Unsolicited Narrative Review

Title: Critically engaging vulnerability: Rethinking oral health with vulnerabilized populations

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Abstract

This paper is the third in a series of narrative reviews challenging core concepts in oral health research and practice. Our series started with a framework for *Inclusion Oral Health*. Our second review explored one component of this framework, looking at how *intersectionality* adds important complexity to oral public health. This current manuscript drills into a second component of Inclusion Oral Health, exploring how labels can lead to 'othering' thereby misrepresenting populations and (re)producing harms. Specifically, we address a common oral public health label: vulnerable populations. This term is commonly used descriptively: an adjective (vulnerable) is used to modify a noun (population). What this descriptor conceals is the 'how,' 'why,' and 'therefore' that leads to and from vulnerability: How and why is a population made vulnerable; to what are they vulnerable; what makes them 'at risk,' and to what are they 'at risk'?

In concealing these questions, we argue our conventional approach unwittingly does harm. Vulnerability is a term that implies a population has inherent characteristic that makes them vulnerable; further, it casts populations as discrete, homogenous entities, thereby misrepresenting the complexities that people live. In so doing, this label can eclipse the strengths, agency and power of individuals and populations to care for themselves and each other. Regarding oral public health, the convention of vulnerability averts our research gaze away from social processes that produce vulnerability to instead focus on the downstream product, the vulnerable population.

This paper theorizes vulnerability for oral public health, critically engaging its production and reproduction. Drawing from critical public health literature and disability studies, we advance a critique of vulnerability to make explicit hidden assumptions and their harmful outcomes. We propose solutions for research and practice, including co-engagement and co-production with peoples who have been vulnerabilized. In so doing, this paper moves forward the potential for oral public health to advance research and practice that engages complexity in our approaches to vulnerabilized populations.

Key words: dental public health, health disparities, oral health, public health, vulnerability

1. Introduction

Myriad examples of oral health research and public health practice demonstrate commitments to understanding and attending to disparities in oral health status and experience.[1] Notwithstanding such laudable goals and accomplishments, critical publications are increasingly underscoring how conventional public health approaches may also be part of the problems they are trying to address.[2] Clinical dentistry is critiqued for inequitably addressing population needs (e.g., more urban than remote coverage; inadequate insurance or sliding scale policies for low income clients; designs excluding disabled bodies);[3,4] the resultant inequity increases disparities across populations and violates the profession's social contract.[5] Education critics suggest that current dental education models over-emphasize invasive treatment compared to preventative care, increasing tooth degradation instead of bolstering natural healing.[6,7] Oral public health research is criticized for "down-stream drift"[8] and point-of-care solutions (e.g., accommodation and charity) which lack engagement with, and advocacy regarding, the structural roots of disparities.[9,10]

If public health problems are so muddled together with solutions, how do we know if our own work is part of the problem or part of the solution? In an effort to contribute to disentangling this muddle, we

offer the following position paper on one particularly vexing component of oral public health: vulnerability.

Inherent to public health foci, generally, is a concern for the individuals and communities who experience the poorest health, who are most excluded from care, and who are at risk for continuing discrimination. The conventional shorthand for these complex, overlapping categories of individuals and communities is *vulnerable populations*. Oral health research and practice is no different, as leading oral public health publications demonstrate: e.g., Canadian Academy of Health Science's *Improving Access to Oral Health Care for Vulnerable People Living in Canada*; the World Dental Federations' *Access to Oral Healthcare for Vulnerable and Underserved Populations*.[11,12] A recent publication shines a critical light on the use of this phrase, however. Through a critical discourse analysis, Katz and colleagues suggest that current usage of 'vulnerable' in public health publications "may serve to conceal the structural nature of public health problems."[13(p.601)] While not the first to contest how vulnerability is used,[8,14,15] Katz and colleagues' reflections compel us to ask of our own work: What do we mean by vulnerability in oral public health? What does this concept do? How might we 'do' differently?

