Increasing cultural competence in the dental hygiene profession

Carole J Charbonneau, DipDH, BDSc (DH), RDH; Melina J Neufeld, DipDH, BDSc (DH), RDH; Bonnie J Craig, DipDH, MEd, RDH; Leeann R Donnelly, DipDH, BDSc (DH), MSc, RDH

ABSTRACT

North American societies are becoming increasingly diverse in their ethnocultural makeup. According to the Canadian Public Health Association, immigrants and refugees as well as Aboriginal people and people in such disadvantaged circumstances as the poor, elderly, and disabled are most vulnerable to disease, and experience the greatest degree of health disparities. Differences in cultural values, beliefs, and language are cited as barriers to accessing health care, and it is possible that health providers may contribute to these disparities by stereotyping, being prejudiced, and being clinically uncertain as to how to provide care to this population. Increasing cultural competence among health providers has been suggested as a possible strategy for reducing such disparities. These strategies include recruiting students and educators of ethnically diverse backgrounds to the health professions, and incorporating cultural education into the curricula in order to improve culturally sensitive communication, to foster respect for cultural differences, and to educate future health professionals in the process of culturally competent, client centred care. This paper discusses the need for increased cultural competency in dental hygiene with the intent of encouraging further research into this highly required area.

RÉSUMÉ

La composante ethnoculturelle des sociétés nord-américaines se diversifie de plus en plus. Selon l'Association canadienne de santé publique, les immigrants et les réfugiés de même que les peuples aborigènes et les personnes défavorisées, notamment pauvres, âgées et handicapées, sont les plus vulnérables face à la maladie et souffrent des plus grandes disparités en matière de santé. On cite les différences entre les valeurs culturelles, les croyances et les langages comme autant de barrières d'accès aux soins de santé et il se peut que le personnel dispensateur de soins contribue à ces disparités à cause des stéréotypes, des préjugés et des incertitudes cliniques sur les façons de soigner ces populations. Comme stratégie de réduire ces disparités, certains proposent d'accroître la compétence culturelle du personnel soignant. La stratégie consisterait à recruter dans les professions de la santé des étudiantes et du personnel éducateur des divers milieux socioculturels, et d'intégrer la formation culturelle dans les programmes pour développer ce type de sensibilité dans la communication, favoriser le respect des différences culturelles et former les futures professionnelles dans la prestation de soins compétents, centrés sur la clientèle. Cet article traite du besoin d'accroître la compétence culturelle en hygiène dentaire afin de favoriser une éventuelle recherche dont on a grandement besoin dans ce secteur.

Key words: cultural competence, oral health, dental hygiene, dental care, ethnic groups, health care disparities, education

BACKGROUND

The ethnic origins of Canada's population are diverse. Although majority of Canadians share an immigrant past of European ancestry, the number of ethnic groups in Canada is growing, giving rise to a portrait that is increasingly multi ethnic and multi cultural.[1] An ethnic group is "a social group or category of the population that, in a larger society, is set apart and bound together by common ties of race, language, nationality, or culture".[2] A minority group is "an ethnic/racial group that has a smaller population than the controlling majority group in a society. Minority groups may also be based on shared gender, age, disabilities, political views, etc."[3] Although over two hundred ethnic groups are listed in the Canadian census, the majority of immigrants arrive from various regions of South Asia and China illustrating the richness in our cultural profile.[1] According to the Canadian Public Health Association (CPHA), new immigrants and refugees, as well as Aboriginal people and people in such disadvantaged circumstances such as the poor, elderly, and disabled, are the most vulnerable to disease, and experience the greatest degree of health disparities in Canada.[4]

Since many areas of North America are becoming increasingly diverse in their cultural makeup, strategies need to be investigated to help ensure that all segments of the population are receiving the health care and oral health care that they need.[5–7] Of current interest among health professions is that of cultural sensitivity and cultural competence.[6–9] This is due in part to findings from the *Unequal Treatment* report in the USA which indicates that health providers may contribute to ethnic health disparities because of stereotyping, prejudice, and ignorance regarding how to provide care to diverse ethnic populations.[10] In Canada, the report *Building on Values: The Future of Health Care in Canada* identifies ethnic minorities and Aboriginal people as vulnerable populations whose health is at the greatest risk, and advocates for development of strategies to address such disparities.[11]

