Beyond Braces, Fillings, and Extractions: A Social Justice-Oriented Educational Response

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Motivated partly by an incident at Dalhousie University's law school in which thirteen male students were found guilty of posting offensive material about their classmates on Facebook, this article argues the need for a social justice educational approach within the training provided to dentistry students at McGill University. Students working in the public service sector, like dental healthcare, should develop a stronger sense of social responsibility, engaging with experiences rooted in agency, power, and civic engagement. Such reforms are necessary to alleviating systemic barriers to healthcare. The article highlights three court decisions involving sexual abuse by dentists to make the case that the dentistry curriculum at the university and pre-professional level (Year 4) should include discussion of case law involving sexual violence by dentists. Such discussion is important not only to deter cases of abuse but also to equip future dentists with the skills to understand the impacts that prior experiences with sexual abuse might have had while in the dentist's chair and to prompt students to consider how dentists and their support staff might best alleviate such fears to ensure they can rebuild patient trust and confidence.

Dans cet article, l'auteur, motivé en partie par un incident survenu à la faculté de droit de l'Université Dalhousie où treize étudiants ont été reconnus coupables d'avoir publié des articles offensants sur leurs camarades de classe sur Facebook, souligne la nécessité d'une approche éducative en justice sociale dans le cadre de la formation offerte aux étudiants en médecine dentaire de l'Université McGill. Les étudiants qui travaillent dans le secteur des services publics, comme les soins de santé dentaire, doivent développer un sens plus fort de la responsabilité sociale, en s'engageant avec des expériences enracinées dans les organisations, le pouvoir et

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The discussion of case law involving dentists in this article was added by Shaheen Shariff, Ph.D., Associate Professor, McGill University and editor of this Special Issue journal. This was important to support and strengthen the author's commitment to developing social justice curriculum content that will equip dentists to deal with the fears of patients who have experienced sexual violence in dental chairs previously, prevent sexual violence within the profession, and ensure a climate of trust and safety within their dental practices.

This article is dedicated to individuals and communities who have made my work possible through supporting me in taking risks and pushing the boundaries of my thinking beyond the limits of my imagination. In that regard, I acknowledge the input of the following contributors to this article: Shanice Yarde, Chloe Garcia, Ayesha Vemuri, Shannon Hutcheson, Shahrokh Esfandiari, Nikoo Taghavi, Shaheen Shariff, and Richard Hovey.

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l'engagement civique. De telles réformes sont nécessaires afin d'atténuer les obstacles systémiques aux soins de santé. L'auteur met en évidence trois décisions de justice impliquant des violences sexuelles par des dentistes pour faire valoir que le programme d'études dentaires au niveau universitaire et pré-professionnel (4e année) doit inclure une discussion sur la jurisprudence impliquant la violence sexuelle faite par les dentistes. Une telle discussion est importante non seulement pour décourager les abus, mais aussi pour donner aux futurs dentistes les compétences nécessaires pour comprendre les répercussions que les expériences antérieures de violence sexuelle ont pu avoir chez le dentiste, et amener les étudiants à considérer comment les dentistes et leur personnel de soutien peuvent mieux soulager ces craintes afin de s'assurer de rétablir la confiance du patient.

1. INTRODUCTION: A RUDE AWAKENING

In 2014, a scandal was brought to the public's 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*.[1] The controversy prompted emotionally charged debate within the oral health community, institutions of higher learning, and the general public. A notable outcome of the scandal was the striking of the "Taskforce on Misogyny, Homophobia and Sexism in the Faculty of Dentistry" (or the "Taskforce") at Dalhousie.[2] Led by legal and human rights scholars Drs. Constance Backhouse, Don McRae, and Nitya Iyer, the Taskforce's "mandate was to investigate the culture, practices and policies within the Faculty of Dentistry; ... [consider] broader policies and practices at Dalhousie; [review] policies, standards and practices at other Canadian universities to address the issues of misogyny, sexism and homophobia; and [identify] policies and practices that could be put in place to investigate anonymous complaints of harassment and discrimination."[3] What was unearthed through the Taskforce brought to light an uncomfortable truth about an ecology of heterosexism, misogyny, and abuses of power that was being perpetuated at Atlantic Canada's only dental professional training school.

The incident at Dalhousie University follows a similar event at The University of Western Ontario's law school. Amid a heated debate taking place on Facebook, a student, Frederick Zhang, wrote comments threatening the student body at large. The University reprimanded Zhang and subsequently

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1 "Dalhousie dentistry student speaks out about sexism in faculty", *CBC News* (17 December 2014) online: CBC News «http://www.cbc.ca/news/»; see, also, "Dalhousie suspends 13 dentistry students from clinic amid Facebook scandal", *CBC News* (5 January 2015) online: CBC News «http://www.cbc.ca/news/».

2 C. Backhouse, D. McRae, and N. Iyer, "Task Force on Misogyny, Sexism and Homophobia in the Faculty of Dentistry", Dalhousie University, June 2015.

3 Above note 1.

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Zhang sued the school, arguing that his online and off-campus behaviour fell outside the purview of the university. The Court found in favour of the university, recognizing that online and off-campus conduct can have significant adverse impact on the campus community by compromising the ability of students to feel safe in their learning environment.[4] In *Zhang*, the court situates the university's responsibility to respond to misconduct by members of the campus within a wider community context with its reference to *Pacheco*: "The University also plays a greater role in the community at large. It has the duty to protect its students, faculty, members of the administration, staff and, indeed, *members of the public who may be affected by the conduct of any member of the University community*."[5]

This decision demonstrates an imperative for universities to respond to student misconduct, online and off-campus, recognizing the role academic institutions can have in shaping communities. Universities have a responsibility to their student communities to provide and ensure a safe learning environment. Applied to the education of students graduating into the public sector, such as health care professionals, the university should recognize how these students will internalize and perpetuate social norms they learn during their studies. By advocating for social justice and being engaged in experiences rooted in agency, power, and civic engagement, students at university can practice being agents for positive change and apply their knowledge, skills, and positionality in positive, meaningful ways when they graduate and enter the real world. This means that the university's responsibility is particularly salient in programs like dentistry in which students are being trained to work within the public sector.