In the following paper, we explore how 'vulnerability' is commonly used in oral health research and practice, beginning with grammar, moving to discourse, and finally to ideas around its social construction. Throughout this exploration, we contemplate both problems and solutions, looking at harmful outcomes of the conventional use of vulnerability and better ways to move forward as oral health researchers committed to social justice and ethical engagement for better care.

2. Never just semantics: Exploring the language and discourse of vulnerability

Katz and colleagues' work uncovers a "vagueness" in how the word 'vulnerable' is used in public health publications.[13] Turning to oral public health specifically, one also sees how this construct is used as an adjective (vulnerable) modifying a noun (population). Vulnerable often appears modifying a specific population category: e.g., vulnerable adults.[16] As Katz and colleagues found, there is rarely an accompanying description unpacking how and why these populations are so labeled; that is, what does vulnerable mean, and what makes these populations vulnerable? We do not have to go farther than our own prior work to find examples of such non-specific grammatical constructions:

- Macdonald et al.'s work with humanitarian migrants addresses a "vulnerable Canadian population"[17]

- Muirhead's et al.'s work addresses "vulnerable foster children"[18] and the "vulnerable group" of working poor[19]
- Freeman et al.'s work looks at the "vulnerable (special care) patient group"[20]
- Doughty et al.'s work describes care for "the most vulnerable members of society" who are experiencing homelessness[21]

On a descriptive level, 'vulnerable' is an adjective that conveys that the individuals in the populations being described have inherent characteristics that *somehow* make them *at risk* for *something*. It could be their developmental stage (e.g., children), their age (e.g., older adults), a health issue (e.g., physical impairment; chronic illness), their social situation (e.g., living in poverty; having recently migrated; being an ethnic minority). Instead of articulating how people come to be vulnerable, how multiple intersecting identities layer and compound one's vulnerability,[22,23] how there are variations in vulnerable states (e.g., transience, progression, severity), or how the same people we have labeled vulnerable also embody their own, self-defined, assets, strengths, and resiliencies,[24] we let the word vulnerable do all the work for us. In so doing, we leave many details out of people's stories. We also imply that things could be otherwise; that is, we construct a binary that makes these individuals 'other' than the non-vulnerable, the normal. And perhaps the biggest blunder for public health is that the downstream focus on these so-called vulnerable populations tends to eclipse upstream engagement with "the political structures, and those who create and perpetuate inequity"[8(p.2)]

Discursive use of vulnerability

To understand the meaning behind our language, from grammar we must move to the discursive level. Language both conveys meaning and constructs meaning; discursive analysis demonstrates both *that* language matters and *how* language matters.[25,26] Unpacking the discursive meaning and related power of vulnerability requires asking: What does vulnerability mean, and what does it do?

Katz and colleagues suggest that the vagueness of vulnerability leaves readers to "fill in the blanks" with narratives that support 'scientific racism'; for example, narratives that blame the victims for the biology and behaviors causing their illnesses, and that imply their social conditions are permanent and immutable.[13] The label 'vulnerable' carries complex meanings and produces implications. At a legal level, attention to 'vulnerability' can ensure safeguards for people with limited power.[27] At a rhetorical level, the term 'vulnerable' can inspire sympathy and charity, compelling urgency and benevolence: a population that is vulnerable suggests victims in need of protection and assistance. This rhetorical power tugs at our ethics of care: it pulls us to create social and health services, justify research grant funding

(e.g., around 'priority populations'), and bolster political agendas to help those we construct as needy and deserving by virtue of what is cast as their helplessness.

While ostensibly – and at times, both substantively and materially[27] – benevolent, labelling smuggles forward multiple agendas.[28] Labels collapse diversity, for instance. Carried with the labels of vulnerable groups (e.g., the homeless, migrant newcomers, foster children) are the assumptions that the individuals in the groups share the characteristics that make them vulnerable and share the repercussions of their vulnerability. For example, we assume that people who are precariously housed do not have the financial resources or organizational wherewithal to successfully seek regular dental care. Similarly, labels cast each vulnerable subpopulation as if discrete entities: the homeless are not also the migrants and are not also the foster children. In contrast, Black American poet and activist Audre Lorde reminded that "There is no thing as a single-issue struggle because we do not live single-issue lives."[29] Our own work on intersectionality[22] responds to Lorde, and building on the work of Crenshaw,[30] proposes that oral health must position itself at the intersection of the overlapping complexities that people live.