While a number of definitions of health disparities can be found in the literature,[12] for the purpose of this paper they will be defined as differences in health outcomes in the population, determined by factors that affect an individual or a group's environment, and predispose them to disease.[13] Factors that commonly contribute to health disparities are socioeconomic status, education, gender, age, and ethnicity.[5,6] These same factors contribute to oral health disparities which are often measured as differences in dental caries rates, periodontal disease, tooth loss, edentulism, oral cancer, and tobacco use.[6,7] Although strategies to improve health and oral health outcomes have been

University of British Columbia
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Correspondence to: Carole J. Charbonneau; carole.charbonneau@vch.ca

suggested, the disparities still persist, and it appears that level of income and access to care are only part of the problem. This is particularly true with respect to oral health and has been demonstrated in the USA among certain ethnic groups such as African-Americans and Hispanics, who have a higher prevalence of oral disease regardless of income.[14,15] The fact that those who do have the financial resources to access dental care still suffer from poorer oral health has led some people to explore how differences in cultural values, and how dental professionals are viewed, impact access to oral care.[6,16–19] Studies conducted in Canada among recipients of government assistance in Quebec demonstrated the impact of those who felt offended by "hurtful" comments made by dental receptionists and dentists. The comments were stated as one of the reasons for avoiding the dental office or interrupting service, and opting for an extraction rather than endodontic treatment. Additionally, a survey of oral health among Canadians found that 70 per cent of respondents in the poor and disadvantaged populations often felt unwelcome at the dental office.[20] While the survey did have a low response rate, it does indicate that barriers to care, other than the financial situation, need further investigation.

Although the poor and disadvantaged populations are not considered an ethnic minority, the concept of culture does not encompass ethnicity entirely; it is much more complex, and extends to beliefs, values, common interests and common needs shared by a group.[21] In the chapter *Cross Cultural Practice*, Darby and Walsh[18] add further to the importance of culture in oral health care by stating "culture plays an integral role in dental hygiene because oral health and wellness, disease, and illness are culturally determined". Culture affects all aspects of daily life, and influences the oral health needs and attitudes of the client.

Objectives

The objective of this paper is to explore how cultural competence impacts health and oral health disparities among ethnic minorities and Aboriginal people as well as to suggest strategies for addressing inequities in health care. Due to the complexity and the vast amount of information available regarding strategies aimed at improving cultural competence among health professionals, it is not possible to fully review all proposed strategies in one article. For this reason, the authors have chosen to focus on cultural competence education and recruitment to begin to answer the question, "How can cultural competence be improved in the profession of dental hygiene to assist in client centred care?"

Methods

A literature search, limited from 2000 to 2009 was conducted through PubMed, CINAHL, PsychInfo, Google Scholar, and Sociological Abstracts using the following key words and their combinations: cultural competence, oral health, dental hygiene, dental care, ethnic groups, health care disparities, and education. In addition, a search of grey literature was conducted through Google and government websites. Of the total number of articles generated through this search, titles and abstracts were read and fifty three full text articles were retrieved that were relevant to the focus of this review. A hand search was also conducted on reference lists of retrieved articles, which added two articles published prior to 2000 that were deemed significant and relevant.

What is cultural competence?

Multiple definitions exist for the term "cultural competence" with one of the first being "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, ultural situations".[22] Fitch[9] states that cultural competence is "the ability to understand and attend to the total context of the client's situation: it involves knowledge, attitudes and skills". Fitch also describes cultural sensitivity as "the knowledge and constructive attitudes towards health traditions among diverse cultural groups", and cultural care as "health care that is culturally sensitive, appropriate, and competent, for the provision of care across cultural boundaries, taking into account the context of the clients' lives".[9] Mouradian et al.[23] add that "cultural competency does not just mean acquiring facts about certain ethnic groups". Given the multitude of cultures and diversity of individuals within a culture such as that experienced in Canada, we must fall back on basic principles: self awareness, respect for diversity, and sensitivity in communication. Mouradian's definition suggests that in order to provide quality health care, a client's individual cultural background and our own biases should be taken into context so that we can consider how they might prevent delivery of the best care.

