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Embedding cultural competence in dental education

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Abstract

Cultural competence plays a pivotal role in dentistry and is increasingly recognised and studied worldwide. As the dental profession evolves to cater to an ever-diverse society, it is imperative that universities consider how they support students in acquiring the skillset for providing culturally sensitive care. Cultural competency in dental education is highly variable globally. The requirement for dental graduates to demonstrate cultural competence is a key part of accreditation frameworks in the United States, Canada and Australia and is a recent addition in the General Dental Council's Safe Practitioner Framework in the UK, alongside the requirement to develop socially responsible graduates. However, there is a lack of consensus on the pedagogical direction for instilling the skillset within dental students and in fostering a desire to work with minority groups. Conceptual methods in cultural competency education are diverse. One theory categorises teaching methods into cultural sensitivity, multicultural or categorical, and cross-cultural, focusing on student attitude, knowledge, and skills development. However, criticisms arise as such approaches may oversimplify diversity, equate culture with race or ethnicity, and perpetuate stereotypes and discrimination. This article argues that a multi-pronged pedagogical approach will best empower future clinicians to meet the needs of today’s diverse society.

Background

Cultural competence is a critical aspect of dentistry that is increasingly being recognised and studied worldwide. Whilst the profession adapts to provide quality care to an increasingly diverse society, it is essential that universities consider how they support students in acquiring the skillset for providing culturally sensitive care.[1] Alongside teaching the fundamentals of dentistry, this also means preparing students to work with patients from diverse backgrounds with varying healthcare needs.[2] Dental professionals have long been trained to communicate effectively with their patients to explain complex dental issues in easy-to-understand language, avoiding clinical jargon.[3] By adopting a patient-centred approach, students are supported to develop their communication techniques to suit each individual; whether a child, adult, anxious patient, or someone for whom English is not their first language, ensuring that patients can make informed decisions about their care.[4] Developing cultural competence skills further expands this notion to acknowledge the requirement to understand and adapt our practice to our ever-changing society. This article explores cultural competence within the context of dentistry, focusing on the challenges faced by minority groups in relation to their healthcare, and discusses strategies for supporting the integration of educational interventions within the dental curricula. By doing so, the objective is to develop the undergraduate skillset for meeting the needs of a progressively diverse patient population.

What is cultural competence?

Cultural competence can be defined in many ways, but fundamentally, it is the ability to interact and communicate with individuals, regardless of their background or culture. In the UK, the NHS defines cultural competence as ‘a set of aligned and transparent skills, attitudes and principles that acknowledge, respect and work together as a system towards optimal interactions between individuals and the various cultural and ethnic groups within a community’.[5] In a broader sense, Dada describes cultural competence as having the knowledge and skills to understand one’s own cultural values and the implications of these for making respectful, reflective and reasoned choices when communicating with differing cultures.[6]

The concept of cultural competence first emerged in the United States in the 1980s with Cross *et al's*. study which focussed on improving the accessibility and effectiveness of health care delivery for people from racial or ethnic minority groups.[7] However, the term was first formulated in 1970 by Dr. Madeleine Leininger, a nurse theorist who proposed the notion in her book, 'Nursing and Anthropology: Two Worlds to Blend'. The original term was culturally congruent care, which later became culturally competent care.[8] Cultural competence has evolved since its emergence from focusing on providing effective care for racial and ethnic minority groups to encompassing a broader spectrum of cultural identities and heritage. Cultural identity and heritage, for example, can be linked to ethnicity, nationality, or religion, as well as a person's sexuality or gender identity.[9]

Why cultural competence matters

The Western world is becoming increasingly diverse, primarily due to an increase in global migration over the past few decades.[10] In the UK especially, the social landscape is changing with 2021 census data showing that England and Wales are more diverse and less segregated than ever before.[11] In an in-depth analysis of the census data, Dr Catney and team from Queen's University Belfast found that people from white, Black, Asian, mixed and other groups are now living alongside each other across thousands of neighbourhoods. They report that the numbers of neighbourhoods with very high levels of diversity (30 or more ethnic groups living in an area) was 342 (1.0%) in 2001. This figure rose to 1,578 in 2011 (4.4%) and to 2,201 in 2021 (representing 6.2% of neighbourhoods).[12]