Labels also stick. For example, after serving their sentence, prisoners often become ex-prisoners, or ex-offenders. Labels are 'othering,' underscoring the social distance between the labeled and the labeler.[2] When and how do former prisoners get to be, simply, citizens? Unpacking labels and their use reveals issues of power. Labels exert power by those who claim the right to create and use them. When political power is the driver, policy makers can decide which groups are 'vulnerable enough' to warrant services and upon whom grant funding priority announcements will focus. When health care professionals or researchers hold the power, they can decide who is most deserving of research attention and clinical services. A recent study on migrants in the Netherlands demonstrates how vulnerability compelled inequitable dental care from dentists in a volunteer network.[31]

The metanarratives in which these labels are embedded assume that the vulnerable are helpless victims, without power or agency. And, victims, these metanarratives tell us, require saviors. We often position our public health research and clinical services from such a vantage point; when vulnerability is cast as an inherent trait, our work is compelled to save the vulnerable from themselves. But, as we move to protect and save the vulnerable, are we not also silencing them with our privilege and power?

3. Social construction of vulnerability

Disability studies has used a social constructivist framework to uncover and challenge how labels 'do' something. Disability scholars put forward the challenge that people with impairments are not inherently 'disabled' (noun); rather, it is the built and social environments that 'disable' (verb) them. In other words,

disability can be thought of as a social construction that is located within our societies; societies, through the built and social environments, disable people who have bodies that are not considered 'normal.'[32] Casting disability as an outcome of social processes means that accountability – and solutions – sit squarely at the societal level. A simple example makes this point: a ramp in place of stairs can transform a person using a wheelchair from being disabled to being abled.

Taking an additional page from disability scholars, we can reflect on how we disable 'vulnerable' people in oral public health. Person-first language leads with the person, followed by the impairment that is making them vulnerable: e.g., a person with a disability, a person with schizophrenia. This construction is most in-line with a person-centred medical model that endeavors to see the patient before their illlness. In contrast, some disability activists argue for identity-first language: e.g., a disabled person. This construction takes the blame off the individual for having an unruly or broken body, instead putting blame on social forces for dis-abling that body.[33] In so doing, identity-first language conveys *how* the person has been vulnerabilized by social policies, and contests binaries (disability vs. normal) that favor normal bodies. It replaces the medical model with a social one.

Our language produces and supports what is thinkable; in so doing, it upholds the status quo. Shifting our language can change our gaze and our actions. Within the Black Lives Matter movement, we see identity-first language. For example, New York Times reporter, Nikole Hannah Jones, refers to *enslaved people* in the *1619 Project*, expressly focusing on the racist processes (enslaving) instead of bodies that were created (slaves).[34] Similarly, the language of *racialized* and *marginalized* peoples stresses how social processes and policies create racial inequalities and what these do to peoples. Race itself does not cause inequity; it is the processes of racializing and marginalizing that do. An Non-Governmental Organization (NGO) in Montreal (Canada) has adopted the language of 'refugeed people'[35] signaling the processes that affect a person's identity and resisting the noun (refugee) that homogenizes and simplifies their experiences.

Following, we are proposing that we shift our grammar and discourse around vulnerability to underscore processes instead of states, avoid binaries, resist simplifying and homogenizing people, and ultimately to convey that people are more than their labels. The noun, *the vulnerable* or *vulnerable populations*, locates the characteristics of vulnerability within individual bodies, homogenizes populations and makes them different from 'normal' populations (i.e., othering). In so doing, we are eclipsing the other characteristics and complexities that make these people citizens. And importantly for oral public health, this approach positions our clinical and research interventions downstream. Vulnerability, as a designated state of being, compels our research and intervention after the fact of its description. For example, in oral

public health, we work to create pathways to help vulnerable populations access services. While such a strategy may help to address urgent dental conditions such as toothache, it does not fundamentally change the *vulnerabilizing* that set up conditions that caused the toothache. In contrast, by locating the production and consequences of vulnerability at the level of society, accountability is relocated upstream, as are the entry points for research and practice.

