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A pilot investigation into the definition of cultural competence of dental health professionals in a Trinidad context

By

[1]William A. J. Smith and [2]*Lynn G. Beck*
[1]Lecturer, Conservative Dentistry, School of Dentistry, The University of the West Indies, Faculty of Medical Sciences, St. Augustine
[2]Dean, Gladys L. Benerd School of Education, The University of the Pacific

Abstract

Accreditation bodies in the United States, Europe and the Caribbean mandate have developed standards relating to cultural competence and the impact of culture on the provision or oral health care. The population and culture of Trinidad is diverse and dissimilar to the United States and Europe. The purpose of this study is to define what cultural competence means in a Trinidad context. Semi-structured elite interviews were conducted by one author of three persons from each of the following groups: dental academics, dental clinicians, Catholics, Hindus, Muslims and Protestants. Trinidadians were generally categorized as 'easy-going' and forgiving of errors in cultural competence. Communication and the ability to put the patient at ease were considered important skills. Knowledge of the various religions was considered to be important especially as it related to their diets- especially during religious festivals and their preferences for the treatment of females. The role of the extended family was identified as being important in history taking and in the management of paediactric patients. Aside from the knowledge specific to Trinidad, the introduction of cultural competence training may be guided by the publications and guidelines of the American Association of Medical Colleges.

Keywords: *Culture, Cultural competence, Trinidad and Tobago, Religion, Dental Education, Race, Accreditation*

1. Introduction

The accreditation bodies for undergraduate dental programs in the United States and Europe refer to cultural sensitivity and cultural awareness as one of the competencies that are necessary for the graduating dentist (C.O.D.A., 2010, pp. 1-37; Cowpe, Plasschaert, Harzer, Vinkka-Puhakka, & Walmsley, 2010, pp. 193-202)This requirement is in recognition that, increasingly, dentists need to develop skills in dealing with a more diverse patient population.(Gregorczyk & Bailit, 2008)Further, the graduating dentist has to be aware of the impact of culture on access to and delivery of oral health care. The medical and nursing professions also recognise the importance of cultural sensitivity in the delivery of health care. The impact of culture on health and disparities of health care access and provision are well documented. (Baldwin, 2003; Karpati, Galea, Awerbuch, & Levins, 2002)

The Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP) developed standards related to cultural competence and cultural sensitivity that are remarkably similar to the US and European standards. These standards speak to the contribution that culture brings to the understanding of clinical problems, multicultural access to oral health care, the way different cultures perceive health and illness and practitioners' cultural biases in the process of health care delivery. (C.A.A.M.-H.P., 2012)

The 1.2 million population of the twin-island Republic of Trinidad and Tobago is cosmopolitan, multi-ethnic and multi-religious.The population is descended from East Indian, African, Spanish, Dutch, American, Chinese, Syrian and English and get along in relative harmony(Ewbank, 2011). The main ethnic groups are Indian (South Asian) 40%, African 37.5%, mixed 20.5%, and others 1.2%(C.S.O., 2000). The University of the West Indies School of Dentistry is located in Trinidad - the larger of the two islands.

Religion plays a visible role in Trinidad and Tobago culture with national holidays commemorating festivals of the Christian, Hindu, Muslim and Spiritual Shouter Baptist religions, national 'days of prayer' and an active interreligious organization(I.R.O.T.T., 2012). The main religious groups are Roman Catholic 26%, Protestant 25.8% (Anglican 7.8%, Baptist 7.2%, Pentecostal 6.8%, Seventh-Day Adventist 4%), Hindu 22.5%, Muslim 5.8%, other Christian 5.8%, other 10.8%, unspecified 1.4% and none 1.9%(C.S.O., 2000). Although the society is secular, these festivals are celebrated at schools, universities, private and public sector workplaces. The extent to which 'divine intervention' shapes perceptions is best identifies through local lore which dictates that whenever the island is spared the effects of hurricanes or earthquakes or other natural disasters, the explanation usually offered by the islanders is 'God is a Trini.'

The patient population of the dental school roughly reflects the ethnic makeup of the general population of Trinidad and are in the main of the lower socioeconomic group (unpublished data). The students are also a diverse population comprising multiple ethnicities and nationalities. The staff of the dental school in Trinidad is similarly diverse in ethnicity and nationality.

The Trinidad dental school's students, staffand patients do not have the same ethnic profile as those in the U.S. and Europe. Indeed, it is quite the reverse: the numbers of Caucasian faculty, students and patients are quite low. This is simply due to the populations from which the university hires its academics, admits its students and the patient population that the university serves.In the undergraduate dental school cohort, the number of female undergraduates far exceeds the number of males. This is a reflection of a national trend in University admissions in Trinidad(U.W.I., 2011).Cultural competence of the graduates of the University in Trinidad therefore must be examined in a different context - the Trinidad context.