More recently, Perloff et al.[24] suggested that cultural competence is a process and not an outcome. This opinion touches on the idea that cultural competence cannot be achieved merely by learning how to act towards a particular group, but involves considering all aspects of the situation and adapting best practice to each individual's needs. Therefore, health professionals need to gain an understanding of each client's values as well as their own personal biases so that a balance can be reached during the delivery of care.[24]

Since there are multiple definitions and terminology for cultural competence, it is recommended that health professions adopt their own definition for cultural competence in order to better understand the term and how to measure it.[8,21] Schim et al.[21] discuss incorporating cultural competence into the delivery of care involves practitioners understanding of culture that encompasses social behaviours, values and attitudes which are not only shared and learned but are also dynamic and diverse. To further emphasize the importance of complexity and dynamics of culture in oral health care, Darby and Walsh[18] define cross cultural dental hygiene as "the effective integration of the client's socio-ethnocultural background into the process of care" and that "cross-cultural dental hygiene encompasses the social, political, ethnic, religious, and economic realities that people experience in culturally diverse human interactions and environments".[18]

In this paper, cultural competence is defined as a process in which an understanding of cultural attitudes, values, beliefs, and practices is used to help guide care for

an individual, taking into consideration specific history and needs, and avoiding the use of stereotypes and personal biases.

Financial barriers in accessing dental care

All Canadians have health insurance coverage regardless of socioeconomic status or the ability to obtain employment. Yet health disparities still exist, indicating the complex nature of access to care issues. Not surprisingly, these disparities are also evident with respect to oral health and may be attributable to dental care not being part of the universal health care system.

Generally, individuals with dental insurance receive more regular oral health care than those without.[6,25] However, this is not true for Aboriginal people in Canada who, despite having access to federally funded dental insurance, known as Non Insured Health Benefits,[26] still experience significant oral health disparities. In the USA, similar findings have been reported by Vazquez et al.[15] among African–American and Hispanic populations. Furthermore, attitudes towards oral health care can vary among those with dental insurance in some minority groups, indicating that culture needs to be explored in further detail to determine its impact on oral health outcomes and access to care.[15] Vazquez et al.[15] found that the Hispanic population may not utilize their dental or health insurance because they may not recognize the need for care, and that they tend to prefer walk in clinics where appointments and long wait times are not required. They perceive the US health care system of booking appointments and arriving promptly to be a barrier to accessing care, which contributes to low compliance and under utilization of dental and health insurance.[15] A similar approach to exploring the attitudes towards oral health care and the usage of Non Insured Health Benefits (NIHB) by Aboriginal people in Canada would be beneficial in determining how cultural values might impact use of such benefits in this population. Moreover, studies such as those by Bedos et al.[19] and Main et al.[20] might provide further information regarding the influence of cultural competence, and its impact on oral health disparities in the Aboriginal population.

Issues of inadequate cultural competence in health care and oral health care

To better understand cultural competence, it is necessary to outline cultural incompetence, and highlight some of the issues for consideration. The examples of Aboriginal people and Chinese immigrants illustrate some obstacles that have been encountered when seeking care.

Lack of understanding of cultural values, beliefs and traditions on the part of health workers is often cited as an obstacle faced by ethnic minorities and Aboriginal people when seeking health care.[17,25] This lack of understanding not only results in ignorance as to how to treat individuals from a cultural background that is different from one's own, but it can also result in prejudice and inappropriate care.[27] An ethnographic study conducted by Hunter et al.[28] in 2006 explored how urban based Aboriginal people use traditions to address health issues. In depth interviews, observations and field notes were used to investigate culture, health care values and the utilization of health care services among members of an Aboriginal health centre. Three major categories emerged from their analysis:

(a) following a cultural path
(b) gaining balance, and
(c) sharing in the circle of life.[28]

Holistic healing was evident across all three categories. The Aboriginal people believed that mainstream health care had "lost touch with the human side" and that people were treated as though they were part of a production line, resulting in care that offered little personal respect and dignity.[28] The study's participants feared losing their cultural values, and therefore feared approaching mainstream health care.[28] This study shows that understanding the cultural background of their clients may allow health professionals to provide such appropriate care as integrating a holistic approach to health care. Culturally competent health professionals would incorporate a client's beliefs and traditions into the treatment plan, ensuring the client's needs are met, and hopefully, increase access to care.

