Cultural Competence for the Dental Provider
A Peer-Reviewed Publication
Written by Sherri M. Lukes, RDH, MS, FAADH

Abstract
Cultural competence is a vast topic of great importance to the field of dentistry. In an increasingly diverse society, it is necessary for dental professionals to be culturally competent healthcare providers. A dynamic process, attaining cultural competence includes awareness and understanding of the many factors that influence culture and how that awareness translates into providing dental services within clients' cultural parameters. Multiple resources are available for dental professionals to become culturally competent healthcare providers, ensuring delivery of the best possible care for all clients.

Educational Objectives
At the conclusion of this educational activity participants will be able to:
1. Describe key trends in the demographics of culturally diverse populations
2. Discuss the evolution of cultural competence in health care and dentistry
3. Define cultural competence terms and ideas about health and wellness
4. Describe communication issues associated with working with diverse populations
5. Explain oral practices and oral health disparities of diverse populations

Author Profile
Sherri M. Lukes, RDH, MS, FAADH – A dental hygienist for 35 years Sherri Lukes holds advanced degrees in education. She is associate professor emerita, Southern Illinois University, where she taught oral pathology, public health and multicultural dental hygiene. Research was concentrated in migrant oral health, pathology and public health issues, resulting in multiple peer reviewed publications. She serves on the PennWell continuing education advisory committee and the peer review board for Dimensions of Dental Hygiene. She is an approved speaker of and holds a pathology fellowship in the American Academy of Dental Hygiene and is immediate past president of the Illinois Dental Hygienists' Association. Honors include Community Service, Research, and Teacher of the Year awards while at SIU, IFLOSS Coalition/Illinois Department of Public Health Oral Health Champion Award and the Sunstar/RDH Award of Distinction.

Author Disclosure
Sherri M. Lukes, RDH, MS, FAADH is a member of the PennWell continuing dental education board.

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Abstract
Cultural competence is a vast topic of great importance to the field of dentistry. In an increasingly diverse society, it is necessary for dental professionals to be culturally competent healthcare providers. A dynamic process, attaining cultural competence includes awareness and understanding of the many factors that influence culture and how that awareness translates into providing dental services within clients’ cultural parameters. Multiple resources are available for dental professionals to become culturally competent healthcare providers, ensuring delivery of the best possible care for all clients.

Introduction
As the US population becomes increasingly diverse, healthcare providers are charged with developing the knowledge and skills to adequately serve clients from multiple population groups. Dental providers are no exception and it is necessary to embrace the wealth of information available for serving clients from diverse backgrounds and cultures. This course will provide an overview of cultural competence as it has evolved in health care and dentistry.

On the journey toward cultural competence, it is important to recognize that no individual can know every aspect of any group, and though society tends to categorize by race, diversity includes more than racial and ethnic characteristics. Many types of population groups can be viewed as a culture.

We are experiencing a rapidly increasing elderly population, with significant implications for health-care policy and delivery of care. The disabled and other groups with lifestyle characteristics bring accompanying health issues and needs to the health-care system. The complexities of treating patients of low socio-economic status continues to challenge systems of care as we strive to provide health services for all Americans. Health disparities have existed for centuries. These disparities have run through all races and ethnicities but are over-represented in the racial and ethnic minority populations. The Office of Minority Health and Health Disparities at the Centers for Disease Control and Prevention states: “Compelling evidence that race and ethnicity correlate with persistent, and often increasing health disparities among US populations demands national attention.”2 An understanding of health disparities must be intricately woven into the tapestry of cultural competence in health care just as much as the knowledge of the characteristics of diverse populations.

US Demographics Concerning Race and Ethnicity
The 2010 Census revealed that the United States is more culturally diverse than ever before.3 The once mainstream white majority is shrinking as minority populations consistently increase. In her cultural competence text, Patti R. Rose identified the new replacement term for minority populations as the “emerging majority.”4 Specter uses the term as well.5 One of the most significant changes in the administration of the 2010 Census was in the wording of questions concerning race and Hispanic origin. The Office of Management and Budget (OMB) sets the standards on race and Hispanic origin and has determined that Hispanic or Latino is not a race but an ethnicity due to the multiple countries of origin included in the designation. As a result, these questions were asked of all persons living in the United States, and people were free to define themselves as belonging to many groups.