The comments made by Dalhousie male students cannot be taken lightly and must be contextualized within a history of incidents in which dentists have sexually assaulted their patients who were compromised and vulnerable after receiving chlorophorm or lying in a dentist's chair with their mouths frozen and forced wide open by a water dam that prevents them from speaking. Many of these patients were women, and some of them children (even those who were hearing impaired).[6] Consider the following three criminal cases in which dentists were convicted of sexually assaulting their patients,[7] highlighting the need for dental schools to address sexual violence and its potential to occur both on-line and physically within the dental practice.[8]

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4 *Zhang v. University of Western Ontario*, 2010 CarswellOnt 10065, 2010 ONSC 6489, 328 D.L.R. (4th) 289 (Ont. Div. Ct.) at para. 39.

5 *Pacheco v. Dalhousie University*, 2005 CarswellNS 358, 2005 NSSC 222, 37 Admin. L.R. (4th) 119, 238 N.S.R. (2d) 1, 757 A.P.R. 1 (N.S.S.C.) at para. 34 [emphasis added].

6 *R. v. Gallagher*, 1993 CarswellOnt 1010, EYB 1993-67586, [1993] 2 S.C.R. 861, 83 C.C.C. (3d) 122, 16 C.R.R. (2d) 287, 155 N.R. 215, 64 O.A.C. 207, [1993] S.C.J. No. 79 (S.C.C.).

7 *R. v. Fujibayashi*, 1989 CarswellBC 1449 (B.C. Co. Ct.).

8 The Dalhousie incident and the two following examples are not to imply that there is a pattern of sexual assault among dentists. These three incidents occurred over the span of 30 years. Rather, the argument is that dentists have power over their patients and, in

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In *R. v. Fujibayashi*,[9] Masaro Fujibayashi, a 51-year-old dentist in British Columbia, was sentenced to four years in jail for committing 17 indecent and sexual assaults on several young boys and women patients while they were in his dentist chair.[10] The dentist had a history of sexual assaults. Although he had received psychiatric treatment, these incidents continued to occur. Numerous affidavits were filed in support of his generally good character and the fact that he was an outstanding member of the Nelson community. Nonetheless, the patients he assaulted testified regarding the devastating impact of the sexual violence on their lives. One male patient reported that after 26 years he still had nightmares about the incident. All of the survivors had suicidal thoughts. Two became sexual abusers themselves (one of them exposed himself) and all survivors developed a fear of going to the dentist.

The judge noticed that, at the time of the case, sentencing for sexual assaults on men or boys carried a maximum ten-year sentence, in contrast to only a five-year maximum sentence for sexual assault of girls or women. This gender disparity in protecting women in the justice system sadly comes as no surprise. Shariff and Eltis address gender inequities in a separate article in this special issue;[11] therefore, it is not expanded on here.

In *R. v. Gallagher*,[12] another British Columbia dentist molested seven male children, six of whom were hearing impaired or completely deaf. These patients were brought to the dentist by a caregiver at the home for hearing impaired and left alone with him in the office. The first witness testified that the dentist performed oral sex on him while he had his mouth held wide open by a rubber dam. The patients collectively expressed anger and frustration given their particular vulnerability to the sexual assaults. The judge noted that initially the survivors were not believed, and that sign language in 1995, at least for these patients, had no symbols to communicate the types of sexual violence they suffered. The lasting impacts on the survivors in this case were similar to those in *Fujibayashi*: the patients expressed having suicidal thoughts and a strong mistrust of the dental and medical systems.

In the third case, *R. v. Gavrilko*,[13] the court convicted a dentist of sexually assaulting four female patients. The court noted that the dentist had repeatedly breached his position of trust in society and consequently the College of Dental Surgeons had revoked his membership. Gavrilko received two years of

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these incidents, the power difference resulted in horrific convictions. Harassment and other similar comments made by dentists are concerns that need to be addressed to prevent future incidents.

9 Above note 7.

10 *Ibid.*

11 See Shaheen Shariff and Karen Eltis, "Addressing Online Sexual Violence: An Opportunity for Partnerships between Law and Education".

12 Above note 6.

13 *R. v. Gavrilko*, 2007 CarswellBC 2377, 2007 BCSC 1476 (B.C.S.C.).

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community service because he had already lost his licence to practice and was not seen as a future threat to patients.

Training on sexual assault in dentistry programs is necessary to respond to the needs of patients who have a history of sexual abuse to prevent dentists from potentially triggering further traumatic experiences. Stalker, Russell et al.[14] interviewed 58 men and 19 women with self-reported histories of childhood sexual abuse about their experiences with health care professionals, including dentists. The participants reported aspects of dental treatment that can be particularly difficult for them and offered ideas about how dental health professionals could make treatment experiences more tolerable for them. The data produced suggestions about how dentists might respond sensitively to patients who frequently cancel appointments and are distressed by the fear of the necessary physical closeness with the dental professionals, especially in certain positions. These patients suggested that dental professionals should be equipped with knowledge relating to the long-term impacts and post-traumatic stress related to experiences of sexual abuse, including how it can affect dental treatment interactions. Stalker and her colleagues agree that such knowledge would enable dental professionals to respond to such patients' needs in a sensitive and trustworthy manner. They found that in view of the prevalence of a history of childhood sexual abuse in the general population, dentists most likely see patients with such histories several times a week. They explain that although prevalence rates vary among studies, reliable evidence indicates that dentists have exposed up to 13 per cent of females and between 5 and 10 per cent of males to sexual violence.[15]

The three cases discussed above and Stalker's article support the need for specifically designed educational initiatives that help all dentists to think about, analyze, and become sensitive to this particular segment of their patients. Moreover, students need to understand the special position of trust they will hold in society vis-à-vis their patients, given that they are in such close physical proximity to them. The need to behave professionally cannot be stressed enough.

At the time the Dalhousie University 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 as directed 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, Dr. Esfandiari, the administrative director of the academic affairs team, Ms. Nikoo Taghavi, and I were compelled to do something in light of these distressing events. Dr.

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[14] Carol A. Stalker et al., "Providing Dental Care to Survivors of Childhood Sexual Abuse: Treatment Considerations for the Practitioner" (2005) 136:9 *J of the American Dental Association* 1277.