Communication is a key component of health care, and language barriers can greatly influence an individual's ability to access and receive effective care. Hamrosi et al.[29] explored the issues surrounding the inappropriate use of prescribed medications within Aboriginal communities in Australia to demonstrate the importance of effective communication.[29] The data collected via in depth interviews with Aboriginal health workers employed in community health centres and hospitals revealed that misuse of medication issues were related to limited understanding of the information provided about the medications.[29] The information was culturally inappropriate and difficult to understand. The format was not visually appealing, and contained no images that the Aboriginal people could relate to, or be enticed to pick up and read. Suggestions to improve this situation focused on adapting communication styles that would better relate to this population.[29]

While the Aboriginal people of Australia and Canada are separate and distinct populations, and cultural diversity exists within the populations, they do experience comparable health disparities specifically with respect to oral health, cardiovascular disease, diabetes, and respiratory diseases.[30] Therefore, drawing on suggestions for improvement in communication to help address barriers to care among Australian Aboriginal people may prove to be appropriate in Canada as well.

Issues of communication and lack of understanding of traditions and beliefs held by dental professionals are highlighted in a study by Dong et al.[6] with Chinese immigrants in Montreal. This study employed a qualitative approach to explore how oral illness was perceived, and how such perceptions influenced the care they sought and the value they placed on professional oral care. They found that the participants' perceptions of dental caries and gingival conditions were a combination of scientific dental knowledge and traditional beliefs. With regard to gingival swelling and bleeding, the traditional Chinese belief that an "internal fire"—created by stress, lack of sleep, and an unhealthy diet—caused the gingivitis. Some participants placed less value on professional dental care and more reliance on traditional Chinese medicine to address the problem. Interestingly, this was not the case with regard to

