of both humanistic dental education, and social justice and critical education however are issues at scales beyond the individual. The ACFD and the ADEA both package their stances on ethics and professionalism with "cultural awareness" and "diversity." The ADEA (2015) touts "cultural competency" as a feature of professionalism in one of the organization's diversity statements. In its position statement on professionalism, the body further upholds that dental educators are to teach students to be "responsive to diversity" (2016b, p. 869). Similarly, the ACFD (2016) states that "competent beginning general dentists in

Canada must be able to… provide oral health care… in a culturally sensitive manner" (p. 2). The next section will address matters concerning cultural diversity, social difference, and the ways these issues intersect with dental and oral public health education.

Diversity Education and Public Health

Words and phrases like "diversity" (ADEA, 2015; ADEA, 2106b, p. 869), "culturally sensitive" (ACFD, 2016, p. 2), and "awareness" of those who are "different" and/or the disadvantaged (ACFD, 2016, p. 14; ADEA 2015; ADEA 2016a, p. 885) partly delineate the principles conveyed by the ACFD and ADEA's in its educational governing documents. The ADEA (2015, 2016a) establishes *cultural competency* as a necessary skill for an oral healthcare provider. The organization defines it as a service provider's "ability to understand and interact with people from cultures and backgrounds other than their own" (ADEA, 2015). The ADEA's regard for cultural diversity and issues of social difference is echoed in other documents. One frames the issue as a public health matter – indicating in one position statement that the care provider is morally obligated to account for the relationship between social inequality and vulnerability to disease in one's care provision practice (ADEA, 2016a, p. 885). Another document takes up the issue from a professionalism perspective, affirming that a "responsiveness to diversity" is characteristic of the ADEA's (2016b, p. 869) educational philosophy. Constituent of *Health Promotion*, a core competency in the ACFD's (2016) educational guidelines, are: attentiveness to the public health landscape (p. 14), ability to identify social determinants of health (which would include, race, class, sexuality, geographic location etc.) (p. 18), and an awareness of cultural diversity (p. 2). These statements demonstrate that Canadian and American dental education are considerate of diversity, its confluence with patterns of illness and inequality, and its importance in the development of professional behaviours.

The literature on dental education often clusters cultural diversity with a concern for those who are socially marginalized and are therefore more likely to be underserved and suffer from oral disease. For example, Albino *et al.* (2012) brought attention to the necessity for educational institutions to tackle oral health inequality along racial lines (p. 75). The researchers additionally reported troubling patterns of oral disease among persons with (dis)abilities (p. 79) and those from precarious socio-economic backgrounds (p. 81). Albino *et al.* in turn provided a number of evidence-based recommendations in their paper, some of which are directed at dental education institutions. They are summarized as follows:

1. Increase racial diversity in dental school admissions – racial minority dentists have been found to be more likely to treat racialized patients (p. 76);
2. Integrate an appreciation for the links between social inequality and oral health disparities (pp. 76-81);
3. Challenge bureaucracies that pose barriers for dentists to take on patients on social assistance (p. 78)
4. Provide more opportunities for students to work with underserved populations in response to studies showing that service-learning increases likelihood for dentists to work in such settings (p. 80; see also Brondani, p. 609)

Recommendation no. 1 resonates with the ADEA's (2015) call to diversify the profession as well as its call to target care provision efforts towards populations disproportionately impacted by oral health disparities. A study by McCann *et al.* (2014) on racial minority students' experiences at a Texan college of dentistry similarly contend that hiring more faculty of colour might be a way to: 1) train more dentists likely to practice in underserved settings (p. 412); 2) broaden teaching perspectives, especially with regards to caring for minority populations; and 3)

to curtail isolation for racialized students, a fifth of whom reported experiencing racial discrimination from teachers and peers at the researchers' setting (p. 411). A relevant study on community clinic student reflections by Victoroff *et al.* (2013) found that common identity(ies) between students and patients can facilitate carer-caree interactions. Of particular note is the sharing of a language other than the dominant one (Victoroff et al., 2013, p. 987).

Further invoked in the work of Victoroff *et al.* (2013) is Albino *et al.*'s (2012, pp. 76-81) second recommendation which advocates for increased education on the links between oral health inequality and social inequality. The researchers tracked the developments in diversity education in American dental curricula from 2007 to 2013, and concluded that much of the curricular reform in dental training institutions was motivated by the necessity to address the needs of a diversifying patient population (p. 982). The authors further cite the work of Campinha-Bacote (2002) to champion "cultural awareness," which can be understood as "the *in-depth exploration of one's own cultural and professional background*.... [and the] *recognition of one's own biases*, prejudices, and assumptions about individuals who are different" (as cited in p. 984, emphasis added). This raises another salient theme in the literature on diversity education: the unearthing of implicit bias. Isaac *et al.* (2015) assert that parallel to deepening students' understanding of diversity, is enhancing their capacity to articulate "points of difference" (p. 313). The authors further suggest that diversity education should dismantle internalized negative attitudes about "the other." Research demonstrates that these deficit beliefs have an adverse material impact on the ways patients are treated by the care-provider (p. 312). Loignon *et al.* (2012) specifically call attention to the deleterious effects of these endogenous beliefs about the "other" to the detriment of from socio-economically disadvantaged patients (p. 548).

Cultural competency emerged during a time when American medicine was criticized for failing to recognize the importance of diversity in the profession (Metzl & Hansen, 2014, p. 126). It is mobilized by dental education as a mechanism with which to train students on "diversity," "difference," and "cultural sensitivity." Scholars of medical education, Metzl and Hansen (2014) defines it as:

> The trained ability to identify cross-cultural expressions of illness and health, and to thus counteract the marginalization of patients by race, ethnicity, social class, religion, sexual orientation, or other markers of difference. (p. 126)

Consequently, American educational accreditation bodies package social responsibility with cultural competency training as a means to address prevalent inequalities in oral health conditions (Isaac et al., 2015, p. 312). Accordingly, undergirding diversity training is dental public health education – a discipline that connects social factors and patterns linked to the oral health of individuals, aggregates, and populations (ACFD, 2016, p. 18; ADEA, 2016a, p. 885).

Recommendation no. 3 as per Albino *et al.* (2012) arguably raises more complex issues and directs attention to institutional arrangements, historical trajectories, and systemic realities that give rise to health disparities. The largely privatized, for-profit nature of dental care is a source of anxiety for both the ADEA (2016a, p. 884) and the Canadian Dental Association (2010). Both bodies articulate that access to oral healthcare is a human right – one to be equitably provided to the public and that systemic changes in oral healthcare and dental education are necessary to realize this.

With the exception of the course I teach, the McGill Faculty of Dentistry currently does not have another course which focuses on diversity education. Rather, the subject matter is woven into the learning goals of several courses. General public health concepts (e.g. social determinants of health, health disparities, social issues linked to health systems) are taught in the

students' first year within the Fundamentals of Dentistry in INDS 111: Molecules to Global Health (Andermann, 2017), in the preclinical phase of the curriculum via DENT 217: Foundations of Dentistry (Allison, 2017), and within the students' junior clerkship in third year through DENT 305: Dental Public Health (Bedos, 2017). Specific issues concerning LGBTQ+ individuals and communities are also touched upon in the Fundamentals of Medicine and Dentistry curriculum in INDS 211: Reproduction and Sexuality (Weibel, 2017). Relevant theories and accompanying practices (e.g. communication skills, patient history taking etc.) are also interspersed in the students' patient simulation and case-based training exercises in INDS 119: Clinical Method (Boillat, Boudreau, & Dawson, 2017) in their first year, and in the preclinical course DENT 224: Transition to Clinic (Macdonald, 2017).

It is evident in the literature that Canadian and American dental professional training institutions acknowledge that care provision in a pluralistic society requires a discursive understanding of diversity and its ties to health inequality and access issues. As this thesis is grounded in the traditions of social justice and critical pedagogy, it must then interrogate an observed absence or lack of focus on a number of issues, as well as the qualitative nature of the ways in which diversity and inequality are taught to dental students. First, this thesis questions the lack of discussion on the links between those who benefit from an unequal oral health status quo and the subordinate conditions of those marginalized by said status quo (see Austin & Paré, 2009, p. 112). What is the interplay between the privileged status of an oral healthcare practitioner and the disproportionate oral health marginalization of minoritized groups within a predominantly for-profit oral healthcare system? How can dental education be a site for broader structural change (see Dharamsi & MacEntee, 2002; Metzl & Hansen, 2014), encourage direct action from the dental professional community (see Choudry, 2015), and disrupt norms from the

individual to the societal scale that perpetuate social and health injustice (see Adams & Bell, 2016 and Farahmandpur, 2009)? To follow will be the second reimagining section of this literature review wherein I propose a social justice and critical education-oriented critique of diversity and public health education.

Structures to Systems: Complicating diversity and cultural competency

To reiterate a quote from Chapter 2, New York City Health Commissioner, Dr. Mary Bassett (2015) reminds that inequalities "are embedded in the political and economic organizations" of society – realities unfelt by those privileged and shielded from the effects of systemic oppression. Both Canadian and American educational governing bodies accept that a predominantly privatized healthcare service has a major role in perpetuating oral health disparities (e.g. ADEA, 2016a, p. 884, ACFD, 2016, p. 20). On that account, I argue that extant dental educational frameworks and techniques do little to teach students on mediating the tensions between the market environment and acting in the interest of social justice and equity. Bureaucratic and political properties of the dental healthcare system sustain barriers to equitable oral healthcare provision (Albino et. al., 2012, p. 78). The emerging dental practitioner might find the task of challenging systems and structures of inequality an abstract, daunting, and disempowering task (see Dharamsi et al., 2007). I therefore propose that a social justice-oriented training program would provide tools to navigate the ideological tensions inherent in the profession of dentistry, and to understand their roles and responsibilities at individual, institutional, and structural levels (see Ferguson, 2007, pp. 16-20).

The dissonance between committing to a social justice-oriented professional ethic, and professional conditions governed by a fee-for-service model, presents a challenge for dental education. Flaitz *et al*. (2013) suggest that a social justice-oriented training for dental students

would give ample space for an understanding of oral disease via the social determinants and institutional actions which give rise to patterns of occurrence and prevalence (p. 191). The infusion of social justice approaches in dental education necessitates a holistic look of illness within the broader social conditions of a patient's life. Does the patient/community have access to potable fluoridated water? Do they live in an oral health dessert where one would be unlikely to encounter a dental clinic because of the meagre profit prospects in the area? Are policy makers acting on behalf of those with the least power and privilege? Without a critical understanding of larger structural realities and historical contexts, and action-oriented learning in dental education, a status quo of inequality and injustice might continue to mechanize, and perhaps worsen (see Albino, 2012, p. 75; Otto, 2017, pp. 223-245).

The ability to trace matrices linking clinical manifestations of oral disease and patterns of inequality, to the socio-political and economic systems put in motion by structures and institutions is termed by Metzl and Hansen (2014) as **structural competency**. Structural competency is the authors' rebuttal to cultural competency – a framework which they argue reduces health inequality and difficulties in clinical interactions as a matter of "cultural difference". They further contend that cultural competency reifies the physician's rendering of a patient's illness which might lead to assumptions that obscures the complexities of a patient's health and social context (DasGupta, 2008; as cited in p. 131; see also Kumagai & Lypson, 2009). Hansen and Dugan (2013), who in their study interviewed faculty from twenty American medical schools, found that participants were primarily driven by teaching on "health disparities." Few demonstrated an authentic investment in understanding the structural, institutional, and political forces which shape and give rise to these health inequalities (as cited in Metzl & Hansen, 2014, p. 130). Pertinently, Loignon *et al.* (2012) discovered manifestations

of deficit professional attitudes among Montreal-based dental professionals which they described as "individualistic-deficit perspective" (p. 546). A number of their study participants attributed their patient's poor oral health or decreased ability to seek and access professional care to an endogenous lack of aptitude and/or laziness. The same participants were also found to be less likely to be willing to explore the array of political, historical, and individual circumstances that may have led to a patient's (or community's) poor oral health (p. 551; see also Raja et al., 2015b, p. 1021). These problematic perceptions and attitudes were found to exacerbate one's adherence to negative stereotypes – stereotypes most likely attributed to socially subordinate identities – and flattens the complexities of health and social injustice.

This thesis moreover troubles the manner in which diversity education and dental public health is deployed in dental professional education. Statistics and the analysis of patterns of health inequality are packaged with diversity education thus framing certain communities and populations as "sites of divestment and dispossession" (Tuck, 2009, p. 412). Narratives surrounding those that are constructed as "marginalized", "underserved", or "minoritized" act as symbolic and rhetorical boundaries between the dental school/profession and the "other". These borderlines play out as a divide between those who are "of" and those who are "other". McCann *et al*. (2014) demonstrate how these symbolic markers of difference (and hierarchy) in their study of racialized students' experiences of exclusion in dental schools impact participants' sense of belonging in the school and the profession (p. 411). In attendance to the work of Weis (2010, p. vii) and Schick (2000, p. 87), dental schools (consciously or not) fortify a professional and institutional landscape of social dominance populated by privileged bodies, and construct those at the margins as alien to its spaces. Needing the aid of those structurally and socially advantaged, i.e. the dental professional, functions to bolster the power discrepancy between the

(elite and privileged) doctor and the (marginalized and underserved) patient. The troublesome implications of locating marginalization and inequality within matters of "cultural difference", often coded as a "social determinant" of health (ACFD, 2016, p. 18), are symptomatic of a dynamic where "marginalized communities" or "minority patients" are endogenously lesser than those dominantly located. Diversity education, cultural competency, and public health, I argue, are limited in how they are currently materialized in dental curricula. They are not adequately responding to structural, political, and historical forces and trajectories which materialize as" oral disease and health inequality (e.g. Albino et al., 2012; ADEA, 2016a; Otto, 2017), underrepresentation of equity-seeking groups in the profession (see ADEA, 2015; McCann, 2014), and incidences of professionals acting in ethically distressing ways (Backhouse et al., 2015; CBC News, 2014, 2015; Dhillon, 2017; Proctor, 2015).

The work of Kumagai and Lypson (2009), who propose adapting critical pedagogy as a direct critique of cultural competency, prefaces a social justice-oriented approach to educating about social difference, diversity, and inequality. Their theorization unlocks a possible conceptual meeting-point between the educational traditions of dental education and social justice-oriented education. The authors, mindful of the political dimensions of health inequality, assert that critical pedagogy carves out spaces for having "engaged, interactive, honest dialogue" (p. 784). Through critical pedagogy, the authors uphold that medical students are enabled to productively interrogate unjust status quo conditions, deconstruct them, and conceive strategies for change (see also Austin & Paré, 2009, p. 112 and Orelus, 2015, p. 1). Kumagai and Lypson further reinforce my arguments, stating:

> [T]here is a distressingly common failure to connect the idea of diversity with the underlying core concept of social justice in health care. (p. 782)

I similarly challenge the treatment of "diversity" and "cultural difference" in dental education, thus proposing a framework which complicates identity and social context through intersectional and structural lenses (see Austin & Paré, 2009, p. 115; Crenshaw, 1991; Combahee River Collective, 2014; Metzl & Hansen, 2014).