[15] *Ibid.*

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Esfandiari and Ms. Taghavi knew of my prior experience in social justice and harm reduction education and prompted me to take an informal spearheading role in our desire to be proactive on these issues. Bearing in mind 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. One thing led to another, and today, I am a graduate student under Dr. Shariff's supervision and a research assistant on her SSHRC Partnership Project IMPACTS: Collaborations to Address Sexual Violence on Campus.[16]

Central to my graduate work and duties as a research assistant is the mandate to develop a social justice education intervention to address social inequality and forms of oppression in the context of oral healthcare. In the 2016-2017 academic year, I piloted a lecture-workshop series under another course in collaboration with Shanice Yarde (Equity Education Advisor at the Social Equity and Diversity Education Office of McGill), Chloe Garcia, Shannon Hutcheson, and Ayesha Vemuri (the latter three graduate students are fellow IMPACTS research assistants). In 2017-2018, the lecture-workshop series will be a stand-alone mandatory course in McGill's Doctor of Dental Medicine program. What began as a "reactionary" response to a dentistry faculty scandal has taken wings as a long-term initiative to equip future dental care providers with a social justice lens necessary to a larger movement for transformative healthcare reform.

2. EMERGING RESEARCHER, EMERGING PRACTITIONER

In donning two new roles as an emerging researcher and social justice educator in an oral health professional training setting, I gained a deeper understanding of the system-wide oral health inequalities in the Canadian and American context. The American Dental Education Association implored training institutions to address these inequalities, especially since evidence-based research shows that such inequalities will become more exacerbated if nothing is done.[17] Research demonstrates that oral health inequality is a glaring concern in Canada and the United States.[18] Moreover, much of this research

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16 IMPACTS: Collaborations to Address Sexual Violence on Campus: Social Sciences and Humanities Research Council of Canada Partnership Grant Number: 895-2016-1026, Project Director, Shaheen Shariff, Ph.D., McGill University.

17 American Dental Education Association, "ADEA Position Paper: Statement on the Roles and Responsibilities of Academic Dental Institutions in Improving the Oral Health Status of All Americans (As approved by the 2004 ADEA House of Delegates)," (2016) 80:7 *J. Dent. Educ.* 884 [ADEA].

18 J.E.N. Albino, M.R. Inglehart, and L.A. Tedesco, "Dental Education and Changing Oral Health Care Needs: Disparities and Demands" (2012) 76:1 *J. Dent. Educ.* at 75; See also above note 17, at 866; S. Dharamsi, D.D. Pratt, and M.I. MacEntee, "How Dentists Account for Social Responsibility: Economic Imperatives and Professional Obligations"

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critiques the predominantly privatized nature of oral health services.[19] My preliminary research also uncovered the existence of a number of news stories detailing scandals implicating health care professionals and calling into question legal and systemic issues faced by public health.[20] This discovery supports Backhouse, McRae, and Iyer's assertion that the incident at Dalhousie should not be viewed as occurring in a social vacuum — that the ideological and cultural landscapes create conditions ripe for incidents like the *Class of DDS 2015 Gentlemen* scandal to unfurl in the way that it did.[21] In line with the ADEA *Statement on the Roles and Responsibilities of Academic Dental Institutions*, I argue that educational institutions have a legal and moral responsibility to respond to these social problems through concerted, critical, and properly resourced individual and institutional work.[22]

3. EVOLVING RESEARCH AND PRACTICE

My research questions have been through many iterations and, as I have grown more familiar with the literature and as my practice has developed, the following questions appear to be most representative of the inquiry:

1. What features of the ideological and cultural status quo in formal dental training create barriers to teaching for social justice?
2. What is a social justice-oriented educational response that will proactively address and help resist systemic and institutional violence and inequality, which have a hand in sexual violence?

I will proceed with a conceptual framework organized into two broad theoretical arches. The first arch identifies what I argue to be major obstacles in training dental students to be social justice-oriented and emphasizes the need for

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(2007) 71:12 *J. Dent. Educ.* 1583; K.A. Mays, "Community-Based Dental Education Models: An Analysis of Current Practices at U.S. Dental Schools" (2016) 80:10 *J. Dent. Educ.* 1188; and M. Otto, *Teeth: The Story of Beauty, Inequality, and the Struggle for Oral Health in America* (New York: The New Press, 2017).

19 P. Axelrod, *Values in Conflict: The University, the Marketplace, and the Trials of Liberal Education* (Montreal;Kingston: McGill-Queen's University Press, 2002); Dharamsi et al., above note 18; and C. Loignon, A. Landry, P. Allison, L. Richard, and C. Bedos, "How Do Dentists Perceive Poverty and People on Social Assistance? A Qualitative Study Conducted in Montreal, Canada" (2012) 76:5 *J. Dent. Educ.* 545; and Otto, above note 18.

20 H. Bird, "Inuvialuit woman says uncle's stroke mistaken for drunkenness", *CBC North* (15 August 2016); B. Labby, "Unequal treatment: First Nations woman denied medical coverage readily available to non-Aboriginals", *CBC News* (29 May 2017); S. Jaffe, "The Tooth Divide: Beauty, Class and the Story of Dentistry", *The New York Times* (23 March 2017); and J. Proctor, "Former UBC dentist Christopher Zed accused of defrauding First Nations clinics", *CBC News* (24 November 2015).

21 Above note 2, at 3.

22 Above note 17.

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systemic responses. The second theoretical arch harnesses knowledge from the following fields: (a) teaching for social responsibility, ethics, and professionalism in the dental education context; and (b) learning for social change, activism, and critical pedagogy. The overall aim is to develop a multifaceted approach to teaching for social justice in the oral health professional training context. More than addressing only the issues of gendered and sexual violence and cis-heterosexism as made salient by the incident at Dalhousie's Faculty of Dentistry, this article seeks to address also the systemic issues that give rise to violence, unprofessional behaviours, and discrimination in oral health care and professional training. Backhouse, McRae, and Iyer assert that "[t]he best route for the future is to focus on systemic change".[23]

This conceptual framework prefaces a discussion to the introductory social justice course I teach at McGill Dentistry, DENT 206. The content of this course will be theoretically examined through two artefacts: (1) the course syllabus; and (2) the lecture and workshop materials (e.g., PowerPoint slides, teacher/facilitator notes), with a focus on the material that concerns or leads to discussing and unpacking systemic violence and sexual violence. My conclusion will summarize the ongoing and future work I am doing and will do through IMPACTS, identify limitations and potential critiques of DENT 206, and provide suggestions on how to move forward as a social justice educator in this context.

4. LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

(a) Oral Health Professional Education: Social Responsibility versus Individualism and Neoliberalism

As Backhouse, McRae, and Iyer have unearthed in their inquiry on the Dalhousie scandal, the overlaying culture is permissive of misogyny, heterosexism, and racism.[24] In agreement, this literature attempts to trace out features of institutional culture that simultaneously fosters oppressive and unprofessional behaviours and perpetuates systemic violence and inequality. Canadian and American dental professional programs, overall, host curricular material wherein ethics, professionalism, and social responsibility are explored and practised. The latest version of the Association of the Canadian Faculties of Dentistry's competency document states that a key skill students must develop is the "recogni[tion] [of] the determinants of oral health in individuals and populations and the role of dentists in health promotion, including the disadvantaged."[25] The ACFD Framework also proposes that dental trainees

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23 Above note 2, p. 3.

24 *Ibid.*

25 Association of Canadian Faculties of Dentistry, "ACFD Educational Framework for the Development of Competencies in Dental Programs." 2016, p. 18, Retrived from: «https://acfd.ca/wp-content/uploads/ACFD-Educational-Framework-for-the-Devel-

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need to also "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*."[26] The disconnect between such statements and the reality of the oral health system, profession, and professional education is troubling.

Within the domain of dental education scholarship in Canada and the United States, Brondani provides a representative definition of social responsibility: "Social responsibility refers to one's sense of duty to the society in which he or she lives and is believed to enhance relationships within communities and to support proactive management of the social and environmental dimensions of a profession."[27] A study by Dharamsi, Pratt, and MacEntee on Canadian and American dental professionals' self-conceptualization of social responsibility revealed a broad set of standpoints among their participants. A number of the interviewed dental professionals demonstrated an understanding of social responsibility within the confines of economic and individualistic goals.[28] The authors contend the need for dental educators to nourish an ethic that extends beyond the confines of self-interest and personal gain — features of a larger field that limits collectivism and acting for health justice.[29] Although there were participants in Dharamsi, Pratt, and MacEntee's study who were aware of the dissonance between their responsibility to equitable health provision and their economic reality, some have accepted that this tension is an inherent feature of the status quo of oral health provision.[30]

When the ideological, cultural, and material landscape is designed such that managing the clashes between individual economic interest and social justice results in backlash, how can educators help unearth the openings in the ruling system and incite proactivity?[31] Should dental professional training institutions wish to be part of a revolutionary shift in educating for transformative social change, is such participation conditional on re-orientating itself away from goals arising from economic drive and personal gain?[32] To quote DePaola, "dentistry

opment-of-Competency-in-Dental-Programs_2016.pdf»; The ACFD Taskforce is comprised of dental educators and educational administrators from the ten Canadian faculties of dentistry [ACFD].

26 *Ibid*., at 20 [emphasis added].

27 M.A. Brondani, "Teaching Social Responsibility through Community Service-Learning in Predoctoral Dental Education" (2012) 76 *J. Dent. Educ*, 609 at 609.

28 Dharamsi et al., above note 18, at 1589.

29 *Ibid*., at 1591.

30 *Ibid*., at 1591.

31 S.L. Carter, "Intervening in Informal Learning: Activity Theory as Teaching Tool" (2013) 48:3 *McGill J. Educ*. 491 at 495; and C.M. Shields, "Dialogic Leadership for Social Justice: Overcoming Pathologies of Silence", *Educational Administration Quarterly*, vol. 40, no. 1, pp. 109–132, 2004.

32 J. Gordon and D. Ramdeholl, "'Everybody had a piece ...': Collaborative practice and shared decision making at the Open Book" (2010: 128) *ACE New Directions for Adult and*

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should be a public good and not simply a private benefit for the privileged".[33] Understanding social responsibility within the boundaries of fiscal responsibility, business-oriented mandates, and economics contradicts the notion of a health professional's duty to be a healer for all. Professional oaths pronouncing a physician's or dentist's duty to society is drained of authenticity when the extent of one's sense of social responsibility does not go beyond lip service. Educators in the fields of oral health and other care professions may be in a position to uncover "the cracks in which to work".[34] More than just "sounding the alarm" with public health statistics that quantify gross inequalities, educators have an opportunity to instill a proactive stance among trainees to be agents for social change.[35] As Brown and Strega note, neoliberalism has deeply entrenched itself throughout the world, in governance structures, popular culture, and media discourses.[36] They argue that an apolitical or tokenistic posture from society's healers will not lead to material progress.

Social justice educational models that make the connections between sexual violence, cis-heterosexism, health inequality, and their roles as healers are integral to this urge for reform. The following take-away from the Backhouse, McRae, and Iyer Taskforce report emphasizes the need for critical systemic responses: "Recognizing the connections between a group of complaints holds more promise than dealing with each incident in isolation. There are tools and approaches to shift the focus to structural change that can transform the culture."[37]

More than a case of overt sexual violence, the *Class of DDS 2015 Gentlemen* was also a manifestation of larger cultural issues that require both small-scale and large-scale action. For the social justice educator, the primary task is to craft an educational response that gives space for learners to unpack and critically look at these issues from the individual level to the societal level. To leave a status quo that upholds economic individualism which has historically oppressed women, LGBTQ+, racialized, (dis)abled, and lower socio-economic status

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Continuing Education 27; and J. Blackmore, "A Feminist Critical Perspective on Educational Leadership", *International Journal of Leadership in Education*, vol. 16, no. 2, pp. 139–154, 2013, p. 1239.

[33] DePaola, 1999; as cited in L.S. Behar-Horenstein, X. Feng, K. W. Roberts, M. Gibbs, F.A. Catalanotto & C.M. Hudson-Vassell. "Developing Dental Students' Awareness of Health Care Disparities and Desire to Serve Vulnerable Populations Through Service-Learning," *Journal of Dental Education*, vol. 79, no. 10, pp. 1189–1200, 2015, at 1198.

[34] Gordon and Ramdeholl, above note 32, at 34.

[35] M. Bassett, *Why your doctor should care about social justice*. 2015; Dr. Mary Bassett, New York City Health Commissioner, TED Talk, online: «https://www.ted.com/talks/mary_bassett_why_your_doctor_should_care_about_social_justice».

[36] L.A., Brown & S. Strega. *Research as resistance: revisiting critical, indigenous, and anti-oppressive approaches* (2nd ed.). Toronto: Canadian Scholar's Press; Women's Press, 2015, p. 1.

