



*Health care providers of all ethnic backgrounds are dealing with a greater proportion of patients whose perspectives are different from those taught in the mainstream health care system.*

*Photo: Center for Lifelong Learning at the 87th Annual Session, 2010.*

## Treating Patients from Diverse Populations

By **Su-yan L. Barrow, RDH, MA, MPH**

### U.S. Demographics

Results of the most recent U.S. Census demonstrate that the face of our patient population is changing. By 2020, 35 percent of the American population will consist of ethnic minorities—an amount considerably higher than today's 28 percent.<sup>1</sup> Racial and ethnic minority groups are currently experiencing poorer health status. Over the next decade, the proportion of U.S. minority populations is expected to grow.<sup>2</sup> These anticipated demographic changes magnify the importance of addressing racial/ethnic disparities in health and health care. Health disparities have existed for more than two centuries. Evidence suggests that human disparities continue with little progress made towards their elimination. The causes of racial/ethnic disparities in health are multifactorial, and perhaps the largest contributors are those related to social determinants of health external to the health care delivery system.<sup>2</sup> Although some of the observed disparities can be explained by lack of insurance coverage and other impediments to accessing health care services, others persist even in the absence of financial barriers.<sup>3</sup> New solutions are needed to resolve some of these old problems.<sup>4</sup>

The changing demographics and economics of our increasingly multicultural world and the long-lasting disparities in the health status of people from culturally diverse backgrounds have challenged health care providers and organizations to consider cultural diversity as a priority.<sup>5</sup> Our increasing diversity means that health professionals must adjust their methods for providing health care to accommodate different cultural attitudes.<sup>6,7</sup> However, health care providers must realize that addressing cultural diversity goes beyond knowing the values, beliefs, practices and customs of African Americans, Asians, Hispanics/Latinos, Native Americans/Alaskan Natives and Pacific Islanders.<sup>5</sup> The U.S. Surgeon General's Report on Oral Health in America provided evidence of racial and ethnic disparities in dental care, as well as a lack of diversity in the professional workforce.<sup>8</sup>

### Diverse Health Care Workforce Shortage

Health care providers of the future are another major concern for health care delivery systems. The decline in the number of minority students in the health care field has reached alarming magnitude.<sup>4</sup> Despite intense efforts to diversify the health care workforce, persons of racial and ethnic groups other than non-Hispanic whites remain dramatically underrepresented in the health professions, a problem that is not expected to change significantly in the near future.<sup>9</sup>

In 2001, there were more than 31.4 million individuals who lived in 1,480 health professional shortage areas, nearly double the 780 shortage areas identified in 1990. Racial/ethnic minorities are the majority of individuals who reside in health professional shortage areas; therefore, they bear much of the emotional, financial and physical burden of poor oral health.<sup>3,8</sup>

Health care providers today face the challenge of caring for patients from many cultures who have different languages, levels of acculturation, socioeconomic status, and unique ways of understanding illness and health care.<sup>10</sup> The absence of a sound patient-provider relationship is one factor that contributes to disparities in the quality of care minority populations receive, which returns us to the issue of health care workforce diversity.<sup>11</sup> The lack of a diverse workforce may foster language and cultural barriers, bias and clinical uncertainty within the patient-provider relationship.<sup>3</sup>

The projected change in our nation's demographic composition<sup>12</sup> and the underrepresentation of several minority groups within the oral health care workforce indicate that oral health professionals will be ill-prepared to provide quality culturally competent care to many of their patients.<sup>13</sup>

The results of the American Dental Association Survey of Allied Dental Education provide statistics on the ethnic/racial profile of dental hygiene students and faculty in dental hygiene programs in the U.S. during the period of 2008-2009 (Table I).<sup>14</sup> The workforce disparity is also evident in the percentage of ethnic/racial dental hygienists who are active

**Table I. Ethnic/Racial Characteristics of Students and Faculty in U.S. Dental Hygiene Programs**

Ethnic/Racial group	Percentage students	Percentage faculty
Non-Hispanic White	78.6%	90.0%
Black	4.4%	3.3%
Hispanic	7.3%	3.0%
American Indian	0.6%	0.2%
Asian	7.0%	2.7%
Unknown	2.0%	0.8%
n=	15,194	4,376

members of the American Dental Hygienists' Association with 90 percent non-Hispanic white (Figure 1).<sup>15</sup>

