Dental Students’ Reflections on Their Experiences with a Diverse Patient Population


Abstract: Recent developments, including national reports and new accreditation standards, have emphasized the need for dental students to be prepared to address the needs of a diverse patient population. The purpose of this study was to explore students’ descriptions of and reflections on their day-to-day interactions with a diverse patient population in the clinical setting, using a qualitative approach. All dental students (sixty-six) enrolled in the third year of the D.M.D. program at a Midwestern dental school were required to write a paper reflecting on their experiences working with a diverse patient population in the general dental clinic of the school as part of a behavioral sciences course. All third-year dental students were invited to participate in the study. The students’ papers were deidentified prior to data analysis. Forty-two students’ papers describing a total of 126 patient-student interactions were reviewed. Data analysis resulted in identification of three key themes: 1) development of cultural awareness and recognition of the need to understand each patient as a unique individual, 2) desire to build rapport with all patients, and 3) realization that the development of cultural competence is a lifelong learning process requiring ongoing experiences working with a diverse patient population. Review of student reflection papers is valuable in providing faculty with an understanding of students’ degree of development of cultural competence. A greater understanding of students’ day-to-day experiences with a diverse patient population can provide insights for dental educators who develop cultural competence curricula.

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opportunity to learn from application, experience, and reflection. A greater understanding of the nature of students’ day-to-day experiences and their reflections on those experiences may help to inform the development and evolution of curricula in this area.

The purpose of this study was to explore students’ descriptions of and reflections on their interactions with a diverse patient population in the clinical setting, using a qualitative approach. A qualitative approach offers the opportunity to collect data with a depth not usually available from survey data and to more fully understand the thoughts, feelings, and experiences of participants. Meadows et al. note that the qualitative approach “expands the researcher’s repertoire of tools to investigate important questions. . . . [It provides the] ability to take into account information about people’s perspectives and experiences, and focus on depth and richness of data, interest in process, and context.” Such an approach seemed appropriate for our purposes.

### Methods

All dental students (sixty-six) enrolled in the third year of the D.M.D. program at Case Western Reserve University School of Dental Medicine were required to write a paper reflecting on their experiences working with a diverse patient population in the general dental clinic of the school as part of a third-year behavioral sciences course. The study was approved by the Institutional Review Board.

Participation in the study was voluntary. Participants were assured that only the researchers would have access to their reflection papers and that no information would be reported in a way that would allow a participant to be personally identified. Students granted permission for their papers to be included in the study by signing a consent form. The class was 36 percent female and 64 percent male, with an average age of 26.1 years. The racial/ethnic composition of the class was 69.7 percent white/Caucasian, 22.7 percent Asian/Pacific Islander, 3.3 percent black/African American, and 4.5 percent not reported. Twenty-one percent were international students, including students from Canada, Korea, the Philippines, and China.

The students had participated in a cultural competence curriculum during the first two years of the D.M.D. program. In their first year, students participated in four hours of didactic instruction focused on cultural competence and professional responsibility to promote oral health for individual patients and in the community. Following this didactic instruction, students participated in the Healthy Smiles Sealant Program, a three-week intensive clinical outreach experience during which they placed sealants and provided individual patient education about disease prevention to a diverse population of underserved school-aged children in an urban school setting. At the conclusion of the three-week experience, students wrote a paper reflecting on what they learned. In the second year of the D.M.D. curriculum, students returned to the schools for an additional three-day clinical outreach rotation similar to the first-year experience.

The students were given a written document describing the reflection paper assignment as part of a third-year behavioral sciences course. The assignment asked each student to reflect on interactions with patients he or she had cared for in the school’s clinics during the summer, fall, or spring semester of the third year. Each student was asked to reflect on his or her interactions with three patients who, from the student’s perspective, reflect the diverse patient population he or she cares for. For purposes of the assignment, diversity was defined broadly, including but not limited to age, gender, race, ethnicity, religious affiliation, language, sexual orientation, physical ability, and socioeconomic status. Students were asked to describe the patients and to analyze their interactions with each patient. Several guiding questions were suggested to stimulate reflection. The questions addressed students’ perceptions of their own biases or assumptions during the interactions; their understanding of how the patient’s background and life circumstances might have had an impact on the patient’s oral health, the interaction, and/or the patient’s treatment preferences; what the student felt was learned from the interaction; and any areas in which the student wanted to learn more in order to become more culturally competent. The reflection papers were deidentified prior to data analysis.