[37] Above note 2, at 3.

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persons unchallenged will give rise to more scandals and hold back much needed transformative change.[38]

(b) Oral Health Professional Education: Learning for Social Change and Working within the Cracks

Current scholarship on ethics and humanistic education in dental schools and learning for activism reveals intersections between these two areas of study. I argue that these intersections are the inroads for critical pedagogy and teaching for social change. In line with Albino, Inglehart, and Tedesco's paper, which argued that formal dental training programs have a direct impact on students' professional attitudes and behaviours,[39] this three-pronged conceptual framework is constructed with the intention of contributing an anti-oppressive social justice-oriented ontology for dental professional education.

Within the Canadian and American context, ethics as a philosophy, service-learning and community-based dental education (CBDE) house the mainstream ideologies on training dental students to be socially responsible. Ethics in dental education is couched in the understanding that "good dentistry depends on individuals committed to treating their patients and society fairly, that is, ethically".[40] The American Dental Education Association[41] offers a deconstructed account of what constitutes "professionalism" in the educational mandate of dental training institutions. It names six constituent competencies: technical competence, fairness, integrity, responsibility, respect, and service-mindedness.[42] In the most recent iteration of its educational framework, the Association of the Canadian Faculties of Dentistry states that graduates must "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."[43]

Currently, service-learning and CBDE are the dominant models mobilized in Canadian and American dental training institutions to teach social responsibility from a ground-level approach. Behar-Horenstein et al. uphold that service-learning provides the "authentic experiences" for students to interface with the patient's context and build an informed empathy for said patient's experiences.[44] The authors argue that it is through service-learning and parallel types of curricular tools such as CBDE that dental trainees "[develop] an awareness of the

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38 *Ibid*., at 2.

39 Albino et al., above note 18, at 77.

40 D.A. Nash, "Ethics, Empathy, and the Education of Dentists" (2010) 74:6 *J. Dent. Educ*. 567.

41 ADEA, above note 17.

42 *Ibid*., at 866.

43 Above note 25, at 20.

44 Above note 33, at 1189.

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ways privilege in class, culture, and education has an impact on health care."[45] Critiques of current models however are leveraged by Brondani and Raja et al.[46] who do not deny the impact of community-based clinical training that exposes students to uninsured or underinsured patients. Sole reliance on these approaches to help students understand the nuances of health inequality and the relationship between social justice and oral health carries its own problems and complications. The "authentic relationships"[47] to which Behar-Horenstein et al. refer depend on earning the trust of marginalized communities — one built by oral healthcare providers who strive to achieve an informed empathy on the experiences of those at the margins of society. These "authentic relationships" also hold importance when health care providers provide treatment to survivors of traumatic experiences such as sexual violence, domestic abuse, and war.

A study by Raja et al. of patient dehumanization revealed that "dental providers who are willing to explore the individual and environmental factors that influence a patient's oral health care utilization are more likely to engage underserved patients in care."[48] In a study on the Professionalism and Community Service Module at the University of British Columbia, Brondani claims that service-learning and CBDE do not necessarily provide a space to add complexity to students' understanding of health inequality.[49] These models often obscure the histories and realities of systemic oppression that have created inequality. They also replicate the power differentials that are implicated in maintaining barriers to access considering the lack of representation of non-white, non-male, and working-class individuals in the dental profession.[50]

Critical pedagogy and emancipatory models are missing pieces in dental professional training curricula and need to be included as institutions reorient their teaching mandate for transformative reforms in healthcare. Potential openings for critical pedagogy are evidenced by the work of Koole et al. on self-reflection in dental programs and Raja et al. on "trauma-informed care".[51] There

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45 *Ibid*., at 1198.

46 Above note 27; and S. Raja, C. F. Rajagopalan, M. Kruthoff, A. Kuperschmidt, P. Chang, and M. Hoersch, "Teaching Dental Students to Interact with Survivors of Traumatic Events: Development of a Two-Day Module" (2015) 79:1 *J. Dent. Educ*. 47.

47 Above note 33.

48 S. Raja, R. Shah, J. Hamad, M. V. Kanegan, A. Kupershmidt, and M. Kruthoff, "Patients' Perceptions of Dehumanization of Patients in Dental School Settings: Implications for Clinic Management and Curriculum Planning" (2015) 79:10 *J. Dent. Educ*. 1201 at 1201.

49 Above note 27.

50 American Dental Education Association, "Need for Diversity" (2015), online: ADEA «http://www.adea.org/GoDental/Dentistry_101/Need_for_diversity.aspx»; Albino et al., above note 18, at 82; above, note 20, pp. 3-4; and E. Tuck, "Suspending Damage: A Letter to Communities" (2009) 79:3 *Harv. Educ. Rev*. 409.

51 S. Koole, V. Christiaens, J. Cosyn, and H.D. Bruyn, "Facilitating Dental Student Reflections: Using Mentor Groups to Discuss Clinical Experiences and Personal Development" (2016) 80:10 *J. Dent. Educ*. 1212; and S. Raja et al. above, note 46.

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is consensus in dental education that self-reflection is an important tool for the ethical training of dental students, although "a lack of understanding remains about how students and clinicians should develop their ability to reflect"[52] and how such a process can lead to a deep understanding of social justice in oral health. Raja's study on the impact of a critical educational module on teaching dentists on how to treat and interact with survivors of trauma supports the argument that critical pedagogy is effective in instilling deeper nuanced learning.[53] This study sought to integrate trauma-informed care more meaningfully, which is "when every part of service is assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual seeking services."[54] It revealed that dental students who had undergone a multifaceted module, which incorporated group discussions, scenario analyses, and self-reflection exercises demonstrated more competence when treating patients who were survivors of traumatic experiences such as sexual violence.[55]

Widening these openings for students to engage in self-reflexivity and critical thinking is vital to adapting a context-specific model for social justice education in dental professional education. A fundamental component in Paolo Freire's critical pedagogy theory is the development of critical consciousness wherein the learner actively participates in their personal sense-making process, accounting for their participation in an ideological, material, and social world mediated by power relations and scaffolded by histories of oppression.[56] Further, Freire's model explicitly adapts a proactive stance on injustice and challenges a "culture of silence".[57] "Well-meaningness"[58] and token commitments to health justice simultaneously obscure and maintain a status quo of oral health inequality. Awareness initiatives and the increasing of dental students' exposure to the underserved and disenfranchised do not necessarily result in increased empathy and desire to work actively against these oppressive realities.[59] Raja's findings from their patient dehumanization study support the view that those "who are willing to explore the individual and environmental factors that influence a patient's oral health care utilization are more likely to engage underserved

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[52] Koole et al, above note 51, at 1212.

