Assess ABCD to ascertain the level of cultural influence in pediatric dental families

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When the pediatric dentist and the child's family are from different cultural backgrounds, the dentist needs to ask questions that respectfully acknowledge these differences and builds the trust necessary for the child and family to confide in the dentist. Pediatric dentists can use this knowledge about particular attitudes, cultural beliefs, values, and practices to respectfully recognize a family's identity and work with it, not against it. The following adapted mnemonic from Koenig and Gates-Williams[1] is presented to help avoid the dual pitfalls of cultural stereotyping and ignoring the potential influence of culture.[2] For each of the issues—attitudes, beliefs, communication/language barriers, and decision-making (ABCD) styles—we will discuss the possible consequences of ignoring the issues and then present strategies for dealing with the issues.

Attitudes towards pediatric dentistry may be influenced by cultural beliefs. Although informed consent is a major tenet of US Health Care, in Italy, France, Asia, Central and South America, and the Middle East health care providers and patients often think that withholding medical information is more humane and ethical than giving families detailed information. Think about that when your patient's parents are asked to sign the anesthesia consent that includes the risk of death. The parents may come from a culture that says, "Don't explain it to me. You are the doctor. Just treat it." In fact, at Children's Hospital in Boston, there is an HIV-positive adolescent boy who is not aware of his diagnosis. He knows that he has severe hemophilia A, but that is all. The hospital lawyers have decided to go along with the family's demand that the boy not know because they feel that the stress of simply knowing his diagnosis will alter his CD_4 levels, which are presently within normal limits. Our service had to be made aware of his diagnosis in order to extract bicuspids for orthodontic purposes.

The potential consequences of ignoring cultural attitudes are anger, mistrust, or even the removal of the child from the health care system if the pediatric dentist insists on treatment modalities against the wishes of the family. Strategies that pediatric dentists can employ include becoming educated about the attitudes common to the ethnic groups that are most frequently treated. For example, a general dentist in Washington, DC was the new associate in a practice that drew heavily from the Portuguese embassy that abutted the practice. The practice's owner saw all the dignitaries and the associate saw all the chefs, butlers, drivers, etc. The new associate attended night school to learn Portuguese. Little, by little, the dignitaries and their families started requesting the new associate, and the owner of the practice felt obliged to fire the new dentist when he was only seeing the embassy's minor staff members. The entire Portuguese embassy followed the new associate to her practice across town as did the entire Brazilian embassy.

A second strategy is to use open-ended questions, such as:

1. "I see you've seen Dr. X previously—why are you not going back to that office?"
2. "Why do think that your child has this problem of decayed top front teeth?" (reply with empathetic comments, such as, "That must be very difficult for you.")
3. "How do you think that your child's dental needs should be treated?"

Cultural competence is not simply a moral or ethical obligation or a "nice thing to do." It is now the law. In December 2000, The Office of Minority Health of the US Department of Health and Human Services released national standards for culturally and linguistically appropriate health services directed at health care organizations.[3] Individual practitioners are encouraged to use these standards. In response to these standards, at Children's Hospital in Boston, our internal Web site contains a huge manual that gives a medical/cultural synopsis of 12 religions and 23 cultural groups including the hearing-impaired and gay/lesbian parents. I bet that the local hospital where you bring your pediatric patients for treatment under general anesthesia has this information as well.

Before we can discuss beliefs, we need to look at trust. Trust is a critical element in ethnocultural relationships. One example of the historical context of this is the African American experience within the United States—the Tuskegee syphilis study, where African American men were deceived and mistreated.[4] Another example is the minority-focused

sterilization initiatives of the 1970s.[5] It has been well documented that older African Americans are more likely to believe that hospitals and health care providers have a profit motive in treatment choices. Potential consequences of ignoring cultural beliefs are a lack of trust caused by the inequities in health care in the United States or an increased desire for futile aggressive care. We've all had parents come to the office and demand that we place a simple "filling" on their child's nonrestorable abscessed tooth. Ignoring the ethnocultural belief systems of our patients results in dissatisfaction with care by all parties involved in that care.

