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A Critical Analysis of Underrepresentation of Racialised Minorities in the UK Dental Workforce

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This article analyses the underrepresentation of racialised minorities across the three stages of the dental workforce pipeline through the critical lens of power. The *reformist* view of power was used, which focuses on concealment caused by systemic biases. We observed adequate representation of racialised minorities in the first two stages of the pipeline; entry to dental schools and completion of dental education. However, the categorisation of diverse groups into a single 'BAME' category conceals the underrepresentation of Black people and those who experience intersectional forms of discrimination rooted in race, gender and class. We observed all racialised minorities to be underrepresented in the third stage of the pipeline; career development and progression. The data suggest that institutional processes are more likely to recruit and promote White[1] people, and racialised minorities are more likely to be exposed to bullying and inequitable disciplinary processes. Consistently across dental institutions, as the level of seniority increases, the representation of racialised minorities decreases. Thus, senior decision-making and agenda-setting spaces in UK dentistry are overwhelmingly White. Multiple actions are suggested; including collation of comprehensive, inclusive data, widening participation and representation initiatives to help re-distribute the power dynamics towards racialised minorities and ensure equality of representation across the dental pipeline, including in senior spaces. We hope this will work towards putting some of the systemic problems that we see in dentistry; such as differential staff and student experiences, inequitable recruitment, promotions and disciplinary proceedings, and colonial dental curricula and research on the institutional agenda.

[1]All racial groups including Black and White have been capitalised. We acknowledge the position that capitalising White as done by white supremacists may subtly legitimate such beliefs (Associated Press [AP] News, 2020). Nonetheless, White is a distinct social category that offers social advantage. The capitalisation of White attempts to let White people reflect on that advantage and fully engage in discussions on race and equality (Ewing, 2020).

Keywords: *Race, Systemic racism, Power, Intersectionality, Workforce underrepresentation, Dentistry*

Introduction

Race is not natural, nor biological, but a social construct. It describes how people have been socially grouped in different categories. In the UK, people belonging from diverse ancestries are grouped together as BAME/BME (Black and Minority Ethnic). Few 'BAME' people themselves identify with the term which collectively homogenises mostly non-white people (Bunglawala, 2020; Milner and Jumbe, 2020). The term BAME has been imposed on minority groups by UK institutions, which brings to the fore how people are actively minoritised by institutional processes shaped by power (Gunaratnam, 2003). Moreover, in any other realm, the grouping of diverse people by a perceived common trait, in this instance the absence of whiteness, would be considered stereotyping. Consequently, we observe how race and racism are innately linked; the social categories people are placed into create stereotyping and 'othering' at an institutional level (Johnson *et al*., 2004). This in turn powerfully influences people's experiences and opportunities (Saini, 2020). Thus, in this article, we avoid the term BAME. Instead, we use racialised minorities to describe people that have been minoritised based on categories of race and who have shared experiences of individual and systemic racism in dentistry and beyond (Milner and Jumbe, 2020).

Systemic racism is when there are clear patterns of differential treatment of racialised minorities caused by overt and covert biases existing in institutional policies, processes and procedures (Institute of Race Relations, 2020). The Black Lives Matter movement has brought to wider public attention the racism embedded in institutional systems.

Social categories and identities are not limited to race. Power dynamics also minoritise based on categories of gender, class, sexuality, religion, disability, citizenship and nationality. Intersectionality recognises that people occupy multiple social identities that interlock and intersect to create unique and complex forms of discrimination. Intersectionality also explicitly recognises the role of power in disempowering and creating complicated inequalities (Brah and Phoenix, 2004; Crenshaw, 1991; Muirhead *et al*., 2020; Yuval-Davis, 2016). In this article, we analyse the underrepresentation of racialised minorities across the dental workforce pipeline through the critical lens of power.

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Power

Our critical analysis placed an explicit focus on racism, intersectionality and the role of power (Crenshaw, 1991; Gunaratnam, 2003; Lukes, 2005). Power is in itself complex, but in its broadest sense power is the capacities of people as individuals or collectives, to make, receive or resist change (Lukes, 2005). The *reformist* view of power was used which focuses on concealment due to biases in the system. These biases exclude some problems from appearing on the agenda; thus power is exercised through institutional non-decisions or absence (Bachrach and Baratz, 1962; Lukes, 2005). Finally, possible actions, or institutional decisions are presented to bring the identified problems onto the agenda; thus, re-distributing the power dynamics towards racialised minorities.