Each of the three authors independently read the reflection papers and took detailed written notes. The authors then met as a group to compare and discuss the themes they identified and to reach consensus agreement on the final list of themes. As recommended by Strauss and Corbin, data analysis continued until the point of theoretical saturation, that is, until review of additional papers failed to provide new insights or themes.
Results

Forty-two students agreed to participate in the study. Forty-two papers describing a total of 126 patient-student interactions were reviewed by each author. Themes identified in the reflection papers are described in this section. The text in quotation marks is quoted directly from the reflection papers.

Developing Cultural Awareness and Understanding Patients as Individuals

A major theme in the students’ reflections was the development of cultural awareness. In her model of cultural competence in health care delivery, Campinha-Bacote9 describes “cultural awareness” as the first stage in the development of provider cultural competence. She defines cultural awareness as “the self-examination and in-depth exploration of one’s own cultural and professional background. This process involves the recognition of one’s own biases, prejudices, and assumptions about individuals who are different.” Through the reflection papers, the students demonstrated their developing ability to recognize the assumptions they make based on a wide range of characteristics. The patients they described were diverse in terms of age, gender, race, ethnicity, religion, physical and cognitive ability, socioeconomic status, sexual orientation, and language, indicating that these students conceptualized diversity in a broad way to include all of these characteristics. The following were some of the students’ comments: “Without even thinking about it, I placed him into a stereotypical class in my mind based solely on his name before I met him”; “The patient is unemployed and living on social security income. I automatically assumed the patient cannot afford implants and possibly cannot afford other treatment options as well”; and “So upon meeting him . . . I assume that he’s not going to be as aware or as willing to do [as much] treatment as a younger person.”

Often, the students’ initial impressions of an individual led them to make assumptions related to how easy or difficult it would be to build rapport and communicate with the individual. In addition, students found themselves making assumptions about an individual’s current oral health status, oral health knowledge, value placed on oral health by the individual, probable treatment preferences, likelihood of adherence to home care recommendations, and extent to which the individual would be willing and/or able to commit resources to pay for the treatment.

Students wrote frequently about the discovery that their initial assumptions about an individual proved to be incorrect. They described how, through getting to know the patient, they developed an appreciation for each patient as an individual with a unique life story. “My biggest challenge is remembering to not judge someone too quickly,” wrote one student. Another student commented as follows: “I assumed being a recent immigrant, she would not have the finances to afford the optimal treatment plan or be fully capable of maintaining the dental work after . . . When we began discussing treatment options, I learned her father had been a dentist in [her country of origin] and her knowledge of dentistry was quite extensive. She wanted to know all the treatment options and had no financial limits. This had stunned me because I had been too quick to judge her.” Another student reported treating a blind person for the first time: “It was the first time I have ever met a fully blind patient in my life. . . . Being naïve, I assumed that her oral health was going to be not well managed . . . was I wrong. She is able to brush and . . . clean her teeth better than most other patients that I have.”

While the students often assumed that interactions with patients whom they perceived as different from themselves would be more difficult, they also assumed that interactions with those whom they perceived as similar would be relatively easy. On some occasions, a shared religion, race, language, and/or culture did allow for an extra level of comfort and rapport between student and patient. “We were able to form a good doctor patient relationship from the start in part because we shared a bit of a common background,” wrote one student. “This patient had grown up in [a rural part of a state] not far from where I have lived for several years. . . . I think my ability to understand her background and to talk to her about her home and culture did a lot to ease her fears as she became noticeably less nervous as our appointments continued.” Another student commented on treating “an Indian female in her late 70’s. . . . I felt comfortable with her because of our similar background. She did not speak English so we communicated with each other in Gujarati (an Indian language). I felt that she instantly trusted me.”

However, students also noted that perceived similarity does not guarantee a better understanding and smoother interactions between provider and patient. “I thought it would be easier for me to communicate with . . . patients with a background some-
what close to my background and ethnicity. In fact, it was harder than what I thought it would be,” wrote one student. Another student commented, “Being the same gender, age, race and religious background as I, I had assumed this would be a patient I would not have to think about cultural competence too much with. But I was definitely wrong. I did not realize that sometimes it can actually be more of a challenge to work with someone that is incredibly similar to you.”