Grounding this social justice theorizing of diversity and public health is a shift of gaze from markers of cultural difference to systemic and structural conditions. The theoretical work to follow attends to Choudry's (2015) call to action, stating how "awareness alone is not enough to bring about change" (p. 88). Social justice education and critical pedagogy are concerned with both the "informative approach" in learning for social change as well as its "transformative" action-oriented properties (Isaac et al., 2015, p. 313). Regarding Albino *et al.*'s (2012, p. 80) fourth recommendation, the following section of this critical literature review will elucidate on ground-level community-based approaches and service-learning in dental training programs. Diversity education, cultural competency, and understanding "difference" not only exist within the didactic and academic clinical spaces of the dental school, but also via outreach and community-based initiatives integrated into DMD and DDS programs in Canada and the United States. At McGill University, DMD students are required to complete a course under its *Community Oral Health Services* (DENT 113, 213, 313, and 413) curriculum in each of the four years of the program (Power, 2017). These courses are comprised of a number of lecture-based sessions, reflective assignments, and off-site rotations in community-based clinics which primarily target underserved populations.

Service Learning and Community-based Dental Education

Service to the community, with an emphasis on those historically underserved, is upheld as a core mandate in the mission of Canadian (ACFD, 2016, pp. 18-19) and American (ADEA,

2016a, p. 888; 2016b, p. 870) dental schools. Brondani (2012) affirmed that service-learning and deepening one's understanding of the social responsibility of an oral healthcare professional go together. Pertinently, Mays (2016) reported on the growth of community-based education (CBDE) in dental programs. The authors claim that this growth was a response to research that found CBDE enriched students' competence and confidence by providing them with opportunities to practice care provision with diverse patient populations (p. 1188; see also Victoroff et al., 2013, p. 986). Major *et al.* (2016) determined that elevated confidence and comfort within CBDE clinical settings increased students' willingness to consider practicing in these care settings (p. 523; see also Loignon et al., 2012, p. 548).

Building students' knowledge and understanding of the "other" appears to be an ostensive educational goal of community-based dental education. Victoroff *et al.* (2013) suggest that these sites of learning through service have a role in increase students' knowledge of those different from themselves and build trusting relationships with underserved communities (pp. 985-987). The authors' analysis of students' reflections on their service-learning modules revealed that there were a number of participants that were frustrated with what they perceived to be deficient health attitudes and behaviours among minoritized patients (p. 986). They further propose that service-learning which integrates reflective components can help students realize their own stereotypes and biases through questioning their initial reactions when dealing with patients from underserved contexts. Behar-Horenstein *et al.* (2015) correspondingly testified that service-learning hosts "authentic experiences" integral to building students' empathy for patients from marginalized social locations (p. 1189). The authors explain that real-life encounters in a community-based setting allow students to witness first-hand the health inequalities they would otherwise learn about in classroom-based sessions and academic texts.

Service-learning initiatives and CBDE are moreover responsive to Albino *et al.*'s (2012) fourth recommendation for responding to oral health disparities – increasing diversity in the profession (p. 76; see also ADEA, 2015). The presence of dental professionals in community clinics were revealed to be effective at recruiting prospective dental students from marginalized communities (Andersen et al., 2007; as cited in Mays, 2016, p. 1189). Further, CBDE falls within the ACFD's (2016) core competency of *Health Promotion* under which service, outreach, and the promotion of public health fall (p. 19). The literature illustrates CBDE as a method by which dental education encourages students to incorporate community service into their professional practice (see Brondani, 2012; Major et al., 2016; Mays, 2016; Victoroff et al., 2013). Service-learning might also be understood as constituent of diversity and dental public health education as it is concerned with providing care to underserved groups in community-based settings (see Behar-Horenstein et al., 2015; Victoroff et al., 2013).

The assertions of Albino et al. (2015, p. 80) and Mays (2016, p. 1189), who depict CBDE as a mechanism to address oral health inequality, however, is complicated by a social justice-oriented approach. The ADEA (2016a, p. 884) and the Canadian Dental Association (2010) recognized that there are systemic and structural factors which have a fundamental role in the maintenance of patterns of unequal access and unequal rates of oral disease. Though CBDE might be perceived as a way to engage dental students in direct community-based action, the literature does not identify the ways in which it can address issues at systemic and structural scales. A social justice and critical education framework problematize CBDE as it appears to do little beyond band-aid solutions, and mostly engages with symptoms of oral health inequality and social marginalization, and fails to take the work towards long-term socially-just possibilities (see Freire, 1993; as cited by Kumagai & Lypson, 2009, p. 783; hooks, 1994, p. 15). The

following section will be a re-conceptualization of service-learning grounded in possibilities for creating social justice-oriented oral health imaginaries (see Rizvi, 2007) and solidarity building practices (Choudry, 2015, p. 88; see also Bofelo et al., 2013, p. 513).

Nurturing Hope and Socially-just Possibilities

Integral to social justice education is fostering conditions where individuals can imagine a hopeful, transformed, and just society (Farahmandpur, 2009, p. 113). Bleakney and Morrill (2010, p. 140) and Choudry (2015, p. 90) warn of the pitfalls of hopelessness in working for social change. There is cause for concern as signaled by findings in a survey of American physicians by Harris Interactive (2011; as cited in Metzl & Hansen, 2014; p. 128). It was found that 85% of respondents feel at a loss when confronting their ability and/or capacity to answer to the "social needs" of a patient from an underserved community. A study by Dharamsi et al. (2007) on dentists' construal of social responsibility discovered that some participants felt conflicted when faced with making a difficult professional and/or clinical decision. These dentists recognized that economic mandates inherent in the oral healthcare system acted as a barrier to taking the course of action that they perceived to be the most ethical or socially responsible (p. 1586). The challenge then is to nurture hope critical of a privileged optimism – an optimism which renders invisible the conditions of suffering those at the margins live and perpetuate an ignorance to injustice and inequality. Concurrently, a social justice-oriented framework avoids the dangers of focusing on "damage-centered narratives" (Tuck, 2009) which positions those in marginal social locations as desolate and creates obstacles in conceiving a hopeful social justice imaginary (Briones, 2017, pp. 78-79).

Metzl and Hansen (2014) promote the symbolic significance of demonstrating to healthcare providers that there are "points of entry" through political work and repurposing one's

power and agency for socially just goals (p. 130). Potts and Brown (2015, p. 18) likewise affirm that social justice work is neither physically nor symbolically bounded. This work can happen even within institutions that have been historically sites of oppression and inequality (e.g. oral healthcare and higher education). Popular education scholars Gordon and Ramdeholl (2010) term this as identifying the "cracks in which to work" (p. 34); illuminating for dental students that despite the perceived omnipresence of injustice and inequality, there remains room to envision an equitable and just society (see also Whitney et al., 2016, p. 948). A social justice framework is grounded in the assertion that all are holders of knowledge and expertise for social change and that one's lived experience, shared within a critical dialogic space, coalesces with others' to build collective emancipatory knowledge (see Berry, 2010, p. 22; hooks, 1994, p. 15). The hope lies in the belief that all are capable of resisting and disrupting an oppressive status quo in solidarity with others (Kumagai & Lypson, 2009, pp. 783-784).

Collectivism and beyond the dental school. The literature depicts CBDE as a site wherein students learn about social difference, work with patients from underserved contexts, and cultivate a professional ethic of social responsibility (see Behar-Horenstein et al., 2015, p. 1189; Brondani, 2012; Mays, 2016, p. 1188; Victoroff et al., 2013, p. 986). While the literature provides evidence of the benefits of service-learning in its discursive applications (e.g. Loignon et al., 2012, p. 548; Major et al., 2016; Victoroff et al., 2013, pp. 985-987), I nonetheless critique CBDE's current state from a social justice and critical education perspective. CBDE might further reinforce power differentials (Nash, 2012, p. 573; see also Weis, 2010, p. vii) that lie between a professional, which has been shown to be lacking in representation from marginalized social groups (ADEA, 2015; Albino et al., 2012, pp. 76-77; McCann), and a patient population marked by deprivation and deficiency (Tuck, 2009, p. 412; see ADEA, 2016a; Albino et al.,

2012; Nash, 2010). A critical social justice framework for dental education highlights this tension, thus complicating CBDE/service-learning.

Before I offer further critiques, I must first acknowledge CBDE's strengths. It funnels oral healthcare services into underserved communities and hosts practical learning experiences around issues of diversity (see Behar-Horenstein et al., 2015, p. 1189). A social justice and critical education critique nevertheless problematizes a number of issues. Metzl and Hansen's (2014) proposal of structural competency in medical education broadens the students' field of vision from the doctor-patient interface in isolation, and considers the wholeness of the illness experience (p. 127). Health inequality and social difference, in the same vein as the earlier proposals on complicating diversity education in this chapter, are genealogically tied to historical trajectories and broader social conditions of oppression and inequality. I argue that service-learning traditions in Canadian and American dental education replicates this problematic I have unpacked in the context of diversity education and dental public health.

A social justice-oriented educational framework would further be responsive to the inherent economic individualism embedded in the educational and professional culture of dentistry. Gaztambide-Fernandez and Howard (2010) conclude that the stress and pressure to excel, endogenous to elite schooling (i.e. medical and dental programs), foster individualism and competition which impede on cooperation and collaboration (p. 4; see also Blackmore, 2013, p. 139). Brondani (2012) points out this issue in dental schools in describing the ways in which the reification of academic and clinical competition in dental professional training programs contradict core values of social responsibility and collaborative social action (p. 615). Once students exit the dental school context, they must navigate a for-profit oral healthcare system, where individualism as academic competition is rearticulated as economic advantage (see

Afrashtehfar and Chung, 2017; ADEA, 2016a, p. 884; Dharamsi & MacEntee, 2002, p. 324). Social justice education and activist practices challenge this and uphold the vitality of collective organizing and cooperation (Farahmandpur, 2009, p. 110; Gordon & Ramdeholl, 2010, p. 32; Smith, 2016, p. 66). A social justice-oriented educational framework therefore would prioritize collaboration over competition – that one's successes in the pursuit of social justice is a shared accomplishment. Good dentistry, therefore, is contingent on prioritizing the achievement of oral health equality and social justice, rather than individual academic or economic success.

I moreover contend that there are multiple avenues for activism and social change beyond CBDE, and espouse that change-making must also happen in arenas beyond the clinic and the dental school (see Bleakney & Morrill, 2010, p. 147). In alliance with the values and practices embedded in critical pedagogy, a social justice-oriented framework in dental education treats its learners as agents of social change, in their right as individuals and as members of a cooperative (Choudry, 2015, p. 88; see also Bofelo et al., 2013, p. 513; hooks, 1994, p. 15). Educating clinicians, within this proposed reimagining of dental education, further veers away from treating skills and knowledge for social justice as "competencies" to be achieved. Rather, I propose a means to develop students' "fluency" in the complexities of health inequality and social injustice (Kumagai & Lypson, 2009, p. 783) as part of their professional commitment to lifelong learning.

Research Objectives

The literature review above illustrates that dental professional training institutions are not lacking in their efforts to educate students on the importance of the "humanistic aspects" of their profession. The critical sections of the literature review however complicate the Canadian and American dental educational landscape from a social justice and critical pedagogical perspective in three ways. First, I questioned how ethics and professionalism qualitatively deploy the "self"

and "self-reflection." I argue that it does not explicitly call attention to the political and structural issues which a social justice-oriented framework would weave into the ways dental students think through their roles as healthcare providers and as actors in their professional and social worlds. Second, the literature review challenges how "diversity" materializes in dental education and public health. The literature on diversity education and dental public health demonstrates that much of it is concerned with marginalized and underserved populations, yet they do not critically consider how the privileged social locations and power of an oral healthcare provider is connected to the patterns of oral health inequality and the illness experiences of socially marginalized groups. Further, though the literature on dental education acknowledges how a primarily privatized health service contributes to access barriers, dental education does not adequately advocate for systemic and structural change specifically as it pertains to the role of the dental professional as a change agent. Third, though I appreciates the strong tradition of community service in dental education, I also argue that Community-based Dental Education does little to call for structural change. It further does not provide tools for emerging dental professionals to interrogate status quo conditions which perpetuate the inequities with which service-learning seeks to engage. To that end, the following research objectives address possibilities for ideologically and qualitatively re-orienting dental education towards social justice educational traditions:

Research objective 1. Weaving together the essential (theoretical) components of social justice education as identified in the literature review in Chapter 3, this thesis will develop a social-justice assessment/conceptual tool that might be used by dental educators and curriculum writers to assess the social justice orientation of their work (see ACFD, 2016; AFMC, 2011, CUS, 2011).

Research objective 2a. To identify action items to further develop DENT 206 based on the results of the assessment.

Research objective 2b. To demonstrate how the framework can be used as a practical tool for potential users by using it to assess my DENT 206 course.

In service of these objectives, the next chapter will outline the two-pronged qualitative case study methodology to be employed: 1) the conception of a social justice-oriented educational framework and conceptual tool for dental education, and 2) an evaluation of the social justice course I teach and direct at McGill University's Faculty of Dentistry via a thematic analysis (DENT 206).

Chapter 4: Methodology and Methods

Two-Phase Qualitative Case Study

I sought to investigate the possibilities for increasing the alignment of dental schools' teaching mission with social justice education via a two-pronged qualitative case study of the social justice and oral health course I facilitate and am developing at McGill University's Faculty of Dentistry, DENT 206: Dentistry Social Justice Seminar. Due to the self-study nature of this case study, it was also an opportunity for me to learn about my own practice and generate action items to improve DENT 206's course content. I made methodological choices in this thesis with further consideration for dental educators who might not have a background in social justice pedagogy. Though I carried out the investigation so that I could identify action items for my own curriculum development work, I also hoped to reach Canadian and American educators for them to consider the potential of exploring theory-informed and context-sensitive strategies to operationalize social justice tenets in their respective dental training programs.

In this chapter, I will first outline the overall design of the case study and explain the appropriateness of this approach for this thesis. This will be followed by a description of the two methodological components of this inquiry, each one corresponding with the two main research objectives stated at the end of Chapter 3.

Case study design and rationale. I conducted a "single case design" study – commonly used to test theory in a practical application (Yin, 1981, p. 100). Here, an emerging educational framework was used to analyze a social justice course I teach at McGill University, DENT 206. DENT 206, in this investigation, was classified as a "paradigmatic case" whereby a primary goal of the study was to develop a school of thought or practice and operationalize it within a practical context, i.e. dental professional training programs (see Flyvbjerg, 2006, p. 231 and

Harland, 2014, p. 1118). There has yet to be a course (or curriculum content) explicitly framed by social justice tenets in Canadian dental education. Through this inquiry, I sought to unearth possibilities for integrating an educational tradition explicitly grounded in social justice and critical education into dental professional programs (see Harland, 2014, p. 1119-1120). This investigation moreover relinquished positivistic tendencies (controls, replicability, generalizability), and prioritized the context and the nuances of the case at hand (Flyvbjerg, 2006, p. 221). As per Harland (2014):

> It is important for the new researcher to recognize that in case study, for the case itself, N =1. Neither the researcher nor reader can truly replicate the study, they can only learn from it… it is still a single case if it is dependent on a specific social context in time and place. (p. 1116)

To that end, this case study was not designed to generate proof, but rather to provide a means of learning through research and build a nascent educational expertise (Flyvbjerg, 2006, p. 224). Harland (2014) additionally affirms that the case study is a means by which university teachers can methodically examine their teaching practice through research through a context-sensitive bridging of theory with practice (pp. 1113-114; see also Flyvbjerg, 2006, p. 220). Fundamental to this inquiry was also to bring to light the potential for a social justice-oriented educational framework and create a conceptual tool for other Canadian dental programs, and educators in the "humanistic" areas of dental education, to consider a social-justice oriented approach. This chapter will proceed with detailing the two constituent components of this paradigmatic single-case study: Method A (theoretical work), and Method B (thematic analysis and practical application of theory).