In 2008-2009, dental hygiene program enrollment increased by 1.2 percent from the previous year as the number of programs increased from 293 to 301. Over the past decade, the number of graduates from dental hygiene programs has risen each year with the percentage of graduates being similar to the enrollment statistics at 1.1 percent.<sup>14</sup>

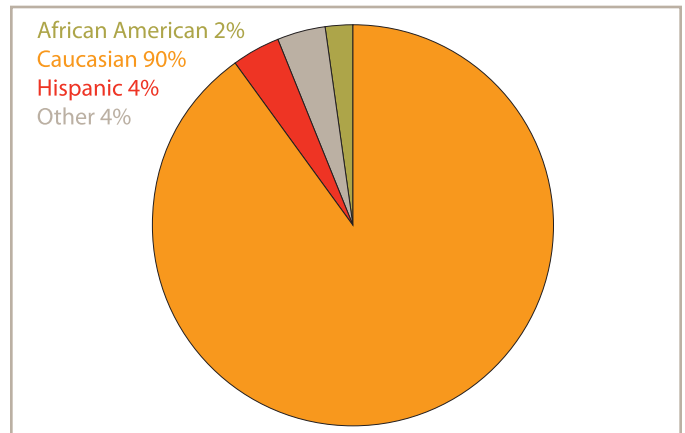
It is both impossible and inappropriate to try to match minority patients to concordant minority providers. Still, these data suggest that there is justification for bolstering the ranks of minorities in the health care professions.<sup>2</sup> Improved recruitment of underrepresented minority practitioners requires increased exposure to the health professions. Such exposure is particularly critical for the dental profession, which some fear and associate with other negative outcomes.<sup>11</sup>

Various studies have demonstrated that minority physicians are more likely than their white counterparts to provide care to poor and minority patients and may provide more effective care to patients of their own ethnicity.<sup>2</sup> Oral health professionals must work in concert with all interested stakeholders (including physicians and public health professionals) to develop and support initiatives that increase minority representation in the oral health care workforce and that reduce disparities in the quality of oral health care received by racial/ethnic minority and economically disadvantaged patients.<sup>11</sup>

### Health Care Delivery

Health care providers of all ethnic backgrounds are dealing with a greater proportion of patients whose perspectives are different from those taught in the mainstream health care system.<sup>2</sup> The clinician needs to be familiar with normative cultural values that may affect the health care of ethnic groups commonly encountered in the practice and to make accommodations for such cultural values.<sup>16</sup> This approach will minimize the clinical barriers that can occur as a result of the interaction between the health care providers and the patient and family. Barriers occur when sociocultural differences between patient and provider are not fully accepted, appreciated, explored or understood.<sup>2</sup>

The Institute of Medicine has reported that the quality of health care in the United States varies according to patient's race and ethnicity.<sup>3</sup> Such variation can result in health care disparities. The root causes of these disparities are not entirely clear. However, the differences in the quality of patient-physician relationships appear to be influenced in part by the physician's race/ethnicity.<sup>17</sup> According to the Sullivan Commission's report, African American patients are significantly more likely to receive their care from African American dentists (who treat almost 62 percent of African American patients) than from White dentists (who treat 10.5 percent of these patients).<sup>18</sup> Findings of a study conducted by Johnson, et al., (2004) indicated that African Americans believe they are treated unfairly and with disrespect in the health care system based on the way they speak English, which lends support to the assertion that cultural dif-



**Figure 1. ADHA Active members by racial background**

*The Institute of Medicine has reported that the quality of health care in the United States varies according to patient's race and ethnicity.<sup>3</sup> Such variation can result in health care disparities.*

ferences between African Americans and their predominately white physicians exist, regardless of language concordance. Perhaps in subtle ways, not only Hispanics and Asians, but also African Americans, are given a message that aspects of their culture, including the way they speak English, are not looked upon favorably in the health care system.<sup>19</sup>

The primary focus is rather on a suggested process for improved communication, which we see as the fundamental need in cross-cultural patient-physician interactions.<sup>20</sup> Incorrect diagnoses or treatment instructions that arise because of cultural barriers can turn misunderstandings into serious mistakes. Patients who have an unpleasant experience as a result of cultural insensitivity (even if the treatment was successful) will not look forward to returning to their doctor.<sup>21</sup> Patient beliefs can have a profound impact on clinical care. They can impede preventive efforts, delay or complicate medical care, and result in the use of natural or harmful remedies. The sensitive, nonjudgmental clinician is able to learn about the patient's belief system and practices.<sup>16</sup>