Data on race has been collected since the first census was conducted in 1790. There are five race categories that were used in the 2010 Census (see figure 1). Additionally, a “some other race” category was added for both the 2000 and 2010 censuses. Census data revealed in 2010 that while the white-only population remains the largest at 63.7%, it grew the least of any population group from 2000 to 2010. The Hispanic ethnic group constituted the largest minority population group, at approximately 16% of the total population and experienced the largest increase from 2000 to 2010. Hispanics predominantly identified as either white or some other race. The Asian population group grew faster between 2000 and 2010 than any other major race group and represented 4.8% of the total population. While all minority groups increased, the black/African American group had not exhibited the percentage increase as much as the other population groups and remained relatively stable at 12–13%. American Indian/Alaska Native and Native Hawaiian/Pacific Islanders represented .9% and .2% respectively of the total population. Those who identified as two or more races was 2.9% and the most common combination of races was white/black.

Definitions
Before discussing cultural competence in health care and dentistry, it is necessary to define some commonly associated terms:

- Culture: While there is no single definition, the term is generally defined as nonphysical traits, such as values, beliefs, attitudes and customs that are shared by a group of people and passed from one generation to the next.
• **Race**: The concept of dividing people into populations or groups on the basis of visible traits and beliefs about common ancestry.⁵

• **Ethnicity**: Large groups of people who are classified according to common racial, national, tribal, religious, linguistic, or cultural origin or background.⁶

• **Ethnocentric**: When a person believes that his or her culture is superior to that of another.⁶

• **Cultural Competence**: The ability to interact effectively with people of different cultures; a set of congruent behaviors, attitudes, structures and policies that come together to work effectively in intercultural situations.⁶

• **Cultural care**: In terms of health care, cultural care is the delivery of services that are culturally sensitive and culturally appropriate; it involves the provision of health care across cultural boundaries, taking into account the context in which the patient lives as well as the situations in which the patient’s health problems arise.⁴

• **Acculturation**: The process of adapting to another culture and/or acquiring the majority group’s culture.⁴

All of these terms are important to consider and understand when investigating the vast array of variables associated with attaining cultural competence.

### Culture and Health

There is a seemingly endless collection of factors that influence culture. Race and ethnicity are only part of a person’s cultural heritage. As shown in Figure 2, everything from a person’s age and gender to place of birth, length of time living in this country, and socioeconomic status greatly influence a person’s culture. Culture is analogous to a rich tapestry, intricately woven with religious beliefs, personal and shared values, actions, communication nuances, laws, and other variables. Learning about cultures can be difficult and inconsistent, as is the artwork of a tapestry—it is beautiful on one side, but when turned to reveal the underside, imperfections and inconsistencies can be observed in the workmanship of the piece. The caveat that accompanies learning about cultures is the recognition that there is as much variation within cultures as there is between them and this should always be part of the thought process when learning about cultural groups.

As with culture, the concept of health itself can also have different meanings for different population groups. The World Health Organization (WHO) defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease.”⁴ Who we are and our beliefs about health often have much to do with our personal world view, which refers to one’s basic assumptions about the nature of reality and human behavior. People from different cultures view the world, health, and illness with different sets of beliefs, values, and attitudes, with multiple ways of attempting to achieve a healthful state. A nonjudgmental, open-minded approach is necessary in the quest for cultural competence as health care providers care for patients with differing perceptions regarding what constitutes their own healthful state.

### Cultural Competence in Health-Care

As in all of society, cultural competence has become of utmost importance in our health-care system, discussed in landmark works and documents such as “Healthy People 2020,” the report on disparities by the Institute of Medicine and the oral health report by the Surgeon General.⁸,⁹,¹⁰ The emphasis is not the attempt to know all of the health practices and cultures of all groups of people but the awareness of general differences as the starting point to build insight and provide appropriate health services. The Office of Minority Health within the US Department

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**Figure 1**: Definition of race categories used in the 2010 Census.

- **White** refers a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicated their race(s) as “white” or reported entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.

- **Black or African American** refers to a person having origins in any of the black racial groups of Africa. It includes people who indicated their race(s) as “Black, African Am., or Negro” or reported entries such as African American, Kenyan, Nigerian, or Haitian.

