Cultural Competency: Dentistry and Medicine Learning from One Another

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Abstract: The Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* is serving as a catalyst for the medical profession to re-examine the manner in which its institutions and training programs relate to cultural competence. This report found that racial and ethnic disparities exist in health care and that a lack of access to care does not fully explain why such disparities exist. The IOM study found bias, stereotyping, prejudice, and clinical uncertainty as possible contributing causes. The U.S. Surgeon General's *Report on the Oral Health of the Nation* also pointed to oral health disparities related to race, ethnicity, and culture. This paper discusses how medicine is responding to the *Unequal Treatment* report and the lessons to be considered for dentistry. Recommendations on how dentistry can apply the knowledge from this report to help reduce oral health disparities are suggested.

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In order to serve the public with the best health care possible, it is important that all of the health professions share information and apply common experiences in the delivery of health care. Although medicine and dentistry are two separate professions, sharing knowledge and information between the two was one of the imperatives of the 1926 Gies Report.[1] During the latter half of the twentieth century, both fields grew in their understanding of disease and in their ability to successfully treat and prevent disease. Today, however, one of the major challenges common in both medicine and dentistry is how to effectively address the health disparities that exist among various ethnic and racial groups in the U.S. population. If we are to meet the national goals established to reduce those types of health disparities by 2010,[2] we need to understand the cause of racial and ethnic health disparities and design interventions to eliminate them. The Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*[3] documents many of the causes of the disparities experienced by minorities in the United States. The purpose of this paper is to explore some of the findings from that IOM report, describe how the field of medicine is responding to its key recommendations, and discuss the findings and responses in relation to dentistry.

Unequal Treatment: A Report of the Institute of Medicine

Congress requested that the IOM assess whether there were differences in the type and quality of health care between minorities and nonminorities in the United States. The study was conducted to "(1) assess the extent of racial and ethnic differences in health care that are not otherwise attributable to known factors such as access to care (e.g., ability to pay or insurance coverage); (2) evaluate potential sources of racial and ethnic disparities in health care, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels; and (3) provide recommendations regarding interventions to eliminate health care disparities." After an exhaustive and critical review of the existing literature, commissioned papers, and focus groups, the IOM study committee found that even in populations with equal access to health care "racial and ethnic disparities in health care exist and, because they are associated with worse outcomes in many cases, [that they] are unacceptable." Among the diseases the study committee

reviewed were cardiovascular diseases, in which there were pronounced differences in treatment regimen associated with worse outcomes based on racial and ethnic differences. Similar findings suggested differences in the treatment for cancer, diabetes, end-stage renal disease, kidney transplantation, and HIV infection.

The IOM study linked three factors unrelated to health care access to the differences in treatments and outcomes between minorities and nonminorities. These are differences due to patients, system factors, and providers. Patient variables, for example, include inconsistent patient behaviors and attitudes related to compliance with treatment regimens, which were attributed to cultural mismatch between minority patients and their providers. At the systems level, basic language facility was cited as a source of problems for many patients. Another example of system factors is mandated managed care, which can disrupt patients who are accustomed to the continuity and personal relationships provided by traditional community-based providers. As members of a managed care plan, patients are faced with an unfamiliar and complex system of care that can result in fewer minorities accessing services, as compared to individuals who can afford to access health care services in self-pay situations without having to work through an HMO/PPO structure. According to the IOM study, the third factor related to treatment differences between whites and minorities may be connected to providers. These include "provider bias (or prejudice) against minorities; greater clinical uncertainty when interacting with minority patients; and beliefs (or stereotypes) held by the provider about the behavior or health of minorities." Because of the time pressure and resource constraints put on the clinical encounter, the IOM study stated that health professionals are often forced to make quick judgments about patients' conditions and treatment. Under these situations, physicians who "are commonly trained to rely on clusters of information that functionally resemble the application of "prototypic" or "stereotypic constellations" are "likely to produce negative outcomes due to lack of information, to stereotypes, and to biases," possibly because health care needs of minority populations do not always conform to prototypical solutions.