It is likely that patient-physician relationships are of greater importance in explaining disparities in the use of surgical or other invasive interventions, in which trust and effective communication play a larger role in decision making.<sup>17</sup> A lack of cultural competence among providers contributes substantially to the racial and ethnic disparities in health and health care that are so pervasive in the United States' health care system.<sup>19</sup> Patients who receive the least adequate care will continue to have the most difficulty identifying willing and competent providers, making oral health disparities even worse.<sup>11</sup>

### Cultural Competent Health Care—Why Is It Important?

A "culturally competent" health care system has been defined as one that acknowledges and incorporates—at all levels—the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.<sup>2</sup> Health care practitioners who understand these differences can more quickly diagnose these conditions and can give patients better care.<sup>21</sup>

Two important aspects of learning cultural competence further articulate the idea that it is a personal process of developing one's own cultural sensitivity and proficiency. The literature emphasizes self-reflection on one's own cultural identity and cultural beliefs, and the importance of experiences with cross-cultural encounters, as important to developing cultural competencies.<sup>22</sup> Ultimately, some

**Table II. Key Aspects of the Cross-Cultural Curriculum<sup>10</sup>**

Aspect	Explanation
Focus on the individual patient	Teaches physicians to analyze the individual patient's cultural and social dimensions rather than simply learning presumed cultural characteristics of certain ethnic groups
Case-based learning	Group analysis of cases highlights the major issues of each module
Exploration of both social and cultural factors	Teaches physicians to more efficiently and effectively study the patient's social context by targeting key aspects of the patient's social environment
Teaching techniques	Case analysis, videotaped patient expositions and physician-actor interviews
Progressive curriculum	Five modules that build on one another are taught over four two-hour sessions
Brief and to the point	By use of simple, direct questions and recognition of "hot-button issues," skills are honed through 10- to 15-minute interviews with medical actors

balance of cross-cultural knowledge and communication skills seem to be the best approach to cultural competence. Education and training are important ways to improve both clinical outcomes and health status of the nation's vulnerable populations.<sup>2</sup>

Many frameworks stress the use of communication for eliciting the patient's understanding of his or her culture and establishing rapport. One model developed by Campinha-Bacote (2002)<sup>5</sup> is one of five interdependent constructs that depend on effective communication in the ability to collect relevant cultural data regarding client's health through a culturally sensitive approach to interviewing clients. It includes consideration of *cultural desire*, *cultural awareness*, *cultural knowledge*, *cultural skill* (conducting culturally sensitive assessment) and *cultural encounters*. This model is useful in caring for all people, because in reality we belong to the same race—the human race, with all the same basic needs. However, it is important that these needs may be expressed differently, and "quality health care services" may mean something different for each patient.<sup>5</sup>

Several interviewing and communication strategies are cited in the literature as important techniques for culturally competent clinical practice. Kleinman and colleagues (1978) developed a set of open-ended patient-centered interviewing questions that facilitate appropriate probing to better understand an individual's health beliefs and expectations. This method of questioning is considered crucial for effective patient management.<sup>23</sup>

Communication is a component of a successful interaction with all patients. One model that can be applied to assist health care providers is the LEARN Model. This model is not intended to completely replace the normal structure of the medical interview. Rather, it is intended as a supplement to history taking.<sup>20</sup> The model consists of five guidelines for health care practitioners with the goal of providing culturally responsive care for patients who represent a diverse cultural group. The guidelines are *Listen* with sympathy and understanding to the patient's perception of the problem; *Explain* your perceptions of the problem; *Acknowledge* and discuss the differences and similarities; *Recommend* treatment; and *Negotiate* agreement.

Culturally competent care requires a commitment from doctors and other caregivers to understand and be responsive to the different attitudes, values, verbal cues and body language that people look for in a doctor's office by virtue of their heritage. An equally important element of culturally competent care is expertise in diagnosing and treating illnesses known to have a higher incidence in a given population;<sup>21</sup> for example, the high incidence of cardiovascular disease among African Americans and diabetes among Hispanic groups. These systemic diseases have been linked to oral health outcomes. Therefore, health care providers should be knowledgeable of the health conditions that affect specific ethnic/racial groups and provide culturally sensitive and appropriate health care. Health care providers should begin to familiarize themselves with these differences to improve treatment outcomes and patient satisfaction.<sup>21</sup> Because culture can have such a profound impact on clinical care, it would seem prudent to increase clinicians' exposure to cultural issues at various points in their training. Opportunities to enhance cultural training might include courses in medical/dental school, lecturer series during residency and continuing education courses.<sup>16</sup>

