Our multicultural society: implications for pediatric dental practice

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There was a time, not too long ago, when health research publications did not mention the ethnicity of study populations, either because there was only one studied, or because no one thought it mattered. This was also the time when many clinical trials were done only on men. We have now established that health risks and health outcomes vary by factors such as cultural identity, and we are attempting to learn more about how, why, and what we can do to eliminate health disparities, including social and economic barriers to optimum care.[1] We are also closer to understanding differences in health-related behaviors, including risk-taking and health-seeking behaviors.[2,3] The papers which follow detail the importance of cultural identity and barriers to care for pediatric dental practices in several diverse cultural settings.

This paper outlines some concepts drawn from anthropology and related behavioral sciences, and from public health. These principles are intended to provide a framework for understanding and addressing cultural and socioeconomic environmental factors such as those described in detail in the accompanying articles. These concepts range from how we perceive human groups to how we understand and measure the factors that affect health and illness.

Recent attention to health disparities

While anthropologists have long drawn attention to variations in perceptions and behavior related to health and illness, the health professions only began to fully appreciate the importance of these when evidence of health disparities was identified. Recent national initiatives on health disparities include:

1. 1997 President's Initiative on Race;
2. 1998 Eliminating Racial and Ethnic Disparities in Health campaign;
3. Healthy People 2010;
4. 2000 Minority Health and Health Disparities Research and Education Act;
5. 2000 Oral Health in America: A Report of the Surgeon General.

Note that the word "race" appears in the earliest of these initiatives, but then words like "ethnicity," "culture," and "minorities" begin to appear. One of the confounders in looking at disparities is the lack of precise definitions of groups and the lack of agreement on who is affected. If disparities are taken to mean groups whose health risks and health outcomes are worse than those for other groups, irrespective of possible genetic causes, then from the epidemiological perspective, health disparities exist for ethnicity, social class, age, economic status, and gender.[3] Our ability to trace the etiology of health disparities is compounded by the fact that many of these categories overlap. A child may lack access to dental checkups both because of poverty and because he or she belongs to a cultural group where preventative oral health is not the norm (eg, because of misinformation and competing priorities for family time investments).

Identification of cultural groups

The health disparities were identified using tools and definitions which have now come under critical scrutiny, and deservedly so. Robert Hahn, an anthropologist working with Centers for Disease Control, has written extensively of the conflicting and changing definitions of ethnicity and race used by various agencies of the federal government.[4,5] Alan Goodman summarizes the view of most contemporary anthropologists, emphasizing that race is not biologically based, but instead is socially based with biological consequences.[6] We are trying to understand health behaviors and health disparities with a conflicting jumble of definitions of race, ethnicity, and culture. This makes it almost impossible to collect meaningful and comparable data.

As noted in the recent Institute of Medicine (IOM) report "Speaking of Health," diversity in the United States is culturally and socially constructed.[3] Discussions about race are based on perceived biological and physical differences that have little basis in contemporary genetics. On the other hand, ethnicity is based on common cultural experiences and values. The report discusses this dichotomy

in detail, and concludes that 2 distinct actions are needed. First, the concept of race and the rigid and inaccurate classifications of ethnicity did serve to identify health disparities and may need to continue to be used for comparative purposes.[3] Second, new ways of defining and understanding cultural groups need to be implemented.

The report critiques the view of culture that assumes that people's behavior is: (1) locked in by their culture on the basis that this assumption is incorrect; and (2) resented as stereotyping by many of the people so labeled.[3] Ethnic groups are not discrete clumps with neat boundaries. Each group has many "subgroups," which may be quite different from each other. For example, a Laotian living in Minnesota and a third-generation Japanese American in New York would both be classified as "Asian," yet have very different languages and cultures. Often, the region of the United States, rural/urban residence, and socioeconomic status are better predictors of health risks and health status than an ethnic category.