4. Vulnerabilized populations: What is at stake for oral public health?

What if we shifted how we thought about vulnerability in oral public health? Using the frame of social construction, we can see vulnerability as not an individual's primary trait or state; instead, people are *vulnerabilized* through social processes. That is, vulnerability is the outcome of vulnerabilizing processes. In writing this paper, we are purposely provoking a tension between the noun and the verb. We invite readers to see this tension as productive, and to help us grapple with the implications. On one hand, we traditionally have taken as our starting point the population that is produced by social processes, the vulnerable population. Professional obligations and Dentistry's social contract compel us to protect and advocate for persons without power or resources.[5] We are proposing, however, that it is *even more urgent* that we work towards uncovering and contending with the processes that produce the vulnerabilities.

Changing our language is a step towards resolving this tension and improving the mission of oral public health. Uncritically using the term vulnerability masks the complexity of individuals' lives and situations; further, it eclipses the social forces that produced this complexity. As such, we have been missing opportunities to unpack this complexity, and unwittingly have been putting our efforts into solutions that will only ever be partial at best. By reframing the vulnerability discourse as processes that *vulnerabilize* people, we are inviting oral public health researchers and practitioners to shift their gaze upstream to socially-sanctioned processes, and to follow these processes down the stream to better understand people's lives. With this approach comes a revived concern for the 'hows,' 'whys,' and 'therefores' that leads to and from vulnerability: How and why does a person come to be vulnerable? To what are they vulnerable? What makes them 'at risk' and for what are they 'at risk'? Ultimately it requires us to ask: What are the processes that vulnerabilize people, and how might our research and practice intervene to mitigate this production?

To be clear, we are not suggesting that we throw away the terms 'vulnerable' and 'vulnerability' entirely; certainly, the legal safeguards that accompany this terminology do important work. Instead, we are calling for a more sophisticated reckoning that begins with the premise that all people live complex lives.

For example, children can be vulnerable by dint of their age and position in society and thus in need of protection, while at the same time demonstrating moral agency that deserves authentic recognition.[36] Similarly, Indigenous peoples can be vulnerable and in need of affirmative action to counter ongoing colonial policies that produce health disparities while also empowered, agential, and working towards decolonized systems and policies.[24,37] Our conventional concepts do not often capture this complexity; and worse, sometimes our approaches actually produce the siloes that simplify rather than complexify.[38,39]

As ethically-engaged health researchers inspired by social justice, we must ask ourselves: How complicit are we in perpetuating the metanarratives of vulnerability in our own work? How might oral public health vulnerabilize people through clinical practice and research? Recently, we have added our own voices to a growing list of concerned scholars grappling with how to better position oral public health research and practice to address issues of social justice. In one recent paper we argued that dentistry's service delivery model compounds the social exclusion that many people are already experiencing, and we put forward a framework of *inclusion oral health* to begin to address the results of such social exclusion.[2] In a follow-up paper, we shone a light more directly on our "current simplistic single-variable oral health inequality research" that eschews complexity and therefore misses the opportunity to understand how intersecting social identities compound vulnerabilities.[22] In both these papers we turn away from investigator-driven research and towards a power-sharing commitment to participatory and co-design models that work *with* instead of *on* people who have been vulnerabilized.

The voluminous 'access to care' research is one location to start this examination.[40] While opening dental care to a broader public is clearly important, conventional research approaches tend both to start and stop with the results of vulnerability, rarely returning to addressing the processes that produced it. Our own research has done just that. For example, Macdonald and colleagues did a study to understand why parents in Montreal (Canada) seek regular dental care for their children in the Emergency Room.[41] Their conclusions lead to important upstream reflections: community-based dental services are experienced by parents as neither child- nor family-centred. Children, as a result, are vulnerabilized by a professional culture that does not prioritize treating children.[41] As a team, we stopped at this conclusion, putting the results out into the academic literature and moving on to another 'access to care' study with another 'vulnerable' population.