### Training Programs

Given current demographic trends, it is probably unrealistic to assume that health care providers can gain in-depth knowledge about the health-affecting beliefs and practices of every ethnic or cultural group they are likely to encounter in practice.<sup>20</sup> Programs to enhance students' cultural competence are now recognized as a strategy to address failures of adherence, as well as reduce racial/ethnic disparities in health and health care delivery.<sup>24</sup>

Traditionally, training in cross-cultural medicine has focused on a categorical approach, describing the relevant attitudes, values, beliefs and behaviors of certain cultural groups.<sup>2,10</sup> Carillo and coauthors warn against a categorical approach to teaching cultural competence that focuses on specific characteristics of certain groups of people. Instead they emphasize a patient-based approach to cross-cultural curricula that focus on differences between individual patients rather than between groups or cultures (Table II).<sup>10</sup>

The skills learned through this curriculum can help promote communication and cooperation, improve clinical diagnosis and management, avoid cultural blind spots and unnecessary medical testing, and lead to a progressive depth of understanding between patient and physician (Table II).<sup>10</sup>

The overarching goal of these educational and training interventions is to equip health care providers with knowledge, tools and skills to better understand and manage sociocultural issues in the clinical encounter.<sup>2</sup> A model curriculum incorporates the concepts of cultural competence from the first semester, integrating didactic, pre-clinic and clinical course work, thereby providing students with the knowledge and skills to be developed and implemented during the educational process through their interaction with fellow students and patients from diverse racial/ethnic backgrounds.

With the huge array of cultures in the U.S. and the many powerful influences such as acculturation and socioeconomic status leading to intra-group variability, it is difficult to learn a set of "facts" about any particular group and hope to be effective in caring for them. Furthermore, these approaches may contribute to stereotyping.<sup>2</sup> Such misunderstanding often reflects a difference in culturally determined values, with effects ranging from mild discomfort to noncooperation and a major lack of trust that disintegrates the therapeutic relationship.<sup>10</sup>

Another pedagogical method is the use of reflective learning in which the students self-evaluate and consider the specific sociocultural issues inherent in the scenarios. Cultural sensitivity versus stereotyping is emphasized as the students acknowledge the relevance of their foundation knowledge and applying such skills in their development toward cultural competence. Through their experiences and introspection regarding their own biases and patient encounters, they begin to recognize that gaining cultural sensitivity and competence is an ongoing process.<sup>5</sup>

On a more intuitive level, however, we acknowledge that the doctor-patient interaction cannot be as maximally successful if the patient feels uncomfortable because of the doctor's gender, age, tone of voice, physical gestures or other behaviors that may be meaningless in one culture but that have cultural significance for others.<sup>21</sup>

Successful communication requires an awareness of the cultural (norms, values, language, etc.) or environmental (educational level, literacy, etc.) factors that may be influencing physician-patient interpersonal communication styles or preempting learning, as well as the development of approaches and skills that can enhance clinicians' efforts.<sup>25</sup>

When communicating with patients, clinicians should also be aware of and understand the norms and roles of non-verbal communication such as body language, eye contact, hand gestures, time and physical orientation and personal space, as these also affect interpersonal communication. Many ethnic minority groups share cultural norms in which direct eye contact is considered disrespectful and close personal space is valued for enhancing relationships.<sup>25</sup>

## Conclusion

To achieve quality in health care from the patient's perspective, the patient's needs and expectations must be met, with success measured not only in improving health status but also in increased patient satisfaction with care.<sup>4</sup> To enhance the patient-health care provider relationship, it is imperative to increase the diversity in the health care workforce. To address the workforce shortage, academic institutions have to be committed to the education of culturally competent health professionals. The culturally competent clinician needs to maintain vigilance for ethnic disparities in screening, prescriptions, procedures and health outcomes.<sup>16</sup> Culturally competent care is a key cornerstone in efforts to eliminate racial/ethnic disparities in health and health care.<sup>2</sup>