The students realized that both individuals in an interaction bring their own beliefs and biases to the interaction. Students were aware of instances in which they made unfounded assumptions about patients, and they also identified instances in which patients made assumptions about the student, particularly related to the student’s gender, age, and race/ethnicity. In some cases, the students anticipated that a new patient might make negative assumptions about the student based on perceived differences. This concern had an impact on the initial comfort level of the student upon meeting the patient. One noted that “I was very nervous and doubted that we would really have a whole lot to talk about. I also questioned whether he would even trust a young [person] like me to be a real dentist.” Another student wrote, “My second patient [was] an older African American gentleman. At our first appointment I was very nervous. This was a . . . population that I really had not dealt with much and I think he was skeptical of me at first as well . . . . This [experience] helped me to realize that as much as I had my guard up going into this interaction and was nervous because it was a new experience, it seemed my patient had the same feeling.”

The students also discussed the impact of patient bias on the student’s comfort level during the interaction. One commented on the impact of gender, writing that her male patient “asked me in the first appointment if the doctor was male, and I quickly came to realize that my gender had a lot to do with the way he felt about me being his doctor . . . . It was hard for me at first.” Another student reported on the patient’s assumptions about nationality: “after commenting on the miserable weather, she asked me whether or not it snowed in China. I was a little bemused, first by the patient’s assumption that I was Chinese, and secondly that I was born/grew up there . . . . She stated that my English was very good. I again told her that English was the only language I spoke . . . , and that I was born in San Diego . . . . When it came to treatment planning, she seemed very uncertain about what was planned, and wanted detailed information on every aspect . . . . I’m not sure whether this was due to her belief that I didn’t understand what she was saying or if it was because I was ‘foreign’ [that she] didn’t believe everything I said.”

**Desire to Build Rapport with All Patients**

The students expressed a strong desire to establish rapport, trust, and clear communication with each patient. Basic strategies for establishing rapport included treating all patients in a respectful manner, making conversation with the patient, and trying to convey a caring attitude to the patient.

An additional strategy that the students frequently described using to establish rapport was to attempt to find “common ground” with the patient in the form of similar interests or life experiences. Students were often hesitant when meeting patients whom they perceived as culturally different because they assumed that it would be more difficult to find this common ground. The students were aware that a lack of rapport and/or common ground could make the interaction less comfortable for both the student and the patient, while finding common ground served to enhance the rapport between the two.

These students learned that common ground can be discovered in unexpected ways. They expressed a great sense of satisfaction in instances in which they were able to connect with a patient with whom they initially felt they had very little in common. One wrote, “As soon as we had mutual ground, the barriers were broken and we were both much more comfortable with each other. The patient now is a welcome and frequent visitor to my cubicle. We have jokes; I have him [laughing] in the chair and he jokingly makes fun of me. If you had asked me at the first appointment whether this would be the case I would have said ‘not in a million years.’” Another student reported finding an unexpected connection with a patient after feeling initial concern: “as I began talking with him, I found out that he was a former Marine. Given my present standing as an [armed forces] officer, we quickly found common ground and mutual respect for one another. Even though we seemingly had nothing in common with each other, the military connection I think gave me a certain level of credibility in his eyes as his student doctor. Because of his rather negative history with dental treatment, I used this common ground to gain back his trust as a health care provider . . . . As the appointments progressed, he became more and more open about his life. He started talking to me.”
that population was younger.”

The students acknowledged that curiosity and genuine interest in the patient as an individual were important to the discovery of common ground. “Cultural competence is not something you can learn in a day. It comes from having an open mind and being willing to listen and communicate,” wrote one. Another noted that “each patient brings their own viewpoint or perspective, and we have the potential to miss out on so much when this is left unexplored.”

Practice Helps

Students recognized the value of experience in learning how to work with a diverse patient population. They observed that each patient interaction represents an opportunity to learn more and that their skills would be developed in an ongoing, lifelong learning process. One wrote that “in clinic we begin to encounter all different kinds of patients. We quickly learn [that] cultural competence and interpersonal skills are imperative. These interaction skills are not something we can be fully prepared for but rather something we must learn . . . through experience.” Another student wrote, “I consider myself lucky to be at a school where we do get to see an array of different people from all different backgrounds, and it’s helping me grow as an individual and a professional.”

In her cultural competence model, Campinha-Bacote emphasizes the value of cross-cultural interactions and experiences. She notes that “cultural encounter is the process that encourages the health care provider to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds. Directly interacting with clients from diverse cultural groups will refine or modify one’s existing beliefs about a cultural group and will prevent possible stereotyping that may have occurred.” The students in our study demonstrated an appreciation for this process. “He is nothing like what I automatically stereotyped him to be,” one commented. “He is the complete opposite of what society portrays [his demographic group] to be and I feel so fortunate to have a patient who has helped me better understand and break down my own prejudices and stereotypes.” Another student wrote, “when I met her and conversed with her, I found that I had a misunderstanding of that population. I learned that the geriatric population is just as diverse now as when that population was younger.”