- **American Indian or Alaska Native** refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. This category includes people who indicated their race(s) as “American Indian or Alaska Native” or reported their enrolled or principal tribe, such as Navajo, Blackfeet, Inupiat, Yup’ik, or Central American Indian groups or South American Indian groups.

- **Asian** refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes people who indicated their race(s) as “Asian” or reported entries such as “Asian Indian,” “Chinese,” “Filipino,” “Korean,” “Japanese,” “Vietnamese,” and “Other Asian,” or provided other detailed Asian responses.

- **Native Hawaiian or Other Pacific Islander** refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicated their race(s) as “Pacific Islander” or reported entries such as “Native Hawaiian,” “Guamanian or Chamorro,” “Samoan,” and “Other Pacific Islander” or provided other detailed Pacific Islander responses.

- **Some other race** includes all other responses not included in the White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander race categories described above. Respondents reporting entries such as multiracial, mixed, interracial, or a Hispanic or Latino group (for example, Mexican, Puerto Rican, Cuban, or Spanish) in response to the race question are included in this category.

**Source:** 2010 Census Briefs, US Census Bureau, 2011.

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**Figure 2**: Factors that influence culture.

- **Age**
- **Gender**
- **Geography**
- **Place of birth**
- **Religious beliefs**
- **Sexual preference**
- **Socioeconomic status**
- **Power relationships**
- **Educational attainment**
- **Family**
- **Length of US residency/acculturation**
- **Individual experiences**
- **Health**
- **Profession**
A number of models and prototypes have also been developed to assist health-care providers in achieving cultural competence. Training programs utilize the cultural competence continuum, the LEARN model, the Purnell model for cultural competence, individual assessments of cultural competence among others, to educate providers in the cultural competence journey. Copious resources exist for training programs for all types of health-care providers and can be easily accessed for training purposes. Possibly most significant is an understanding by the provider of his or her own culture. Afterall, how can one understand other cultures if one does not have a good grasp on one’s own cultural identity? Self-assessments and the models referred to previously are available throughout the medical and dental literature for providers to access and become comfortable with their own culture, enabling them to understand and appreciate the cultural parameters of others.

Cultural Competence in Dentistry

In an integrative medicine journal, Dahiya and colleagues reminded readers of the proverb: “If the eyes are a window to the soul, then the mouth is the doorway to the body.” The Commission on Dental Accreditation requires cultural competence training for dental and dental hygiene students as part of the standard curriculum; schools are taking steps to increase the cultural competence of students through various educational methods. It is an ongoing process and additional research is warranted to determine the effectiveness of cultural competence training in US dental programs. Attaining cultural competence is a dynamic, ongoing process that is difficult to achieve; however, dental providers should be cognizant of the significance of cultural parameters when delivering services and make every effort to function within those parameters. The “one-size-fits-all” mentality is no truer in dentistry than in medicine, and dental providers must seek the knowledge and skills to treat patients from a variety of cultures.

Communication

One of the primary considerations in cultural competence training is that of communicating with patients of diverse cultures. The dimensions of individualism and collectivism are major aspects of how a person communicates with others. People of individualistic cultures tend to focus on the “I,” with each person having a personal responsibility for themselves. Independence, uniqueness, and competition are valued, with the needs and preferences of the individual coming before those of the group. This is the common thread in mainstream US culture. Collectivistic cultures tend to focus on the “we,” with the dependence and connections of the group being most valued and its needs and interests taking priority over a single member. This is often the view held by emerging majority groups in the US. These contrasting concepts become very significant when making decisions regarding health-care services and treatments requiring sensitivity of the health-care provider to both conceptual frameworks.
Verbal communication nuances can be especially challenging when working with diverse cultures. A report from the US Census Bureau revealed that 21% of the US population age five and over speak a language other than English in the home. Those who speak the same language often have difficulty communicating; one can imagine how difficult it must be to communicate with those whose first language is not English. Four of the 15 National CLAS Standards address communication and language assistance to assure equity in communication needs of all patients. Effective use of interpreters is essential in health messaging; trained interpreters are always preferred over ad hoc, untrained interpreters such as children and other family members. Interpreters should be able to interpret smoothly, be fluent in both English as well as the patient’s language, understand confidentiality issues, possess knowledge of medical/dental terminology in both languages, and understand both the mainstream American as well as the patient’s culture.