The IOM committee made seven categories of recommendations, nineteen recommendations in all, to deal with the five findings of the study (see Appendixes A and B). It would be impossible to review and apply all of the IOM findings and recommendations to dentistry in this paper; however, two recommendations that are particularly pertinent will be explored in the next section. The two recommendations are that 1) health care providers' awareness of disparities needs to be increased, and 2) cross-cultural education needs to be integrated into the training of all current and future health professionals. Developing a general awareness of the reasons for health disparities between minorities and nonminorities and educating practitioners and students on their role in reducing such disparities are an important first order of action to create support within the field to implement the other important IOM recommendations.

A Growing Awareness of Cultural Issues in the Delivery of Health Care

Focusing attention on cultural issues and how they influence and impact upon the delivery of health care grew during the 1990s, as U.S. society became more racially and ethnically diverse and as the country reckoned with the fact that minorities would constitute 40 percent of the population by 2035.[4] Racial bias and prejudices have heavily impacted on U.S. society throughout its history. During the last half of the twentieth century, several well-known movements took place to confront such bias and to remove institutional barriers based on race, ethnicity, and gender. In the 1960s, President Johnson's Great Society initiatives such as Medicaid and Medicare were intended to widely open up access to care for most Americans. Backed up by civil rights legislation, it became illegal to discriminate based on race, color, or gender. The result of governmental action meant that the United States, within the limitations of Medicaid and Medicare, was moving toward a system of health care for all, regardless of race or color. The IOM study, however, goes well beyond such societal responsibility for improving the health of minorities. Instead, it points to how *individual* provider bias, racial attitudes, and stereotyping, no matter how subtle, impact on the treatment of minorities. Taking a closer look at individual provider bias is risky as few practitioners will acknowledge that the care they provide is in any way influenced by such behavior. How has the level of awareness about provider bias been raised

in the medical community as recommended by the IOM study? A number of initiatives have emerged to encourage the medical profession to confront this vexing issue. Some examples are described below.

The Liaison Committee for Medical Education[5] has developed accreditation standards that are encouraging medical schools to incorporate coursework in cultural competency into the medical curriculum. Two statements are of particular relevance to the IOM report. The first states "the faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments." The second states that "medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others and in the process of health care delivery." At the graduate medical education (residency) level, the Accreditation Council for Graduate Medical Education has incorporated competencies into its common program requirements. These competencies include "sensitivity to a diverse population" and "the ability to communicate effectively." Family medicine programs have been in the forefront of incorporating culturally sensitive training into their residency programs. The Society of Teachers of Family Medicine developed curricular guidelines, endorsed by the American Academy of Family Physicians, for family physicians to promote cultural sensitivity and culturally competent health care. The philosophy of the family physicians is that meaningful, accessible, effective health care requires a deeper understanding of the sociocultural background of the patients, their families, and the environment in which they live. They also express the belief that it is critical for the physician to become more aware of how one's own cultural values, assumptions, and beliefs influence the provision of clinical care.[6] Such training has been shown to be effective in significantly improving the level of cultural competence in residents.[7]

As awareness of the IOM unequal treatment report has grown, so too has attention from the public and private sectors in the United States. In January 2003, the Henry J. Kaiser Family Foundation published a compendium of cultural competence initiatives in health care.[8] They listed and briefly described ten federal/state/local initiatives and twenty-two initiatives of health care institutions, professional organizations, academic institutions, and policy research organizations. Federal initiatives cited include those of the U.S. Department of Health and Human Services (HHS) such as the Office of Civil Rights Title VI enforcement authority related to cultural competency and the HHS Office of Minority Health Report on *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. Among the twenty-two other initiatives cited are the American Medical Association's *Cultural Competence Compendium*; the California Endowment's funding of projects that address cultural competency, work force diversity, and access and disparities in health care; and the Robert Wood Johnson Foundation's Hablamos Juntos program to improve patient-provider communication. Also listed were the Cross Cultural Health Care Program started with a W. K. Kellogg Foundation grant that brings ethnic communities and health care organizations together, as well as the National Center for Cultural Competence at the Georgetown University Center for Child and Human Development, a center that provides cultural competency training and technical assistance. This recently developed Kaiser Foundation guide includes a list of experts in the field.