Aim and Objectives

The purpose of this study is to define what cultural competence means fordental health professionals' interaction with patients in a Trinidad context.
The questions to be addressed are:

1. How do dental educators and non-dental educators understand and define cultural competence for dental professionals in Trinidad? What specific knowledge, skills and understandings do they associate with this phenomenon?

2. How do leaders of different cultural/religious groups understand and define cultural competence for dental professionals in Trinidad? What specific knowledge skills and understandings do they associate with this phenomenon?

3. How do the definitions of cultural competence of the above groups align with and support or challenge prevailing ways of understanding cultural competence for dental professionals?

2. Method

A series of semi-structured elite interviews were conducted to elicit opinions on cultural sensitivity and cultural competence in the context of oral health care delivery. One author conducted all the interviews and a digital audio recording as well as written notes weremade. The elite interview methodology was considered most appropriate for this study since it allows for the deeper exploration of the motivations and attitudes that shape the initial responses of the research subject. Interviewing allows the researcher to know what a set of people think, or how they interpret an event or series of events.(Aberbach & Rockman, 2002)In a review of the use of elite interviews, Kezar(Kezar, 2003) states that 'within an ethnographic perspective (researchers) use elite interviews to develop a fuller picture of multiple realities and to try to develop the most complex picture as possible.' She goes on to summarize a number of studies that conclude that 'people in positions of authority might have different perspectives, this it is important to understand their viewpoints to more fully understand the social world.'(Kezar, 2003)

The group of interviewees was comprised of three dental academics, three non-dental academics, three dental clinicians, three Catholics, three Protestants, three Muslims and three Hindus all based in Trinidad. The twenty-one interviews were conducted individually. The study purpose was explained to each interviewee, and assurance of anonymity was given. Written consent wasobtained from each interviewee to use the information in an aggregate manner for the purpose of publication. The interview generally followed the outline specified (attached). The selected interviewees were not meant to reflect a representative sample of the population of Trinidad, but rather to elicit a broad base of opinion from 'elites' that can speak to specific cultural issues, educational issues and issues related to the delivery of oral health care.

The interview responses werecoded and classified into manifest, latent and global coding items(Aberbach & Rockman, 2002). They were subsequently clustered into themes which were analysed to detect the emerging definitions of the topic.

3. Results

The definition of Culture in a Trinidad Context

The interviewees had a wide range of responses for the definition of culture. One interviewee stated that 'The culture of Trinidad is very complex and is influenced by class, race, religion and politics.' Other interviewees spoke of dance, art, poetry, food and religion as elements of culture. Others still, mentioned value and belief systems. One respondentdefined culture as the way a society structures its families and its communities. He also stated that culture is perceived by one's experiences and background. He described culture as a 'lens' through which one views his communities and country. He drew the example of himself – that he viewed the culture of the country through a religious lens as he was a religious leader.

One respondent remarked that the history of Trinidad and Tobago had no religious or other wars indigenous to the islands and as such, there was no historical animosity that grew out of any such disputes. European colonization, African slavery, East Indian indentureship and immigration created disparate groups of people on the islands. He remarked that 'we all ended up here from various origins and had to figure out a way to live together.'

One interviewee noted that culture is never a static thing- that it changes over time. It was also stated that the improvement and immediacy of communication among people of varying cultures across the world has an impact on the country's culture. He observed that these new forms of instant communication actually have their own culture.

The definition of Cultural Competence

Generally, the interviewees were unfamiliar with the term cultural competence and, hence, did not have an immediate definition to offer. When asked what he understood by the term cultural competence, one dentist answered 'no clue.'Most respondents agreed that it was a difficult concept to define. Some respondents stated thatcultural competence is contextual: a person might be considered culturally competent in one country but may not be in another.

A prerequisite to cultural competence was knowledge of the cultural practices of the country/ community/hospital or office where one works.Everyone agreed that there should be knowledge of the different races, language and religions in Trinidad and how these may impact on the day to day living and by extension - oral health care.

A common theme that emerged from all the interviews was that the key element of cultural competence was communication.One respondent observed that 'no matter what level of health care is delivered, if the

communication is poor- the patient has a bad experience. There is very little focus on this in medical/dental school training.' Another academician remarked that 'you cannot teach students everything about culture and communication, but you have to make them aware of its presence.' One respondent said that an element of cultural competence was the skill of being able to quickly analyse a situation that you are in and communicate effectively in that situation. Being able to recognize when a mistake is made and to apologize for that mistake was alsoconsidered to be important.