In this article, the consequences of power were observed across the dental workforce 'pipeline'. The pipeline model proposes that the success of minoritised groups in professions depends on their capacity, or power to move through three key stages. In dentistry, these stages translate as: first, entry into dental schools; second, successful completion of dental education; and third career development and progression (Berryman, 1983; Clark Blickenstaff, 2005; Cronin and Roger, 1999).

Pipeline Stage 1: Entry to UK dental schools

Figure 1 shows that there were more racialised minorities in UK medical and dental schools in 2018/19 when compared with the overall UK universities' intake. However, scrutiny of the data showed Black and Chinese students were underrepresented. The record high, 8.2% increase in the entry of Black students into UK universities is not mirrored within dentistry (UCAS, 2020). Unfortunately, data on university student entry are published as single categories of gender, age, disability, and race, which precludes intersectional analysis; for example Black women.

Pipeline Stage 2: Successful Completion of Dental Education

Table 1 shows White students were more likely than any racialised minority to obtain a first-class honours degree, and more than twice as likely when compared with Black students. Research has ascribed these differences to systemic problems that lead to differential student experiences (Mountford-Zimdars *et al*., 2015).

Except for gender, there were no specific data available for successful completion or attainment gaps in undergraduate dentistry. The General Dental Council (GDC) is UK dentistry's professional regulator with statutory oversight of dental education, training and registration. Therefore, we assessed the number of GDC registered dentists as a proxy for the successful completion of dental education.

Table 2 shows that racialised minorities represented 29% of the UK dentist workforce, despite only constituting 14% of the national population, which is a positive facet of diversity in dentistry. Nevertheless, scrutiny of the data showed Asian dentists made up 79% of the category. Thus, the use of the BAME category conceals the underrepresentation of Black dentists. Specifically, only 1.3% of UK dentists identified as Black male and 1.5% as Black female (General Dental Council, 2020a; Office for National Statistics, 2011).

Moreover, even for 'Asians', the pattern was not homogenous. Indians and Pakistanis were more likely to enter dentistry than Bangladeshis (Figure 1). This differential entry pattern mirrored class. UK Bangladeshis on average earn significantly less than Pakistanis, who earn less than Indians; and 'Asians' overall earn less than their White counterparts (Office for National Statistics, 2018). Thus, the picture is complex, intersecting with race, class and gender.

