

## Putting the Patient First: Topics in Cultural Competency



# Cultural Diversity and its Role in Reducing Oral Health Disparities

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### **Abstract**

African-American, Hispanic and Native-American/Alaskan Native dental students and professionals are often referred to as underrepresented minorities (URMs) because of their poor representation in the profession compared to their proportion in the U.S. population. Disparities in oral health services may, in part, be attributable to minority and economically disadvantaged patients' lack of confidence in the dental profession's ability to provide care in a culturally sensitive manner. Increasing diversity within the oral health workforce is one way to address this perception. However, an effective remedy will require all oral health professionals to devote additional attention to diversity and cultural competency issues.

THIS MANUSCRIPT reviews the existing literature indicating that increasing diversity within the oral health care workforce is worthy of the profession's continued attention. Current and projected

future demographic profiles of the U.S. and the oral health care workforce present a compelling case for the forecast that the oral health profession will be unprepared for an increasingly diverse patient population unless there is effective action to bolster the diversity of its workforce.<sup>1-3</sup>

The lack of a viable plan to increase diversity in the workforce will likely exacerbate existing oral health disparities affecting minority and economically disadvantaged populations. The recruitment of additional underrepresented minorities (URMs), namely, African-American, Hispanic and Native-American/Alaskan Native oral health professionals, is one obvious approach to addressing the issue of oral health disparities. Nevertheless, a comprehensive solution cannot be attained without the active participation and commitment of all dental professionals and oral health stakeholders.

The racial/ethnic composition of the health professions workforce, including the dental workforce, fails to reflect the increasing diversity of the U.S. population. As of the 2000 Census, African-Americans, Hispanics and Native Americans/Alaskan Natives comprised 12.3%, 12.5% and 0.9% of the U.S. population, respectively, for a total of more than one-quarter of the U.S. population.<sup>4</sup> However, recent data published in the Sullivan Commission's "Missing Persons: Minorities in the Health Professions" report indi-

cate that these groups comprise only 5% of dentists, 6% of physicians and 9% of nurses.<sup>5</sup>

Nevertheless, indicators of the future of diversity within the oral health care workforce paint a dismal portrait. In 2003-2004, African-Americans, Hispanics and Native Americans/Alaskan Natives represented only 5.4%, 5.9% and 0.4%, respectively, of predoctoral dental students. If steps are not taken to remedy these disparities, projected changes within the U.S. population (resulting in URM comprising 40% of the nation by 2050)<sup>6</sup> will render the existing misrepresentations even more glaring. This will be particularly true in heavily populated, diverse states such as New York, whose population already consisted of 31.4% URM group members in the 2000 Census.<sup>4</sup>

### **Shortages and Substandard Care**

The discrepancy between minority representation in the general population and in the oral health workforce is a challenging issue in its own right. In addition, this discrepancy contributes to the documented substandard health care received by impoverished populations and racial/ethnic minorities. In 2000, the Surgeon General's report on our nation's oral health<sup>7</sup> highlighted that approximately 25 million individuals resided in Health Professional Shortage Areas (HPSAs) and, therefore, had limited access to quality health care. A year later, the American Dental Education Association's (ADEA) "Trends in Dentistry and Dental Education" report<sup>6</sup> indicated that more than 31.4 million individuals were living in 1,480 HPSAs, a nearly 100% increase in the number of shortage areas since 1990 (from 780 to 1,480).

Members of racial/ethnic minority groups represent a disproportionate number of the individuals residing in HPSAs and, therefore, are unduly affected by the emotional, financial and physical consequences of poor oral health.<sup>7,8</sup> Compounding this issue is the frequent association of lower socioeconomic status with status as a member of a minority group. As highlighted in the ADEA's position paper addressing the roles and responsibilities of academic dental institutions in improving the oral health of all Americans, health care services are inappropriately treated as "marketplace commodities" in the U.S., with those unable to pay having less access to quality resources.<sup>9</sup> Consequently, low-income minority patients bear the brunt of poor oral health, receive lower quality health care, and are less likely to receive routine care than their more affluent, white counterparts.<sup>7,9</sup>

The absence of a sound patient-provider relationship is one factor contributing to the disparity in the quality of care received by underserved populations, returning us to the issue of diversity in the health care workforce. Several publications have demonstrated the importance of a racially diverse workforce to the quality of care provided to minority and low-income groups. Specifically, increased diversity of the workforce has been associated with improved access to care, satisfaction with care received and communication between patients and providers,<sup>1,3,8</sup> while the lack of a diverse workforce has been suggested to foster lingual and cultural barriers, bias and clinical uncertainty within the patient-provider relationship.<sup>8,10</sup>



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### **Minorities Take the Lead**

URM professionals have historically taken the lead in providing care for underserved populations. It has been repeatedly shown that URM health professionals are more likely to practice in underserved areas than their non-URM colleagues.<sup>5,11,12</sup> Specifically, according to the Sullivan Commission's report, black patients are significantly more likely to receive their care from black dentists (who treat almost 62% of black patients) than white dentists (who treat 10.5% of these patients).