Other elements of cultural competence that emerged were that of empathy, understanding and respect.
There was disagreement on whether the interviewees thought that Trinidadians were inherently culturally competent. There were strong views on both sides. All of the non-Trinidadian interviewees thought that Trinidadians were naturally culturally competent. They based this opinion when comparing themselves growing up in their homeland to their children growing up in Trinidad. Their children, they said, were exposed to a lot more diversity in culture than they were and thought them to be more culturally aware.

There seemed to be an agreement that there are elements of national behaviour that suggests a broadly held 'culture' that all Trinidadians shared – e.g. theirtolerance for running late, their tendency to look for humour in discussing serious matters and the Trinidadian creole language. However, their knowledge about the subcultures might be limited. Some expressed the opinion that Trinidadians have an awareness of different subcultures and the visible aspects of the culture- e.g. Islamic dress, flags outside Hindu homes, deyas, mosques and temples. They participate in the religious and historical festivals. They enjoy the different foods.However, they do not have a deep understanding of the historical basis for the diversity or the meaning of the religious practices.'There is a broad tolerance, and respect for how people are, but not fully understanding what it means, nor do they consider it is important to have that knowledge,' remarked one interviewee.

Everyone agreed that there was limited exposure to, knowledge of and skills related to managing patients who speak a different language. It was also observed that dental students, for whom English was not their first language, were perceived as incompetent by some of their patients. This was due to the fact that there was a pause in their communication when these students were translating the English into their native language. The pause was perceived as hesitance and interpreted as incompetence by the patient.

TheKnowledge, Skills, and Attitudes that Dentists ought to have
The overall impression about patients from Trinidad was that they were generally an easy-going group of people and may easily forgive errors in cultural competence. There was general agreement that cultural competence is dependent on the country/community/clinic where one works. There was also agreement that cultural competence is a lifelong learning experience.

All interviewees stressed the importance of having a dentist that is interested in them as a in person as well as a patient. They all expressed the need for a dentist to be able to 'chat' and know the patient beyond the clinical problem they came to manage.

The diets of the various cultural groups and the variability of the diet around religious and national festivals was knowledge that dentists thought to be important. The diet of Hindus, Muslims and vegetarians was also considered useful knowledge for a dental professional.

Islamic religious leaders as well as other dentists stated that the culturally competent dentist ought to be aware of the specific needs of the Muslim female patient who is dressed in a hijab. They ought to know that the female practising Islam would have an inherent shyness (Haya) and she would prefer to be examined by a female practitioner if at all possible. However, if there is no female dentist available, Islam allows for her to be examined by a male dentist. Muslim interviewees thought that the dentist ought to have knowledge of drugs that might use alcohol or animal products as coatings or ingredients. The dentist also should know that patients who practice Islam should not have any grafts derived from human tissue.

They also suggested that knowledge of the basic tenets of Islam might help a dentist understand his patients more (e.g. fasting during Ramadan, prayer 5 times a day and the Haj pilgrimage}.

Hindu females- especially older females - might be shy about talking about medical problems. The culturally competent dentist ought to know that they might need to address a family member – preferably a female family member – to elicit a complete medical history.

Knowledge of the role of the extended family is an important factor in dealing with Trinidadian patients. Children, for example, often spend a lot of time with (and in some instances raised by) grandparents, aunts and uncles. Therefore, management of a child's oral health care might involve educating the complete family and not just the parent. This was thought to be have more relevance in Indian families.
No particular disease patterns could be distinguished between the various cultural groups in Trinidad.

The dentist ought to be able to communicate effectively with the individual patient or with a family member when obtaining a history. The culturally competent dentist ought to be able to recognize when an error in communication has been made and very quickly be able to apologize for that mistake. It was believed that the establishment of a good patient rapport would aid in this skill.

The interviewees all mentioned that all patients should be treated equally and fairly without bias.The dentist ought to be able to recognize his/her own biases and not let it influence patient management. The dentist needs self awareness and continuous critical reflection on their own attitudes and behaviours in the area of culture.

One dentist remarked that 'teeth have no culture – they need to be treated regardless of culture.' He went on to say that a patient's culture should not influence the treatments that are proposed to him/her. There was general agreement that it was important for the dentist to present all the available treatment options to patients and not customize the treatment based on what the practitioner assumes that the patient would accept.