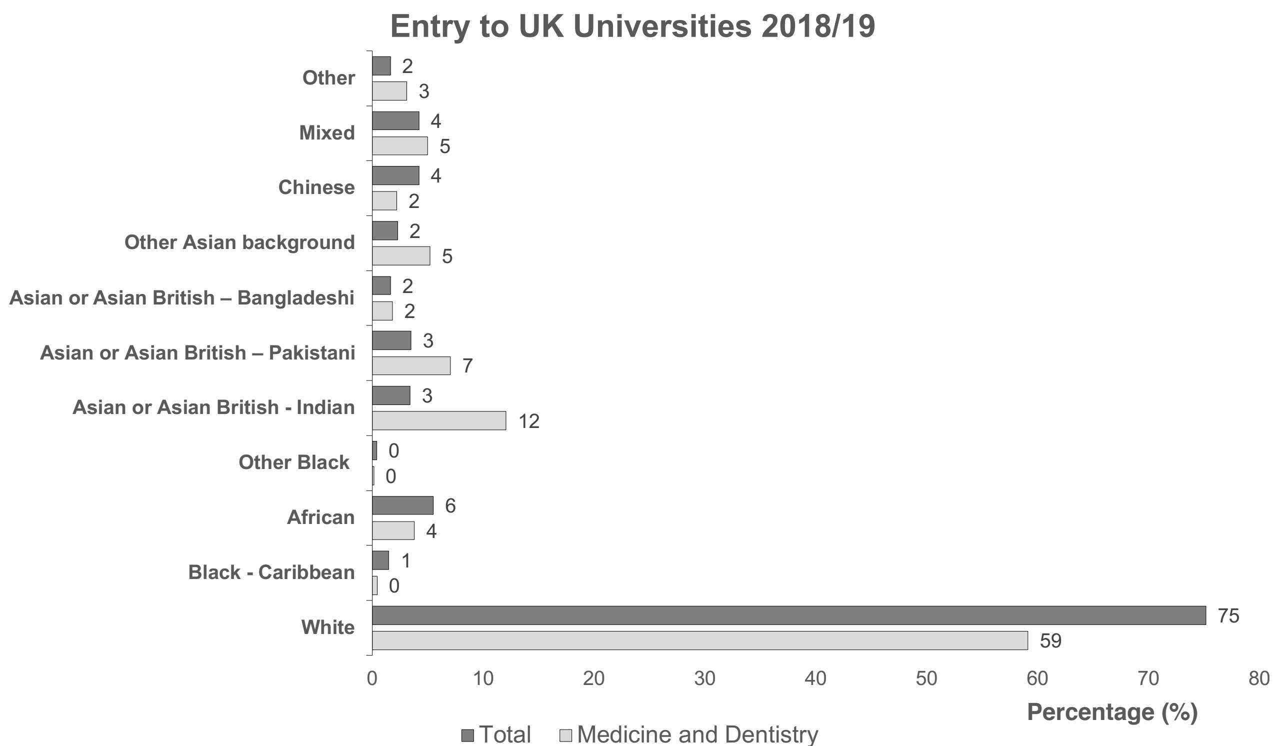

***Figure 1**. Entry to UK Universities and Dental Schools by Categories of Race (Higher Education Statistics Agency, 2020)*

Pipeline Stage 3: Career Development and Progression

There are varied career options for UK dentists: primary care, hospital services, specialist and academic careers. With postgraduate training and qualifications, dentists can be included on specialist lists. Table 3 shows the proportion of registered specialists within each racialised category. It seems Chinese dentists were most likely to be registered specialists. However, we observe Chinese people were once again pooled with people from 'any other ethnic background' (see Table 2) (GDC, 2020b). Furthermore, the 'unknown' category in all the tables demonstrates that a significant proportion of people's race category is not identified using the current institutional processes. In addition, a large proportion of people 'prefer not to say' how they have been categorised (Tables 2 and 3).

Regardless of these limitations, Table 3 shows that despite initial barriers to entry, Black dentists were just as likely as White dentists to be registered as specialists. But Asians and dentists with mixed heritage were least likely to be registered specialists.

Registered specialists can work as hospital consultants; the highest clinical grade in the public sector. Of the 4,388 registered dental specialists, 884 worked as hospital consultants in England (GDC, 2020b; NHS Digital, 2020). Despite parity of specialist qualifications amongst Black dentists, hospital consultants were more likely to be White when compared with all racialised minorities (UK Government, 2020).

Some specialists work as clinical academics in dental schools housed in universities. Overall, racialised minorities were underrepresented in UK universities. In 2003/4, 83.1% of UK academics identified as White and 4.8% categorised as BAME. Over a decade later, in 2013/14 the data slowly improved with 75.7% identified as White and 6.7% BAME (Watson *et al*., 2018).

Specifically in dentistry, despite only constituting 52% of UK practising dentists, in 2015, 81.4% of clinical academics were White and 18.6% categorised as BAME (12.4% Asian, 1.7% Chinese, 1.1% Black, 1.1% Mixed and 2.3% Other). Moreover, as the level of seniority increased, the proportion of those identified as White increased. At the professorial level, 92.7% of clinical academics were White and 7.3% categorised as BAME (Advance HE, 2015). However, the latest data showed a little improvement; 78% of clinical academics were White and 22% BAME (Watson *et al*., 2018). Additionally, university dental school websites showed that 100% of UK dental deans were White; with 78% White male (correct on 20/11/2020).

Unfortunately, there were no data available for dental academics from an intersectional perspective. However, in universities overall, 66.3% of UK professors were White male and 23.6% were White women. In contrast, 8.4% of professors were categorised as BAME male and only 2.3% BAME women.

As well as being underrepresented, racialised minorities were also likely to have poorer working conditions in UK universities with White academics more likely to be on open-ended permanent contracts as opposed to fixed-term, time-limited contracts (Watson *et al*., 2018).

The picture of underrepresentation carries through to postgraduate dental education. Health Education England (HEE) is responsible for postgraduate education and training of dentists. In 2020, 100% of postgraduate dental deans were White; with 73% White male (correct on 20/11/2020) (Committee of Postgraduate Dental Deans and Directors, 2020).