Some students noted that a particular patient interaction motivated them to want to learn more. This corresponds to the second stage (cultural knowledge) in Campinha-Bacote’s model. She defines the cultural knowledge stage as “the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups.” One student in our study wrote, “when you know the subtleties of a different culture, it makes it much easier to pick up on non-verbal communication.” Another remembered a meeting with “a middle-aged female patient who spoke very little English. . . . I . . . transferred her to a Spanish-speaking student doctor who could better meet her needs. . . . That situation has definitely made me consider learning Spanish so . . . I can handle it on my own and better accommodate a diverse population of patients I may encounter.” Yet another student reported understanding “there are areas in my level of cultural competence that I am lacking. I hope to learn more and be able to develop these areas to be able to interact well with all my patients in the future.”

Specific Challenges

The students identified a number of specific challenges they encountered in their interactions with a diverse patient population. These included differences in prioritization of oral health, differences in levels of trust in health care providers, and language and communication barriers. Through their experiences, these students identified certain areas in which they would seek out additional knowledge to help them interact more effectively with their patients.

Differences in prioritization of oral health. Students struggled to understand differences in the priority individuals placed on oral health, differences in the extent to which individuals sought out care, and differences in individuals’ ability or willingness to commit resources (time, effort, and/or financial resources) to addressing their oral health. These differences appeared to arise from a complex interplay of cultural, socioeconomic, and individual factors. In some cases, students relied on the decision making and prioritization process used in their own family of origin as the reference against which their patients’ decision making about oral health was judged. As a result of this, students expressed frustration when their patients did not value or prioritize oral health in the way the student believed was appropriate. One commented this way on a patient interaction: “She has somewhat different priorities than the ones that I understand. The differ-
ent priorities reflect different beliefs when it comes to oral disease. She does not see the problem with the decay, but sees the problem with the discoloration. It seems to me that it’s a completely different cultural attitude towards health care.” Another student recognized the link between her family history and her current attitudes: “My parents always went and took . . . [me] to the dentist regularly and valued oral health. If something was needed it was completed. . . . I, consequently, think that patients should value and make dental treatment a . . . priority as my parents did.” Another student reported understanding the origins of one patient’s attitude: “I found out that several older people in her family have lost all their teeth and are in dentures and she believes that losing her teeth is inevitable. She therefore doesn’t see the point in getting any fillings.”

**Trust.** At times, the students experienced varying levels of trust in health care providers among their patients. “It seems that she is distrustful of health care providers, and she seems to have preconceived beliefs that we . . . are trying to ‘just get her money,’” one student commented, and then continued, “I must recognize when socioeconomic, gender, and ethnic differences between my patients and me may create or foster distrust in my motives or my abilities. By recognizing these situations, I will be well equipped to communicate my way through them to still deliver optimal care.”

**Communication/language challenges.** The students also encountered challenges related to language and communication. Lack of a common language was a barrier that could be addressed by transferring the patient to a student dentist who spoke the same language as the patient or through the use of a translator. However, even when the student and the patient spoke the same language, smooth communication was not guaranteed, as vocabulary and comprehension differences could still get in the way of effective communication. One student commented, “though we’re both speaking the same language, she speaks in a very different dialect. . . . When it comes to talking about care we both use very basic words and understand each other fine. But every now and then when I ask her how she has been . . . she throws in some slang that I don’t know what the word means. It just really emphasizes the care that I need to take to make sure that she understands what I’m saying when I’m trying to explain her care to her.”

Several international students noted that they have a unique perspective and challenge, as they are negotiating an unfamiliar culture themselves while also becoming part of the health care culture. They confront language issues themselves when English is not their first language (for example, lack of familiarity with colloquial expressions), and they may bring a set of health beliefs from their culture of origin that differ from their patients’ beliefs. One wrote that “I am [from outside the United States] and English is my second language. . . . I grew up with [a] different background and perspective about life than most of my patients. In addition, differences in language and culture have been the biggest concern that I find myself struggling with every day.”