The IOM report has stimulated the Aetna insurance company, one of the nation's largest insurers, to test practical ways of reducing racial and ethnic health disparities and to undertake research to better understand their causes.[9] Another initiative designed to increase awareness of the IOM report and its recommendations is the October 2002 report *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* prepared by Betancourt et al. under a grant from the Commonwealth Fund.[10] Barriers to culturally competent care were linked to a lack of diversity in health care leadership and workforce, systems of care poorly designed for diverse patient populations, and poor cross-cultural communication between providers and patients.

Betancourt et al. described four culturally competent models of health care that can overcome these barriers. Key lessons are extracted from each model leading to a framework for culturally competent care. What is apparent from their report is that the system or institution must be in harmony with cultural competency principals for training programs of substance to develop. This report and most experts in the field suggest that each institution begin the process of moving toward cultural competency by exploring a definition of the term. According to Brach and Fraser,[11] there are many definitions available with

most of these stemming from one developed by Cross et al.[12] in 1989. Cross defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations."

As a result of these activities and others, awareness is growing in the medical community of the need to confront bias and stereotyping from the perspective of the individual practitioner and from the institution or systemic level. With awareness raised, there is a growing demand now to develop appropriate educational programs that weave cultural competence into training. What do we know about effective education programs? How is cultural competency training incorporated into the education of students?

Educating Students on How to Understand Race, Culture, and Ethnicity in Practice

An understanding of the concepts that need to be included in cross-cultural issues and the training of future practitioners was set out in 1978 by Kleinman et al.[13] These authors recognized that traditional biomedical solutions could no longer solve major health care problems such as patient dissatisfaction and inequity of access to care. Drawing a distinction between a diagnosis of a specific disease by a physician and how the patient perceives of his or her illness, Kleinman et al. pointed out that only through a keen appreciation of culture could treatment lead to a satisfactory outcome. Integrating the social sciences and anthropology into the clinical medical sciences and into the education of students would result in practitioners with an explicit understanding of the impact of social and cultural factors on the patient's illness.

Other work in this area has followed that of Kleinman et al. In 2002, Green et al.[14] discussed the importance of social issues in caring for patients of all cultures. They proposed four domains of information that should be included in a "social" review of a patient. Students can learn how cross-cultural factors influence the presentation of symptoms by questioning patients about the influences of social stressors and support networks, change(s) of environment, levels of empowerment, and literacy. In 1996, the Society of Teachers of Family Medicine[6] described the attitudes, knowledge, and skills that a core curriculum should develop in students and residents. According to this report, the curriculum should develop appropriate attitudes in students as a moral and ethical obligation to challenge racism, classism, and other forms of bias and prejudice in the health care setting and promote recognition of the student's own biases and reactions to persons from different minority, ethnic, and sociocultural backgrounds. Knowledge of sociocultural issues related to health care, the way culture affects the patient's perspective of disease, and what groups comprise the multicultural makeup of the United States become important. Developing communication skills, both verbal and nonverbal, and working collaboratively with other health care professionals in a culturally sensitive manner become critical in the development of the student. The importance of training was underscored by Brach and Fraser,[11] who described nine categories of cultural competency activity that could lead to reducing the disparities in the health of minorities. These included such strategies as the use of community health workers, the development of culturally competent health promotion, and cultural competency training programs. Training is important "to ameliorate problems stemming from the cultural mismatches that result whenever patient and staff do not share a common subculture and mutual understanding of each other's health beliefs."