Board Level Representation

The British Dental Association (BDA), Principal Executive Committee; the decision-making board of UK dentists' trade union was 86.7% White, and 80% White male (correct on 20/11/2020) (BDA, 2020a).

Table 1. *Student attainment in UK universities 2018/19 (Higher Education Statistics Agency, 2020)*

	First class honours degree (%)	*Upper second-class honours degree (%)*	*Lower second class honours degree (%)*	*Third class honours degree/Pass (%)*
White	29.7	47.1	14.8	2.8
Black	14.1	42.9	30.6	9.2
Asian	21.5	44.4	22.3	5.2
Mixed	25.1	48.3	18.4	4.9
Other	21.5	42.1	25.1	5.6
Unknown	16.8	32.7	22.5	18.7

Table 2. Proportion of UK Registered Dentists by Categories of Race (General Dental Council, 2020a)

White (%)	*Asian/Asian British (%)*	*Black/Black British (%)*	*Chinese and any other ethnic background (%)*	*Mixed (%)*	*Prefer not to say (%)*	*Unknown (%)*
52	23	2	2	2	6	12

Table 3. Proportion of UK Registered Dental Specialists within each Racialised Category (General Dental Council, 2020a, 2020b)

White (%)	*Asian/Asian British (%)*	*Black/Black British (%)*	*Chinese and any other ethnic background (%)*	*Mixed (%)*	*Prefer not to say (%)*	*Unknown (%)*
12	8	12	13	9	11	7

Akin to universities, within the NHS, the largest single employer of UK dentists, as seniority increased the representation of racialised minorities decreased. Overall, women represented 41% of NHS boards (Sealy, 2020). However, the representation of racialised minorities at board-level was only 8.4% (NHS, 2020).

Board level underrepresentation and even absence of racialised minorities was a recurring pattern across UK healthcare/dental institutions. The latest data from 2019 showed that 100% of board members at HEE were White. Similarly, the board membership at the Health Research Authority, NHS Business Services Authority, NHS Digital, National Institute for Health and Care Excellence was 100% White. Even minimal representation is declining. NHS England and Improvement, which commissions all public dental services has had a drop in board-level 'BAME' representation from 11.8% in 2017 to 6.6% in 2019. The Care Quality Commission which assesses the quality of dental services has also seen a drop from 5.6% in 2017 to 4.5% in 2019 (National Health Service, 2020).

Pay

Gender pay discrepancies in primary care dentistry have been reported (BDA, 2020). However, there were no data available regarding pay discrepancies in primary care based on race. This pattern recurred across dental institutions, with no pay discrepancy data based on race available for hospital or university dentists. However, we have seen White doctors and dentists were more likely to reach and be paid at the senior consultant grade, and the lack of racialised minorities at senior levels across UK healthcare institutions suggested pay discrepancies.

The only data available on pay and race related to Clinical Excellence Awards (CEAs), which financially reward consultants who demonstrate various achievements. CEAs were disproportionately awarded to White males, who were more likely than women and racialised minorities to apply. However, when applications were received from women their success rates were comparable with men (30.2% v 31.3%). Nonetheless, only 23.3% of BAME applications were successful when compared with 31.8% of White applications (Advisory Committee on Clinical Excellence Awards, 2020).

In summary, there was a relative block for Black people at the first stage of the pipeline, and all racialised minorities were underrepresented at the final stage. We argue that this block and underrepresentation is the consequence of power (Figure 2).

The Consequences of Power

At initial glance, it seems racialised minorities are adequately represented in UK dentistry. Despite only constituting 14% of the UK population, they make up 29% of the workforce (GDC, 2020a). Nevertheless, the picture is complex. This section highlights three interrelated ways power conceals institutional biases that work towards underrepresenting racialised minorities across the dental pipeline whilst simultaneously presenting a picture of 'diversity'.