Method A: Theoretical Work and Creation of Conceptual Tool

The methods used for Part A of the study, in service of Research Objective 1, created a framework built from theories and practices from the two pertinent educational traditions in this

study. The outcome of this phase served two purposes. The first was to construct a conceptual tool for dental educators to re-orient their teaching mission toward social justice ideals. The extant bodies of knowledge lying in two distinct traditions of teaching, social justice education (as outlined in the Chapter 2, Conceptual Framework) and the "humanistic" aspects of dental education (Chapter 3, Literature Review), provided the raw materials for building the emerging social justice-oriented dental educational framework .The second was to equip the study with a theory-driven analysis framework with which I analyzed and assessed the contents of my dentistry and social justice course via a thematic analysis. In summary, this theoretical work functioned to determine if the substance of my teaching practice is resonant with a context-sensitive social justice educational framework.

Content and format. hooks (1994) describes her teaching praxis as informed by the convergence of her lived experiences and the social and educational theories from which she drew. She asserts that revisiting theory and the act of theorizing are constituent practices of working towards social change and liberation (hooks, 1994, p. 69). Austin and Paré (2009) echo this, stating that "theory is congealed experience which, in a concentrated form, can bring years of accumulated knowledge to bear on a particular issue or cause..." (p. 115). In Chapter 3: Literature Review, I gave a broad overview of the humanistic aspects of dental education and provided a 3-category representation of this area of dental education. For each category, I described its divergence from social justice and critical education and offered a social justice-oriented reimagining of it. The literature review therefore is a representation of the "congealed experiences" and expertise from the two educational traditions which address issues of social responsibility, social difference and inequality, and service to community. In order to transpose the proposals which I laid out in the literature review (Chapter 3) into a theoretical and practical

tool for dental educators, it was therefore necessary to distill them into a usable format similar to the ACFD's (2016) *The Competent Beginning General Dentists*.

This move is methodologically supported by Howe *et al.* (2018) who integrated social construct theories of race and epidemiological statistical analysis frameworks to analyze HIV intervention and race disparities in the United States (p. 318). Beach *et al.*'s (2008) nascent framework for integrating spiritual therapeutic practices with marital and family therapy similarly accomplished a joining of two divergent frameworks. The authors took analogous themes from the two bodies of literature to demonstrate points of meeting among the two practices. For example, the authors considerd the promotion of relaxation, a core skill for marital and family counsellors, and identified parallel practices from the literature on spiritual therapeutic practice, e.g. "prayer for self-soothing and self-healing" (p. 647). Within the broader theme of relaxation, prayer, and self-soothing, Beach *et al.* also drew on evidential support from the literature on the ways spiritual practices can be used to complement this particular skill in conventional therapeutic practice (p. 649). In the vein of creating a theoretically informed assessment framework, the Observatoire sur la Formation à la Diversité et l'Équité's (2018) equity and diversity competency tool for educational leadership identified benchmark competencies and guiding questions in their report by drawing on a conceptual framework of social justice, equity, and inclusive education (pp. 20-21). The Centre for Urban Schooling (CUS) (2011) likewise conceived an instrument for the Toronto District School Board to assess school and classroom-level implementation of equity and inclusive education by transposing a framework based on Culturally Relevant and Responsive Pedagogy (p. 1).

Accordingly, I teased out concepts from the literature review, with specific attention to the sections wherein I provided a social justice-oriented critique and reimagining of dental

education. The assessment tool's format was based on three documents: ACFD's *The Competent Beginning General Dentist* (2016), the Association of Faculties of Medicine Canada's *Equity and Diversity Audit Tool* (2011), and the CUS's *Equity Continuum: Action for critical transformation in schools and classrooms* (2011). Through an iterative process, I first generated higher-order concepts which served as the broad conceptual themes in the assessment tool. These ***higher-order concepts*** were based on high-level abstract themes presented in the "reimagining" sections of the literature review. I conceived these sections by engaging with an area of "humanistic" dental education as an entry point for a social justice education-oriented critique and reconceptualization. These broader themes, e.g. Politicizing Dental Education, were therefore attentive to both the conceptual framework of social justice and critical education and the context of dental education (i.e. ethics and professionalism). Medium- and lower-order concepts respectively served as the basis for indicators and guiding questions. These lower level concepts populated the broad themes/higher-level concepts of the conceptual tool.

Medium-order concepts/indicators were concepts which hold under the high-order themes, i.e. it is a constituent concept and/or a sub-theme of a higher-order concept. Characteristic of an indicator was its ability to maintain attentiveness to both social justice and critical education, and dental education. For example, "structural awareness" (see Metzl & Hansen, 2014) would be a medium-level concept under high-level/broad theme of "Social Justice-oriented Diversity Education and Public Health**"**. It respected dental education's mandate to train students on diversity matters and public health issues (ACFD, 2016, p. 18; ADEA, 2015) and attended to social justice educational critiques of diversity education which located poor health conditions in marginalized bodies and communities rather than the social conditions and structures which were permissive of them (see Flaitz et al., 2013, p. 191; Metzl and Hansen,

2014, pp. 126-127). Medium-order concepts/indicators therefore exhibited lower levels of abstraction than the higher-order concepts/broader under which they were categorized.

Lower-order concepts/guiding questions were granular concepts which held within medium-order concepts and showed attentiveness to only one of the two concerned educational traditions. Lower-order concepts served as guiding questions which facilitated identifying the presence or absence of an indicator/medium-level concept. Additionally, guiding questions either: 1) calibrated an indicator's ideological and qualitative orientation towards that of social justice education, or 2) ensured attentiveness to the context of oral health professional education. Guiding questions were generated through a side-by side comparison of the indicators with the main themes presented in the conceptual framework (Chapter 2, overview of social justice and critical education), and the literature review (Chapter 3, humanistic aspects of dental education). Concrete examples were also provided for user-friendliness and to elaborate on what is being asked by the guiding question.

In summary, the assessment-conceptual tool was laid-out as follows:

1. **Broad Theme:** higher order concept of the highest level of abstraction drawn from the major themes in the social justice-oriented reimagining of dental education sections of the literature review (Chapter 3).
    a. **Indicator:** medium level concept demonstrating a lower level of abstraction than a broad theme; they were sub-concepts which resonate with social justice education and could explicitly demonstrate a sensitivity to the context of dental professional education.
        i. **Guiding questions (GQ) and examples:** contained the most concrete (lowest level of abstraction) proposals in the assessment-

> conceptual tool; served to ensure either an attentiveness to the context of dental education, or an adherence to social justice educational tenets.

Method B: Thematic Analysis

Clarke and Braun (2017) define thematic analysis as "a method for identifying, analyzing, and interpreting patterns of meaning ('themes') within qualitative data," (p. 297). It is grounded in recognizing trends in a data set – ones that demonstrate substantive significance which is "the consistency of themes across and within [the data set and when it] deepen[s] understanding of extant knowledge about the object of inquiry" (Floersch et al., 2010, p. 408). A coding framework built with the concerned educational traditions (p. 409; see also Clarke & Braun, 2017, p. 298) guided a coding process, deductive (theory-driven) in this investigation. Using the framework method, as outlined by Gale *et al.* (2013, pp. 4-5), I harnessed the theoretically-driven conceptual tool in Chapter 5 to perform a deductive thematic analysis of DENT 206's instructor-generated course content in service of Research Objective 2. I coded the themes emerging in the DENT 206's course content via an analysis of its textual artefacts, which are: 1) the course-specific items of the syllabus, and 2) the course presentation slides and instructor/facilitator notes.

I chose thematic analysis due to its flexibility as it can operate under a variety of research paradigms (Braun & Clarke, 2014, p. 2; Clarke & Braun, 2017, p. 29; Floersch et al., 2010, p. 408). Further, thematic analysis has been historically used in tandem with critical theoretical frameworks to "interrogate patterns with personal or social meaning around a topic" (Clarke & Braun, 2017, p. 297). In light of these properties of thematic analysis, it was therefore

appropriate for executing a critical theory-driven interrogation of the social justice course I teach in a dental professional program.

Step 1. I created an **analytic framework** founded on the assessment-conceptual tool housed in Chapter 5 (i.e. result of Method A). This chapter acted as the theoretical skeleton which provided high- and medium-level theories and concepts to be used in the deductive coding process (detailed in Step 3).

Step 2. I printed multiple hard copies of the of the DENT 206 course syllabus, course slides, and instructor notes and **defined my unit of analysis** i.e. a *course unit*. A course unit was a stand-alone section that includes learning content, context, and learning strategies centered around a specific topic or theme (see McGill University's Course Design Workshop, 2017 and Whetten, 2007, p. 349). Note that only the parts of the textual artefacts authored and/or generated by the course instructor and co-facilitators, and were relevant to the teaching content of the course were analyzed here (e.g. attendance policies, academic integrity policies, reminder slides for submission deadlines and the like will be excluded).

Step 3. The analysis began with an iterative **deductive coding process** (Braun & Clarke, 2006, p. 78; 2014, p.1). Predetermined codes were based on the assessment-conceptual tool indicators resulting from the first phase of inquiry. I indexed them accordingly onto a spreadsheet reflecting the structure of the conceptual/analysis tool from Method A.

Step 4. In this step, the codes were **reviewed and verified** (Braun & Clarke, 2006, pp. 89, 91) within the framework. A course unit's resonance with the assessment-conceptual tool were reviewed as follows: 1) reviewed course units at the level of indicators and guiding questions, 2) reviewed course units at the level of broad themes (see Saldaña, 2009, p. 4).

Step 5. The **assessment stage** was concerned with identifying the course content's areas of strength, and of improvement. I first tallied the number of course units which resonated with each of the analysis (assessment) framework's indicators. Then, I took note if each indicator appeared in all four of DENT 206's lecture-workshops and the syllabus. To gain a sense of an indicator's and broad theme's representation within DENT 206's course content, I then took stock of the mean number of course units across all of the framework's indicators. The following criteria guided the assessment stage to concretely identify areas of strengths and/or of improvement (see Garner, 1991, pp. 159-161):

- At the indicator level: the indicator appeared around the mean frequency across all indicators; it was satisfied by at least one course unit in each of the four lecture-workshops and the indicator was satisfied in the syllabus.
- At the broad theme level: most (more than half) or all of a broad theme's indicators were present consistently in course units across the four lecture-workshops; most or all of a broad theme's indicators were satisfied in the syllabus

Researcher's Position and Additional Checks

In accordance with the conventions of qualitative research, I must address my positionality in this investigation (Flyvbjerg, 2006, p. 235; Rossman & Rallis, 1998, p. 35). I have a particularly close proximity to the subject of study as the individual who created the course and as the primary practitioner teaching the content. Each of DENT 206's lecture/workshops, in line with social justice and popular education tenets, is co-facilitated by an expert in the featured topic. I invited each of these co-facilitators for a peer-check (Garner, 1991, p. 164) pursuant to the outcomes of Step 4 of Method B. I requested for them to share any disagreements with, and further insights on, the ways I coded and analyzed the lecture/workshop

on which we collaborated. After peer-checking, I performed a "return to the field" (Garner, 1991, p. 156), revisited the artefacts of analysis and each step of Method B in mind the feedback that arose from the peer-check.

In the following chapter, Chapter 5, I will present the assessment tool generated from Method A pursuant to the mission of research objective 1: the creation of an emerging social justice-oriented educational framework for dentistry. This will be followed by Chapter 6 where the results of Method B will be discussed in service of Research Objectives 2a and 2b. This chapter will be concerned with demonstrating a practical usage of the assessment tool as well as exploring possibilities for developing my teaching practice as a social justice educator in dentistry.

Chapter 5: A Social Justice-Oriented Assessment and Conceptual Tool

This chapter will present the outcomes of the first methodological phase of this paradigmatic single-case study. Its primary aim was to develop an emerging social justice-oriented assessment-conceptual tool for dental education, and in turn, an invitation for dental educators to consider an educational tradition with which they might not be familiar. It was also used as the basis for the analytic framework for the thematic analysis of my course, DENT 206: Dentistry Social Justice Seminar, pursuant to Method B. This conceptual tool was developed via a theoretical distillation of the critical sections of this thesis' literature review (Chapter 3) wherein I offered a social justice reimagining of the major aspects of humanistic dental education.

The tool is organized into four overarching themes. Each overarching theme contains indicators based on more micro-level concepts arising from the critical sections of the literature review. Guiding questions are provided to gauge the ideological and qualitative orientation (social justice and critical education), and/or the context attentiveness (dental education) of each indicator.

Theme A: Politicizing the Self in Dental Education

Themes A and B provide a conceptual guide for deploying **professionalism and ethics education** oriented towards the traditions of social justice and critical education. The proposals in theme A are geared towards supporting students in situating themselves as political and professional actors within the contexts of oral healthcare, health inequality, and social injustice; whereas theme B (to follow) speaks to the broader profession-level scale.

Indicator A1. Political-neutrality and depersonalized engagements in social and health injustice are challenged. Students are supported in reflecting on and interrogating their own

political beliefs, personal values, and lived experiences. They are further challenged to think about the ways in which these inform their understanding of professional behaviours and ethics.

Guiding Questions:

1. Are students guided in self-reflexively considering their own understanding of what it means to be an equitable and socially just oral healthcare provider?
    a. Example: Students are asked to critically assess their personal ideologies concerning race politics and to be aware of the ways in which this might impact their professional ethic.
2. Are students supported in analyzing their various locations along different axes of identity and experience? In "locating" themselves, they also asked how their particular position(s) impact their personal and academic experiences? Does the course content challenge students to think about the ways in which privileged social locations might render invisible the experiences and injustices lived by those in marginalized locations?
    . Example: Students are asked to think about their lived experiences from the perspective of gender and sexuality. Students who identify themselves as cisgender and/or heterosexual are encouraged to think about possible challenges in dental school (and elsewhere) that negatively impact LGBTQ+ students. For those who identify as queer and/or trans, they are asked to think about their experiences in dental school and are supported in naming the violence, exclusion or discrimination they have gone through. Collectively, students are then asked to collaboratively reflect on

how to resist homophobia and transphobia in their school environment in ways that centre the experiences of LGBTQ+ students.

Indicator A2. Spaces are provided for students to critically think through (individually and collectively) the particularities of dental professionals' privilege and power and their intersections with other social privileges they possess. Moreover, this thinking is applied to the doctor-patient level as well as institutional and structural levels.

Guiding Questions:

1. Does the course support students in developing an appreciation for the ways in which one's location along axes of identity and experience (race, class background, gender identity, sexual orientation, ability/(dis)ability etc.) inform and intersect with their status as dental professionals.
    a. Example: The course provides dialogic spaces where students can discuss how their professional privileges and powers might not be experienced equally. The course might bring up how gendered social relations impact the experiences of women and LGBTQ+ students in dental school and in the profession (see Anderson et al., 2009; Tiwana et al., 2014).
2. Does the course unpack professional roles other than healthcare provider, e.g. business owner, employer, health policy maker, dental educator? Does the course address the ways in which dentists might hold additional privileges other than being the holders of privileged medical expertise, e.g. high earning potential, symbolic prestige of being a medical doctor, having matriculated from one or more institutions of higher learning etc.?