[53] Raja et al. above, note 46.

[54] *Ibid.*, at 47.

[55] *Ibid.*, at 51.

[56] P. Freire, *Pedagogy of the Oppressed* (New York: Continuum, 2000).

[57] *Ibid.*

[58] K.L. Potts and L. Brown, "Becoming an Anti-Oppressive Researcher" in L. Brown and S. Strega, eds., *Research as Resistance: Revisiting Critical, Indigenous, and Anti-Oppressive Approaches*, 2d ed. (Toronto: Canadian Scholar's Press, 2015), 17 at 18.

[59] Above note 48, at 1205.

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patients in care",[60] as well as gain the trust of those who hesitate to seek the care of a dentist, for example, sexual violence survivors.

(c) Locating the Problem

Armstrong's Foucauldian concept of medical spatialization facilitates a juxtaposition between how physicians spatially locate disease versus how they spatially locate social inequalities and social problems.[61] He explains how disease has gone from being understood as a lesion on a physical location on the human body to something abstracted outside of it. With the rise of new medical technologies, activities, and bureaucracies, disease can be situated in medical records, in laboratories, and in public health statistics. Social inequalities in healthcare have undergone a parallel process of abstraction and spatialization. The ADEA articulates its position on the obligation of dental education institutions to respond to health inequalities[62] but does not explicitly call attention to the implications of these disparities for the oral healthcare system and the individuals who participate in it.[63] The problems are spatialized as outside, disembodied from individuals' actions, "in a nebulous 'out there' ... [with] no connections to themselves".[64] The problems, the "damage", and the "depletedness" that have led to poor healthcare conditions are bounded within marginalized communities.[65] Public health statistics, and the entities and activities that mobilize them, draw one's gaze onto historically and systemically oppressed individuals and communities, but do not direct scrutiny on to the forces that play out health inequities and medical violence — forces that are borne in and mobilized in institutions complicit in injustice. Oral health professional programs then must "reverse the gaze"[66] and recognize the "two-sidedness"[67] of structural violence to educate authentically for social justice.

Educational governing and regulatory bodies like the ADEA and ACFD articulate a general understanding that becoming a healthcare professional

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60 *Ibid.*, at 1201.

61 D. Armstrong, "The Rise of Surveillance Medicine" (1995) 17:3 *Sociology of Health & Illness* 393.

62 Above note 17.

63 Above note 58, at 18.

64 P.S.S. Howard, "On Silence and Dominant Accountability: A Critical Anticolonial Investigation of the Antiracism Classroom" in G.J. Sefa Dei and A. Kempf, eds., *Anti-Colonialism and Education: The Politics of Resistance* (Rotterdam: Sense Publishers, 2006), 43 at 45.

65 Tuck, above note 50.

66 Above note 36, at 6; and Sefa Dei and Kempf, above note 64, at 47; and above note 58, at 19.

67 Sefa Dei and Kempf, above note 64, at 47.

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entails an ascension to a privileged social location.[68] This entry into an elite social and economic status is understood as carrying a set of responsibilities — a notion enshrined via an array of policies, guidelines, and curricular content. Somehow, educational institutions continue to divorce themselves, however, from an embodied accountability for the systems and realities of inequality and oppression in which they are complicit.[69] Ahmed offers her words as informed by her years of doing anti-racism work in institutions: "if we start with complicity, we recognize our proximity to the problems we are addressing."[70] Learning from adversity, knowing better after making mistakes, and self-reflexivity are not novel concepts in the field of education. Educators of society's future healers are in a position to "[respond] creatively to the conditions and realities of society"[71] and help trainees "not lose sight of the picture, that is the daily context where a person lives, grows, and loves".[72] Those who are afforded power and privilege in society, including healthcare professionals, have an opportunity to critically interface with their power for the sake of those systemically excluded, violated, and oppressed. Beyond braces, fillings, and implants, dental education can be the site of key disruptions in an inequitable and oppressive status quo where access to care barriers and violence in a multitude of forms — sexual, economic, racial — remain under-addressed. The scandal at Dalhousie's Faculty of Dentistry not only brought to light sexual violence and homophobia, but also the structural matters that have allowed such realities to perpetuate themselves. Educators, administrators, and the health community have a choice in repurposing the impact of these tragedies for the benefit of transformative change.[73]

68 ADEA, above note 17; ADEA Statement, above note 18; ACFD, above note 25; above note 50.

69 S. Ahmed, "'You end up doing the document rather than doing the doing': Diversity, Race Equality and the Politics of Documentation" (2007) 30:4 *Ethnic and Racial Studies* 590; S. Ahmed, *On Being Included: Racism and Diversity in Institutional Life* (Durham, NC; London: Duke University Press, 2012; and see above note 2; and Sefa Dei and Kempf, above note 66.

70 Ahmed *ibid*., at 18.

71 M. Bofelo, A. Shah, K. Moodley, L. Cooper, and B. Jones. "Recognition of prior learning as 'radical pedagogy': A case study of the Workers' College in South Africa", *McGill Journal of Education*, vol. 48, no. 3, 2013, p. 517.

72 Above note 35.

73 Above note 2, at 2.

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5. CRAFTING A SOCIAL JUSTICE-ORIENTED EDUCATIONAL RESPONSE AT McGILL UNIVERSITY

Dentistry course 206, titled Social Justice Seminar 1, is the first of three social justice, ethics, and professionalism-focused courses offered in the Doctor of Dental Medicine (DMD) program at McGill University.[74] DENT 206 is offered in the program's second year and is a prerequisite to DENT 306 and DENT 406, courses which focus on ethics as a philosophy and jurisprudence.[75] Community-based dental education and service-learning are housed within the Community Oral Health Services curriculum wherein students must partake in mandatory clinical rotations in underserved communities.[76]

DENT 206 was piloted under another course in the 2016-2017 academic year and based on informal feedback from students and colleagues, my own reflections, as well as my current graduate research, the course was revamped for the 2017–18 offering. I also took part in an intensive workshop offered by McGill University's Teaching and Learning Services[77] on course design and learning-centered approaches,[78] which informed DENT 206's overall structure and assessment strategies. Furthermore, the existing format of DENT 206 was heavily inspired by my own experiences in popular education, both as a participant and as a facilitator.[79] It should be noted that "students" and "participants" are interchangeably used in the following section. Popular education prefers to use the word "participants" to counter the hierarchical positioning of a teacher-student binary.