First, institutions have the power to create categories. Institutional categories consistently aggregate the data, which conceals the complex picture. The data are categorised as 'medicine and dentistry' and 'BAME'. UK institutions have the power to create aggregate categories and then selectively fill categories like BAME with data that are of institutional relevance to demonstrate racial diversity. However, this reality is biased; only showing a partial view. This institutional view does not show the realities of people in the 'other', 'unknown'

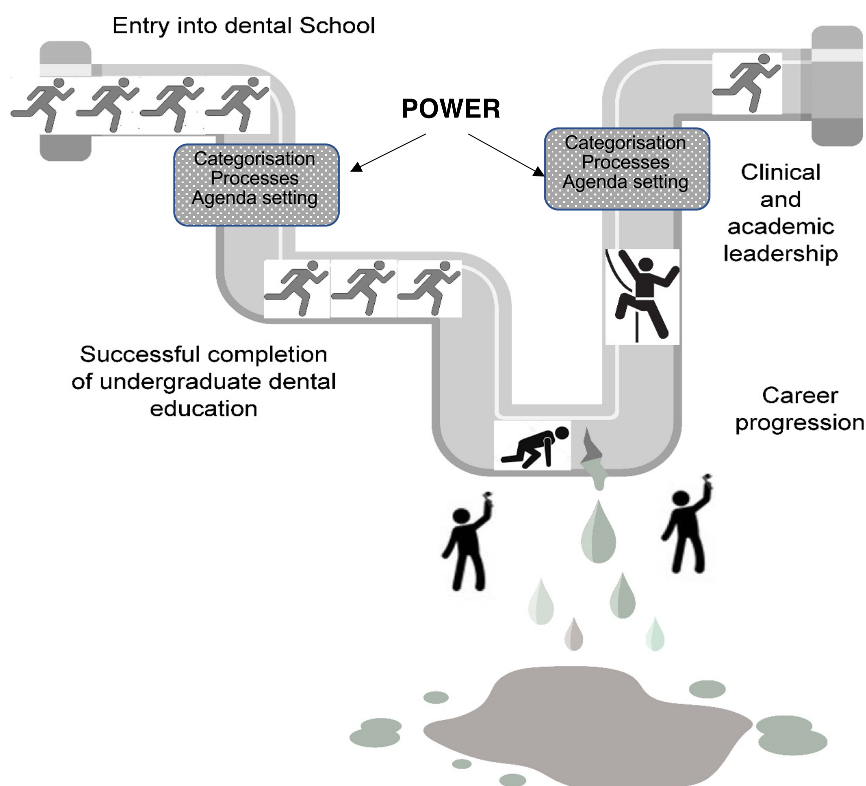

***Figure 2**. Power and the underrepresentation of racialised minorities across the dental workforce pipeline*

and 'prefer not to say' categories. The 'other' and 'unknown' categories expose the inadequate sensitivities of institutional processes. The 'prefer not to say' category reveals disengagement of racialised minorities which has been attributed to a legacy of discrimination leading to distrust of institutions (Boulware *et al*., 2003; Office for National Statistics, 2009). This partial institutional view also fails to capture the lived experiences of Black people and creates 'intersectional invisibility'. Intersectional invisibility is the failure to distinguish the people that occupy multiple minoritised categories and the consequent complicated unique forms of discrimination they experience (Muirhead *et al*., 2020; Purdie-Vaughns and Eibach, 2008; Schmid, 2000; Smith, 2005).

Our intersectional analysis has shown the unique barriers experienced by Black men and women. Misogynoir is a distinct form of misogyny experienced by Black women rooted in dual biases of race and gender (Bailey and Trudy, 2018). Studies have shown White people and Black women experience reduced forms of discrimination with increased levels of education and income. However, this is not the case for Black men because they are consistently singled out as threatening (Assari, 2017; Curry, 2017; Hudson *et al*., 2012).

Second, institutions have the power to design processes or the system. The representation of 'BAME' people at the initial stages conceals systemic racial biases. There is limited research to explain why 'Asians' are drawn to medicine and dentistry (Neville, 2018), which likely reflects the absence of racialised minorities in senior research roles. Britain has a history of recruitment of racialised minorities from former colonies, particularly South Asian doctors to plug staff shortages; consequently, racialised minorities are adequately represented across UK healthcare (Caceres, 2020). Despite adequate representation in the first two stages of the pipeline, we observed a relative blockage for Black people and the picture is particularly complex when an intersectional lens is adopted with racial biases interlocking with gender and class. Moreover, a significant 'leak' is seen at the career development and progression stage for all racialised minorities; even though a significant proportion hold specialist qualifications. But specifically, Asian dentists are least likely to progress as specialists (Table 3). Consistently, as the level of seniority increases, the proportion of White people increases across institutions related to dentistry.