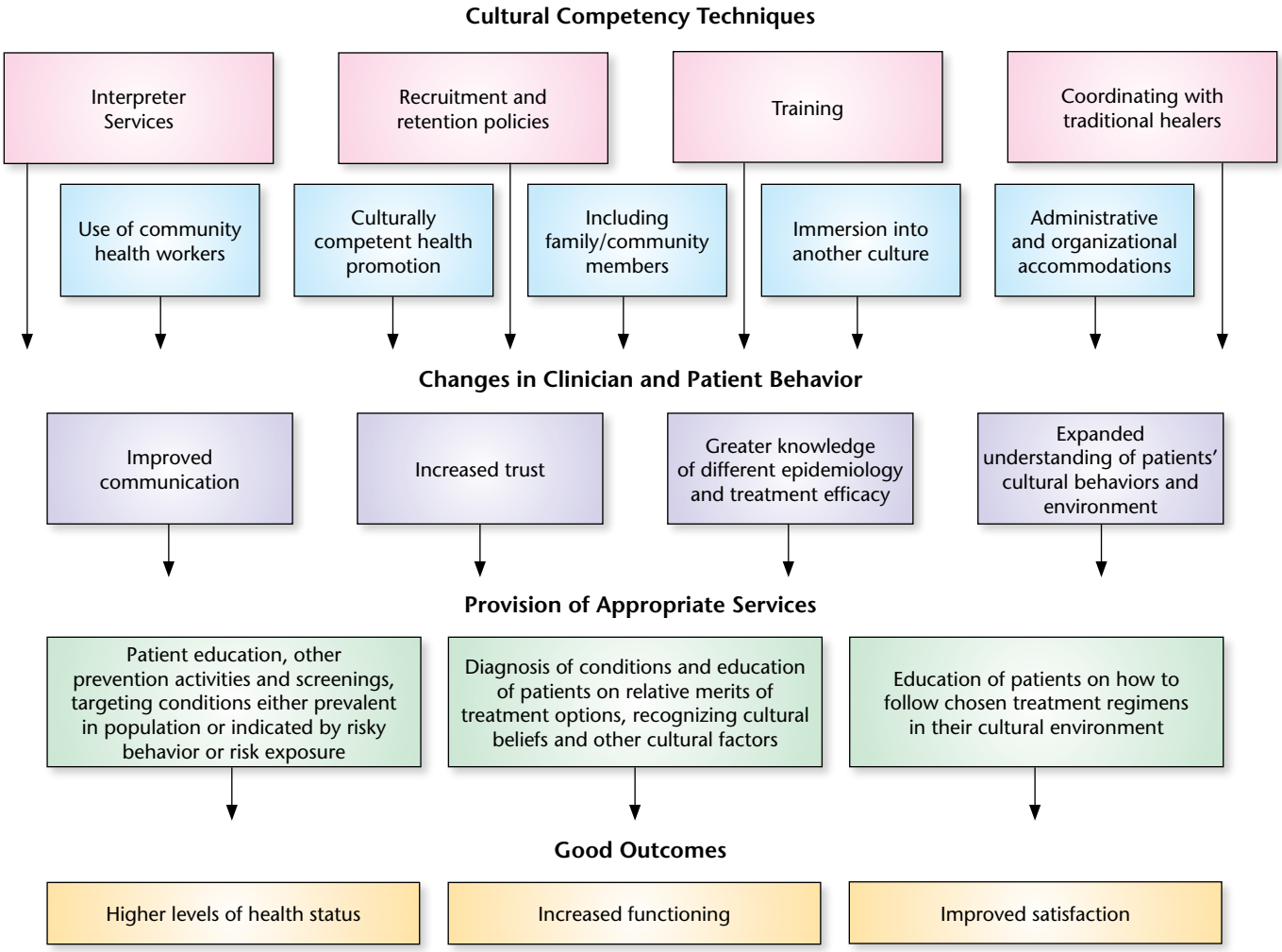

Figure 1: Conceptual model of how nine cultural competency techniques could reduce health disparities.
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caries. Although the participants still used traditional Chinese terms such as "tooth worm" to describe the etiology of the dental caries, they had a fairly good understanding of the scientific process, prevention, and treatment of the disease. This understanding ultimately influenced their decision to seek professional dental care. The authors suggested that public dental health care education in both China and Canada played a role in the participants' increased scientific understanding of dental caries; and recommended that similar education be provided for other oral diseases. This study highlights that although participants were open to accepting scientific dental knowledge, their traditional beliefs were still important to them. The authors believed that dental professionals need to respect other cultural beliefs and should try to provide dental education to complement such beliefs in a manner similar to what has been done with dental caries. The authors concluded that dental professionals be more informed about the acculturation process, and how oral health perception varies among diverse populations, specifically new immigrants, to provide better care and communication.[6]

These studies demonstrate the importance of understanding other beliefs and values in order to deliver culturally competent care. However, to avoid the risk of stereotyping, health professionals must also be cognizant that these ideologies may not be reflective of all members of a particular ethnic or cultural background. Ultimately each client should be treated as an individual.

Conceptual model of cultural competence

Considering that inadequate cultural competence can result in avoidance of mainstream health care or ineffective treatment, it is important to explore how cultural competence can be improved among health providers. Romanow,[11] in his report, *Building on Values: The Future of Health Care in Canada*, discusses the importance of eliminating disparities in health outcomes based on race and ethnicity as a goal to improve the Canadian health care system.[11] A conceptual model of cultural competence such as that proposed by Brach and Fraser may aid in reducing these disparities.[31] The model highlights nine strategies that could be used to increase cultural competence among health professionals (Figure 1). The model includes

interpreter services, recruitment, and retention of minority staff, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family, or community members or both, immersion into another culture, and administrative and organizational accommodations.[31] Although all of these techniques are important, it will require more than one article to adequately address each technique. For this reason, the authors focus on two aspects of the model: recruitment of ethnic minority students and educators, and improved cultural education—important initial steps in increasing cultural competence in the dental hygiene profession.

Recruitment of culturally diverse health care providers

Mitchell and Lassiter[32] discuss the topic of recruitment of underrepresented ethnic minority workers as a way to promote culturally competent care. They found that although ethnic minority populations are increasing dramatically, these increases are not reflected in the number of ethnic minorities entering health care education programs.[32,33] The authors suggest that it is important to increase minority representation in health professions because they are more likely to provide care in underserved communities which often comprise minority groups.[32] The authors conclude solving the problem at its source by increasing the exposure of health professions among minorities.[32] The Dental Pipeline program in the USA is a community based program designed to address oral health disparities and increase access to care.[34] Funded by private donors, the program involves participation of fifteen US dental schools to increase the number of underrepresented minority students and low income students to increase diversity in the dental workforce and to provide senior dental students experience in community and client centred care. All fifteen schools had four years (from July 2003 to June 2007) to implement their programs. In February 2009, an evaluation framework for the Dental Pipeline program was developed by the National Evaluation Team at the University of California to provide support in evaluating the program, and evidence for expanding the Dental Pipeline program to other universities.[35] An evaluation of the Dental Pipeline program must demonstrate that its objectives are achievable, and that the program is sustainable without outside financial support for it to continue and expand. In addition to the workforce diversity issue, it is argued that minority students may not pursue a health career simply because they are not aware of the career options available.[32] To respond to the health career awareness issue, it is suggested that campaigns be developed to increase the visibility of health professions.[32] The authors also stress the importance of supporting minority students who have begun their health care education so they can succeed and graduate, and in turn help other underrepresented groups.[32,34]