4. Discussion

The literature is replete with definitions of culture(A.A.M.C., 2005). The definition of culture in a Trinidad context varied little from what has been written. One unique idea expressed was that culture depends on the lens one wears to interpret their community/country. However, there was no overall consensus as to what constituted culture based on the responses.This is to be expected given the diversity of ethnicity and religion in the island.

The interviewees' definition of cultural competence seemed to centreon the dentist's ability to communicate. They also indicated that foundation knowledge of the main tenets of the culture of the organization/community/country was an important prerequisite. Not much has been written about cultural competence from a dental perspective. Much of the work on cultural competence comes from publications of The Association of American Medical Colleges (AAMC). The AAMC defines cultural competence as 'a set of behaviours, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations(A.A.M.C., 2005).' This definition is broader than what was discussed with the interviewees. This could possibly be due to the fact that the interviewees themselves might not be culturally sensitive or were never exposed to any training in cultural sensitivity. Also, because the group of interviewees all lived and worked in the multicultural Trinidad society, they may have never considered the knowledge and skills necessary for working in other cross-cultural situations.

The CAAM-HP mandates that the faculty and students of Dental Schools in the Caribbean 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.'This objective is identical to the AAMC Liaison Committee on Medical Education standards on cross cultural curriculum and students' learning outcomes(Gregorczyk & Bailit, 2008).

The CAAM-HP accreditation body requires that dental schools must be able to provide documentation of 'objectives relating to the development of skills in cultural matters, knowledge of international codes of professional conduct, and demonstrate the extent to which the objectives are being achieved.'(C.O.D.A., 2010)However, they have not provided any guidance on what those objectives should be. The AAMC developed a 'Tool for Assessing Cultural Competence Training'(A.A.M.C., 2012) to guide U.S. dental schools in introducing cultural competence training into their curricula to meet the AAMC accreditation standard. The dental school in Trinidad may find this tool useful in introducing formal training in cultural competence training into its curriculum.

In a 2005 survey of U.S. Dental Schools, 82% stated that they did not offer a specific stand-alone course in cultural competency but instead had objectives embedded into multiple courses(Rowland, Bean, & Casamassimo, 2006). The literature refers to studies that examine students' perception of the adequacy of their cultural competence training (Hewlett et al., 2007; Rowland et al., 2006; Wagner et al., 2008) but does not refer to objective measurements of it. The dental education community does not have a widely accepted instrument to measure cultural competence. Grezorczyk and Bailit discuss various approaches to evaluating the impact of cultural competency training on student knowledge and categorized them into four categories: qualitative, quantitative, practical and self-evaluation(Gregorczyk & Bailit, 2008). They refer to a number of instruments that assess cultural competence in a U.S. context(E.R.C., 2012; H.R.S.A., 2004; N.C.C.C., 2012). There is scope for the development of instruments that measure cultural competence in a Trinidad or Caribbean context.

The interviewees felt that Trinidadian patients are forgiving in errors of cultural competence. They are aware of cultural differences, are tolerant of them and do not perceive them as threatening. Using the Milton Bennett Model of 'development of intercultural sensitivity' Trinidadians may be positioned between the ethnocentric stage of 'minimization' and the ethnorelative stage of 'acceptance'of cultural awareness(Paige, 1993). In general, dental practitioners may find it easy to treat this population of patients. Even in this accepting culture, dentists who treat patients who practice Islam will require specialized knowledge of the religion – especially with regards to the treatment of Islamic females and the use of drugs and other dental materials. The diet of the various cultural groups is also considered important knowledge especially when providing patients with dietary advice related to their oral health.Further,Islamic females – aswell as older Hindu females may be shy when talking about their medical problems. A complete medical history may require consultation with the extended family. The extended family is an important entity to engage when planning the oral health care – especially of a child because of the nature of the closeness of the Hindu and Indian families.

The 2000 report of the U.S. Surgeon General on 'Oral Health in America' provides evidence of evidence of disparities in oral health care based on race, culture and ethnicity(Formicola, Stavisky, & Lewy, 2003). In contrast, there were no specific oral disease patterns or disparities in oral health care that could be discerned among the various cultural groups in Trinidad by the respondents.This might be an area that has not been fully investigated.

5. Conclusion

The culture of Trinidadis diverse and its population is multi-ethnic and multi religious. In this context, cultural competence is judged by the knowledge of the various religious restrictions on the delivery of oral health care, and the dietary practices and family structures of the various communities.

Communication was thought to be the most important skill to deliver oral health care in a culturally competent manner. The population has a broad tolerance and respect for all the subcultures of the islands and is generally forgiving of cultural competence errors made by dental practitioners.

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