. Example: Students are asked to discuss the economic power embedded in the role of dentists who are proprietors of private clinics and therefore employers of junior dentists, allied professionals, administrative staff etc.

Indicator A3. In light of the powers and privileges afforded to dental professionals, students are asked to think about their personal and professional responsibility to act in socially just ways and work towards health equality and justice.

Guiding Questions:

1. Are individual and/or group reflections and discussions grounded in concrete clinical and/or personal experiences?
    a. Example: Students are asked to analyze a clinical scenario where an uninsured patient requires extensive endodontic work and is having difficulty accessing subsidized or pro-bono services. The course facilitates spaces where students can conceive creative solutions and contemplate their responsibility to patients who are economically or otherwise marginalized
2. In consideration of diverse axes of identity and experience (race, class background, gender identity, sexual orientation, ability/(dis)ability, mental illness, trauma etc.), do students explore how these might ideologically and materially inform their sense of duty to and actualization of their personal/professional responsibility?
    . Example: Indigenous students who wish to deliver care in their respective communities are supported in visioning their work and navigating the privileges afforded to them as future health professionals. Non-indigenous

dental students are supported in understanding their position in relation to Indigenous colleagues and communities, and are provided tools to develop concrete strategies for their roles as allies to their Indigenous colleagues.

   a. Example: A course critically unpacks the intersections of systemic racism and poorer oral health conditions in Canada and the United States (Albino et al., 2012). Students of colour are supported in holding their privilege and power as emerging elite health professionals while reconciling this with their experiences of racial marginalization. White students are challenged to think through the ways in which they have a responsibility in supporting their racialized colleagues and in resisting racism from the individual to the systemic level.

3. The "so what now?" factor: in recognizing students for demonstrating a critical awareness of social injustice and health inequality, are students then challenged to be proactive and action-oriented in their work? Are there opportunities for them to generate concrete ideas to use their privileges in service of social justice outcomes?

   . Example: Students are provided real-life examples of healthcare providers doing social and/or health justice work, and students can either independently or collaboratively formulate their own ideas for using their social and/or professional privilege for socially just ends. Further, the course incorporates collaborative work, facilitated group discussion, and consults sources of knowledge outside of dentistry and health sciences

(e.g. news media, popular writing pieces, works of fiction, popular movements, past social justice work)?

Indicator A4. Discomforting emotions or learner resistance resulting from internal dissonance, disagreement with others, not knowing, or guilt, are de-stigmatized and are repurposed as openings for critical learning. To that end, there are "safer spaces" for students to: 1) critically reflect on possible ways one is actively or tacitly complicit in injustice and inequality, 2) individually and/or collectively work through resistance to social justice ideals, 3) individually and/or collectively strategize on how to challenge one's own complicity to injustice.

Guiding Questions:

1. Are students supported in navigating transitions between feeling guilt and/or resistance, and with facing their personal responsibility for providing quality care in an equitable fashion to all their patients?
    a. Example: In an activity on unearned social privileges, space is provided for students to name their guilt while they are challenged them to push towards action and allyship.
2. Given that students may fall in various locations along discursive axes of identity and experience, are there ways to attend to the range of student needs for safer learning spaces?
    . Example: A course module ensures that Indigenous students' needs are centered during discussions of colonialism and Indigenous health.
3. Does the course provide students with tools to manage and engage with disagreement with the course content, the facilitator, and their peers?

. Example: Rules of engagement ground class activities and discussions in respect, critical thinking, and collaboration.

4. Does the course recognize that students might be at different points in their social justice learning journey?

. Example: Students are assessed through pass/fail journal assignments as formative evaluation mechanisms for the instructor to: 1) create a safer space wherein students can articulate their learnings and reflections, and 2) provide feedback and suggestions for further reading or thinking tailored to where the student is in their learning path.

Theme B: Politicizing the Profession in Dental Education

While Theme A addresses a political and social justice understanding of the self, the proposals in Theme B does so at the level of the dental profession and the structures which give rise to oral health inequality and social injustice.

Indicator B1. Students are guided in connecting broader political and social issues with the profession of dentistry and the delivery of dental care. These connections are moreover interrogated within the context of working towards social justice and health equality.

Guiding Questions:

1. Are issues of colonization, racism, heterocissexism, classism etc., both historical and contemporary, addressed within discussions about determinants of oral health, and the lack of diversity in the profession (see ADEA, 2015)?

a. Example: Students are asked to consider the connections between the historical and ongoing subjugation of Indigenous peoples of Canada and high rates of oral disease in these communities.

2. Are students asked to think about the links between trauma and structural violence and/or systemic oppression and the ways in which a critical awareness of these inform patients' experiences in accessing (or not accessing) dental care?
    . Example: Students are presented with clinical scenarios to unpack the ways in which gendered and sexual violence create access barriers, and the importance of trauma-informed care (see Raja et al., 2015a).

Indicator B2. Students are asked to consider social justice implications in the primarily privatized landscape of oral healthcare. They are guided in engaging with the dissonance between a predominantly a fee-for-service model of care delivery and a commitment to a democratic oral healthcare system.

Guiding Questions:

1. Is the role of dental professionals in the history of the privatization of oral healthcare highlighted and critically analyzed through a social justice lens?
    a. Example: Students are provided materials to explore the history of privatization of dental care delivery and the role of dentists and other political actors therein. These materials further explore the impact of these political activities on contemporary issues re: the delivery of dental care and oral health inequality.
2. Are students challenged and supported in identifying potential contradictions between professional statements, codes of behaviour, human rights documents, and/or professional commitments to quality and availability of care?
    . Example: Students are asked to reflect on and name possible dissonances between statements on ethics and professionalism (e.g. The American

Dental Educational Association's commitment to service-mindedness (2016b, p. 870) or the Canadian or the Canadian Dental Association's (2010) stance, affirming that "*All* Canadians have the right to good oral health," and the dental care delivery status quo.

Indicator B3. Students are supported in critically thinking about the stakes for those marginalized and those privileged by a primarily privatized oral healthcare landscape.

Guiding Question:

1. Are there learning materials which problematize dentists continuing to economically benefit from a fee-for-service model? Do they address both tacit and active acceptance of the oral healthcare economic status quo and how it might perpetuate barriers to access for those underserved and marginalized?
    a. Example: Students are asked to unpack the moral stakes in dentists incurring monetary profit while there are those who cannot afford life sustaining/saving dental care. They are then asked to reflect on possible systemic and individual-level changes to address this issue.

Theme C: Social Justice-oriented Diversity Education and Public Health

Theme C contains conceptual anchors for specifically qualitatively aligning **diversity and public health education** within a social justice-oriented framework. The indicators herein call attention to and critique dental education's general treatment of "cultural diversity" and "social difference" and complicates them from a social justice and structural perspective.

Indicator C1. Matters of diversity, dental public health, and social difference are consistently situated within historical and contemporary issues of social (in)justice.

Guiding Questions:

1. Are students asked to reflect on their own understandings of diversity and inequality and to connect them with larger issues of social inequality and oppression?
    a. Example: A case discussion on community-based dental care and the demographic of patients who tend to access subsidized dental services are interrogated through the lens of systemic exclusion (e.g. racism, colonialism, heterosexism, cissexism, classism etc.).

Indicator C2. There are guided and supported spaces wherein students can exhume and challenge their own deficit views of historically marginalized individuals and communities. Further, students reflect on these negative biases in relation to broader histories and structural issues. Example: A student demonstrates an acceptance of the stereotype that low-income Parent(s)/guardian(s) are neglectful of their child's oral healthcare needs. This deficit view is then challenged and the student is supported in critically reflecting on structural challenges that low-income families face in navigating a privatized health service.

Guiding Questions:

1. Are there materials which carve out spaces for challenging self-reflexive activities whereby students can unearth their personal biases and preconceived notions? Are students further supported in owning up to these negative biases and are given opportunities to challenge them and transform their thinking?
    a. Example: Students are presented with a scenario based on real events whereby a refugee patient on social assistance was subject to discriminatory treatment by clinical staff. They are then asked to identify reasons why this is reflective of systemic violence against displaced

persons. Either within the same exercise or in a follow-up assessment, students are invited to think about when they might have demonstrated similar negative attitudes and/or behaviours and identify how the scenarios-based discussion might help them come to realize their own deficit views.

b. Example: The course elicits ideas from students on possible sites where deficit views might have originated or taken shape, e.g. deficiencies in their historical knowledge, negative media portrayals, social pressures, power and hierarchy structures etc.

c. Example: The course privileges students wanting to "do better" over lingering in guilt or shame. Students are supported in working through deficit attitudes by providing openings for them to own up to them in safer spaces and strategize on concrete reparative work.

2. Are students guided in realizing their personal and professional accountability in challenging these negative stereotypes and implicit biases? Are they then supported in understanding how this process can improve their patient care skills and professional ethic?

. Example: A module presents a case study on the oral healthcare experiences of those on social assistance. A follow-up activity then elicits a discussion on professional behaviours complicit in stigmatizing these patients and discourages them from accessing the necessary health services (see Raja et al., 2015).

   a. Example: Given a lack of racial diversity in the profession (see ADEA, 2015), and experiences of marginalization of students and professionals of colour (see McCann et al., 2014), students are supported in realizing their duty to push for unlearning deficit views.

Indicator C3. This indicator advocates against disproportionately focusing on issues of "cultural difference" in diversity education. It shifts the gaze towards status quo conditions and structural norms which undergird individuals' and groups' social location and experiences of health/illness. This indicator seeks to resist framing marginalized communities as "sites of depletion", but rather problematizes structural and systemic factors (see Tuck, 2009, p. 412)

Guiding Questions:

1. Are there facilitated open discussions on these issues which further elicit diverse student perspectives?
   a. Example: A facilitator supports an open discussion which begins with what "diversity" means to students and why it is important to have a critical understanding of diversity, difference, and inequality in their roles as future oral healthcare providers.
   b. Example: Rather than solely discussing patterns of poorer oral health among non-whites in the United States, the course helps students uncover evidence-based factors which locate issues in the structures and systems that subjugate people of colour. For instance, the course asks students to cross-examine dentists of colour being more likely to provide treatment for patients of colour and a lack of racial diversity in the profession (ADEA, 2015; 2016a, p. 888). What are the implications of failing to

question the over-representation of white persons in dentistry? Who is structurally positioned as "knowers" and "doers" of specialized medical knowledge and skills? Who is structurally positioned to be "known" and the receivers of care?

2. Do students have the opportunity to explore the ways in which a social justice understanding of structural violence and structural inequality can help them improve their patient care and health advocacy skills?

    . Example: The course facilitator reads the following vignette: *A southern Filipinx family with one parent and two children arrived in Canada three months ago. They had to flee their home province due to increasing violence stemming from poverty and a corrupt regime backed by wealthy foreign powers. The parent was able to claim refugee status for her and her children. She secured work as a domestic employee for a wealthy white family. Her wages were meagre and barely enough to pay for a small apartment across town from her employers. Another way for her to cut costs was to buy high calorie, sometimes high sugar, foods to make sure her children had three full meals per day. Her youngest child started to complain about a sharp pain in their mouth. The parent inspected their mouth and discovered a cavity. The parent does not get additional benefits to her wages and asks her employers for a salary advance to pay for her child's dental care needs. The employers refuse and blame their employee for not being more mindful of her children's dental hygiene and nutrition.*

The facilitator then assigns small groups to discuss the issues embedded in the refugee family's situation and analyze the employers' response.

Theme D: Hope and Social Justice in Action in Dentistry

This final section of this assessment tool will outline conceptual anchors for change-making work and community-based dental education. The tenets within theme D directly converse with **community-based dental education and service-learning** to support students in conceptualizing long-term sustainable and ground-level efforts to challenge health inequality.

Indicator D1. Students are supported in developing a personal sense of responsibility for socially-just change making work. Dentists are posited as agents of socially-just change.

Guiding Questions:

1. Bearing in mind that a number of dental professionals organized to lobby for the privatization of dentistry in Canada, does the course propose the possibility for dental students to organize to do political advocacy work to challenge status quo conditions and relations? Does the course advocate to move beyond awareness and open up spaces for students to contemplate socially-just possibilities for the future of the dental profession and oral healthcare?
    a. Example: Students are provided facilitated and supportive spaces to think about social and/or oral health inequality issues which speak to them. They are guided in reflecting on, and perhaps generate ideas for, advocacy and change-making work which necessarily involve supportive peer-feedback mechanisms.

Indicator D2. Students are enabled to identify activities within the oral healthcare arena that are possible sites for social justice-oriented work.

Guiding Questions:

1. Are students asked to reflect back on their own experiences and encounters in the oral healthcare arena and identify social justice possibilities therein e.g. political campaigns, community-based healthcare initiatives, trauma-informed care workshops? Does the course carve out generative spaces for students to share their ideas?
    a. Example: During a group debrief and self-reflection after a community clinic observation, students are asked to brainstorm oral healthcare solutions tailored to the meet the community's needs and the ways in which they can ensure that the process is community-led.

Indicator D3. This indicator advocates for collaborative work, cooperation, and building solidarities within and outside the oral healthcare arena. It is grounded in the belief that a social justice future for dental education, the profession, and the oral health of society is a collective achievement rather than an individual one.

Guiding Questions:

1. Are there guided dialogic spaces for students to share their imaginaries? Are students challenged to be inclusive of other actors within and outside the dental profession i.e. educators, patients, advocacy groups, policy makers, activists etc.?
    a. Example: Students have opportunities to do collaborative work geared towards conceptualizing, planning, and actualizing social justice and oral health initiatives. Students are consistently reminded that their initiative requires the involvement of actors outside of the dental profession and must be accountable to the target community.

The following chapter will report on the findings and analyses generated in pursuit of this thesis' second research objective: a social justice assessment of my own social justice course in McGill University's dental training program, DENT 206. The assessment-conceptual tool presented above will be transposed into an analysis framework. This will serve as the initial coding framework with which I will conduct a deductive thematic analysis of the textual artefacts of DENT 206, namely its syllabus, lecture/workshop presentation material, and instructors' notes. I will begin Chapter 6 by briefly describing the course – its learning objectives, its assessment tools, and a general summary of the course's contents. The remainder of the chapter will summarize findings unearthed via the thematic analysis.

Chapter 6: Social Justice Audit of McGill University's DENT 206

This chapter will summarize the outcomes of the second methodological component of this thesis' qualitative paradigmatic case study: a deductive thematic analysis of the textual artefacts of McGill Dentistry's DENT 206 (Briones et al., 2016). I will first report on the analysis of the course syllabus. Following this, I will provide an overview of my analysis of the course presentation slides and instructor notes using the conceptual tool developed in Chapter 5 and a comparative assessment of the two sets of artefacts. Note that I will be referring to broad "themes" (e.g. Theme A) and "indicators" (A1, A2, A3 etc.) from the framework presented in Chapter 5. I will include insights gathered from the peer-checking phase of analysis method in this assessment. As an additional check-point for my analysis activities due to my personal and professional proximity to the artefacts of study, I engaged the co-facilitators who supported the delivery of DENT 206's course content in a peer-checking exercise. The chapter will end with an overture to the final chapter of this thesis.