(a) The Syllabus

The DENT 206 2017-2018 syllabus provides a general course description, a short blurb published on the Faculty of Dentistry's DMD course calendar to give students a summary of what the course is about:

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74 E. Briones, S. Esfandiari, C. Garcia, S. Hutcheson, A. Vemuri, and S. Yarde, "DENT 206: Dentistry Social Justice Seminar 1", McGill University, 2017.

75 R. Hovey, A. Wiseman, and J. Ainsworth, "DENT 306, 406: Dentistry, Ethics and Jurisprudence", McGill University, 2017.

76 F. Power, "DENT 113, 213, 313, 413: Community Oral Health Services Curriculum", McGilll University, 2017.

77 T. & L.S. McGill University, "Course Design Workshop", McGill University, May 2017.

78 D.A. Whetten, "Principles of Effective Course Design: What I Wish I Had Known about Learning-Centered Teaching 30 Years Ago" (2007) 31:3 *Journal of Management Education* 339.

79 E. Clare, E. Harvey-Peake, P. Isaac, and A. Vicaire, *Race Project: Facilitation Guide*, McGill University, Student Housing and Hospitality Services, 2014; and Student Housing and Hospitality Services McGill, SACOMSS, and Queer McGill, "Rez Project – Year VIII", 2011.

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> 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.

The syllabus also outlines broad learning outcomes for students taking the course:

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). 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;

   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.

Like all courses in the McGill DMD program, DENT 206 is not graded and students are given a "Pass" or "Fail". Similarly, written assignments are not given a number or letter grade; they are assigned to provide students an opportunity to articulate their thoughts, reflections, and emerging understandings — once at the midpoint and once again at the end. Detailed below is the DENT 206 evaluation scheme for the 2017-2018 academic year:

1. Attendance to 4 mandatory seminars/workshops and Participation — 10% (Complete/Incomplete). Students must submit at least 1 discussion question (via email) 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% (Complete/Incomplete). Journal must demonstrate students' thinking and analysis, personal takeaways, and emerging learnings and understandings as they pertain to the first two workshops;
3. Final Summative Journal — 50% (Complete/Incomplete). 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. 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.

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(b) The Workshops

DENT 206 is comprised of four two-hour lecture-workshops. Each one is delivered by myself and a co-facilitator, a practice I have modeled after other popular educationists and anti-oppression workshops.[80] This is to ensure that a sole facilitator is not seen as the sole holder of knowledge[81] 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.

DENT 206 is couched in the ideology that the safety of the learners is prioritized while simultaneously challenging them to critically think through discomforting reactions and emotions.[82] Distinguishing a lack of safety versus discomfort is one of the first concepts clarified in the course's introductory lecture-workshop. Scholars on activism contend that new knowledge can often emerge through these internal struggles.[83] Through proper guidance and fostering a commitment to safer-space in the classroom, we hope to encourage participants to be open about these dissonant feelings and critically reflect on their resistance to some of the ideas proffered in the course. The preceding section outlined that oral health professional education and the profession itself are "site[s] for ideological conflict",[84] where economic and individualistic goals clash with notions of social responsibility and collective good. DENT 206 is designed to put these dissonant entities at the forefront and facilitate an active self-reflexive and critical engagement therein.

(c) Spatializing, Connecting, and Interfacing with Power

McGill's Doctor of Dental Medicine program contains compulsory courses that explore public health and social determinants of health. Additionally, the program's mandatory community clinical rotations are complemented with classroom-based modules that seek to nuance the nature of working with traditionally underserved populations. What DENT 206 offers, concurrent with these areas of the curriculum, is a platform to interrogate attitudes that locate inequality, oppression, and violence as outside the learners' contexts, to unpack their "two-sidedness".[85] The course attempts to bring to light the potentially

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80 *Ibid.*

81 Above note 56.

82 M. Zembylas & C. McGlynn. "Discomforting Pedagogies: Emotional Tensions, Ethical Dilemmas and Transformative Possibilities," *British Educational Research Journal*, vol. 38, no. 1, p. 42.

83 Bofelo, above note 71, at 513; A. Choudry, *Learning Activism: The Intellectual Life of Contemporary Social Movements* (Toronto: University of Toronto Press, 2015).

84 I. Ferguson, *Reclaiming Social Work: Challenging Neo-liberalism and Promoting Social Justice* (London: Sage, 2008) at 16.

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unsettling realization of one's complicity, whether explicit or tacit, in the very systems that we traditionally critique through public health statistics or the news stories that detail dentists "behaving badly". DENT 206 seeks to foster "power-literacy", a term used to indicate a level of critical awareness of one's social location, privilege, and power (i.e., a dentist who has an elite status in society and has access to patients' bodies). "Power-literacy" is an integral part of a social justice education model for training health care providers. To know how one's power manifests in one's various roles and social worlds can help prevent abuses of these powers. Scholars and activists point to the issue of systemic and material violence, power, and vulnerability to the misuse of power as fundamental matters concerning gendered and sexual violence.[86] DENT 206 explicitly targets this issue through improving participants' "power literacy". Knowing the genealogy of one's power and privilege at the systemic, institutional, and individual levels might help prevent their abuse to the detriment of those most marginalized.

Workshop 1, for instance, begins with a land recognition; those in the classroom who are settlers recognize the Indigenous stewards of the colonized land in which we live and learn. From there, facilitators proceed to ask the participants why a land recognition is important and in line with the objectives of the course. The openings provided by a brief land recognition acts as a conduit to greater understandings of settlerhood and is followed-up by a case study on the White Eagle/Lim dilemma involving the barriers faced by Indigenous people in accessing proper oral healthcare services.[87] Students are asked follow-up questions such as, "How is the privatization and the bureaucratization of oral health disproportionately impacting Indigenous populations?" and "How is the continued participation in these systems perpetuating poor oral health in these communities?"