In addition to increasing exposure to health professions, other strategies may also be required to increase the number of diverse ethnic health practitioners. In their study of the Nursing Education Program of Saskatchewan (NEPS), Arnault-Pelletier et al.[36] discovered that Aboriginal students experienced culture shock when they left their reserve to enter a health program at an urban centre, resulting in disinterest and discontinuation of these programs. In response to concerns about recruitment and retention of Aboriginal students in health programs in Saskatchewan, the Native Access Program to Nursing (NAPN) was established at the University of Saskatchewan with funding from Health Canada. Currently the NAPN model provides support and retention services for Aboriginal students, including support with the academic demands of postsecondary education; access to elders and culturally appropriate counselling; personal and academic advisement; advocacy for childcare, housing, and funding concerns; tutoring, mentorship, computer and Internet access; and a fall orientation for new students. The overwhelming success of the NAPN model was copied by many other institutions and programs, including the Health and Science Division of the Saskatchewan Institute of Applied Science and Technology (SIAST). The orientation also provides the students with the opportunity to practise their culture on campus through organized activities, meals, and shared accommodation to make the transition less intimidating. Twelve per cent of all seats available in 2006 were occupied by Aboriginal students, and at the time of writing this paper there are often more qualified Aboriginal applicants each year than available equity seats, suggesting that the program is succeeding.[36]

Cultural competence education

In addition to recruiting ethnic minorities to health professions, cultural competence education is another important strategy to be considered to help reduce health disparities among ethnic minority populations. Although there is a recognized need for cultural competence education in health care across North America, the content and evaluation of cultural competence curriculum is inconsistent.[37–42] Furthermore, although frameworks for integrating cultural competence training into health care education have been described, there are no guidelines to help educators design or report cultural competence interventions.[42] Despite these limitations, the evidence available for evaluating the effectiveness of cultural competence education suggests health professionals who participated in cultural competence education show an increased awareness and improved knowledge and attitude toward ethnic minorities.[41–44] Since studies evaluating cultural competence education in dentistry and dental hygiene are limited, we will draw on studies in health care to illustrate the impact of such education.

A case study conducted by Crandall et al. at Wake Forest University School of Medicine concluded that a year-long course in cultural competence improved students' knowledge, attitudes, and skills significantly.[12,43] The course itself included experts on cultural health from around the world presenting topics involving race and ethnic diversity, social class, disability status, sexual orientation, and the influences of these circumstances on health status. The material was presented through lectures, videos, demonstrations, case studies, and patient interviews. The students were also required to design a project that would help meet a need in the community with respect to health care access for vulnerable populations.

Crosson et al.[44] evaluated a cultural competence course offered to first year medical students. The course employed a problem based learning approach in which the students worked through six cases with a mentor. During the cases, the students were introduced to the cultural and psychosocial issues facing multi generational ethnic minorities, as well as their health beliefs and practices. This provided them with the opportunity to develop strategies to improve communication with clients of diverse backgrounds and beliefs. In addition, the students gained practical experience by working in an ambulatory clinical setting with medical practitioners. They used their new skills in history taking and physical examinations. At the end of the course, students' attitudes and awareness towards the importance of assessing and responding to patients' cultural beliefs had significantly improved. However, the authors queried if these changes in attitudes would persist over time and recommended that further longitudinal research was required to determine if these changes could be maintained throughout the students' careers.[44]

In contrast to the above studies, Assemi et al.[45] assessed the impact of an 8-hour elective didactic course on cultural competence for pharmacy students. They also found that the course could have a positive impact on the students' knowledge, awareness, and communication skills with respect to clients of ethnic minorities.

The different approaches to cultural competence education among health professionals raise the question of what type of education and experience are required for students to value and adopt culturally competent care.