Culture can be a more accurate way of describing people than race, but the report suggests modifications to the way people's cultural identities are formed and measured. There are many definitions of culture, but basically they include shared ideas, meanings, and values that are socially learned, not genetically transmitted, and patterns of behavior that are guided by these shared ideas, meanings, and values. These are constantly being modified through "lived experiences," and often exist at an unconscious level.[3] Rather than existing rigidly in the same way across time, change and variation occur constantly within cultural group. These variations occur among individuals in the same setting, across generations, between genders, across geographic and rural urban settings, and so on.

As a counterpoint, much is shared across apparently diverse cultures, such as popular music and fast foods. Anthropologist Linda Garro suggests that to account for diversity within cultures and sharing across cultures, it is important to stop focusing on cultures as entities, and instead think in terms of the cultural processes through which enculturation, or the learning of one's culture, occurs. She notes that the concept of cultural processes allows us to highlight the connection between lived experience, learning, and sharing. By virtue of learning about, having membership in, or participating in social groups, individuals become exposed to ways of thinking about the world (or specific aspects of the world) and ways of acting and responding.

Culturally acquired knowledge may also reflect understandings gained through cultural products like books, television, and computers. The term cultural processes refers to these ways of learning which contribute to the way an individual thinks, feels, and acts. There are many potential sources of shared understanding—such as ethnicity, training in a specific occupation, education, age, religion, language, gender, and generation—that may provide a basis for social groupings within which these cultural processes unfold. Intracultural variation is expected because individuals participate in or are exposed to different cultural processes. Both individuals and groups are shaped by these cultural processes. Garro notes that a strength of the concept of cultural processes is that it allows us to see individuals as unique and complex but still very much exemplifying culture. It facilitates the understanding of the complexity of the multiple social and cultural influences that contribute to and shape who we are, what we do, and the way we live.[7,8]

Thus, we need to move to ways that measure individuals' cultural identities as shaped by their lived experiences. While much of the work of developing and validating such measures remains to be done, the field of medical anthropology does offer some assistance to the practitioner who is working in our multicultural society.

Medical anthropology

"If you wish to help a community improve its health, you must learn to think like the people of that community. Before asking a group of people to assume new health habits, it is wise to ascertain the existing habits, how these habits are linked to one another, what functions they perform, and what they mean to those who practice them."[9]

Medical anthropologists look at different cultures and their perspectives on disease and illness by examining the biological and the ecological aspects of disease, the cultural perspectives, and the ways in which cultures approach prevention and treatment.

To understand the cultural context of health, it is essential to work with several key definitions. First, the concepts of "insider" and "outsider" perspectives allow us to examine when we are seeing things from our point of view and when we are trying to understand someone else's view of things.[10] "Insider" ("emic" in anthropological terminology) refers to the culture as viewed from within. It refers to the meaning that people attach to things from their cultural perspective. The "outsider" perspective ("etic" in anthropology) refers to the same thing as seen from the outside. Rather than meaning, it conveys a structural approach, or something as seen without understanding its meaning for a culture. It can also convey an outsider's meaning attached to the same phenomenon. For example, in some cultures the "insider" view is that gold or jeweled inlays in teeth enhance beauty. From the "outsider" (modern dentistry) perspective, this practice damages the teeth and can invite decay.

The "insider-outsider" concept leads to another set of definitions. "Disease" is the outsider, usually the Western biomedical definition. It refers to an undesirable deviation from a measurable norm. Deviations in temperature, white cell count, red cell count, bone density, and many other factors are seen as indicators of disease. "Illness," on the other hand, means "not feeling well." Thus, it is a subjective, insider view. This sets up some immediate dissonances between the 2 views. It is possible to have an undesirable

Body Balances
Temperature: Hot, Cold
Energy
Blood: Loss of blood; Properties of blood reflect imbalance; Pollution from menstrual blood
Dislocation: Fallen fontanel
Organs: Swollen stomach; Heart; Uterus; Liver; Umbilicus; Others
Incompatibility of horoscopes