Different word meanings, relating information about a health problem, and comfort with discussions between the health-care provider and patient can also vary greatly among cultures. Some may not want to know a negative diagnosis or prognosis and may make decisions concerning treatment only after consulting with family members or cultural leaders (collectivism). Health-care providers must make certain to avoid jargon and technical terms, selecting words that will be understandable for the patient for complete comprehension. The provider should also seek to guard against stereotyping and the patient perception of being “talked down to”.

Nonverbal and verbal communication skills are equally important in health-care settings. Facial expressions, gestures, physical touch, proximity, eye contact, personal appearance, emotional expressiveness, and many other non-verbal cues can be relayed and perceived in a variety of ways. Smiling can show pleasure but also be a sign of embarrassment or emotional pain. A “thumbs up” gesture in the US denotes something positive, but in other countries and cultures it can be the equivalent of giving someone “the finger.” The same is true with the two-finger “peace” or “victory” gesture.

Physical touch is accepted and encouraged in many Hispanic cultures, but considered offensive in some Asian and Middle Eastern cultures, especially touching a person’s head, which is certainly problematic for the dental provider. Some cultures enjoy close proximity during communication, where others may not. Dentistry tends to be invasive of the patient’s personal space, requiring providers to be sensitive to comfort levels. Eye contact or lack thereof can be perceived differently in varying cultures; lack of eye contact can be perceived as portraying dishonesty or that the person is hiding something by Westerners, whereas direct eye contact can be perceived as disrespectful among Asian, Latin American, and American Indian cultures. When experiencing pain, patient reactions can range from highly expressive to stoic which can be learned cultural attributes.

**Oral Practices of Diverse Cultures**

Diverse populations engage in a variety of health practices that may be used alone or in conjunction with Western medicine. A comprehensive description of alternative therapies used by the designated US racial and ethnic groups is beyond the scope of this course; however, the use of home remedies, folk healers, and other alternative therapies is demonstrated among the diverse populations and spans a vast array of practices and treatments both for general and oral health. Pertaining to oral practices, the literature is lacking in respect to specific oral practices for each US racial/ethnic designation, however, some practices have a dominant presence in the literature, possibly due to their unusual nature, when compared to mainstream practices.

Knowledge of alternative oral cleaning devices used by various cultures is valuable for dental providers when dealing with clients of diverse cultures. The miswak, or chewstick, is a common alternative oral cleaning device used by cultures in many parts of the world as well as diverse groups in the United States. A pencil-sized stick from the *Salvadora persica* tree or “toothbrush tree,” the miswak is used to remove plaque and has actually been shown to have antibacterial properties. Multiple social media sites discuss the use of the miswak, including a video of an interview about its use by a Chicago dentist. As with any oral hygiene device, proper technique is required to guard against tooth abrasion, gingival recession and other trauma.

Alternative therapies for gum health are many and can be culturally derived. Polish Americans may use yarrow tea for “pyorrhea” and Native Americans may grind lichens to rub on inflamed gums. Other cultures have used bayberry tea for gingivitis. Additional home remedies from a wide variety of cultures often contain herbs and other substances such as bloodroot, clove oil, garlic, soy, lemon balm, Echinacea, fennel, licorice root, grapeseed extract, eucalyptus, and ginger. Some Irish may prefer to brush with Ivory soap or table salt instead of toothpaste and the rationale for such practices is sometimes elusive.

It has long been recognized that tobacco use has detrimental effects on the oral cavity; however, dental providers may not be aware of additional harmful oral habits practiced by diverse cultures. The use of betel nut and betel nut combination products are common in Asian cultures and like tobacco can be addictive and damaging to the oral cavity. A nut from the *Areca catechu* palm tree, betel nut is often chewed or combined with other products, wrapped in a leaf from the betel tree, and held in the buccal vestibule. The primary attraction for using betel nut is its psychostimulating effects. Consequences for the oral cavity include tooth attrition and staining, periodontal disease, submucous fibrosis, and oral cancer.