Shapiro et al.[46] recently conducted a qualitative study using focus groups consisting of medical students who had received both didactic and practical training. Although the results revealed that the cultural competence education was "less effective at teaching interventional skills", the researchers discovered that most students thought both forms of education were useful and relevant.[46] The authors further emphasized the importance of the practical education since it allowed the students to implement their knowledge and skills, and to learn directly from the clients and other practitioners. In addition, the students preferred cultural competence education be integrated into the curriculum in the third year when they were ready to begin rotations. The students believed that this way they could apply the knowledge they learned immediately to practice, and thus better retain their newly acquired skills. This study emphasizes the issue that cultural competence is a dynamic process that needs practice, and that a curriculum which relies solely on a didactic approach to teaching the subject may not be ideal.[25,39,46]

More studies evaluating the outcome of cultural competence education over time are needed to determine the best approach to this subject. Additionally, studies evaluating the outcome of cultural competence education in dental and dental hygiene programs are required to determine if such education can help reduce oral health disparities among ethnic minorities.

Cultural competence and the dental professions

Dental professionals have a responsibility to reduce barriers to care experienced by ethnic minorities by providing culturally appropriate care. The number of people with an ethnically diverse background is growing in Canada and the USA, and there will be a greater number of these individuals needing dental care in the future.[9] Communication has been proposed as an important aspect of culturally sensitive care since poor verbal and nonverbal communication can result in misunderstanding, lack of trust, anxiety, and inaccurate diagnosis and treatment.[9,17]

Dental professionals need an accepting outlook towards beliefs and practices that are not their own, and an understanding that patients' cultural values are important, and should be integrated into their individual care plan.[18] This involves an awareness that a variety of behaviours and beliefs towards oral health care exists, such as the preference of some Aboriginal people for a holistic approach to healing, or the reliance of some Chinese immigrants on traditional cultural beliefs to explain oral disease.[6,29] Culturally competent practitioners are cognizant that there can be various contextual approaches to oral health care to improve their provision of care.

Culturally competent care in the dental setting can promote patient rapport and honour patient autonomy.[47] A dental professional is obligated to practise culturally competent care by treating clients with respect for their individual needs and values to provide the best possible care for them.[9,18,47,48] Some instances may occur where a patient's cultural values and beliefs do not align with those of the dental professional who is treating them, and the professional may even believe it influences safe and appropriate practice. Such cases require a deeper understanding of both cultural practices and their relationship with ethical considerations for decisions to be made appropriately.

To illustrate some of the ethical challenges that dental professionals may face, Donate-Bartfield and Lausten[47] provide the example of a client requesting an elective treatment that may not be aesthetically pleasing to the dentist providing care, such as showing gold restorations in anterior teeth; however, the treatment requested may be important to the client's cultural background.[47] They also highlight the fact that dental professionals might not be aware of certain cultural norms such as the necessity for family consent, regardless of the client's age, prior to providing services.

Furthermore, it is argued that issues of social justice need to be emphasized and incorporated into dental and dental hygiene ethics courses in order for the students to recognize and understand the access to care and oral health disparities that currently exist in society.[49] Donate-Bartfield and Lausten highlight the link between multi culturalism and social justice, particularly in regards to access to care and respect for the client's decisions and cultural practices.[47] They suggest offering courses to dental students that require analyzing ethical dilemmas, and an understanding of the ethical issues of paternalism to better prepare students to provide care to a culturally diverse population. Beemsterboer[49] supports this view in stating that "more discussion and understanding around the professional contract that dentistry has with society in didactic and clinical courses might help sustain that message throughout the dental education program". It is important that cultural competence education in dental

and dental hygiene schools addresses ethical issues in conjunction with cultural understanding, communication, and traditional practices.[9,47]

Haden et al.[50] state that dental professionals have an obligation to serve the public's best interests, and part of that means recognizing that vulnerable populations "have a unique priority". Their report to the American Dental Educators Association (ADEA) states that "oral health professionals must individually and collectively work to improve access to care by reducing barriers" and that this not only includes promotion of public health and advocacy for a model of oral health care that is more equitable, but it also includes the responsibility of academic institutions to educate dental professionals to be aware of their social responsibility, to be culturally competent, and to be prepared to work with a diverse population.