Assessment of DENT 206 Syllabus

As stated in a course design workshop offered by McGill University, the syllabus (or course outline), enshrines "the skills, knowledge, and attitudes that students will develop as a result of participating in the course" (McGill University, 2017). This is accordingly reflected in the institutional requirement that syllabi must provide a general description of the course, its primary learning outcomes, and the methods with which students will be evaluated. In accordance with the criteria outlined in Chapter 4, Method B (see McGill University's Course Design Workshop, 2017 and Whetten, 2007, p. 349), the syllabus stands as a unit of analysis which textualizes learning content (course description), learning context (learning outcomes, and learning strategies (methods of assessment). For the purposes of this assessment, I decidedly

focused the analysis on the instructor-generated course-specific elements of the syllabus (see Appendix A for relevant DENT 206 syllabus excerpts).

I recorded 14 instances of Theme A indicators appearing in the course syllabus text I summarized above, with all four indicators represented (4 instances of A1 and A2, and 3 for A3 and A4). Theme B appeared via four instances of indicator B1 and Theme C with 2 appearances of Indicator C1. The course syllabus communicates an explicit attention to political social justice issues as they related to students' roles as emerging healthcare providers. The general course description invokes indicators A1, B1, and C1. It signals the course's orientation towards social justice and inequality perspectives on students' prospective roles as healthcare providers, as private individuals, and as actors in the public health domain. The following text demonstrates these assertions:

> ...greater socio-cultural and historical implications of social justice and systemic oppression, as they relate to the role of oral health care professionals as well as personally (A1, B1). This course links ethics, professionalism, and public health discourse with social justice and anti-oppression discourse (see Indicators A1, B1, C1).

I argue that the syllabus serves as a statement of values to which the course adheres and should be indicative of the grounding ideologies that operate therein. The course description explicitly implicates social justice and systemic oppression in the students' professional and personal arenas as well as names context-attendant concepts (ethics, professionalism, public health) to be taken up within a social justice framework.

A course syllabus' learning outcomes not only delineate the knowledge and skills to be gained by the learner, but also how they might expect a change through their experiences in the course (Whetten, 2007, p. 344). DENT 206's syllabus establishes an expectation of students to directly engage in social justice issues at individual, interpersonal, institutional, and systemic

scales. Learning outcome 1 of 3 regards students as political actors in the elisions of oral health, health inequality, and social justice:

> Understand the broader context of oral health and social inequality as they relate to their various professional and social roles (healthcare provider, educator/mentor, community leader, business owner/employer, private life) (learning outcome 1).

The cited text above calls attention to their eventual roles as dentists, but also various of medico-social roles they (will) don (e.g. employer, clinic owner, community leader, private life; see indicators A1, A2, and A3). Learning outcome 2 follows this logic and indicates a cognitive shift in their thinking on matters of social justice, stating that students will be able to "[c]ritically analyze professional and personal dilemmas through a social justice and anti-oppression lens" (learning outcome 2). This is then further qualified with "apply appropriate professional behaviours" to reiterate that these analytical skills are dependent on students' ability to materialize them in their roles as care providers (see indicators A1 and A2). Learning outcome 1a puts forward issues of diversity and equity and announces that the course will take up these known issues in dental education within a social justice framework:

> Develop a nuanced understanding and appreciation for equity, social justice, and diversity as they relate to students' various professional and social roles (learning outcome 1a).

The text therein also retains a commitment to implicating their professional and social roles (see indicators B1 and C1).

The final set of learning outcomes features the only two instances where Theme D of the assessment tool manifest in the syllabus (see indicators D1 and D2). Learning outcome 3 and 3a positions students as active participants in social justice-oriented work as dentists:

> Understand their roles as agents for transformative social change both at the individual and societal level (learning outcome 3); Develop an appreciation of the complexity and challenges inherent in social justice and oral health (learning outcome 3a).

The text above further demonstrates an appreciation for the complexity of weaving social justice into their practice and evokes action at scales beyond the individual.

DENT 206's assessment methods demonstrate a sensitivity to social justice education and critical pedagogy. Though specific indicators from the conceptual tool did not necessarily emerge therein, the assessment methods nevertheless indicate a disposition towards the traditions of social justice and critical education. The two writing assignments carve spaces for students to critically reflect on themselves, their understandings, and new ideas or positions that may have arisen from their course experiences. Seven of the 13 indicators in the conceptual tool, as outlined by the guiding questions, call on critical self-reflection and/or a push towards critical consciousness. Though the writing assignments do not outright signal the appearance of an indicator, they nonetheless create openings to operationalize learning techniques coherent with social justice-oriented learning. Additionally, I provide students with more granular writing assignment guidelines supplemental to the what is described in the course outline. I explicitly state therein that students are free to write about reflections beyond their professional and academic spheres and weave in personal reflections and experiences outside of the dental school context. The goal therein is to provide spaces for students to rethink their lived experiences in relation to the course material and affirm them as sources of knowledge (see hooks, 1994, p. 15). These written submissions moreover serve as a method by which I can provide individualized feedback and assess where the student is in their learning path.

The participation mark similarly accomplishes this coherence with dialogic and participatory-based learning which appear as guiding concepts in five (5) of the thirteen (13)

indicators of the assessment tool. The participation grade is given based on the students' attendance and their contributions to group and small group discussions. Bearing in mind that students may thrive in dialogic spaces in uneven ways (or not at all), I instituted a mandatory anonymized discussion question submission. Students are required to submit one discussion question to be shared with the class that must demonstrate "a personal or professional wondering, or… critical thinking as they relate to the course material" (see Howard, 2016). The anonymization of these discussion questions might also invoke some aspect of Indicator A4 of the framework, which calls on ways of holding discomfort and resistance in social justice learning. Students may have questions or contentions with the course material that might not be openly shared due to shame or hesitation with how they might be received. Overall, the assessment methods exhibit an adherence to tenets of social justice and critical education.

Next steps for syllabus. These constituent components of DENT 206's syllabus illustrate a strong resonance with Theme A (Politicizing the Self). Themes B (Politicizing the Profession), C (Complicating Diversity Education) and D (Socially-Just Possibilities in Dentistry) of the conceptual tool however, were not as well represented in the analysis compared to Theme A. Furthermore, not all of their indicators were satisfied - Indicators B2, B3, C2, C3, and D3 being the ones that did not appear. The analysis calls the syllabus to task due to its failure to address these assessment-conceptual tool indicators. In the succeeding and final chapter of this thesis, I will specify concrete modifications to the course outline pursuant to the absence of the aforementioned indicators.

Assessment of DENT 206 Lecture-Workshops

DENT 206 is comprised of four two-hour lecture-workshops. They are as follows:

1. Lecture Workshop 1, Thinking Through Social Justice: An overview of social justice concepts and discussions of dentistry-related cases involving social justice matters, e.g. racism, positionality, colonialism, allyship etc.
2. Lecture Workshop 2, Gender, Sexuality, and Gendered and Sexual Violence: A critical look at gender inequality, LGBTQ+-related issues as they relate to students' personal attitudes and lives, and their duty to sexual and gender minorities as healthcare providers.
3. Lecture Workshop 3, Critical Thinking, Digital Citizenship, and Critical Media Literacy: Given the role of the internet, social media, and mass media in individuals' private, public, and professional lives, this workshop engages students in adapting a critical take on consuming and analysing information from various online and mass media platforms.
4. Lecture Workshop 4, Moving Forward with Social Justice: This concluding lecture-workshop serves as a retrospective on the course for students and unpacks the importance of taking on a social justice understanding of their roles.

Summary of analysis results. The analysis of the workshop artefacts (slides and instructor notes) involved the coding of **25 course units** (unit of analysis as defined in Chapter 4) over the four lecture-workshops. For instance, in lecture-workshop 2, the consent education unit therein counts as one unit of analysis. It constitutes a clearly defined set of content (consent, rape myths which contradict consent culture, power), a context (gendered and sexual violence, patient care), and directed learning strategies (small-group activity, group discussion and distillation of learnings). Overall, I identified 10 course units in the first lecture-workshop, six in the second, five in the third, and four in fourth/last. The 25 course units are as follows:

Table 1. Summary of DENT 206 Course Units (Total: 25)

Lecture-Workshop	Course-Unit Name
1	Land Recognition and Discussion on Traditional Territory Acknowledgement
1	Ground Rules and Accountability
1	Iceberg Model: Understanding Systems of Oppression
1	Social Location Exercise and Debrief
1	Unpacking Social Privilege and Power
1	Case Discussion on "Haida Dental Project" and Colonialism
1	Unpacking Allyship and Accountability
1	Case Discussion on Hugh Papik Incident and Implicit Bias
1	What is Social Responsibility?
1	Safer Spaces and Submitting Questions in Confidence
2 (3, 4)	Discussion of Anonymized Student-generated Questions
2	Oppression Tree Model: Another way of understanding systems of inequality and directly engaging with oral healthcare
2	Breaking the Gender and Sexuality Binary
2	"Degrees of Intimacy" Exercise (SACOMSS et al., 2011) and Challenging Rape Myths
2	Gendered and Sexual Violence: Closer look at power and coercion
2	Supporting Survivors of Gendered and Sexual Violence
3	Digital Citizenship and Critical Media Literacy Overview
3	Case Discussion of Dalhousie Incident (see Backhouse et al., 2015)
3	Critical Media Analysis Activity: Unpacking a pharmaceutical advertisement
3	A Closer Look at #MeToo and #TimesUp
3	Critical Media Literacy and Professionalism: Conclusion and debrief

4	Group Watching of Bassett (2015) Social Justice Talk and Discussion
4	Differentiating between Cultural and Structural Competency
4	Making Mistakes and Calling Out (In)
4	Course Conclusion, Community, and Solidarity

Note. Left-hand column refers to which of the four DENT 206 lecture-workshops. Right-hand column contains the course unit's name (generated after refinement of analysis) to summarize content of unit.

Below is a table summarizing the outcomes of the deductive analysis as per total appearance of each indicator of the assessment-conceptual tool presented in Chapter 5:

Table 2. Summary of Indicator Appearance in Course Units

Indicator	Number of Course Units	Representation in all 4 Workshops?
A1	19	yes
A2	12	yes
A3	12	yes
A4	*0*	No (None)
B1	16	yes
B2	*5*	No (Workshop 1, 2, and 4)
B3	*1*	No (Workshop 4 only)
C1	14	yes
C2	10	yes
C3	13	yes
D1	8	yes
D2	7	yes
D3	*4*	No (Workshop 1 and 4)

Note. Left-hand column refers to the assessment framework indicator (see Chapter 5). Middle column indicates the number of course units that satisfy the indicator (those *italicized* indicate possible areas for

improvement). Right-hand column states if the indicator appears across all 4 lecture-workshops or not (workshops in which the indicator does appear).

Overall, the course content fulfilled indicators most consistently under Theme A (Politicizing the Self), and Theme C (Social Justice Reimagining of Diversity Education). All of Theme C's three constituent indicators emerged in the analysis across all four lecture-workshops in a considerable number of course units. As for Theme A, three of its four indicators (A1, A2, and A3) appeared consistently across the four lecture-workshops. However, none of DENT 206's 25 course units demonstrated a clear adherence to the requirements under Indicator A4 (managing discomforting emotions, resistance, and disagreement). With regards to Theme B, concerned with a social justice-oriented understanding of the dental profession and oral healthcare landscape, the analysis revealed uneven representation across its three constituent indicators. DENT 206 fared well with respect to Indicator B1 (making critical and political connections to the profession), in a considerable proportion of its units across all four lecture-workshops. However, the other two indicators in this theme were demonstrated consistently across the course content. B2 appeared in only five course units and did not appear in any of the course units in the third lecture-workshop. The lecture-workshop content demonstrated the weakest overall resonance with Indicator B3, arising only in one course unit in the fourth lecture-workshop. The analysis further revealed a relatively sparse representation with respect to Indicator D3 (collaborative approaches to social justice work in dentistry). Indicator D3 only appeared in four of the 25 course units and did not appear in lecture-workshops 2 and 3.

The remainder of this chapter will provide a theme-by-theme report of the deductive framework-led analysis of the lecture-workshop content. Each report will contain analysis highlights that demonstrate the course's strengths as per the framework. Based on this analysis, I will address the ways in which the social justice impact of DENT 206 can be improved.

Theme A report. Theme A was generally well represented in DENT 206's lecture-workshop content. Composed of four indicators, this broad theme is concerned with supporting students in understanding themselves as political actors within the realms of oral healthcare and a landscape of health and social inequality. Indicator A1 - which calls for supporting self-reflexivity with respect to social (and health) injustice, professionalism, and ethics - appeared the most frequently in the analysis out of all 13 indicators across all four broad themes in the assessment tool. Nineteen of the 25 course units satisfied this indicator suggesting that DENT 206's course materials consistently posits students as political actors and supports them in gaining a politicized understanding of themselves in relation to social and health inequality.

Early in the first lecture-workshop, the course sets the tone via three units: 1) recognition of Indigenous traditional territory, 2) the iceberg model of oppression, and 3) a social location and positionality exercise (see Clare et al., 2014; Howard, 2016; SACOMSS et al., 2011). The course content politicizes the learning space at the onset and asks students to think through broad social justice issues and how they trickle down into institutional life and their everyday material lives. For instance, to initiate a discussion on colonialism, a discussion question after the traditional territories acknowledgement which recognizes the Kanien'keha:ka as the indigenous stewards of the land (i.e. Montreal which is known as Tio'tia:ke in Kanien'keha in which their training institution is situated) reads: "For those who went to school in Canada what did you learn about the Indigenous peoples of North America?." In line with the prompts set forth by Indicator A1's first guiding question (GQ), the course asks students to think back to what they, as students of a settler institution, perhaps have either taken for granted or failed to take stock of with regards to the colonial violence embedded in their surroundings (see Orelus, 2015, p. 2). The knowledge and understanding with which students bring to the course act as a point of entry

for questioning students' current beliefs about the histories and contemporary realities of Indigenous peoples of North America. In response to Indicator A1's second guiding question, which ensures that one's positionality is foundational to students' practice of political self-reflexivity, the iceberg model of oppression then serves as a platform on which the facilitators can engage students in locating themselves relationally to colonialism. It also carves out symbolic space for Indigenous' students and interrogates others' status as a settler. Colonialism here is further treated as a broad historical and ideological system which translates materially into the institutions relevant in their lives as future dentists (e.g. higher education, healthcare). Below is a summary of the presentation slides and instructor notes which guide students through this group exercise (see also **structural competency** in Metzl & Hansen, 2014 and Indicator C3 of the Assessment Framework/Conceptual Tool):

1. Colonialism as a broad system of oppression (the invisible section of the iceberg submerged underwater).
2. Healthcare institutions (the surrounding ocean which keeps the visible part of the iceberg afloat).
3. The material outcomes of health inequality visible via the patterns of oral health inequality among Indigenous communities (the visible tip of the iceberg).