**Need for additional cultural knowledge and understanding.** The students identified the need for additional knowledge of cultural norms around, for example, gender roles, physical contact, greeting behaviors, and verbal and nonverbal communication styles. One male student wrote, “My plan of treating everyone with respect . . . works well 99% of the time except for a few exceptions. One of these exceptions happened when I tried to shake a female patient’s hand. . . . The patient politely told me that she does not shake hands, which made for an awkward moment. [It is her religious] belief that physical touching between males and females in public should not happen. . . . This was a . . . learning experience because it exposed me to a new situation. It taught me that cultural competence is an ongoing learning process.”

**Discussion**

The students’ reflections included in this study demonstrate that the dental school clinical setting offers multiple opportunities for students to gain experience in interacting with a diverse patient population on a day-to-day basis. Several themes in the students’ reflections were identified. Key themes were students’ development of cultural awareness and recognition of the need to understand each patient as a unique individual, students’ desire to build rapport with all patients, and students’ realization that the development of cultural competence is a lifelong learning process.

The nature of qualitative research should be considered when interpreting the results of this study. First, qualitative research is intended to provide detailed insights into a particular group, event, or process. This study includes data from a particular student body enrolled in a particular dental school in a particular region of the country. Were this study to be repeated in a dental school with a significantly differ-
ent student body, curriculum, or patient population, it is likely that there would be some variation in the themes that emerged. Second, students selected the interactions they wrote about. Although a definition of diversity was provided, the selection of the interactions was still influenced by each student’s perception of what constitutes a diverse patient population. Third, the possibility that students may not have been entirely candid in sharing their thoughts, perceptions, and behaviors cannot be ruled out. Filtering may have occurred due to social desirability pressures. Fourth, in seeking to understand students’ day-to-day interactions with a diverse patient population, this study focuses only on the students’ perspective. An exploration of patients’ experiences and perceptions would enrich our understanding of the interactions that occur on a daily basis.

The insights gained through review of students’ reflections on their interactions with a diverse patient population can benefit dental educators responsible for the development of cultural competence curricula. An in-depth reading of students’ reflection papers provided the authors with an enhanced understanding of our students’ stage of development of cultural competence. Without these insights, faculty members may make inaccurate assumptions about the stage of development students are or “should” be in. By understanding students’ current attitudes, knowledge, and beliefs and the challenges they encounter daily in the clinical setting, we can more effectively design instruction and experiences that will meet their learning needs.

Students’ reflections in this study underscored the value of clinical experiences with a diverse patient population in helping them to develop cultural competence. One student noted: “Of course, as I learned more from interacting with different patients, the more assumptions were changed and new understandings were formed.” As educators we should also be cognizant of the fact that experiences alone do not guarantee rapid changes in attitudes. Students’ development of cultural competence is an ongoing learning process requiring diligence and self-awareness. Faculty assistance to students in identifying and discussing “teachable moments” that occur in the clinical setting, asking students to write reflectively about these moments, or providing opportunities to discuss students’ experiences, perhaps in a small-group setting, may enhance the learning process.

Students’ reflections were focused on their own perceptions and experiences during their interactions with patients. Educators should consider how best to facilitate students’ understanding of their patients’ experiences during the dental visit and in the health care system. Some students expressed concern about offending patients whom they perceived as different. They were hesitant to engage their patients in talking about the patient’s cultural norms, health beliefs, and health practices, yet Campinha-Bacote identifies genuine curiosity as a necessary factor in developing cultural competence. Students could benefit from instruction about how to ask questions sensitively, so that they can feel more comfortable in expressing curiosity and can take advantage of the opportunity to learn from their patients.

Students struggled to understand differences in the prioritization of oral health among their patients, often relying on the decision making and prioritization process used in their own family of origin as the reference against which their patients’ decision making about oral health was judged. Curriculum components that address the source of differences in prioritization of oral health, with an emphasis on improving students’ understanding of factors and complexities that might lead a patient to make a particular choice about his or her oral health, would be helpful.

Conclusion

A greater understanding of students’ experiences and reflections on their day-to-day interactions with a diverse patient population can provide insights for dental educators responsible for the development of cultural competence curricula. In this study, students demonstrated their developing ability to recognize assumptions they make based on differences. They acknowledged the need to understand each patient as a unique individual and expressed a strong desire to build rapport with all patients. Students perceived the development of cultural competence as a lifelong learning process requiring ongoing experiences working with a diverse patient population. Review of student reflection papers is valuable in providing faculty members with an understanding of students’ degree of development of cultural competence.

REFERENCES