Unequal Treatment in the Context of Dentistry

How do the findings and the recommendations from the IOM *Unequal Treatment* report apply to dentistry? Are the lessons from medicine in developing an awareness of the influence of cultural competency factors in the treatment and outcome of treatment applicable to dentistry? The IOM Unequal Treatment Study Committee did not investigate if disparities in the oral health of minorities were linked to the same possible cultural causes, as they did cardiovascular disease. Nor did the committee assess racial and ethnic differences in health care for many other diseases. However, the committee did recommend that cultural competency training be provided to *all* health professionals, most likely because they documented that cultural factors impacted on the dis-

eases they did study and bias was ingrained into the health care system.

On the other hand, *Oral Health in America: A Report of the Surgeon General*[15] did find that there were disparities in oral health based on race, culture, and ethnicity. African-American males, for example, are diagnosed with oral cancer at a later point in the disease than whites, and the mortality rate for black men is far greater than it is for whites.[16] It is not known whether a lack of access to care alone would account for that difference. However, we could speculate that similar to medicine, when access to care is eliminated as a barrier, some of the same cultural factors that account for the worse outcomes in the treatment of cardiovascular disease are also in play in the treatment of oral disease. We also know that the growing racial and ethnic diversity in the population will have an impact on dental practitioners similar to that on medical practitioners. Dentists must confront the same set of sociocultural factors that physicians face when considering treatment plans and treatment outcomes. A number of studies have linked oral disease to socioeconomic and cultural issues. If dentistry is to reduce oral health disparities related to race and ethnicity, dentistry will also need to recognize how its systems of care and its individual practitioners are influenced by bias, stereotyping, and beliefs about minorities.

Both the Surgeon General's report and the IOM report identified a lack of diversity within the professional workforce as a barrier to the collective capacity of the health care system to understand and cope with cultural issues. From a health systems point of view, minority health professionals may be better able to take sociocultural factors into account when organizing delivery systems to meet the needs of minority populations.[17] Language barriers impact as heavily on the patient-doctor interaction in dentistry as they do in medicine. Finding ways to compensate for different languages becomes the responsibility of the provider and cannot be ignored. Good communication skills also are one of the attributes of a culturally competent practitioner, and studies have shown that patient satisfaction is better when interpersonal communication is effective.[18] Yet a recent study found that instruction in interpersonal communication skills in dental education is inadequate.[19]

Recommendations

There are a number of ways in which dentistry can respond to the critical challenges of serving culturally diverse populations. Dentistry can accept the findings and recommendations from the IOM *Unequal Treatment* report and apply them to oral health disparities. The current multicultural statement* contained in the Standards for Accreditation of Dental Schools[20] can be strengthened to include cultural competence statements similar to those statements contained in the Accreditation Standards for Medical Schools. The training programs in medicine can be directly transferred to dental faculty and students. Schools can rethink their institutional policies and systems to make sure they take into account cultural differences of their patients, students, and staff and re-examine their curricula to determine how the social sciences, including cultural competency training, fit into the education of students. Student and resident case reports could take into account cultural factors in the same way as recommended for medicine, and students should receive experience treating patients in culturally diverse communities. Service-learning opportunities provide students and residents with community-based assignments that can deepen and enrich awareness of the numerous cultural influences that are intertwined with treatment decisions and outcomes. Improving diversity for dental schools by increasing the numbers of underrepresented minority faculty and students can lead to a learning environment more apt to consider the effects of bias, ethnicity, and cultural issues in the provision of care.

An institutional culture can be cultivated in which faculty and staff understand the importance of recognizing and eliminating bias and stereotyping as an essential step in reducing long-standing disparities in oral health. Such a culture can be developed by considering and adapting some of the other IOM recommendations. For example, the school dental clinic could employ interpretation services that, in turn, can improve communication, patient education, and provider-patient trust. Dental school clinics' quality assurance programs could include measures of racial and ethnic disparities in

*The current Dental School Accreditation Standard 2-17 states that "graduates must be competent in managing a diverse patient population and have the interpersonal and communication skills to function successfully in a multicultural work environment."

performance measures and monitor progress toward the elimination of any health care disparities found.