A social location exercise borrowed from local popular education modules follows this structural analysis and group discussion (see Clare et al., 2014; SACOMSS et al., 2011). It asks students to line up in the middle of the room and close their eyes. They are then instructed to step forward if a privilege statement applies to them, e.g. "step forward if your ancestors' history was taught in your primary or secondary school", and to step backwards for a marginalization statement, e.g. "step backwards if you did not grow up receiving preventative dental care

because of financial barriers." These three opening units, in accordance with Indicator A1 of the assessment-conceptual tool, set a precedent that political engagement, critical thinking, and self-reflexivity are foundational to the course's mandate. The social location exercise is also responsive to both of A1's guiding questions (GQs). Students here have an opportunity to rethink their past experiences as sources of knowledge (see A1, GQ1), and relationally understand their positionality in a participatory space (see A1, GQ2). Ultimately, the opening activities are possible sites for developing a social justice-oriented understanding of both their personal lives and their prospective profession as healthcare providers (see hooks, 1994, p. 15). Furthermore, these three units set the stage for the course topics and activities that follow wherein the embedded goal is to support students in consistently politicizing and critically reflecting on their agency, personal ethic, and their social and ideological position. The iceberg model reappears in all four lecture-workshops as a reminder to attend to the various layers and levels of abstraction inherent in social justice learning (see Adams & Bell, 2016; Orelus, 2015).

The course content also demonstrated consistent consonance with Indicators A2 and A3, each one appearing in 12 of the 25 course units and being represented in all four lecture-workshops. These two indicators tackle issues of power and privilege through a social justice lens. Indicator A2 relates to critically engaging students on discursive meanings, implications, and intersections of social privilege and professional powers. Further, this indicator attends to the ways in which privilege and power play out at individual and interpersonal levels, as well as broader institutional and societal levels. Indicator A3 addresses how a course might engage students with their social privileges and professional powers as a means to cultivate a professional responsibility to act in service of health equality and social justice (see Howard, 2006, p. 59). Lecture-workshop 2, whose ostensive focus is on gender, sexuality, and gendered

violence, offers a space where students explore discursive meanings and material implications of their power as dental professionals. In this particular sub-unit of this lecture-workshop, students discuss how these powers might be misused. Students are asked to think through a sample clinical scenario where a male senior partner socially isolated a female dental hygienist who expressed dismay with their employer's sexual advances (see A3, GQ3). Here, students contend with the structural violence faced by women in the workplace (see A2, GQ1 and A3, GQ2), and how such gendered structures underpin the dental hygienist's vulnerability to the dental professional's economic power as an employer (see A2, GQ2 and A3, GQ1). Immediately after this group discussion is a follow-up conversation on centering survivor needs (see Utt, 2014). In accordance with Indicator A3 (see GQ1 and GQ3), this group discussion is geared towards students generating ideas for using their professional privileges and powers to support survivors and resist norms which give rise to sexual and gendered violence. The discussion is bookended with a reminder slide wherein it states: "allyship is not an identity, it is a lifelong action-oriented commitment" (see Clare et al., 2014; SACOMSS et al., 2011).

A self-reflexive, political and action-oriented engagement with students' future roles as healthcare providers is foundational to Theme A of the assessment tool. Course units which resonate with Indicators A1, A2, and A3 function to politicize "the self" as a means to promote a social justice-oriented professional ethic and identity. Indicator A4 consequently serves to hold accountability to the discomfort and emotional challenges inherent in social justice learning. Within Theme A, I propose that a social justice-oriented understanding of the self is contingent on the recognition of one's proximity and complicity in injustice (Ahmed, 2012, p. 18) which might involve challenging emotions and learner resistance (Schick, 2000, p. 84; Zembylas & McGlynn, 2012, p. 41).

A small group activity in DENT 206's fourth lecture-workshop involves a hypothetical scenario where a high-achieving senior dental student tokenizes a queer first generation first-year student. Within this course unit, the course facilitates a conversation about making mistakes. Drawing from a popular education piece by Utt (2014), this activity holds group reflections and discussions on acknowledging errors, apologizing to those one may have harmed, and taking concrete steps to reconcile and repair. The intent therein is to normalize human error, but to also nurture students' willingness to learn from their mistakes and support each other in this process (see Estrella, 2017). Though this module captures a sense of Indicator A4, it fails to personalize an array of issues. It does not necessarily invite students to reflect on making mistakes, reasons for rejecting social justice ideals, nor to think of themselves as potentially complicit in injustice and/or oppressive behaviours. The scenario might serve as a possible heuristic to help students think about how they can support and call on each other when they disagree with the actions of another (see GQ3). However, as this module does not personalize the situation for the students themselves, it is difficult to determine if it does hold space for processing discomforting emotions and instilling a sense of duty to learning from one's mistakes (see GQ1). Another issue with not personalizing this module for students is that there are no openings for them to consider their unique positionality. The scenario in lecture-workshop 4 recounts a senior dental student's insensitivity towards the vulnerability of a junior queer first-generation student, but such a situation does not necessarily speak to all students' social locations and experiences. Echoed by the peer-checking of the analysis, the module fails to engage students within the framework personally as the scenario involved imaginary characters, rather than an exercise which gets students to consider their own social privileges and powers. The course should be able to provide

a space for students to consider their personal social context, the social privileges they might hold, and how might their individual social positions inform their understanding of social justice.

Social justice learning involves some personal risk (ADEA, 2016b, p. 868) and emotionally unsettling experiences (Brown & Strega, 2015, p. 10; Lather, 1995, as cited in Schick, 2000, p. 100) especially for those in privileged and powerful professional capacities (Lugg & Shoho, 2006, p. 205). Indicator A4 beseeches educator-facilitators to ensure that deep transformative learning occurs as a result of these learning risks. DENT 206's underperformance with regards to this indicator thus warrants a closer look into the ways the course holds and critically utilizes discomforting pedagogies and learner resistance.

Theme B report. Unlike Theme A, DENT 206's lecture-workshops appears to fare less consistently with respect to Theme B of the assessment tool. Indicator B1, in contrast to the two other indicators under this theme, appeared in 16 units across all four lecture-workshops - one of the most consistent among the 13 indicators. This indicator suggests that DENT 206's content facilitates critical connections between broader health and social issues and the dental profession.

In lecture-workshop 1, a case discussion and group analysis of a real-life incident involving the controversial actions of a Canadian clinician-educator and senior administrator at a dental training institution (see Dhillon, 2016; Proctor, 2015) illustrates the educational aims embedded in B1 (politically linking the profession and care delivery status quo with social injustice). This module demonstrates an attendance to Indicator B1's first guiding question which calls for connecting systems of oppression, in this case colonialism, with contemporary manifestations of oral health inequality. Here, students read and discuss two articles from different news sources detailing the actions of the clinician-educator wherein he misreported and misused funds for a project intended for improving oral healthcare services in a First Nation

community. The instructor notes for this particular activity provoke student-led dialogue on the short- and long-terms impacts of this incident on the First Nations community and consistently refers to colonial relations to guide students' responses. This course unit is not only sensitive to the various institutional and structural powers of dental professionals (see Indicators A2 and A3), but also calls attention to present-day manifestations of colonial violence as it implicates the dental profession. The case discussion includes small group reflection and discussion prompts for students to think through the political role of the dental professional and educational leader in perpetuating the ongoing subjugation of Indigenous peoples. Further, large group debrief questions in this activity call into question the underrepresentation of minorities (instructor note: "what are the problems in non-Indigenous peoples making decisions for these communities?"), and elicit possible reasons from students as to why a critical awareness of colonialism and the dental professional's institutional power is integral to a social justice professional ethic.

The social relations embedded in the case study and the relevant discussion questions which ask students to identify short- and long-term impacts of the clinician-educator/leader's wrongdoing on the First Nations community, satisfy Indicator B1's second guiding question (linking structural and systemic violence with care delivery and the profession). These data extracts suggest that the course opens up participatory learning spaces where students can analyze a contemporary event which implicate an actor in an oral healthcare institution (a dental educational leader and clinical) and the state (government funding for Indigenous health placed in the hands of a non-Indigenous leader), this replicating historical dynamics of subjugating Indigenous peoples. These data points demonstrate that the course content seeks to flesh out critical connections between structural violence and visible outcomes of inadequate access to care and poorer oral health outcomes faced by Indigenous peoples. With 15 other course units

resonating with Indicator B1, DENT 206's course content therefore exhibits a push towards a political social justice-directed dental professional identity as it relates to institutional arrangements and ideological structures of injustice and inequality.

In contrast to Indicator B1, Indicators B2 and B3 appeared much less frequently and consistently among DENT 206's course units. Respectively, these indicators direct criticism at the predominantly privatized landscape of oral healthcare, its dissonance with social justice tenets and outcomes (Indicator B2), and the stakes for those either privileged or marginalized by the dental care delivery status quo (Indicator B3). Indicator B2 arose in five course units, and B3 in only one course unit - much less than a large majority of the other indicators in the assessment tool. Lecture-workshop 3 had none of its course units resonate with the former, and the latter was only present in one unit in the last lecture-workshop.

DENT 206 first introduces Metzl and Hansen's (2014) response to cultural competency, **structural competency**, in lecture-workshop 4. Responsive to Indicator B2's first guiding question, the group discussion instructor notes for this topic include a facilitator-prompt to raise the array of issues in a largely fee-for-service and for-profit model of dental care delivery, while invoking the historical role of Canadian dentists in lobbying for said model of care delivery (see Afrashtehfar & Chung, 2017). With respect to Indicator B2 GQ2, the notes further detail a group interrogation of students' perspectives on possible contradictions between this structural reality (i.e. privatized dental care), with ideologies around oral health equality as enshrined in the professional oath to which dental students pledge at the beginning of their clinical training years: "I pledge my commitment to work for my community and the benefit of all society… and providing compassionate care for all" (excerpt of McGill White Coat Ceremony Oath, n.d.; as cited in Briones et al., 2016). In the only instance in the entire course, DENT 206 thus answers to

Indicator B3 and its sole guiding question which raises the moral dilemma in dentists continuing to economically benefit from the continued marginalization of those who cannot adequately access dental care. The course content's scant attention to the issues raised by a dental status quo defined by economic gain (see ADEA, 2016a, p. 884; Afrashtehfar & Chung, 2017; Dharamsi & MacEntee, 2002, p. 324), has social justice implications for developing the social justice alignment of DENT 206's teaching content. This concern was also reflected by the peer-checking conducted by the lecture-workshop 1 who suggested adding more discussions or readings on the impact of the privatization of dental care on Indigenous communities – a central topic in lecture-workshop 1. Dental students, as the assessment-conceptual tool endeavors to uphold, must confront the injustice inherent in accepting a privatized oral health system. Moreover, they must also realize and actualize their role in challenging it. Enhancing DENT 206 in with respect to Indicators B2 and B3 is crucial to developing a professional conscience which rejects economic individualism and embraces social justice (see Dharamsi et al., 2007, p. 1591).

Theme C report. The results of the coding and analysis process established that DENT 206's lecture-workshop content exhibits a strong and consistent accordance with Theme C – a social justice reimagining of diversity education. All three indicators under this theme appeared multiple times, ranging from 10 to 14 of the course's 25 units, and were present in all four lecture-workshops. This indicates that DENT 206 is a course which explores social difference, individual implicit bias, and structural inequalities through a social justice lens. The case analysis and discussion on the Dalhousie DDS 2015 Gentlemen's Club incident (Backhouse et al., 2015; CBC News, 2014, 2015; see also Chapter 1 of this thesis, pp. 1-2) in lecture-workshop 3 is of particular note as it exemplifies agreement with all three indicators under Theme C. Again, its constituent indicators are: C1 which refers to diversity and/or inequality as historically

and contemporarily situated, C2 which is concerned with the unearthing and challenging of deficit views, and C3 which aims to push past cultural difference and structurally attends to constructs of social difference, and experiences of injustice and inequality.

A follow-up discussion on humour, designed to complicate public responses in favour of the aggressors (e.g. “dumb jokes should not have launched a Dalhousie shitstorm”; Backhouse et al., 2015, p. 12), answers to Indicator C1, GQ1. This guiding question advocates for students (re)framing their understandings of social difference within a social justice context through self-reflection and dialogue. These documented public reactions, and others of the like, operate with the logic that the misogynistic and homophobic jokes in the males-only social media group were meant to be taken lightly, thus delegitimizing the criticisms of those who were harmed.

The instructor notes contain a discussion prompt where students are asked to critically think through and discuss the male-dominated and heteronormative profession of dentistry (see Anderson et al., 2009; Backhouse et al., 2015; Tiwana et al., 2014) and how “humour” is situated within these historical and structural gendered power dynamics and social relations. An instructor cue which interrogates the presence of humour in a clinical setting brings the discussion to matters of patient care and communication. Thus, this excerpt concurrently responds to both of Indicator C3’s guiding questions. GQ1 (dialogic spaces for student perspectives on structural injustice), and G2 understanding social diversity within a structural framework) are aimed at fostering social justice-oriented patient care and advocacy skills.

This course unit further demonstrates resonance with Indicator C2 (challenging deficit views). GQ1 asks for course materials which foster self-reflexivity and challenge students to address these negative attitudes. The notes depict a move for the facilitator to ask students to “provide examples of popular viral jokes and humour pieces… that exploit stereotypes that you

might have found entertaining, offensive, or both." Here, the course content further directs the facilitator to rename these examples as sources of harm and to invoke them as part of ideological systems of oppression – the discussion being opened with the following eliciting prompt: "who is privileged [in exploiting humour based on racism/sexism etc.], and who tends to be more likely be vulnerable to someone's careless approach to 'freedom of speech'?" (see also C3, GQ1). With respect to GQ2, students are invited to unpack the importance of a critical awareness of the ways in which deficit views manifest in everyday behaviours, professional conduct, and ultimately the ways in which these attitudes impact the type and quality of care patients receive (see instructor note: "how do these relate to patients' experience of receiving care and how could this be understood as an ethical issue?"). These discussions, built around various implications of a real-life incident in the dental education sphere, is one of a number instances wherein DENT 206's course content tackles diversity and social inequality from a critical social justice perspective. Through a critical unpacking of the Dalhousie incident, students have the space to interrogate their own attitudes and beliefs, connect them to larger ideological and material structures, and consider their implications in their professional duties (see Absolon and Willett, 2005, as cited in Brown & Strega, 2015, p. 1; Adams & Bell, 2016, p. xiii; Ferguson, 2007, pp. 16-20; Loignon et al., 2012, p. 546).

Theme D report. DENT 206's lecture-workshop content might appear to have underperformed with respect to Theme D, the assessment tool's social justice response to service learning and community work. Table 1 above shows that all three indicators under this theme appeared less than those of Themes A and C. The first two indicators, D1 and D2, respectively appeared in eight and seven course units. These indicators, though seemingly emerging less, did not do so by much compared to what I had described as potential areas for further investigation:

A4 (0 course units), B2 (5), B3 (1), and D3 (4). Furthermore, unlike A4, B2, B3, and D3, Indicators D1 and D2 appeared in course units across all four lecture-workshops. Given the criteria set out in Chapter 4: Methodology and Methods, these two indicators appear to be well represented among DENT 206's course units.

In the fourth and final lecture-workshop, all three Theme D indicators emerged in a course unit centered on a video viewing of and group debrief-discussion on *Why your doctor should care about social justice* (Bassett, 2015). Delivered by Dr. Mary Bassett (New York City Health Commissioner, physician, and epidemiologist), the talk explored the intersections of healthcare, the frontline role of the clinician, and physicians' social responsibility to "sound the alarm" in the face of social injustice. Here, the course content demonstrates that it fulfills what is asked for by Indicator D1, GQ1 (moving beyond awareness and political engagement with health injustice). The video provides an opportunity for students to hear from a clinician who lived the consequences of failing to do right by social justice as a healthcare professional. Embedded within Dr. Bassett's stance on transforming her conceptualization of responsibility as inherently political (see also Indicator A1, A3, and B1), is the moral duty to break physicians' silence – to "sound the alarm" on injustice, and to take meaningful sustained action.