## References

1. US Census Bureau, Population Division. Population estimates: race/ethnicity. Available at: <http://www.census.gov/popest/data/race.php>. Accessed Jul. 10, 2010.
2. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong II O. Public Health Reports. 2003; 118:293-302.
3. Institute of Medicine. Unequal treatment: confronting racial and ethnic disparities in health care. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Healthcare. Washington, D.C. National Academies Press, 2003.
4. Baldwin D. Disparities in health and health care: focusing efforts to eliminate unequal burdens. Online Journal of Issues in Nursing 2003; 8(1). Manuscript 1. Available at [www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No1Jan2003/Disparities-inHealthandHealthCare.aspx](http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No1Jan2003/Disparities-inHealthandHealthCare.aspx). Accessed Jun. 28, 2010.
5. Campinha-Bacote J. The process of cultural competence in the delivery of health care services: a model of care. Journal Transcult Nurs. 2002; 13(3):181-4.
6. Drake MV, Lowenstein DH. The role of diversity in the health care needs of California. West J Med. 1998; 168:348-5.
7. Zweifler J, Gonzalez AM. Teaching residents to care for culturally diverse populations. Acad Med. 1998; 73:1056-61.
8. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000. At: [www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/default.html](http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/default.html). Accessed Jul. 10, 2010.
9. Smedley BD, Butler AS, Bristow LR. In the nation's compelling interest: ensuring diversity in the health care workforce. Washington, DC: National Academies Press, 2004. In: Pilcher ES, Charles LT, Lancaster CJ. Development and assessment of a cultural competency curriculum. J Dent Educ. 2008; 72(8): 1020-8.
10. Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. Ann Intern Med. 1999; 130(10):829-34.
11. Mitchell DA, Lassiter SL. Addressing health care disparities and increasing workforce diversity: the next step for the dental, medical and public health professions. Am J Public Health. 2006; 97:2093-97.
12. Washington, D.C.: Sullivan Commission; 2004. U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau. Projected population of the United States, by race and Hispanic origin: 2000 to 2050. Available at <http://www.census.gov/ipc/www/usinterimproj/natprojtab01a.pdf>. Accessed Jul. 10, 2010.
13. American Dental Education Association. Position paper. Statement on the roles and responsibilities of academic dental institutions in improving the oral health status of all American. J Dent Educ. 2005; 69: 817-825. In:

Mitchell DA, Lassiter SL. Addressing health care disparities and increasing workforce diversity: The next step for the dental, medical and public health professions. Am J Public Health. 2006;96:2093-7.

14. American Dental Association. 2008-09. ADA Survey Center. Surveys of Allied Dental Education. November 2009.
15. American Dental Hygienists' Association. Membership Division. Active membership statistics. Chicago: American Dental Hygienists' Association: 2010.
16. Flores G. Culture and the patient-physician relationship: Achieving cultural competency in health care. J Pediatr. 2000; 136:14-23.
17. Saha S, Arbelaez JJ, Cooper LA. Patient-physician relationships and racial disparities in the quality of health care. Am J Public Health. 2003; 93(10): 1713-19.
18. Missing persons: minorities in the health professions. Washington, D.C: Sullivan Commission; 2004.
19. Johnson RL, Saha S, Arbelaez JJ, Beach MC, Cooper LA. Bias and cultural competence in health care. J Gen Intern Med. 2004; 19:101-10.
20. Berlin EA, Fowkes WC. A teaching framework for cross-cultural health care: Application in family practice. West J Med. 1983; 139: 934-8.
21. Goldsmith O. Culturally competent health care. Permanente J. Winter 2000;4(1). Available at <http://xnet.kp.org/permanentejournal/winter00pj/competent.html>. Accessed Jun. 29, 2010.
22. American Institutes for Research. Teaching cultural competence in health care: A review of current concepts, policies and practices. Report prepared for the Office of Minority Health. Washington, D.C.: American Institutes for Research; 2002.
23. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med. 1978; 88: 251-8.
24. Broder HL, Janal M. Promoting interpersonal skills and cultural sensitivity among dental students. Journal Dental Education. 2006; 70(4): 409-15.
25. U.S. Department of Health and Human Services, Office of Minority Health. Physician Toolkit and Curriculum: Resources to implement Cross-cultural Clinical Practice Guidelines for Medicaid Practitioners March 2004. University of Massachusetts Medical School Office of Community Programs.



**Su-yan L. Barrow, RDH, MA, MPH, is a senior lecturer and second-year coordinator, Bachelor Oral Health Program, Melbourne Dental School, The University of Melbourne, Australia, and program coordinator for the Minimal Intervention Dentistry Pilot Project for Dental Health Services Victoria. She was formerly the dental hygiene baccalaureate program coordinator at New York University College of Dentistry. Her teaching and research interests are in public health dentistry, health promotion and culturally competent health care with special interests in the social determinants of health. She has presented at**

**national and international professional meetings, published articles/ case studies and co-authored a text-book chapter on topics relevant to dental hygienists.**