Whilst there is no doubt that the UK's evolving diversity enriches our cultural landscape, diversity also brings challenge, with one of the most documented areas being health inequalities. The Office for Health Improvement & Disparities define health inequalities as unfair and avoidable differences in health outcomes between different groups within a society or across populations.[13] In their report 'Place-based approaches to reducing health inequalities', they set out the range of characteristics and societal factors that contribute to health inequalities. These are socio-economic status and deprivation; for example, those who are unemployed, have a low income or are living in a deprived area associated with poor housing. Vulnerable or inclusion health groups; for example, vulnerable migrants; Gypsy, Roma, Traveller, and

people experiencing homelessness. Those with protected characteristics, as defined by the Equality Act 2010; such as age, sex, race, sexual orientation, religion and disability. The final factor is geography; for example, the environments in which we live, such as levels of connectedness and whether we live in a rural, urban or coastal setting. Fundamentally, where we are born, raised, work, live and our age are all contributing factors to health inequalities as these conditions affect our cognitive, physical and psychosocial development.[14] In essence, the conditions in which we grow influence our opportunities for good physical, mental health and wellbeing.

In the publication 'health of people from ethnic minority groups in England' Raleigh reports that some ethnic groups are more likely to report poorer experiences of using healthcare services than their white counterparts and to be in poorer health.[15] NHS dentistry is one of the most affected services in the UK for health inequalities who reported in their 2023 data; 'Patient access to and satisfaction with NHS dental services' that Gypsy or Irish Traveller ethnic groups were least likely to report successfully booking an NHS dental appointment closely followed by Black African ethnic groups. The percentage for these groups successfully booking an appointment were consistently below the national average.[16] The complexities in these experiences are multi-faceted and include challenges such as navigating overly complicated and difficult processes to access healthcare services, and these may be compounded by a lack of interpreting services for those who do not confidently speak English. Institutional and interpersonal racism have also been reported impacting on poor experiences when using healthcare services and an avoidance of seeking help for health problems due to fear of racism from NHS professionals.[17]

Aside from the institutional and systemic challenges experienced by minority groups, we should also consider differing beliefs, knowledge and attitudes around oral health. Cultural variations impact oral health through dietary habits, behaviours, beliefs, and care-seeking practices and these differences can create obstacles to receiving dental care.[18] For instance, some communities may not prioritise primary teeth and believe that childhood tooth decay is unavoidable, leading to delayed treatment.[19, 20] In many cultures, tooth loss is considered a natural part of aging, potentially resulting in missed opportunities for preserving natural teeth. [21, 22, 23, 24]

Transgender patients may feel uncomfortable disclosing their status to healthcare providers, which can lead to avoidance of necessary care or withholding relevant information about their transition. This can negatively impact their overall treatment and safety.[25, 26] Some patients may not speak English as their first language, limiting their ability to accurately convey their symptoms, needs, or concerns.[27] In some cultures, it is considered inappropriate or rude to ask questions of a medical professional, further hindering communication.[28] As a result, patients may feel embarrassed, uncomfortable, or unable to seek clarification on their treatment.

Cultural competence in the dental curricula

The challenges faced by minority groups in our society are complex and dental educators must ask themselves the crucial questions: How can we effectively assist our students in acquiring the necessary skills to address these challenges? And Is it sufficient to just support the development of students' cultural competence skills, or should we also strive to instil in them a genuine desire to engage with all sectors of our community in their future practice? Considering the ongoing recruitment and retention crisis within the NHS dental workforce leading to large numbers of dentists leaving the NHS, [29, 30] one could argue that efforts should be made during undergraduate training to enhance interest in this field. New graduates are also following the same trend with many moving to private practice and departing from NHS work shortly after completing their training.[31] More graduates than ever are allured to the world of social media influencing and promoting aesthetically driven treatments that fall outside the scope of NHS services. Consequently, there is a noticeable decline in needs-based, biological care for patients.[32] This significantly impacts on patients from minority groups who experience more barriers of access to NHS dentistry.[15, 16, 17]

