# ORAL HEALTH CARE IN A CHANGING WORLD

HIGHLY ESTEEMED RECTOR MAGNIFICUS,
HONOURABLE DEANS AND DIRECTORS,
DEAR COLLEAGUES AND FRIENDS,
LADIES AND GENTLEMEN,

Let me start by thanking the University of Granada and my Spanish colleagues, especially my padrone Professor Miguel Gonzales-Moles, for the honour bestowed upon me, a welcome addition to honours from UK, Greece, Finland and South Africa, and quite unwarranted, since the immense pleasure I have had working with friends in Spain and elsewhere in the world, is more than adequate recompense. We work of course, increasingly in a multicultural society.

In most parts of the world, society, culture and lifestyles are changing. Healthcare workers including dentists and other dental care professionals may work in countries foreign to them, or provide care to refugees or other patients who have immigrated into their country of work.

History shows centuries of conflict and movement of populations in many, if not most parts, of the world. Colonization and the subsequent decolonization; wars, natural disasters; competition for limited resources; and the natural desire of human beings to explore new worlds, has resulted in enormous changes, especially in the last and this century. The world is also shrinking with globalization following the tremendous technological advances facilitating travel and communication.

Most countries, in particular the so called developed countries, are thus becoming increasingly culturally, ethnically and racially diverse, and this trend is certain to continue and probably to escalate. The many diverse people of the world are thus now widely distributed throughout the different countries of the world, living in either fully integrated or multicultural societies. Similarly,

people travel widely for education and pleasure, with increasing exposure to other cultures.

Few places in the world are as religiously, ethnically and culturally diverse as UK. For example, in London, about 300 languages are spoken, and more than 1 in 3 of the population are from minority ethnic populations. Our experience in London and other UK centres, teaching and working with colleagues from a multitude of backgrounds, and by time working abroad in Australasia, Continental Europe, the Middle East, Asia, North America, Scandinavia, the Caribbean and South America, and our establishment of a transcultural centre and research in London collaborating with many Universities from overseas, particularly Brazil, Finland, Greece, Japan, Spain and Turkey, has made us even more aware of culture. All this has made us particularly aware of the need for formal guidance for dentists and dental care professionals in this field. This need extends to the dentists and indeed all healthcare workers who themselves come from many different cultures. Now in the UK, there are more new registered dentists who have qualified overseas than there are those who have qualified in the UK and, furthermore, many of the latter are not of Anglo-Saxon British culture. Many are of Asian origin.

Culture is a term used to refer to shared patterns, meanings and behaviors of a social group. Understanding and respecting the differing cultures, religions, ethnicities and values within society is increasingly recognized as critical to good quality healthcare provision. Some healthcare providers have been tardy in appreciating the importance and the improved quality of care that comes from patient-centred care. Each patient is of course, an individual with personal views about their illness and health-views which may not always concur with those of the HCP. Patients have personal wishes, needs and concerns that demand the understanding and respect of the healthcare providers. Patients increasingly and rightly expect to be offered choice not just about when and where they receive treatment, but also about what kind of treatment they receive, how it will be delivered and by whom. Extending choice is particularly important in responding to the needs and preferences of an increasingly diverse population.  At the same time, it is increasingly

recognised that involving patients as full partners in decisions about treatment leads to better health outcomes.

Many studies have shown that patients' attitudes to the benefits and risks from treatment, and the extent to which they find adverse effects tolerable, can differ markedly from assumptions made by healthcare providers, and yet patients' beliefs and views are key influences as to whether and how they accept treatment. Patients are generally much more likely to follow treatment if their views and preferences have been recognised and taken into account, and if they have been active partners in the decisions. Client-centered, contemporary dental practice will be realized only if clinicians are equipped to interact with and provide care for clients of varied cultures or cultural backgrounds.