Answering to Indicator D2's only guiding question (unearthing social justice possibilities in dentistry), the featured speaker underlined the ways in which physicians have particular agency within political arenas of healthcare to do the work of social justice and patient advocacy. Dr. Bassett advocated for doctors to be in alliance with social movements and tease out their implications in the realms of healthcare. This section of the talk simultaneously resonates with Indicator D3 and its guiding question which calls for alliances with those "outside" the oral healthcare arena. Of note is Dr. Bassett's explicit call to work with popular movements resisting

anti-Black racism (e.g. #BlackLivesMatter) in the United States and making material links between the patterns of poorer health among Black communities (e.g. infant and maternal mortality rates) and histories of slavery and Jim Crow era laws. Her speech argued that these alliances with popular social justice movements are necessary to a doctor's responsibility to patients and to broader society. The debrief discussion, directed by a number of eliciting questions such as: "why would it be understood as 'responsible' for healthcare professionals to be attentive to social conditions and popular social movements?", aims to foster dialogue around students' ideas and reflections on the political role of dental care providers - dialogue being an operative part of Indicator D3, GQ1. A subsequent slide titled "Now it's up to you…" follows-up on this group discussion with the following instructor cue: "what does activism mean to you, and how do you see yourself incorporating activism into your future practice as a dentist, educator, or leader etc.?" (see D2, GQ1). Bassett's speech serves as an opening for generative social justice- and action-oriented discussions in the course content. A medical professional who incorporates social justice into their actualization of social responsibility here acts as a heuristic for a social justice-oriented professional identity (Dharamsi et al., 2007, p. 1591; Schick, 2000, pp. 99-100).

Notwithstanding the course unit I described above, of concern is the sparse representation of the tenets outlined in Indicator D3. Four course units in only half of DENT 206's lecture-workshops satisfied the requirements within this indicator. D3 is concerned with a course unit's propensity to support students in building collective social justice imaginaries and relinquishing individual competition in service of collaboration. In accordance with Gaztambide-Fernandez and Howard (2010, pp. 2-4), Blackmore (2013, p. 139) and Brondani (2012, p. 615), social justice necessarily requires collectivism and solidarity. Possibilities are only socially-just when everyone is treated as equal in their capacity to be a changemaker and that the voices of those at

the margins are privileged (see Bleakney & Morrill, 2010, p. 146; Berry, 2010, p. 22; Choudry, 2015, p. 88). Developing DENT 206, accounting for its shortcomings in addressing the issues raised by Indicator D3, therefore requires consideration.

Next steps for lecture-workshop content. The deductive thematic analysis of DENT 206's course content artefacts identified three major areas of course content development. The first two areas of concern were reflected by at least one of the peer-checker/co-facilitators. In line with the concern of the lecture-workshop 4 co-facilitator, the first consideration is the absence of course units which resonate with Indicator A4 which stipulates a course's attendance to supporting social justice learnings through discomforting emotions. The second consideration is the course content's apparent lack of attention to the contradictory relationship between the economic status quo of dental care and social justice and health equality as per the relatively low emergence of Indicators B2 and B3 – a sentiment echoed by the co-facilitators for lecture-workshops 1 and 4. Lastly, the course content demonstrated a noted deficiency in fostering collaboration and challenging competitiveness and individualism as per Indicator D3 of the assessment-conceptual tool. The following chapter will elaborate on concrete action items to address these areas of potential growth for the course content.

Chapter 7: Moving Forward

This thesis's paradigmatic case study and its constituent methods were driven by two main research objectives. The first was to develop a assessment-conceptual tool for dental educators (and their respective training programs) who might not be anchored in the traditions of social justice and critical education. The second was of two parts of: a) demonstrating the framework's practical usability to assess the contents of a social justice course in a Canadian dental professional program, and b) generating actionable steps to further develop DENT 206's content. With respect to Research Objective 1, I will begin this chapter by providing a general summary of the conceptual strengths of the assessment-conceptual tool. Again, the tool, presented in Chapter 5 assesses for the major themes and their constituent concepts embedded in the social justice-oriented literature addressing dental professional education (presented in Chapter 3). I will describe what the assessment-conceptual tool helped to uncover and the bridging work it facilitated between the two concerned traditions of education. I will then report on what it was not able to do and offer possibilities for future research to address the tool's limitations.

With respect to Research Objectives 2a and 2b, I will then offer concrete content development recommendations for DENT 206, first for the syllabus then followed by the lecture-workshop content. These recommendations are pursuant to the analysis outcomes from Chapter 6 to demonstrate more concretely the tool's usability. These will then be interspersed with critical connections to larger issues concerning the integration of social justice educational theories into dental professional education. As with Research Objective 1, I will also identify limitations with regards to the second part of this case study and offer recommendations to address the study's blind spots. I will end the chapter with broader research possibilities and concluding remarks.

Conclusions and Implications: Research objective 1

The assessment-conceptual tool presented in Chapter 5 represents meeting points between two educational traditions: 1) social justice and critical education, and 2) the humanistic aspects of Canadian and American dental professional education. It further encapsulates critiques of standing traditions in dental educational from a social justice and critical pedagogical perspective. Having used this tool to evaluate the contents of my social justice course in a dental program, I was able to identify specific areas for development. In the spirit of paradigmatic case studies, I pursued an educator-centered learning exercise through theory and research (Flyvbjerg, 2006, p. 231; Harland, 2014, p. 1113). These areas of improvement uncovered in the study will be further elaborated on in the following section in attendance to Research Objectives 2a and 2b.

Strengths of the assessment-conceptual tool. The tool revealed possibilities for exploring medico-social issues pertinent to the professional development and ethical training of future oral healthcare practitioners. It facilitated this in a manner which honours both the context of students' prospective profession, as well as the complexities of the humanistic aspects of a practitioner's duty to patients and society (see ACFD, 2016; CDA, 2010; ADEA, 2016a, 2016b).

A notable strength of the assessment-conceptual tool is its congruence with what I had referred to as the three main components of the humanistic aspects of dental education. The tool's usability is contingent on its ability to speak to dental educators who do not necessarily have the training and familiarity with social justice and critical pedagogy. First, the assessment-tool's broad themes being in direct conversation with analogous traditions in dental professional education would allow for dental educators to look at specific areas of their teaching and recognize the tool's sensitivity to the context of their teaching mandate. For instance, a community-based dental educator would be able to consult the proposals embedded in Theme D,

the tool's social justice-oriented answer to **service-learning**. Consequently, should there be components in their teaching mandate which tie into **ethics and professionalism** or **diversity and/or public health** education, Themes A and B, and C respectively would be able to provide social justice guidance. The tool is first and foremost grounded in creating a dialogue with existing components of Canadian and American dental professional education, thus demonstrating that it endeavours to be responsive to the needs of dental education.

Pertaining to the tool's indicators, their encapsulation of the extant bodies of literature - therefore the concepts and practices operationalized in dental and social justice education - facilitated the process of identifying strengths and weaknesses of a specific component of my teaching practice i.e. the contents of my course. Again, I was able to do this due to the assessment-conceptual tool's respect for the context of dental education and its alignment with social justice and critical education. Consider Indicator A2 which states:

> Spaces are provided for students to critically think through (individually and collectively) the particularities of dental professionals' privilege and power and their intersections with other social privileges they possess.

This indicator was distilled from the work of scholars of dental education (e.g. Anderson, 2009; Raja et al., 2015a; Tiwana et al., 2014) and educational governing bodies (e.g. ACFD, 2016, p. 18; ADEA, 2016b, pp. 867-869) which points out that a key feature of dental ethics and professionalism education is a critical gaze onto the ways in which power gradients between care providers and patients (and broader society) inform these relations (see Nash, 2010, p. 573). Social justice and critical educators have advocated similarly with regards to the education of individuals on discursive matters of power and privilege (e.g. Howard, 2010, p. 79; Hsia, 2010, p. 116). Indicator A2 allowed me to assess, for example, a specific course unit explored in DENT 206's second lecture-workshop: sexual and gendered violence. The indicator in question guided

me in examining if the course unit's contents were conducive to creating critical connections between the implications of being holders of medical, physical, economic and social privileges, and how social justice-oriented techniques (e.g. dialogue, self-reflexivity, attention to positionality; see A2 guiding questions) provide holistic and nuanced learnings around the medico-social issue at hand.

The assessment-conceptual tool I developed for this thesis represents a bridging of two seemingly divergent traditions of education. It allowed me as a researcher-educator to demystify the liminal space between social justice education and the humanistic aspects of dental education (see Flyvbjerg, 2006, p. 224). The tool highlights the two fields' mutual concerns for social injustices, inequalities, and violence such as sexual and gendered violence as I described above. Privileging a social justice-oriented lens moreover, enabled me to call attention to un/under-addressed aspects of a medico-social problem. These possibilities might invite other educators in dental professional programs to consider the potential of social justice and critical education in ensuring their educational mission fosters critical, structural, and political self-awareness. Further, beyond awareness, the conceptual tool ultimately also holds these learnings accountable to take the work outside the dental school, and theories of social (and health) justice towards hopeful possibilities (see Berry, 2010, p. 22; hooks, 1994, p. 15; Farahmandpur, 2009, p. 110; Howard, 2006, p. 48; see also Theme D of assessment-conceptual tool).

Limitations of assessment-conceptual tool: course design. In this study, I harnessed the assessment-conceptual tool to hone in on the social justice alignment of DENT 206's content. Course design is a factor which may also shape a course's (or curriculum) alignment with social justice education. For instance, each lecture-workshop is delivered by myself and a co-facilitator - a practice I have adopted from other popular educators and anti-oppression education initiatives

(see Clare et al., 2014; SACOMSS et al., 2011). This is to ensure that a single facilitator is not seen as the holder of knowledge (Freire, 1970, 2000), and should the discussion be derailed, another facilitator is there to redirect the lecture-workshop back on topic. Further, due to the sensitive and potentially emotionally triggering nature of some of the topics, a second facilitator can leave the room with a participant who requires the support of an active listener. I made this course design decision in accordance with educational traditions within the discursive field of social justice and critical pedagogy – a course feature not reflected within the course content artefacts. The content might demonstrate resonance with social justice educational tenets, but the ways in which it is delivered and scaffolded must also be examined. For example, a social justice course taught/facilitated by a single practitioner would have a chilling effect on the course experience. Learning for social justice necessarily implicates collaborative practices, and therefore power over the space should not be centralized onto one individual (see Berry, 2010, pp. 20-21; Clare et al., 2014; SACOMSS et al., 2011). Future work to develop the assessment-conceptual tool should consider its ability to comment on the alignment of course design elements with social justice and critical education (see Whetten, 2007, p. 352).

Limitations of assessment-conceptual tool: Policy and governance. The assessment-conceptual tool is the product of transposing a social justice reimagining of the humanistic aspects of dental education. I was able to harness it to generate practical steps for increasing the alignment of DENT 206's course content towards that of social justice and critical education while attending to the context of training future oral healthcare providers. This thesis nonetheless could not investigate other textual artefacts beyond the purview of the course. The outcomes of the case study demonstrated that the tool was able to produce social justice-oriented content

development action items at level of course content, however it is important to note there are other textual artefacts which shape the materials within a dental curriculum.

For example, the assessment-conceptual tool might not be well-suited to examine policy and governance documents which inform and/or shape entire curricula or the governance activities of a training program. At a number of instances in this thesis, I contended with norms and social relations of economic (and academic) competitiveness and individualism embedded in the current state of oral healthcare and dental education (see Nash, 2010, p. 575). Dental schools prepare its students to engage with the economic competitiveness inherent in the fee-for-service system of dental care delivery (ACFD, 2016, p. 18; ADEA, 2016a, p. 884). In fact, a standard practice at McGill Dentistry for its course outlines is to include the ACFD's (2016) *Competencies for the Beginning General Dentistry* (CBGD), where in it states that students must be able to present "estimated fees, payment arrangements, time requirements and the patient's responsibilities for treatment" (p. 18). Herein lies a tension which invokes a sense of Theme B of the assessment-conceptual tool, in particular Indicators B2 and B3 which critique the economic status quo of dental care delivery. I could not confirm if this complex policy document resonated or not with the assessment-conceptual tool as the methodological decisions around its conception and its deployment as an analysis framework did not suit a policy/governance document. In accordance with my methodological choices, the syllabus was analyzed as a "course unit", and therefore only parts of it which the instructor would author and provide, and were unique to DENT 206 (e.g. course description, desired learning outcomes, and assessment criteria). The study did not investigate, for example, the ways in which higher level standardized governing texts such the ACFD's CBGD, impact the social justice alignment of DENT 206, nor any course which falls under the "humanistic" aspects of dental education. A possible research direction

would investigate the ways in which policies and governance entities might either enhance or debilitate the social justice alignment of training programs. To what extent policies, governance documents, and/or professional statements, which respond to market forces and economic individualism in dental care, impact the potential for curricula to stay in line with social justice educational tents? Such future research is important to determine if the curricular, governance, and policy landscape, in which courses like DENT 206 exist, are favourable to their social justice development.

Conclusions and Implications: Research objectives 2a and 2b, the syllabus

The deductive thematic analysis of DENT 206's syllabus tool not only revealed elements of DENT 206's strengths, but also identified clear areas of improvement given the non-emergence of five indicators which are: B2, B3, C2. C3. and D3. I will first itemize concrete adjustments to the syllabus pursuant to the analysis outcomes described in Chapter 6. After a detailed exploration of potential developmental actions for the syllabus, I will do the same for the lecture-workshop content in the section immediately following.

The analysis of the course outline's course description, learning outcomes, and methods of assessment demonstrated a generally strong resonance with the indicators of the assessment-conceptual tool (8 out of 13), with all of the broad themes represented. Nonetheless there were unrepresented indicators which should be reflected in the syllabus in its future iterations. With respect to indicators B2 and B3, which call for a critical engagement with the largely privatized Canadian (and American) dental care delivery system, might be best housed in the syllabus' learning outcomes. The learning outcomes, which describe an expected shift in students' knowledge and skills, should include a statement expressing the following: "gain a nuanced understanding of: a) the role of a dental delivery care system's role in oral health inequalities

(B2); and b) the healthcare implications in sustaining the current system of care for those currently disadvantaged by it (B3).” Indicators C2 (unearthing and challenging deficit views on minoritized identities), and C3 (structural understanding of social difference and injustice), could likewise be championed in the course outline’s learning outcomes. C2 and C3 can be understood as indicators which interrogate students’ ability to critically think through standing concepts, i.e. implicit bias and diversity, through a social justice lens. Therefore, explicitly reflecting these indicators in the document’s learning outcomes would be the most appropriate action to take. Indicator D3, which promotes collective social justice action, might be best integrated in the assessment methods of the course. The two current course assignments involve individual submissions. The inclusion of group assignment or a task where students must approach non-dentist teaching staff (e.g. hygienists, dental assistants, clinical administrators) to develop a community or service initiative would honour the spirit of collaboration and solidarity building embedded in Indicator D3.