A key driver for change in UK dental education is the General Dental Council (GDC) Safe Practitioner Learning Outcomes and Behaviours Framework published in November 2023 which highlights a requirement of UK graduate dental professionals to 'Explain cultural competence and its relevance in assessing the needs and planning care for patients from diverse backgrounds' and 'Demonstrate cultural competence, accepting and respecting the diversity of patients and colleagues'.[33] The framework also places a greater emphasis on developing socially accountable

practitioners. These components are already embedded in the accreditation frameworks of the United States, Canada, and Australia.[34, 35, 36] and the Association for Dental Education in Europe in their approach to European undergraduate dental education 'The Graduating European Dentist'.[37] emphasises the importance of patient-centred care, indicating a global shift in the expectations for dental graduates. Consequently, UK dental schools must determine how they will prepare their students to deliver culturally competent care and how student behaviour will be monitored.

In the United States, several research studies address the integration of cultural competence in the undergraduate dental curricula. A study conducted by Ocegueda *et al.*[38] aimed to determine which US dental hygiene programmes were integrating cultural competency education into their curriculum and to identify the methods used in delivery. They found that of the 27% of US dental hygiene schools that responded, 91% indicated the inclusion of cultural competence in the curriculum. The return on the survey was low, however the results suggest that integration of cultural competence has value and relevance within the curricula. 98% of the schools reported their students participate in community outreach projects as part of their cultural competence training however 42% of these indicated that their students are not evaluated for cultural competency knowledge, skills and attitudes. The authors indicate that the focus of further studies should look at types of assessments or evaluation methods used to measure cultural competency. Consequently, a study by Holyfield and Miller.[39] surveyed all 71 US and Canadian dental schools to determine best practices for cultural competence education. Based on findings from their survey, they discuss how best cultural competence skills can be developed providing suggestions such as role-play, interactive discussion of case scenarios and videos to introduce valuable discussion around cultural competence. An overwhelming feature from the study was the sense of urgency in which strategies should be put in place for dental students in developing their skillset to support effective communication and establish trust with patients from all cultures, identities, religions and ages.

Australia has also shown a growing recognition of the importance of integrating cultural competence in their undergraduate dental curricula. The Australian Dental Council, through its accreditation standards for dental programmes, emphasise the

importance of cultural competence through the addition of a domain on 'Cultural Safety'.[36] The domain requires dental schools to demonstrate 'students are able to provide culturally safe care for Aboriginal and Torres Strait Islander Peoples'. Additionally, a systematic review conducted by Forsyth *et al.*[40] looked at literature on teaching of cultural competence in dental education and explored the relevance of oral health care teaching for Indigenous populations in Australia. Their findings suggest that using a combined approach of didactic learning, community engagement and reflective writing on their experiences could increase cultural awareness and communication skills of dental students.

The existing research underlines the importance of UK schools to not only integrate cultural competence into the curricula, but also to consider the most effective way of developing their students' skillset and their desire to support all sectors of our society.

Discussion

Betancourt *et al.*[41] propose that the pedagogy of cultural competency education can be categorised into three conceptual methods: the cultural sensitivity method, the multicultural or categorical method, and the cross-cultural method. Each method emphasises a distinct aspect of cultural competency education, namely attitudes, knowledge, and skills. The cultural sensitivity method focuses on the attitudes of the healthcare provider or student, especially in relation to the cultural influences on the patient's health beliefs and practices. The multicultural or categorical method focuses on the knowledge of values, beliefs and behaviours of differing cultural groups and the cross-cultural method focuses on developing the clinical skillset required to care for diverse populations.