The knowledge base to be culturally sensitive to all the different peoples is enormous and lists of cultural traits and religious customs and beliefs can help but inevitably give a very false impression of uniformity. Thus, it is crucial to remember that there is considerable variation within every cultural and religious group and to avoid stereotyping. Guidance applies only to certain patients and is not a recipe for all solutions and is simply a starting point for individualizing dental healthcare. Individual's views, practices, needs and wishes vary widely and can be influenced by religion, ethnicity, educational, socioeconomic, acculturational and other factors.
*Culture* (Latin *colere*; to inhabit, to cultivate, or to honour), is a term that refers to patterns of human activity and the symbolic structures that give such activity significance. Culture can be seen as consisting of three elements:

- Values; which comprise ideas about what in life seems important, guide the rest of the culture.
- Norms; consist of expectations of how people should behave in different situations. Each culture has different methods, *sanctions*, of enforcing its norms, which vary with their importance. Norms that a society enforces formally have the status of *laws*.

- Artifacts; are things, or material culture which derive from the culture's values and norms.

*Cultural differences* are based on combinations of the above three elements but, apart from religion, a key difference between non-Anglo-American and Anglo-American cultures is that the latter stress the independence of the individual while the former emphasize the individual's dependence on the family. This has many implications for healthcare.
*Cultures are often based on some sort of religion* or faith, or similar basis developed for inculcating and preserving established or "correct" cultural behavior. Groups of immigrants, exiles, or minorities often also form cultural associations or clubs to preserve their own cultural roots in the face of a surrounding (generally more locally-dominant) culture.
*Cultural changes can and do occur* – particularly due to the environment (including education and socioeconomic status), to inventions (and other internal influences), and to contact with other cultures. When this affects an individual or groups of people, it is often termed "acculturation". *The health manifestations of culture are significant and determine patient behaviors*.
Immigration is not a new phenomenon and is unlikely to cease. Migrants from diverse social, economic and educational backgrounds arrive and have arrived for centuries in other countries for a variety of reasons. Many are refugees fleeing war, political upheaval, persecution, natural disasters or deprivation in their home countries. Some are joining families from which they have been separated for years. Yet others come seeking education or financial advantage, or to provide or seek work. All the evidence suggests that the desire or need to emigrate from various places around the world is unlikely to diminish.

Many immigrants arrive with inadequate economical support and language skills, and suffer social exclusion and often inequality of healthcare provision. In many countries there is also inequality of healthcare provision to a minority of the population who are the most deprived and socially excluded: this minority is often related to ethnic or cultural differences.

*Culturally sensitive health care* is a phrase used to describe a healthcare system that, in addition to being accessible, respects the beliefs, attitudes, and cultural lifestyles both of the professional and the patient and, as a consequence, is sensitive to issues including culture, race, gender, sexual orientation, social class and economic situation. At the most simple level, it is easy to offend by asking for a “Christian” name (from someone who may not at all be Christian) rather than a “personal” name. To avoid showing religious preference, many now the neutral era designation BCE (before the common era) in place of the Christian designation BC (before Christ) and CE (of the common era) and AD (anno domini, 'in the year of the Lord').

*Cultural competency* is the understanding that we all have different values that affect the way we view our health and healthcare, and how we view the world. It implies the ability to successfully navigate through other cultures while understanding, appreciating, making comparisons to, and moving beyond stereotypes, while remaining sensitive to one’s own cultural elements and those of other persons. The goal is to provide the best care possible to each individual patient. Culturally competent care requires more than simply a knowledge of other cultures; it involves attitudes and skills as well.

Once attuned to the cultural beliefs of the patient, the healthcare professional (HCP) can become a more effective healthcare provider and a more positive health advocate. Thus health care is offered in a way that respects and recognizes everyone’s religions and cultural needs.

Immigration can lead to a dramatic and powerful change in lifestyle, can result in a range of behavioural changes in newcomers, and has been divided into three main phases.

The first or “Acute Phase” following immigration, in particular from the developing world, war zones and some tropical regions, attracts most concern, because of the serious and sometimes communicable nature of the illnesses with which new immigrants may present, and consequently the potential public health threat. Other problems include accidents and violence and psychiatric reactions. Generally speaking, new immigrants tend to be young, lack linguistic fluency, be stressed and anxious, be part of an extended family, have low income and often have low standards of housing.

Social exclusion and barriers to healthcare are often present and can prevent access to care. Immigrants may also run into conflict with aspects of their new life, because of different views and values. For example, few immigrant groups have flexible attitudes towards issues such as women's' equality.
In terms of health and health care, new immigrants may lack full understanding of the new health care system in which they find themselves; lack awareness of preventive practices and screening; have some reliance on traditional (folk) medicine and have views on consent issues unaligned to westernized thoughts and practice.