Similarly, in surveys of practice trends among dentists, Solomon et al.<sup>11</sup> and Brown et al.<sup>12</sup> reported that URM dentists serve significantly higher proportions of patients characterized as urban, having less formal education and belonging to lower socioeconomic classes. If the ADEA's most recent survey of graduating seniors is an indication, this trend of URM health professionals shouldering the majority of care provision for underserved populations is likely to continue unless there is an active intervention.

Among the newest entrants into the oral health profession, blacks were significantly more likely to expect to encounter underserved patients as more than half of their patient loads. These students also tended to place a higher premium on "the opportunity to serve vulnerable and low-income populations" and to view low-income individuals less negatively as potential patients than their white counterparts.<sup>13</sup> With underrepresentation of minorities in the workforce, and inadequate training of health professionals in cultural competency issues, patients who receive the least adequate care will continue to experience undue difficulty identifying a provider who is willing and able to effectively address their needs. Under these conditions, it is easy to imagine the unacceptable persistence and even worsening of oral health disparities.

## Enlarging the Applicant Pool

Increasing the representation of URMs in the nation's dental schools is a challenging yet critical necessity for addressing oral health care disparities. Exposure of URMs to the oral health profession and continued dedication to their success as health professionals are key elements needed to accomplish this goal. Increasing exposure can occur at several levels, including continuing to improve the identification and enrichment of potential URM students at the K-12 and undergraduate stages of their education.<sup>1-3,9</sup> Two model programs that exemplify this principle are the New York State-funded Science & Technology Entry Program (STEP)<sup>14</sup> and the national Summer Medical & Dental Education Program (SMDEP)<sup>15</sup> funded by the Robert Wood Johnson Foundation.

The STEP exposes economically disadvantaged URM middle and high school students to the sciences, while the SMDEP provides an intensive, six-week enrichment experience to premedical and pre-dental undergraduate college students.

As early identification measures, the STEP and SMDEP initiatives work to increase the pool of quality URM applicants (a challenging task in its own right, as this pool has not increased significantly in the past decade),<sup>9</sup> a step that must be taken to ensure the enrollment and successful integration of URMs in dental schools around the country. This will provide an additional challenge, as most URM students tend to matriculate at a relatively small number of dental schools.<sup>5,16</sup>

Increased enrollment of URM dental students will not be the final hurdle, however, as retention efforts will be required to address the financial, academic and psychosocial factors that may impede these students' success in the pursuit of a dentistry career.<sup>1,17-19</sup>

The ADEA has called all academic dental institutions to action, placing issues of disparate access to oral health care at the feet of current and future professionals of all races and ethnicities. Over the past 40 years, steps have been taken to address diversity in the health professions. Recommendations for further actions at the policy, institutional and provider levels include collaborations with outside agencies (including less-thought-of collaborators such as the National Congress of Black Churches, NAACP and Congressional Hispanic Caucus),<sup>1,2,9</sup> restructuring of health care systems (to, for example, ensure timely reimbursement and reduce undue interference with clinical decision-making),<sup>2</sup> modifying admissions procedures for health professions schools (including balancing the influence of qualitative and quantitative factors on admissions decisions),<sup>1,3</sup> and improving current dental school curricula (including the consistent inclusion of diversity issues, early clinical experiences in community settings and encouragement of careers involving care of the underserved).<sup>9</sup> These measures will likely reduce existing disparities while strengthening the training and resultant skills of oral health professionals, a beneficial situation for all patients and providers regardless of race or ethnicity.<sup>1,3</sup> Further, measures to ensure accountability, such as the inclusion of diversity criteria in accreditation procedures, will help guarantee a sustained commitment to diversity initiatives.<sup>1</sup>

## Conclusion

With the above recommendations in mind, oral health professionals must work in concert with all interested stakeholders to increase minority representation in the health care workforce and reduce disparities in the quality of oral health care received by racial/ethnic minority and economically disadvantaged patients.

As we look to the future, which will be marked by rapid changes in the demographic landscape of our nation, oral health professionals must commit individually and collectively to diversifying the oral health care workforce.

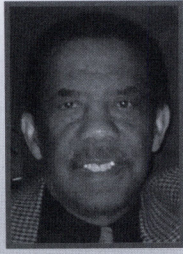
As described above, much work has been done to illuminate and address existing oral health disparities. Yet, there is still much to be done. The dental profession holds the promotion of the common good and the maintenance of public trust as important values; the provision of quality oral health care to all is, therefore, a social and moral imperative<sup>2,9</sup> that all oral health professionals must consistently and proactively strive to achieve. ■

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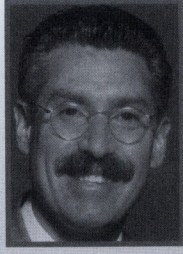
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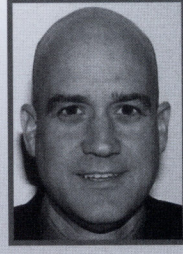
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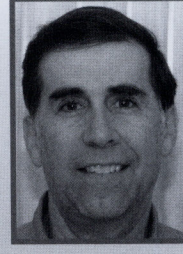
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### **Unusual Radiographic Presentations**

#### **Report of Five Cases**

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