Systemic biases experienced by racialised minorities contribute to the leak. The NHS Workforce Equality Race Standard (WRES) shows White applicants are more likely to be shortlisted and appointed for all jobs, more likely to have access to training at work, less likely to enter disciplinary processes, less likely to experience bullying and abuse from patients and colleagues. Patients and colleagues are also less likely to complain about White people to regulatory authorities like the GDC (Coghill, 2020; National Health Service, 2020). As well as education and registration, the GDC also assess dental professionals' *fitness to practise (FtP).* Complaints can lead to FtP investigations that may result in removal from the GDC register, leaving professionals unable to practise (GDC, 2019). The FtP cases against Asians are more likely to proceed onto later stages of the GDC disciplinary process in comparison to White peers (Zahra *et al.,* 2017).

Third, institutions have the power to set the agenda. Our analysis has shown gender equity has been placed on the institutional agenda with data on gender available across the dental pipeline. However, data regarding race, class, disability, religion, sexuality and intersectionality were recurrently sparse or absent. These absences are not accidental, they are silences that reveal institutional biases and non-decisions to prioritise these groups (Foucault, 1998; Smith, 2005). As an example, despite racial discrepancies in CEAs, the Advisory Committee on Clinical Excellence Awards report states that *"we believe scoring is fair and unbiased and ethnicity is not a factor…"(Advisory Committee on Clinical Excellence Awards, 2020, p. 25).* Thus, we observe institutional inaction and silences around problems related to race.

In summary, our analysis has revealed the institutional power to create categories, design processes and, set the agenda, have created biases in the system that have led to underrepresentation of racialised minorities across the dental pipeline. The reformist view of power aims to bring the identified problems onto the agenda to reduce systemic biases. Thus, the next section describes institutional decisions or actions to reform these biases to start unblocking the dental pipeline.

The Actions

Data Comprehensiveness

Data were often combined for medicine and dentistry. Therefore, dental institutions should collate and present dental specific data to enable analysis of any distinct dental blocks and leaks.

Institutions do not consistently collect data on any other category besides gender. People from diverse backgrounds are often reduced to a single BAME category. Even the disaggregated categories are poorly defined. Asian encompasses Indians, Pakistanis and Bangladeshis and Chinese people are sometimes pooled with 'any other ethnic group'. In particular, there was no detail available about people placed in the 'other' category which includes communities known to experience multiple intersectional forms of discrimination such as Arabs (Laird *et al*., 2007). The 'unknown' category also demonstrates the inadequacy of current institutional processes. Moreover, the large proportion of people in the 'prefer not to say' category demonstrates lacking sensitivity of institutional processes and a distrust of institutions by minoritised communities (Boulware *et al*., 2003; Office for National Statistics, 2009). Thus, institutions should collate and publish detailed data on race, class, gender, religion, disability, sexuality, citizenship and nationality. Moreover, institutions should actively consider data sensitivity and inclusiveness processes to create trust, capture people with multiple minoritised identities and avoid intersectional invisibility (Purdie-Vaughns and Eibach, 2008).

The focus on quantitative metrics has concealed the lived experiences of racialised minorities and created intersectional invisibility; therefore, we call for greater collation of qualitative data. In particular, we advocate the use of participatory and decolonial research approaches to address power imbalances (Brocklehurst *et al*., 2020; Smith, 2012).

Decolonising is a process of undoing the effects of colonialism. The worst legacies of colonialism are linked with research. Decolonising research approaches are cognisant of colonial legacies and their continued influence on institutional knowledge production which persistently exclude colonised people (Smith, 2012). Following this, our analysis has shown the persistent exclusion of racialised minorities from senior research roles. Decolonising the curricula involves including diverse knowledges within teaching to pay particular attention to what is being taught and how that shapes perspectives. Consideration should also be given to creating safe spaces for open, diverse dialogues between staff and students that break down power dynamics (Charles, 2019).

Widening Participation Initiatives

Most UK dental schools have widening participation initiatives to recruit students who have traditionally been excluded (Gallagher *et al*., 2009). These initiatives are most effective through complex activities that include academic support, careers advice in schools, mentoring and financial advice (Younger *et al*., 2019).

School support is important because school achievement is linked to low participation in universities for students from socially disadvantaged backgrounds (Chowdry *et al,*. 2013). In addition to support, dental schools should develop flexible models of entry beyond the narrow school-leaver model.