Finally, it is critical that medical and dental practitioners, both of whom are held in high trust by the public, take on the challenges brought forth by the IOM *Unequal Treatment* report. The Pipeline, Profession & Practice: Community-Based Dental Education program funded by the Robert Wood Johnson Foundation, the California Endowment, and the W. K. Kellogg Foundation is designed to help dental schools address the challenges contained in the Surgeon General's and IOM reports. Some of the lessons learned from the schools involved in the pipeline program should help the field over the long haul in reducing oral health disparities in the United States attributable to race, ethnicity, and culture. Dentistry should join with medicine and conduct further research as recommended in the IOM report to "identify sources of racial and ethic disparities and to assess intervention strategies."

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Appendix A. Summary of the IOM committee's findings

Finding 1-1: Racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable.

Finding 2-1: Racial and ethnic disparities in healthcare occur in the context of broader historical and contemporary social and economic inequality and evidence of persistent racial and ethnic discrimination in many sectors of American life.

Finding 3-1: Many sources—including health systems, healthcare providers, patients, and utilization managers—may contribute to racial and ethnic disparities in healthcare.

Finding 4-1: Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare. While indirect evidence from several lines of research supports this statement, a greater understanding of the prevalence and influence of these processes is needed and should be sought through research.

Finding 4-2: A small number of studies suggests that racial and ethnic minority patients are more likely than white patients to refuse treatment. These studies find that differences in refusal rates are generally small and that minority patient refusal does not fully explain healthcare disparities.

Appendix B. Summary of the IOM committee's recommendations

General Recommendations

Increase awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders (Recommendation (2-1).

Increase healthcare providers' awareness of disparities (Recommendation 2-2).

Legal, Regulatory, and Policy Inventions

Avoid fragmentation of health plans along socioeconomic lines (Recommendation 5-1).

Strengthen the stability of patient-provider relationships in publicly funded health plans (Recommendation 5-2).

Increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals (Recommendation 5-3).

Apply the same managed care protections to publicly funded HMO enrollees that apply to private HMO enrollees (Recommendation 5-4).

Provide greater resources to the U.S. DHHS Office of Civil Rights to enforce civil rights laws (Recommendation 5-5).

Health Systems Interventions

Promote the consistency and equity of care through the use of evidence-based guidelines (Recommendation 5-6).

Structure payment systems to ensure an adequate supply of services to minority patients, and limit provider incentives that may promote disparities (Recommendation 5-7).

Enhance patient-provided communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice (Recommendation 5-8).

Support the use of interpretation services where community need exists (Recommendation 5-9).

Support the use of community health workers (Recommendation 5-10).

Implement multidisciplinary treatment and preventative care teams (Recommendation 5-11).

Patient Education and Empowerment

Implement patient education programs to increase patients' knowledge of how to best access care and participate in treatment decisions (Recommendation 5-12).

Cross-Cultural Education in the Health Professions

Integrate cross-cultural education into the training of all current and future health professionals (Recommendation 6-1).

Data Collection and Monitoring

Collect and report data on health care access and utilization by patients' race, ethnicity, socioeconomic status, and where possible, primary language (Recommendation 7-1).

Include measures of racial and ethnic disparities in performance measurement (Recommendation 7-2).

Monitor progress toward the elimination of healthcare disparities (Recommendation 7-3).

Report racial and ethnic data by OMB categories, but use subpopulation groups where possible (Recommendation 7-4).

Research Need

Conduct further research to identify sources of racial and ethnic disparities and assess promising intervention strategies (Recommendation 8-1).

Conduct research on ethical issues and other barriers to eliminating disparities (Recommendation 8-2).