Supernatural
Bewitching; Evil eye
Demons; Offending god or gods
Spirit possession; Soul loss

Food
Hot, cold, heavy (rich), light
Spoiled foods
Dirty foods
Sweets
Raw foods
Combining the "wrong" foods (incompatible foods)
Mud

Emotional
Fright; Envy
Sorrow; Stress

Weather
Winds
Change of weather
Seasonal disbalance

Sexual
Sex with forbidden person
Overindulgence in sex

Vectors or Organisms
Worms; Parasites
Flies; Germs

Heredity

Old Age

Figure 1. Types of insider cultural explainations of disease causation.
Source: Scrimshaw SC. Culture, behavior, and health. In: Merson M, ed. International Public Health: Diseases, Programs, Systems and Policies. Gaithersburg, Md: Aspen Publishers; 2000.

Indigenous
Midwives
Shamans
Curers
Spiritualists
Witches
Sorcerers
Priests
Diviners
Herbalists
Bonesetters

Western Biomedical
Pharmacists
Nurse-midwives
Nurses
Nurse practitioners
Physicians
Dentists
Other health professionals

Pluralistic
Injectionists
Indigenous health workers
Western trained birth attendants
Traditional chemists/herbalist
Storekeepers and vendors

Other Medical Systems
Chinese medical system
- practitioners
- chemists/herbalists
- acupuncturists

Ayurvedic practitioners
Taoist priests

Figure 2. Types of healers.
Source: Scrimshaw SC. Culture, behavior, and health. In: Merson M, ed. International Public Health: Diseases, Programs, Systems and Policies. Gaithersburg, Md: Aspen Publishers; 2000.

deviation from a Western biomedical norm and to feel fine. Hypertension, early stages of cancer, HIV infection, and early stages of diabetes are all instances where people may feel well, but have a disease. This means that health care providers must communicate the need for behaviors to fix something that people may not realize is wrong.

It is also possible for someone to feel ill and for the Western biomedical system not to identify a disease. When this occurs, there is a tendency for Western-trained health care providers to say that nothing is wrong or that it is a "psychosomatic" problem. While both of these can be the case, there are several other explanations for this occurrence. One possibility is that Western biomedical science has not yet figured out how to measure something. Several recent examples of this include AIDS, generalized anxiety attacks, and chronic fatigue syndrome. All of these were labeled psychosomatic at one time, and now have measurable deviations from a biological norm. Similarly, painful menstruation used to be labeled "subconscious rejection of femininity," but is now associated with elevated prostaglandin levels and can be helped by a prostaglandin inhibitor.

Another possibility is something that anthropologists have called "culture-bound syndromes," but which might be better described as "culturally defined syndromes."[11] Culturally defined syndromes are an "insider" way of describing and attributing a set of symptoms. They often refer to symptoms of a mental or psychological problem, but a physiological disease may exist, posing a challenge to the health practitioner. For example, temporomandibular joint disorder may be described as having a "bewitching" cause. With culturally defined syndromes, it is important to ask about the symptoms associated with the illness, and to proceed with diagnosis and treatment on the basis of those symptoms.

Cultural views of health and illness

"Failure to understand the different lifestyles, including logic in behavior, naming systems, dress, diet, ideas about diseases, modesty, and personal hygiene, can lead to irritation.Hence, they become regarded as 'problem patients.' Effective patient care demands the understanding of ethnic identity and related concepts of illness. Dentists, thus, require social and cultural skills as well as scientific and technical capabilities."[12]

Cultures vary in their definitions of health and illness. A condition that is endemic in a population may be seen as normal, and may not be defined as illness. For example, in rural Latin America, people expect to loose their teeth beginning in early adulthood, and view a toothless old age as normal. Persuading people to begin preventive dental care in young children is a difficult task under these circumstances.