A 2017 study by Behar-Horenstein *et al.*[42] supported the cultural sensitivity approach and found that 'privileged' dental students that were exposed to the lived realities of others unlike themselves, challenged their preconceived biases. The authors concluded that experiential learning was an important catalyst in shifting dental student's attitudes. This view is also supported by Mariño *et al.*[43] in a study on

cultural competence of Australian dental students who purport the merits of first-hand experience where students interact with diverse patient groups. The findings from their study showed that students reflecting on these experiences assisted them in preventing stereotyping and refined existing beliefs around cultural groups. The concept of reflection as part of the learning process supports Dada's notion of cultural competence.[6] Dada implies that cultural competence requires individuals to understand their own cultural values and the implications of these when communicating with differing cultures and this requires critical reflection of oneself. This highlights the significance of reflection as a crucial step in cultivating the cultural competence skillset. It could therefore be suggested that all learning related to cultural competence should incorporate a component of reflection.

The multicultural or categorical method focussing on the knowledge of values, beliefs and behaviours of differing cultural groups is perhaps the simplest pedagogical method to employ. Pilcher *et al.*[44] determine that didactic methods do increase dental students' knowledge of cultural competency topics. Furthermore, Forsyth *et al.*[40] report in their systematic review that multiple studies use didactic teaching through seminars or web-based training with no reported difference in improvement between the two methodologies.

The cross-cultural method focuses on developing the clinical skillset required to care for diverse populations. A study by Witton & Paisi.[45] incorporating social responsibility projects in the local community supports that contextual learning opportunities helped students to understand the complex health needs of disadvantaged groups in a 'real-world' environment. The study emphasizes the necessity for additional research to assess the long-term effects on students participating in social accountability programmes and their desire to work with minority communities.

Conversely, Hester states that the use of culture in a pedagogical approach has been critiqued widely as it oversimplifies human diversity by attributing it solely to cultural characteristics, and mistakenly equates culture with race and ethnicity, ignoring other factors. It can also perpetuate stereotypes and discriminatory behaviours that often actually lead to unequal healthcare treatment and health

disparities. Moreover, it overlooks the structural factors influencing health, leading to a tendency to fault the individual for their health conditions.[46] Furthermore, Price *et al.*[47] argue that the pedagogies of cultural competency fail to methodologically prove that they are achieving their objectives or that they hold any significance for the field of medical education.

A key concept could be to distinguish between the words; 'culture' and 'competence'. We can employ the pedagogical principles set out by Betancourt *et al.*[41] by didactically teaching knowledge around cultures and diverse societies. This can equip student dental professionals to recognise the values, beliefs, and behaviours of different cultural groups. However, we mustn't lose sight of having the ability to use that cultural knowledge effectively both to support patient care and to encourage socially responsible future practitioners. Therefore, one could draw the conclusion that a range of pedagogical methods are integral to cultural competency education and a multi-pronged approach can help dental schools to start this journey; some key considerations are summarised below:

- Dental schools should review curriculum content to ensure students are trained adequately to recognise varying values, beliefs and behaviours. Dental schools may need to develop bespoke learning resources and assessments to meet these goals.

- Dental institutions should make effective use of connections with their local communities to provide contextual learning opportunities in the 'real-world' environment; essential in the development of empathy and challenging preconceived perceptions.

- An essential step in supporting students to develop the attitude, knowledge and skills for providing culturally sensitive care is to incorporate a component of critical reflection into all learning associated with cultural competence.

- Considering that some UK dental schools are located in more diverse areas than others, collaboration to share ideas, resources and strategies across

schools could be a supportive approach to increasing cultural competence for all dental professional undergraduates.

Conclusions

The ability to provide culturally sensitive care is considered a crucial skill for dental professionals, yet there is a lack of consensus on the curriculum that can effectively instil this competence. Dental schools in the UK must actively pursue the integration of cultural competence in their curricula to promote the development of graduates who are socially responsible. This article argues that a multi-pronged pedagogical approach will best empower our future clinicians to meet the needs of today's diverse society whilst also fostering a genuine enthusiasm to engage with minority groups in their future practice.

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