5. Strategies for moving forward

In response to the productive tension we pose above, we can learn from sister disciplines to find ways to move forward. Phelan,[33] for example, offers 'critical reflexivity' as a modality for occupational therapists to query the metanarratives that their models reproduce and uphold. Drawing on Hammell,[42] Phelan counsels: "health care professionals have been socialized in a culture in which their ideas and beliefs 'appear not only to be natural and self-evident but benevolent and beneficial.'"[33(p.170)] While writing specifically about disability, Phelan's critical reflection pertains to vulnerability more broadly, compelling us forward to imagine un-doing our comfortable dichotomies (e.g., vulnerable vs. non-vulnerable/normal) so they no longer appear as if 'natural and self-evident.' Rather than 'benevolent and beneficial,' they actually do harm in that they frame populations as inherently at risk and needing our protection. In so doing, we do harm to those we intend to help; further, we diminish oral public health by not learning from the complexity that is inherent in the human condition.

We can learn from nursing and social work as well, two professions that continue to push against problem-focused deficit models, championing strength-based approaches focusing on capacities, self-efficacy, and empowerment.[43,44] A logical extension of strength-based care is the research and clinical work using participatory, co-production and co-design commitments which demonstrate authentic engagement for and with citizens across multiple subpopulations. Strong statements by public health journals are reinforcing this imperative.[37] Oral public health has taken up this banner in clinical approaches; for example, Bedos and colleagues' *Montreal-Toulouse Biopsychosocial Model* trains the clinical gaze onto the person as embedded in their socio-cultural-political environment.[45] Similar examples can be found in oral health research.[46]

Our key recommendation for this position paper is to engage in a solution-finding dialogue with vulnerabilized peoples to determine the future agenda of oral health research and practice. The following are points to be interrogated through an inclusive process of participation and co-development with vulnerabilized peoples.

The first is to engage the populations with whom we work in dialogue about the labels that they want us to use to describe them, and their preferences for self-description. Some may prefer person-first descriptors, other identity-first descriptors. Through the dialogue, we can recognize how vulnerability is simultaneously constructed and resisted, is layered and complex, is produced through micro, meso and macro structures and policies. We can also rethink our professional approaches to advocacy and policy.

The second is authentic inclusion of vulnerabilized peoples in the endeavors intended to help them, facilitated by creative research strategies. Strategies may include art-based methods,[47] and long-term

observation in-situ to gain insight within the context of their everyday environments, and community-based participatory research in which research questions are designed with communities from the outset to identify their key aims and measures of success.[48] In support of this approach, multidisciplinary collaborations with researchers external to oral health can provide useful insight.

The third proposed solution is to integrate a social and structural determinants discourse into vulnerability research, education and policy.[49] In education, action should begin from the undergraduate level through to continuing education,[50] including educating dental professionals about how to support vulnerabilized peoples to empower themselves. At a practice level, this could also include trauma-informed care, and grief literacy.[51,52] Additionally, empowering dental professionals to engage with and navigate the landscape of policy makers is key to supporting a united goal for participatory action *with* and not *for* vulnerabilized peoples. And finally, as Katz and colleagues point out, public health has not traditionally included research or research approaches that get at "individuals and groups that benefit from services others cannot access," or "the individuals and groups responsible for enacting the policies and processes that generate vulnerability in the first place."[13(p.605)] Future work needs to look at all sides of vulnerability, including how our services and policies incentivize care for some while excluding others.

6. Conclusion

Though oral public health research and practice with populations who are vulnerabilized are no longer novel endeavors, rapid growth in this area has instigated this critical review. Herein we have recognized limitations in our current thinking around the manifestations of vulnerability, and though we recognize the risk that solutions may create new problems, we implore readers to rethink vulnerability labels, reveal and radically readdress power imbalances, and redirect their gaze upstream in a bid to unmask both the persons and the social constructs that exist behind the labels.

Author Contributions

All authors were involved with the conceptualization of the paper, drafting, and critically reviewing the manuscripts. All authors contributed and approved the final manuscript.

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