Cultural beliefs shape the perception and understanding of health and disease, and thus behaviors, since many immigrants come from healthcare systems that differ from traditional western medicine, may not always be as advanced, and may involve traditional remedies and healers. For example, some immigrant patients expect or demand medication, even for a minor illness and are not impressed if the healthcare provider does not offer medication. Others routinely share prescriptions or over-the-counter medications with friends or family.

Those coming from, in particular, countries in upheaval can also suffer from a variety of health problems and post-traumatic stress syndrome. Some suffer from psychiatric disorders consequent on persecution, racism or perceived racism. Depression and anxiety are common, related to these factors and to the stress of emigration and adapting to a new life. Such factors, combined with the stigma associated with ill health in their home countries and being cut off from traditional family support networks, may prevent many from seeking healthcare.
Some immigrant groups also suffer social deprivation and have related medical problems such as accidents and high perinatal mortality rates.
In places where dentists have not been available, and branded toothpastes hardly affordable, people may still practice traditional toothbrushing with for example, salt or a Miswak. A lack of understanding of the healthcare system can dissuade newcomers from attending to their health needs. Newcomers are confronted with understanding the complexity of health care in developed

countries—the decentralized structure, the principle of choice regarding health care providers and insurance plans, the need for health insurance, the emphasis on preventive health, and more. They may well lack understanding of the existence or roles of the various health care professionals.

Many newly arrived immigrants therefore suffer from lack of proper immunizations and medical and dental healthcare, and help-seeking behaviour is often one of emergency treatment rather than one of on-going preventive care. This can result for the newcomers in alienation, mistrust, frustration, wasted time, poor treatment, increased morbidity and even increased mortality.

The second phase of immigration, transition, which typically takes up to at least five years. The rate and degree of acculturation is influenced largely by: religion, place of birth and degree of exposure to the majority culture, age, historic background, socioeconomics and education.

Most younger immigrants become well-integrated into the community to a far greater extent than parents: this is more obvious in cultures where religion does not vary significantly from that of their new home country. The rate of acculturation can also be influenced by the attitude of the majority culture. Typically, uprooted or threatened cultures or religions become increasingly conservative (“fundamental” or “radical”).

In the transitional phase, communicable diseases prevalent in the first stage of resettlement are generally brought under control, but conditions such as hypertension, diabetes and ischaemic heart disease become more prevalent from lifestyle factors such as lack of exercise, smoking and diet.

Psychological disorders, including conversion reactions, seizures and other post-traumatic stress sequelae also typically become more prevalent. The latter may arise from the stress of adjustment to a new culture, the burden of the past and separation from traditional family and cultural support systems, intergenerational conflict, and conflict with other cultures (sometimes originating from conflicts in the home country), domestic violence, gambling and substance abuse. Other problems which may arise with acculturation include the sequelae of changing name; some members adopt a western style surname, which can lead at the very least to confusion and family strife.

Immigrants in the transition phase thus tend to acquire skills in the language of the locally dominant culture, gain better access to, and use of health care services, and adapt increasingly to westernized health practices, yet at the same time may develop additional health problems.

The third phase, ten or more years after arrival, is typified by the resettled immigrant using the host country healthcare services, but suffering from a variety of chronic conditions linked, at least partly, to the consequences of resettlement and, in many cases, emotional difficulties arising from change or possibly break down in family structures. Lifestyle can also significantly influence disease. For example, in the United Kingdom, tobacco smoking is high in Bangladeshi men; and in both Caribbean men and women. Hypertension, coronary heart disease and diabetes are common. In some communities there can be heavy alcohol consumption with high rates of liver disease, cirrhosis, and other concomitants. Similarly, the morbidity and mortality from cancers are high.

Drug abuse may be seen in some groups. Intergenerational conflicts can arise, with exclusion of older people and breakdown of family structures and values. Occasionally the consequences can be as dramatic as gang conflicts. Immigrants in the third phase thus tend to have gained access to, and make use of healthcare services, increasingly using the locally dominant culture language, and following westernized health practices but, concurrently, acquire the lifestyles, habits and diseases of the culturally locally dominant community, often associated with breakdown of the extended family and intergenerational conflicts. In contrast, some individuals and groups may choose to retain or even accentuate their ancestral heritage.