Strategies that may be employed by the pediatric dentist include being explicit that you and the child's family will work together to achieve the best possible care for that child. Don't assume the family knows this—say the words. Work with the family to improve access and reduce inequities. Train your staff to help new immigrant families get through the "system." Understand and try to accommodate desires for more aggressive care, and use respectful negotiation when this is contraindicated.

Communication/language barriers often exist with new immigrants from the Far East. In their culture, the need to preserve the family and community honor is so strong that a health care provider never puts the parents into an embarrassing situation or a state of loss of honor by directly posing potentially sensitive questions. "Face" is saved by using indirect communication. Hypothetical cases may work best. Try to depersonalize your conversation: that is, try not to use the word "you." Instead, use hypothetical cases to describe treatment choices. For example, say, "Others who have dental conditions similar to your child's have found it helpful to consider several options for care, such as nitrous oxide/oxygen analgesia to keep the child as happy as possible during treatment."

As Dr. Scrimshaw pointed out earlier (and we all do this), we use a minor as the interpreter for us. The use of a child who interprets for parents, whatever the setting, inverts the role that most cultures ascribe in the family hierarchy by putting the child in a temporary superior position. Parents will hesitate to ask questions in front of their children. The child will feel pressured to be accurate and clear in his/her interpretation and will become frustrated when unable to meet those expectations. The child may also feel ashamed of his/her parent(s). Remember, the interpreter holds the keys to the communication process and as such, wields considerable power. One child who visited orthopedic surgery at our hospital interpreted for his newly emigrated Russian mother. When the mother frantically called the interpreter saying that she "did not have $100 for the fancy basketball sneakers," it turned out that the child had tried to interpret for his own goals. Interpreters are also our "cultural brokers." They may spend an hour explaining to the parent why "baby teeth" need to be preserved before they reach your office.

The consequences of ignoring communication may be bidirectional misunderstandings and unnecessary physical and emotional suffering. Avoid the use of family members as translators, especially minors, if you can. Hire bilingual and bicultural staff to be the bridge across cultural and linguistic gaps. Use the language telephone lines.[6] Check for understanding frequently in your conversation. For example, say, "So that I can make sure that I am explaining this well, please tell me what your understanding is about your child's dental needs and the treatment we're considering." Try to avoid medical/dental or complex jargon. Try to be concise and think more to the point.

Decision-making styles are often misinterpreted in medical offices. We've all seen it—the patient is called back and 10 members of the extended family come into the operatory. The familial mode of decision making is the norm in many cultures. In these cultures, families provide a great deal of emotional strength and social support. If you ignore the decision-making style of the family, you will create disagreement and conflict within the family and between the family and the dental staff. Strategies that may be employed include ascertaining the key members of the family and ensuring that they are included in discussions. Ask, "Is there anyone else that I should talk to about your child's condition and treatment?" When someone else accompanies the parent and child, ask about the person's involvement in receiving information and decision making. Try to treat all patients with equal empathy. Understand that in several cultures it is normal to bottle- or breast-feed until age 5 or 6 years. Ask, "How can we support your needs and practices while preserving your child's teeth?"

Every month in seminar, one of our Latino pediatric dentists tells her fellow attendants and residents about how she was bottle-fed with chocolate milk until age 5 or 6 years. Every month we all laugh, but does anyone really believe her? Be sure that your staff understands that a patient from a high socioeconomic status may not have a high dental IQ and may still be very dependent on cultural beliefs, even though they speak well and are very well dressed and are obviously affluent. The opposite is just as true.

The number one strategy is to realize that "time," for the average American, is of utmost importance. To the new immigrant, Americans seem to be more concerned with getting things accomplished on time (according to a predetermined schedule) than they are with developing deep interpersonal relationships or than they are with the quality of their work. For the American, schedules are meant to be planned and then followed to the smallest detail. Understand that tardiness can be cultural. Also realize that that in some cultures, saying yes is a universal given, even when they mean no.

The final strategy is to recognize manifestations of prejudice in our own behavior and the behavior of our staff. Failure to take culture seriously means we elevate our own values and fail to understand the value systems held by those of different backgrounds.

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