Issues of complicity and participation are reconnected to the participants' own lives through a social location activity. Students are asked to line up along the middle of the classroom and close their eyes. One facilitator reads out a "move forward statement", such as "one or both of my parent(s) or guardian(s) is a medical professional", while the other facilitator reads out a "move back statement", such as "neither of my parent(s) or guardian(s) hold(s) a university degree". The statements are crafted in a way that speaks most to the context of the students: the "move forward statements" showcase a social privilege that might inform a student's life in and after dental school, whereas the "move back statements" bring to light aspects of one's identity that may give one a disadvantage (in contradistinction to those who may not be aware of a privilege they might have). These activities can be challenging because they may prompt

[85] Above note 74, at 47.

[86] K. Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color," *Stanford Law Review*, vol. 43, no. 6, 1991, pp. 1241–99; and bell hooks, *We Real Cool: Black Men and Masculinity* (New York: Routledge, 2004); and A. Lorde, *Sister Outsider: Essays and Speeches* (Berkeley, CA: Crossing Press, 2007).

[87] Labby, above note 20.

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participants to disclose information about themselves that might be embarrassing and/or private. Participants are always reminded that they have a right to pass or remove themselves from an activity, especially when they are asked personal or revealing information about themselves.

Workshop 1 hopes to provide a baseline understanding of the premise of the course through collective self-reflection and situating oneself in society at the individual, institutional, and systemic levels. One's personal histories, experiences, and beliefs are unpacked and contextualized through a social justice and intersectional lens.[88]

The second and third lecture-workshops are extensions of the fundamental concepts explored in the first (e.g., power and privilege, positionality, systemic and institutional oppression, and intersectionality). Workshop 2 focuses on gendered violence, rape culture, and a conversation about the Dalhousie *Class of DDS 2015 Gentlemen* incident. This module takes a critical look at the intersections of power, cis-hetero patriarchy, violence, and health care. At this point, participants are taken through a process of interfacing with their power. Participants are challenged to think about how power can be used for coercion beyond physical means. As future dentists and therefore potential owners of clinics and employers, facilitators and participants discuss how their power can translate to harm, such as socially isolating a subordinate through offensive jokes or making inappropriate sexual advances.

(d) Agents of Social Change

DENT 206 aims to precipitate critical reflections and ideas that counteract disconnection from social justice-oriented attitudes and practices.[89] More than just bringing awareness to these issues, this course treats participants as agents of social change who are in a position to disrupt these oppressive norms: they have the opportunity to use their power and privilege for social good and transformative change. The fourth and final lecture-workshop operates in the belief that each participant, although immersed in the problematics of a privatized health service and an unequal society, can find opportunities to challenge the status quo.[90] Here, facilitators advocate ideas of community and solidarity, encouraging participants to realize that if a critical mass of social justice-oriented oral healthcare providers take on proactive roles in socially just work, transformative change is within reach. At one point, a slide in the workshop reads, "Social change is not brought about solely by people acting individually ... community requires accountability to oneself, but also patience, understanding, and collaboration." This emphasis on community building and

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[88] Crenshaw, above note 86.

[89] Albino et al., above note 18; see also Axelrod, above, note 19; and above, note 36, at 11; and F. Rizvi, "Lifelong Learning: Beyond Neo-Liberal Imaginary", In *Philosophical Perspectives of Lifelong Learning*, Vol. 11, 2007.

[90] Gordon & Ramdeholl, above note 32.

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solidarity reinforces the notion that transformative change is achievable when people come together and actively advance social justice work. Finally, it is recognized that a course that only identifies social problems can lend itself to creating an environment of hopelessness and inaction.[91] To quote Choudry, "tenacity is crucial in long-haul organizing, education, and learning for social change."[92] Overall, DENT 206 is structured to foster learner agency and encourage critical consciousness so participants recognize their individual power and privilege and discover how to challenge the confines of a culture restricted by systemic violence, economic gain, and institutional advancement.[93]

6. CONCLUSION AND MOVING FORWARD

In the 2017-2018 academic year, as a research assistant for IMPACTS,[94] I will be collecting and analyzing qualitative data on the experiences of the participants from the DENT 206 pilot offering. The work on crafting a social justice educational platform for McGill's DMD program must speak to the context of oral healthcare provider trainees — a task incomplete without meaningfully accounting for the learners' perspectives. Moving forward, I hope to develop a deeper understanding of the barriers to acting for social justice, dismantling sexual, racial, and other forms of systemic violence, and also gain "power literacy", which I will enact toward transformative change. More than just building a solid theoretical foundation, I will continue to explore how to teach for social justice in this context through exploring activist learning and educating for social movements and expanding on the notion of working within the cracks.[95]

I share Choudry's concern that "awareness alone is not enough to bring about change".[96] Courses like DENT 206 can be subject to the same pitfall that Ahmed describes in her work on university race-equality work, wherein such work is taken up as "doing the good work".[97] As much as possible, the co-facilitators and I endeavour to foster an understanding that the difficult work of participating in socially just change is in the hands of the participants. Taking a social justice course should not be conflated with being proactive in transformative processes: the hard work of social justice is rooted in action

[91] D. Bleakney and D. Morrill, "Worker Education and Social Movement Knowledge Production: Practical Tensions and Lessons" in A. Choudry and D. Kapoor, eds., *Learning from the Ground Up: Global Perspectives on Social Movements and Knowledge Production* (New York: Palgrave Macmillan, 2010), 139–155 at 140.

[92] Choudry, above note 83, at 118.

[93] Above note 74; and see Rizvi, above note 89; and see Choudry, above note 83, at 90.

[94] Above note 14.

[95] See Gordon and Ramdeholl, above note 32, at 34.

[96] Choudry, above note 83, at 89.

[97] Ahmed (2007), above note 71, at 594.

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and, at times, self-sacrifice.[98] A politicized consciousness will not solely bring about the transformations required at the individual, institutional, and system scales in order to eliminate social injustice, systemic violence, and health inequality. So long as dental training institutions continue to operationalize contradicting messages of social responsibility, and individualistic and economic mandates without complicating them, it is unrealistic to hope that these reforms will authentically emerge and give rise to a health care system free from all forms of violence.

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[98] C.A. Lugg and A. Shoho, "Dare Public School Administrators Build a New Social Order? Social Justice and the Possibly Perilous Politics of Educational Leadership" (2006) 44:3 *J. of Educ. Admin*. 196 at 205.

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