Despite acculturation however, there typically remain disparities in health and health beliefs between people of minority ethnic backgrounds and the culturally locally dominant population. These often wide disparities in health, health beliefs and healthcare between people of different socioeconomic backrounds, between people from rural and urban regions in many countries, between resource poor areas and developed countries, and between people of minority ethnic backgrounds and the culturally locally dominant population can be influenced especially by many factors.

Illustrative of these inequalities are the following facts from a recent study in London;

- *Non-White groups are more likely than White people to be living in poor quality housing*.
- *There are variations in school performance between cultures*. Black Caribbean children perform less well than most other Black and Minority Ethnic Minority (BME) children at school. Gypsy/Roma children and those of Travelers of Irish Heritage have the lowest attainment in schools. In contrast, Chinese and Indian children perform better than others in school
- *Non-White groups are twice as likely as White people to be unemployed.* Bangladeshis have 4 times the rate of unemployment (20%) compared to White British (5%). Black groups have the highest unemployment rates for the under-25s and Bangladeshi households also have the lowest gross hourly earnings and incomes.
- *There are variations in type of employment.* Asians account by far for most recruits to the medical, dental and pharmacist professions. Chinese and Indian people are as, or more likely, to be in professional and managerial positions as Whites. People in BME groups who have qualifications are far more likely to be in employment than are those without. Whites, Indians and Chinese people are more likely than other BME groups to have parents who are salaried.
- *There are significant health problems in, and barriers to health care for, BME populations*. Health care services, and primary care, NHS Direct, and walk-in centres are underused by the BME population. One in 6 refugees has a health problem severe enough to affect their lives.

As to oral diseases, many of the risk factors are modifiable, and thus all patients need to be aware of the risk factors and have access to effective strategies to reduce them. Some patients of all cultures may have limited knowledge of the risk factors for common oral disease such as dental caries and periodontal disease, as well as serious conditions such as cancer, especially those who have not had the luxury of a good education or a high level of socioeconomic support. This can apply to immigrant groups many of

whom are unlikely in the early stages of acculturation, to routinely visit a dentist or other healthcare provider. Furthermore, the perception of health and disease may vary in different groups; for example, whilst older Chinese subjects perceive themselves as being at lower risk for periodontitis they actually have more objective signs of periodontitis than subjects of European descent but comparable age. The importance of oral hygiene is often appreciated by people from or who have had contact with such Anglo-American cultures, but this is not always the case in some other cultures. The miswak - a stick made from the roots or twigs of various trees - is used commonly in Muslim countries as an effective and inexpensive tool for oral hygiene. The plaque removing properties of the miswak and conventional toothbrush are similar and, in some studies, the miswak has even been superior. Miswaks may also have some anti-caries activity by virtue of fluoride contained.Miswak users however, develop significantly more gingival recession and occlusal wear than do toothbrush users, and the teeth may develop a distinctive yellow stain. Teeth are also cleaned in some cultures using tooth powders derived from a variety of sources, such as charcoal, ash, silica or tobacco.

Tongue cleaning is another ancient habit used in some cultural groups such as Hindus and Chinese, while in others (including most westerners) it is a novel concept. It can however, help reduce oral malodor.

Racial and socioeconomic status disparities in oral health are also strong determinants of tooth loss. Children from deprived backgrounds in most cultures, have more caries (tooth decay). For example, in the USA, African Americans and lower socioeconomic status adults have relatively fewer remaining teeth and are more likely to receive a dental extraction once they enter the dental care system, given the same disease extent and severity, than are other groups.

Periodontal (gum) disease is also more common in some socioeconomic and/or cultural groups, often because of inadequate oral hygiene, and sometimes because of smoking or smokeless tobacco use. Acute ulcerative gingivitis is seen particularly in debilitated malnourished children from resource-poor countries, in smokers, and in immunocompromised people. Cancrum oris (noma or facial gangrene) is fortunately a rare complication.