Dharamsi et al.[51] explored the concept of social responsibility and its application by dentists in clinical practice. They discovered that because dentistry in North America is a private enterprise, there appears to be a conflict between dentists perceiving themselves as "business persons" and as "health care providers".[51] From the authors' analysis, some dentists consider themselves ethically responsible to "take people out of pain and try to remove disease". However, any treatment beyond that was considered to be a luxury for those who could afford to pay the fees. Many felt there was a lack of guidance around social responsibility from the code of ethics within dentistry. Academic institutions must therefore prepare dental professionals to give more consideration to their social responsibility which includes providing care for an ethnically, culturally, and socially diverse population to ensure that their graduates are competent to care adequately for a changing society.

Recommendations for cultural competence in the dental hygiene profession

Cultural competence is not consistently taught across Canada, and suggestions have been made to incorporate cultural competence content into health care education to address the issue.[8,21,39,41,52] In the dental hygiene profession, incorporating specific abilities into dental hygiene curricula could be an effective way to improve cultural competence. Another strategy to consider is to increase continuing education opportunities for practising dental hygienists who may not have studied this particular content as part of their undergraduate education. This could result in both new and experienced dental hygienists being better prepared to provide client centred care and ultimately improve the oral health of all Canadians.

Although a significant impact in increasing the access to oral care of ethnic minorities may be realized through cultural competence education for dental hygienists, it is important to recognize that increasing the number of dental hygienists with ethnically diverse backgrounds may have a positive impact.[27,40,53,54] In doing so, the profession might ultimately increase diversity of dental hygiene educators. In their national survey of ethnic minority students dental hygiene programs in the USA, Dhir et al.[53] found that of all the oral health professionals, the dental hygiene profession is the least ethnically diverse.[53] They proposed that an educational environment consisting of ethnic minority instructors would help minority students feel more comfortable and confident enough to succeed, since students from the same ethnic background as their professors are more likely to enroll and stay in programs.

There are similarities in Canada regarding the lack of ethnic diversity in the dental hygiene profession as demonstrated by Lux in her position statement on access to oral health services by Aboriginal people.[55] She emphasizes that, in addition to a lack of understanding of cultural issues by non Aboriginal health providers, there is also a lack of cultural representation in the Aboriginal communities in northern Canada. She recommends that "dental hygiene educational institutions develop admissions policies which take into account an awareness of demographic patterns and cultural needs of various communities".[55] Since the public seeks and has a preference for health providers who are of their own cultural background,[17,40,53] the suggestion to change admissions policies should be considered. However, it should be noted that even with altered admissions policies, increasing ethnic diversity in the dental hygiene profession may be challenging and to date has not proven successful in dentistry among certain culturally diverse groups such as the Aboriginals.[55]

In addition to changing admissions policies, such strategies as the NAPN could be used in more dental hygiene programs as a model since it has been successful in the Health and Science programs in Saskatchewan. The Dental Pipeline program may also prove to be successful, and could be adapted to dental hygiene programs in Canada. Because the profession of dental hygiene may not be well known or understood among ethnic minorities and Aboriginal people, it will also be important to take steps to increase its visibility among such populations. In doing so, those who may not have previously thought of a career in dental hygiene may consider it. This may best be accomplished by having dental hygienists and dental hygiene students visit schools, community centres, or reserves. Not only would this bring visibility to the profession, but it would also provide dental hygienists with valuable experience among these specific cultural groups.

CONCLUSION

It is clear from the literature that general health and oral health disparities are most prevalent among vulnerable populations. They include, but are not limited to, Aboriginal people, ethnic minorities, and new immigrants. Oral health professionals may contribute to these disparities due to their lack of knowledge and skills with respect to providing care for these populations. A better understanding of cultural values, norms, and beliefs as well as increasing the numbers of ethnic minority and Aboriginal oral health providers and educators may be possible solutions to these disparities.

Due to the integral role that dental hygienists play in oral health care, it is imperative they are prepared to provide client centred care within ethnically diverse societies. Dental hygiene programs and continuing education organizations could help accomplish this by providing more cultural competence education. As well, efforts need to be made to recruit members of various ethnic backgrounds to the profession of dental hygiene in order to

increase its ethnic diversity. Canadian society is becoming ever more diverse and steps need to be taken now by the dental hygiene profession to ensure that disparities in oral health do not persist or worsen. Cultural competence can be complex since diversity exists not only between ethnic groups but within them as well. While additional awareness, education, and an ethnically diverse profession can be important in beginning to address oral health disparities among populations, these strategies require further development and evaluation to determine the best course of action for our dental hygiene profession.

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