Mentoring would be most effective if it was undertaken by academics with perceived similarities because role modelling is a strong predictor for university participation (Cheryan and Plaut, 2010; Oyserman *et al*., 2006). This demonstrates how widening participation is more effective with adequate representation across the pipeline.

Finance may be a particular barrier for some groups. UK dental students can graduate with debts exceeding £76,000 (BDA, 2018). Black students have been shown to be more debt-averse (Ford and Patterson, 2019) and more likely to study dentistry as a second degree leading to greater debt-levels (Niven *et al*., 2013). Therefore, UK dental schools should consider graduate-entry scholarships and bursaries for under-represented groups.

Widening Representation Initiatives

Racialised minorities are less likely to be short-listed or appointed for jobs (Coghill, 2020; NHS, 2020) due to well evidenced race biases in short-listing and interview processes (Growth, Equal Opportunities, Migration & Markets, 2019; Lin *et al*., 1992; Neckerman and Kirschenman, 1991). Therefore, institutions should have anonymised job application shortlisting processes and have adequate representation of minoritised people on interview panels including panels for entry to dental schools. Such representative panels should provide a more equitable interview experience for minoritised candidates. The value of this approach has been recognised within the UK senior civil service (UK Government, 2019).

Dental institutions should audit their recruitment and promotions records and present disaggregated WRES metrics for dentistry including metrics for bullying and complaints. The GDC should evaluate its complaints processes to ensure fair disciplinary proceedings. Moreover, there should be parity of training opportunities for racialised minorities including widened access to leadership training (NHS Leadership Academy, 2020).

UK dental schools have largely adopted the Athena SWAN Charter that aims to further gender equality (Advance HE, 2020a). Although Athena SWAN has recently included intersectionality in their application process, it is currently not a requirement at department level (Advance HE, 2020b). As such, consideration of intersectionality remains voluntary for dental schools and is thus not widely adopted. Moreover, Athena SWAN does not address the barriers experienced by racially minoritised men. Therefore, dental schools should also pay attention to the Race Equality Charter (REC) framework to tackle institutional racism (Advance HE, 2020c; Bhopal, 2019). Dental schools should adopt the REC, which will support them to develop action plans to address and evaluate the inequalities experienced by minoritised groups.

UK Athena SWAN applications increased by 400% after the British Medical Research Council announced funding applications by dental schools would not be considered if they did not hold at least a silver award (Bhopal, 2019). In parity, research-funding bodies should consider an institution's race equity record when allocating resources.

In summary, comprehensive, inclusive data and widening participation and representation across the dental pipeline will help re-distribute the power dynamics towards racialised minorities. In particular, racialised minorities themselves will have the power to design equitable processes and set the institutional agenda.

Conclusion

By examining the different stages of the dental pipeline we have demonstrated how power leads to a consistent pattern of underrepresentation of racialised minorities across different cohorts of the dental workforce at various stages of their careers. In particular, senior decision-making and agenda-setting spaces in dentistry are White. The institutional actions presented aim to re-distribute the power dynamics towards racialised minorities to represent them across the pipeline, including senior spaces. The subsequent racial and intersectional diversity will work towards improving institutional trust and support institutions to recognise the complicated inequities and biases, such as intersectional invisibility that exist in their processes. Moreover, the empowerment of racialised minorities will better enable them to place their complex experiences and concerns on the institutional agenda. As such, institutions would be supported to continually improve on their data inclusiveness, staff and student experiences, equity record on recruitment, promotions and disciplinary proceedings, and work towards decolonising the dental curricula and research (Coghill, 2020; National Health Service, 2020).

Decolonising UK curricula and research are particularly pertinent given the British Empire's history of denying healthcare education and healthcare to people in the colonies and the role of the transatlantic slave trade in using Black bodies to advance medical science (Esmail, 2007; Savitt, 1982). Decolonising approaches are also imperative to understand how race and racism systemically contribute to oral health inequalities. Despite

this, race and racism are virtually absent from UK dental education (General Dental Council, 2015, 2010). These absences are not inconsequential; they reveal the institutional power to remove. Nevertheless, the decolonisation of dentistry can only happen if minoritised voices are centred in the process. As such, the pipeline blocks and leaks must be addressed.

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