A number of lifestyle habits are implicated in disease pathogenesis, especially various chewing and smoking habits, particularly those involving tobacco. Tobacco, whether chewed (smokeless tobacco) or smoked in various forms is implicated in many diseases both systemic and oral, and often of a serious nature such as cancers. It is the single habit most associated with ill health whether general health or mouth health. Tobacco-associated mouth problems include tooth stains, malodour, acute necrotizing ulcerative gingivitis and other periodontal conditions, smoker's melanosis, burns and keratotic patches, black hairy tongue, nicotinic stomatitis, palatal erosions, leukoplakia, epithelial dysplasia and cancer, and impaired healing after exodontia, surgery, implant and periodontal treatment.

Areca or betel nut chewing is another lifestyle habit, especially common in people from South and South East Asia. Around 20% of the world population use betel. Following migration from these countries to developed countries, predominantly to inner city areas, the habit has remained prevalent amongst its practitioners. Common effects of betel use are brown or black tooth and mucosal staining, and possibly increased periodontal disease but some protection against dental caries. Oral submucous fibrosis is also related to the use of betel and has a malignant potential – mouth cancer develops possibly in up to 8%. The carcinogenic effects of the betel quid also extend to cause pancreatic cancer. Chewing khat (qat) from the leaves of a cultivated, alkaloid shrub (*Catha edulis*), a habit mainly seen in the Arabian Peninsula and eastern Africa is another stimulant which produces oral effects including cancers. Shammah may have similar effect.

Traditional practices which persist today in various cultures include deliberate mutilation of hard or soft tissues. Tooth mutilation or tooth evulsion is seen especially in the developing world, particularly Africa. A number of cultures deliberately chip or reshape teeth. In parts of Uganda, Tanzania and Nigeria the operation of ebino, or "false teeth", refers to the extraction of deciduous canine tooth buds when gingival swellings appear during the eruption of the primary canine teeth in infants. A similar practice in Somalia is 'Ilko dacowo:' Tooth staining is another practice in some indigenous African people and in Peru and Ecuador, Vietnam, Laos, Thailand, Indonesia, and the Philippines.

Temporary mutilation by facial piercing is seen in Hindus as part of the religious ceremony Thapasyam. Facial or oral piercing is of course now common in westernized societies but also seen elsewhere, mainly in Africa and South America.
Facial scarring is seen in many tribes in tropical Africa. Tattoos are also not uncommonly seen in some cultures. Tattoos on the face or elsewhere on the head and neck are seen in Maori, Nigeria and Cameroon, some Bedouins, and in some western cultures. Lip tattooing is seen mainly in North Africa. In Nigeria some people have the lip or gingivae tattooed before marriage. Maxillary blue-black gingival tattooing is seen in some female Muslims in North Africa and the Middle East. In some East African groups, children have uvulectomy in the belief that their health will be improved.
Traditional healers are commonplace in some cultures, especially in the developing world and associated with particular religions, particularly those of African or Chinese background. Traditional healers are also found in the West. Indeed, the concept of healthcare providers may be quite alien to such peoples, or they can be used along with traditional healing. Untrained or partly trained dentists provide oral health care, at least to some degree, in many cultures where healthcare providers are unregulated. Traditional Chinese Medicine for example, is increasingly commonly used and not just by people from that culture, not least because here are clear barriers to conventional or westernised oral health care in some BME and other communities.
Many people attend for emergency care only; for example, UK studies have shown that 40% of Vietnamese attended only when in pain and 30% of Bangladeshi children had never visited a dentist.

Efforts to address these disparities include public education and community screening efforts, dental curriculum development, professional education, intensive research efforts, and significant dental-medical collaborations, oral health education/awareness programs, specifically customized to the various dental-medical professionals/trainees and to populations at risk.
It is imperative therefore, that all dental healthcare providers acquire the knowledge and communication skills that will make them attentive to the cultural differences of their patients and one of the best ways are to become

more involved in the relevant communities. Furthermore, if healthcare providers are more exposed during their training to primary care and community health centers, not only will they have an opportunity to participate in service-learning for underserved and disadvantaged patients, but they may also be more willing to establish practices in and for these communities.
A workforce of more diversity that can address the disparities in oral health problems based on race and ethnicity is also needed. Affirmative action has thereby been introduced into academic dental institutions at least in the USA. This will more fairly assesses candidates' qualifications and increase the diversity of the dental student population, and ultimately will achieve a body of more diverse healthcare providers, with an improvement in culturally sensitive health care.

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