Conclusions and Implications: Research objectives 2a and 2b, lecture-workshops

The deductive thematic analysis of DENT 206’s lecture-workshop slides and instructor notes revealed three major areas of improvement: 1) discomfort in social justice learning (Indicator A4), 2) contending with the market-drive of dentistry (Indicators B2 and B3), and 3) collaboration as inextricable from social justice work (Indicator D3). The following section will delve into the implications of these deficiencies and offer actionable steps in accordance with the assessment-conceptual tool. The section will conclude with limitations and challenges in using the tool to conduct a review of the course content.

Repurposing discomfort. As signaled by the non-emergence of Indicator A4 of the framework-tool, I will accordingly strategize on integrating social justice-sensitive strategies to

harness and hold learner discomfort. Discomfort, as stated in the conceptual framework of this thesis (Chapter 2) and the literature review (Chapter 3), can be characteristic of learning about injustice and inequality. The affective and cognitive challenges in reversing the gaze onto oneself and considering one's status as accomplice (or perpetrator) are points of entry for the educator to disrupt problematic norms (see Zembylas & McGlynn, 2012, p. 41). Consider the module on sexual and gendered violence which did not resonate with Indicator A4 of the assessment tool. Backhouse et al.'s (2015) systemic report on Dalhousie University's Faculty of Dentistry noted a culture where power abuses, in which many faculty and clinicians were implicated, are normalized (p. 3). This cultural backdrop at the institution in question was foundational to material experiences of misogyny, homophobia, and other forms of exclusion and violence. How can this module support students in reversing the gaze onto themselves as possible accomplices (or perpetrators) of inequality and violence (see Brown & Strega, 2015, p. 10; Howard, 2006, p. 58)? How can DENT 206 use these affective and cognitive challenges as openings through which to transform students' thinking, challenge an assumed benevolence (see Shick, 2000, p. 87), and learn through their proximity to injustice (Ahmed, 2012, p. 18)?

A possible way to remedy this is for students to journal an instance where they may have thought or behaved in way that is complicit with gendered and/or sexual violence. Students would be asked to reflect on their social location and the power dynamics from which they benefit, and to brainstorm how they might (re)centre the needs of the person/group/community they have marginalized (see A4, GQ2). A small group peer-feedback, supported by an intentional reminder of the ground rules given at the beginning of the lecture-workshop, (see A4, GQ1 and GQ3), would then act as a platform for students to articulate their reflections and elicit actionable feedback grounded in mutual respect (see A4, GQ4).

The privilege and power to which dental professionals have access could be repurposed for health and social justice. However, students who are not provided self-reflexive and social justice-oriented tools to keep their professional (and social) privileges and power in check, might be at risk of replicating these norms. Educational theories for consideration are Kumagai and Lypson's concept of "cognitive disequilibrium" (p. 786) and Howard's (2006) "confessional approach" (p. 58). DENT 206 must interrupt an unearned benevolence (see Schick, 2000, p. 87), and hold spaces for students to do the responsible and challenging work of exhuming deficit attitudes and behaviours which might be complicit to injustice and violence (see Loignon et al. 2012, p. 548; Meyer, 2008, p. 555). Through discomfort arising from challenging an assumed deficit self-perception of "goodness," there might be possibilities for transformative learnings.

Challenging the economics of dentistry. As determined by the analysis, DENT 206 requires further work with regards to providing opportunities for students to confront the predominantly privatized Canadian and American landscape of dental care delivery. The scant presence of course units which attend to the role of a fee-for-service model in perpetuating patterns of oral health disenfranchisement (ADEA, 2016a, p. 884; Afrashtehfar & Chung, 2017; Dharamsi & MacEntee, 2002, p. 324; Otto, 2017; see Indicators B2 and B3 of tool) will drive course development work moving forward.

The three case discussions already included in DENT 206's course content all were able to satisfy multiple assessment framework indicators, anywhere from six to as much as eight, across three to four broad themes. This demonstrates the effectiveness of discussing health and social justice issues via a critical unpacking of real-life recent events (see Kumagai & Lypson, 2009, p. 786). In chapter 1, I referred to the story of Deamonte Driver (see Otto, 2017). The 12-year old boy died of complications from a preventable dental health issue. Though his family

was enrolled in a socially assisted health program, dentists were hard to find and access as the prospects for profit in their impoverished community were meagre. A discussion of the Deamonte Driver case and the history of dental care privatization might be a way for DENT 206 to provide a platform whereby students can critically unpack the for-profit oral healthcare status quo (see B2, GQ1). Through this, students would learn about the histories of the privatization of oral health and the political work of dental professionals who pushed the pendulum towards such a direction (see Afrashtehfar & Chung, 2017; Otto, 2017, pp. 108-109). They would be asked to consider why a social justice-oriented professional ethic necessarily involves rejecting individualistic economic individualism. What are the historical, structural, and institutional pathways which give rise to cases like that of Deamonte Driver? What are the moral and material stakes for those who continue to be denied their right to dental care (ADEA, 2016a, p. 884) should dental professionals allow a privatized oral healthcare system go unchallenged (see B2, GQ2 and B3, GQ1)? Given the discursive privileges afforded to dental professionals, what are the possibilities and limitations in their agency to act for those marginalized by such a system?

Hopeful collectivism in oral health. Under Theme D of the assessment tool, the course content demonstrated a consistent attention to instilling students' agency and duty to social and oral health justice (Indicator D1; see Choudry, 2015, p. 89) and conceptualizing the oral healthcare arena as a site for social justice possibilities (Indicator D2; see Gordon & Ramdeholl, 2010, p. 34; Potts & Brown, 2015, p. 18). Of consideration however is the enhancement of the course content's ideological orientation with respect to supporting cooperative socially just imaginaries for oral health (Indicator D3; see Farahmandpur, 2009, p. 110; Gordon & Ramdeholl, 2010, p. 32; Smith, 2016, p. 66). The analysis of the syllabus, which had considerably similar analysis outcomes to that of the course content, also did not meet

requirements as per Indicator D3. The document did not demonstrate DENT 206's commitment to: 1) prioritizing collaboration over competition, 2) supporting thinking and activities conducive to collectively imagining a socially-just future.

Concretely, I will add a learning outcome to DENT 206's course outline to more explicitly communicate the primacy of collaboration and collectivism in social justice-oriented work. I will add the following in the syllabus' next iteration: "By the end of the course, students will be able to appreciate the necessity of collaboration and solidarity building in social justice-oriented change making work." In the course's third lecture-workshop, the case discussion on the Dalhousie 2014 incidents of sexual and gendered violence (see Backhouse et al., 2015; CBC News, 2014, 2015) showed a concern for students' professional responsibility for social justice work (Indicator D1), and conceptualized oral healthcare as a field wherein such work is necessary and possible (Indicator D2). The unit's contents however did not show that it provided a space for students to conceive collaborative activities to prevent and challenge gendered and sexual violence (Indicator D3). A possible next step could be the addition of self-facilitated break-out small group reflection and discussion on the Dalhousie case. These self-directed groups can be supported by prompts such as: "how could students have demonstrated critical and accountable allyship for those harmed by the perpetrators", or "how can your own cohort work together to challenge behaviours and norms which perpetuate sexism, homophobia, and transphobia?" Sustaining and developing DENT 206 must necessarily be grounded in the belief that all are holders of socially transformative experience and knowledge (see Berry, 2010, p. 22; Choudry, 2015, p. 88), and that the advancement of justice is a shared accomplishment rather than an individual one.

Other considerations. There are other logistical factors which play into the development work ahead for DENT 206's course contents. McGill's Doctor of Dental Medicine program is dense, with 200+ required academic and clinical credit hours packed into four academic years. DENT 206 itself represents only 0.5 credits of the curriculum thus limiting my contact with students to four two-hour lecture-workshops. In total, I co-facilitate eight two-hour lecture-workshops as I split the class into two smaller groups to make more space for group discussions, reduce the number of small groups if the activity calls for such an arrangement, and to ensure educator-facilitator resources are not spread thin. The three main areas for developing lecture-workshop content (learner discomfort, economics of dentistry, and solidarity/cooperation) would have to be addressed with these logistical realities in mind.

The thematic analysis not only identified un/under-addressed concepts and issues, but also drew attention to ones that were perhaps relatively over-addressed. Indicator A1 (concepts around a "social justice-self") emerged in 19 of DENT 206's 25 course units and Indicator B1 in 16 (concepts around the social justice-oriented dental professional). Both emerged considerably more frequently in comparison to the assessment-conceptual tool's 11 other indicators. Moving forward, I will revisit course units which exhibit a resonance with Indicators A1 and B1 and revisit their contents to accommodate the un/under-represented indicators (A4, B2, B3, and C3).

Case Study Limitations and Other Research Possibilities

Through this paradigmatic single-case study, I demonstrated the potential and the educational possibilities in reimagining dental education within a social justice framework. Consequently, I was able to construct a conceptually informed tool which demonstrated usability at the course content level. Developing course content however is not the endpoint to challenging the educational status quo of Canadian and American dental professional training programs.

Before concluding this thesis, I will offer other research possibilities aimed at transforming dental programs; the first which speaks to the scales of curriculum and institution, and the other calling for research which centres students' voices.

Beyond course development. Though beyond the scope of this research, tools are needed to make assessments at higher levels such as at the curricular scale (e.g. Association of Canadian Faculties of Dentistry's (2016) *Competencies for the Beginning General Dentist*), or at the institutional scale (e.g. the Association of Faculties of Medicine of Canada's (2011) *Equity and Diversity Tool*). What is a social justice-oriented framework for designing and/or reforming an entire Canadian or American Doctor of Dental Medicine program? How are individual courses and requirements in conversation or in tension with each other as per a social justice framework? What kinds of tools are needed to examine the aggregate of institutional arrangements, activities, and norms embedded in a professional training institution which either resonate with, or contradict social justice and other emancipatory frameworks? DENT 206 is but one of many sites of learning and unlearning for McGill's DMD students. Embedding social justice and transformative change across the oral healthcare landscape requires more critical research working at larger scales and the involvement of actors beyond the dental educational arena. A more extensive and resourced research project is required in order to elevate these findings and analyses at these levels.

The student perspective. I consulted a number of scholarly works on dental education which study the perspectives and experiences of dental students (e.g. Anderson et al., 2009; Behar-Horenstein et al., 2015; Tiwana et al., 2014 etc.). Major *et al.* (2016) studied changes over time in students' beliefs about and willingness to treat patients from socially marginalized backgrounds. Raja *et al.* (2015a) compared the learning depth of students who took a

predominantly lecture-based model versus those who had gone through an interactive module on treating survivors of trauma. Whereas this thesis privileged the educator-researcher's viewpoint in examining the textual content of a social justice course in a dental professional program, it did not account for the course-related experiences of the students who took DENT 206. Though I argue that this investigation took a learner-centered approach which involves a critical consideration of learner needs (see Whetten, 2007, p. 343) - in this case what they would need to become a social justice-oriented dental care provider – I did not assess cognitive and material shifts in students' ideologies and behaviours. Therefore, I cannot fully comment on how well DENT 206's course incites critical social justice-oriented learning given this perspective I did not investigate. It is of paramount importance that future educational advocacy, research, and collaborations take stock of students' experiences to hope that they will don the role of a politically engaged, self-critical, and social justice-oriented dentist.

Conclusion

I began this thesis by "sounding the alarm" (Bassett, 2015). Patterns of oral inequality which reflect historical and contemporary social relations of colonialism, racism, and classism present daunting challenges for educators, clinicians, and most importantly, patients (see ADEA, 2016b; Albino et al., 2012; Behar-Horenstein et al., 2015; Dharamsi & MacEntee, 2002; Mays, 2016; Otto, 2017). I presented cases which detail dentists acquiescing and even actively pushing for the privatized market-driven dynamic of care delivery (e.g. Afrashtehfar & Chung, 2017; Otto, 2017, pp. 223-245). Backhouse *et al.*'s (2015) systemic investigation on a Canadian faculty of dentistry, instigated by a group of male dental students behaving in misogynistic and homophobic ways (CBC News, 2014, 2015), revealed a culture of abuse, intimidation, and otherwise oppressive norms (pp. 2-3). The everyday conditions of suffering that those at

society's margins endure need to be brought to light, often obscured or ignored by those with power and privilege (Bassett, 2015) - hence the ostensibly despondent overture.

However, as the work progressed, this investigation uncovered overtures to more encouraging educational possibilities. This thesis demonstrated the significance of theoretical work and distilling the experiential knowledge encased therein for practical applications (see Austin & Paré, 2009, p. 115 and hooks, 1994, p. 69). The assessment-conceptual tool is a representation of this and harnessing it to study the technical aspects of my social justice teaching practice in a healthcare professional program led to concrete developmental work moving forward. In using existing knowledge from two ostensibly divergent areas of education, I was able to show dental education's potential to move towards a socially-just future. This thesis stands on the shoulders of those who have struggled for social justice (see Bofelo et al., 2013, p. 513), and have capitalized on opportunities to push the boundaries of dental education (e.g. Backhouse et al., 2015; Brondani, 2012; Dharamsi et al., 2012 etc.). The work herein honours those who have come before, are currently immersed in the work of health and social justice, and hopes to contribute to the work that has yet to be done.

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Appendix A

McGill University DENT 206: Relevant excerpts from course outline

Course description. *Developing students' understanding of the greater socio-cultural and historical implications of social justice and systemic oppression, as they relate to the role of oral health care professionals as well as personally. This course links ethics, professionalism, and public health discourse with social justice and anti-oppression discourse.*

Learning outcomes:

1. *Understand the broader context of oral health and social inequality as they relate to their various professional and social roles (healthcare provider, educator/mentor, community leader, business owner/employer, private life)*
    a. *Develop a nuanced understanding and appreciation for equity, social justice, and diversity as they relate to students' various professional and social roles*
2. *Critically analyze professional and personal dilemmas through a social justice and anti-oppression lens*
    . *Apply appropriate professional behaviours*
3. *Understand their roles as agents for transformative social change both at the individual and societal level*
    . *Develop an appreciation of the complexity and challenges inherent in social justice and oral health*

Assessment methods:

1. *Attendance to 4 mandatory seminars/workshops and Participation – 10%*

a. *Students must submit at least 1 discussion question (via email to the course director) that reflects a personal or professional wondering, or that demonstrates critical thinking as they relate to the course material.*

2. *Emerging Understandings and Reflections Journal – 40%*

. *Two (2) to Three (3) pages typed, double space, 12-point font size. Journal must demonstrate students' thinking and analysis, personal take-aways, and emerging understandings as they pertain to the first two workshops.*

3. *Final Summative Journal - 50%*

. *Journal must demonstrate that the student has made critical connections between social justice and anti-oppression concepts, their various professional and social roles, oral health inequality, and their personal implications in the issues and ideas explored in the course. Further, students are invited to write about how this course may or may not have shifted and/or informed their professional and personal views.*

a. *Creative formats are allowed so long as the course director is consulted beforehand. Creative formats include, but are not limited to: video productions with written rationale/analytical writing, poetry, artwork with written rationale, a social justice-oriented project proposal, musical performance with written rationale etc.*

DENT 206 assessment and evaluation: note that the entire Doctor of Dental Medicine program at McGill University is evaluated on a pass/fail basis, therefore no numerical nor letter grade is given to the students.