Types of insider cultural explanations of disease causation found in the literature for many cultures can be summarized in a recent chapter entitled Culture, Behavior, and Health.[13] While the chapter should be referenced for more detailed discussion, 3 summary tables are reproduced here. Figure 1 classifies the various causes of disease from the insider perspective. Figure 2 lists types of practitioners. While the chapter was written for a book on international health, the cultures represented in it can all be found in the United States. It is important to note that

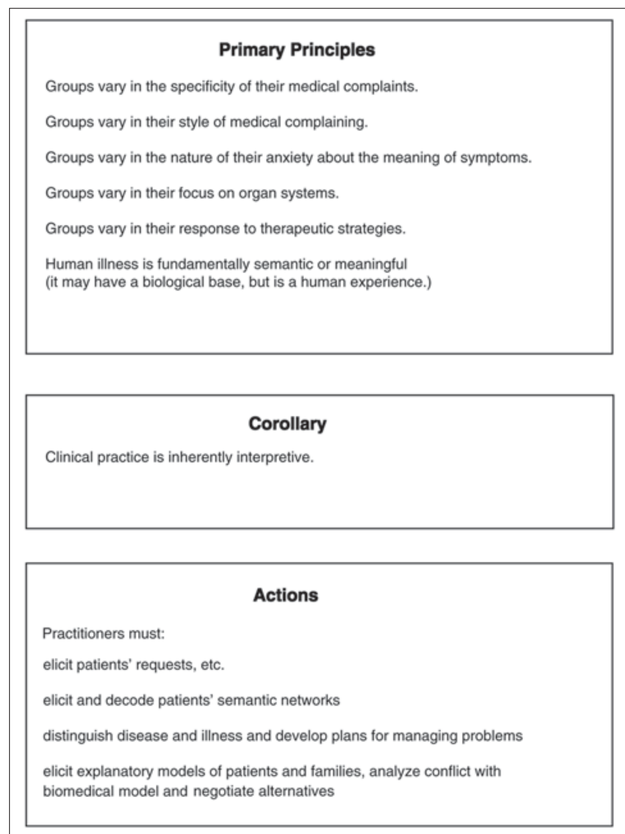

Figure 3. Meaning-centered approach to clinical practice.
Source: Scrimshaw SC. Culture, behavior & health. In: Merson M, ed. *International Public Health: Diseases, Programs, Systems and Policies.* Gaithersburg, Md: Aspen Publishers; 2000.

not all causes or all types of practitioners listed are found in all cultures. Also, individuals will vary in their belief systems. Because of this, Figure 3 is important.

Figure 3 is based on the work of Good and Good.[14] It lists some basic principles about cultural groups' approaches to defining health and illness, then suggests a line of questioning to elicit individual patient's beliefs and behaviors.[13] While this has yet to be adapted to oral health, it should be useful in helping to determine beliefs that facilitate or complicate the delivery of pediatric oral health care.

There is an emerging literature on cultural diversity and oral health.[15-18] In addition to cultural factors, several barriers to accessing quality dental health are noted in the literature.[16,19-22] These barriers include:

1. the cost of services;
2. lack of dental/health insurance and communication problems between the dentist and the patient, which may include language barriers;
3. transportation needs, especially for those in rural communities;
4. patients' negative image of the dentist (ie, the one who inflicts pain);
5. cultural issues (beliefs about oral health, concerns about access, etc).

In general, the articles conclude that ethnic minorities (either living in the United States or Great Britain) have poorer oral health compared to Caucasians. The ethnic minorities visit the dentist less. In comparing low SES groups vs higher SES, the articles also mention that the low SES groups fare worse in dental health.

Conclusions

Dentistry has long been more focused on patient attitudes and comfort than many of the other health sciences, in part because of the need to encourage people to practice prevention. There is now an emerging literature on cultural issues in oral health, including a few studies focusing on pediatric dentistry. The concepts and constructs from anthropology presented here are intended to inform and assist pediatric dentists and researchers in better accessing cultural issues. The papers which follow present some detailed examples for several cultures. Practice based on information like this can lead to improved access to care and improved preventative behaviors for children and their families in the diverse cultural groups found in our society today.

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