Paan is a betel nut quid, it may contain other ingredients such as perfumes and spices, and is sometimes used as a palate cleanser and breath freshener. Additional uses for the betel nut are as an appetite stimulant, a flatus reliever, a dentifrice, a diuretic, and a laxative. Gutka is a combination of betel nut, tobacco, catechu, lime, and flavorings, and is sold in small packets for
increased marketing potential. The betel nut's carcinogens are enhanced in gutka as a result of the addition of tobacco and lime. All products containing betel nut are harmful to the oral cavity and consequences of their use should be recognized and discouraged by dental professionals.

Oral Health Disparities

Racial/ethnic disparities in health and health care have been well documented, revealing that emerging majority groups suffer disproportionate rates of many conditions and diseases, including those affecting the oral cavity. The Surgeon General’s report on oral health, released in 2000, discussed the “silent epidemic” of oral diseases affecting our most vulnerable citizens—the poor, the elderly, and many members of certain racial/ethnic groups. The reasons for these disparities are multifactorial, and include the variations in patients’ health values, beliefs, preferences, and behaviors which are often culturally determined.

Developing cultural competence among health-care providers is a strategy to help address disparities and reduce organizational, structural, and clinical barriers to care. Increasing the racial/ethnic diversity among the workforce can help to address organizational barriers, as diversity in the workforce has been well correlated with the delivery of quality care to diverse populations. Appropriate interpreter services and culturally and linguistically suitable education materials assist in addressing structural barriers. The oral health-care providers’ understanding of socioculturally based health beliefs, practices, and values may differ from the mainstream care process, and can ultimately reduce clinical barriers as providers work with patients to provide care within their cultural parameters.

Problems with multifactorial causes often require multifactorial approaches for resolution. Increasing cultural competence in all dental-care delivery systems is one approach that can have a large impact on reducing oral health disparities.

Conclusion

Well-trained oral health providers should not only be experts in clinical skills, but also be able to identify, provoke, accept, and respond appropriately to, and serves the unique needs of diverse groups—even if their cultural beliefs, values, and practices may be different from those of the mainstream dominant culture. Maintaining an open mind about cultural variances can go far in maintaining patient rapport and trust in the dental services environment to provide the best care possible for all patients.

References


Author Profile

Sherri M. Lukes, RDH, MS, FAADH - A dental hygienist for 35 years Sherri Lukes holds advanced degrees in education. She is associate professor emerita, Southern Illinois University, where she taught oral pathology, public health and multicultural dental hygiene. Research was concentrated in migrant oral health, pathology and public health issues, resulting in multiple peer reviewed publications. She serves on the PennWell continuing education advisory committee and the peer review board for Dimensions of Dental Hygiene. She is an approved speaker of and holds a pathology fellowship in the American Academy of Dental Hygiene and is immediate past president of the Illinois Dental Hygienists’ Association. Honors include Community Service, Research, and Teacher of the Year awards while at SIU, IFLOSS Coalition/Illinois Department of Public Health Oral Health Champion Award and the Sunstar/RDH Award of Distinction.

Author Disclosure

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Questions

1. The US population group that grew the least between 2000 and 2010 was:
   a. Black
   b. Asian
   c. White
   d. American Indian

2. The Office of Management and Budget (OMB) of the federal government determined that the term Hispanic/Latino:
   a. Represented the smallest minority in the country
   b. Was a designation of ethnicity, not race
   c. Was a race category to be utilized for the 2010 census
   d. Represented only one race

3. Which of the following influence a person’s cultural identity?
   a. Religious beliefs
   b. Socioeconomic status
   c. Place of birth
   d. All of the above

4. The population group that grew the fastest between 2000 and 2010 was:
   a. Asian
   b. Black
   c. White
   d. Native Hawaiian or Other Pacific Islander

5. In spite of the fact that the United States has some of the best health-care services in the world, a significant issue affecting racial and ethnic minority populations is:
   a. Health policies
   b. Multiple systems of care
   c. Health disparities
   d. Culturally diverse health providers

6. As the mainstream white population shrinks in number in the United States, the replacement term for minority populations is:
   a. Emerging majority
   b. Ethnic minorities
   c. Race groups
   d. Declining minority

7. The US Census questionnaire allows persons to identify as more than one race. The most common combination of races in the 2010 Census data was:
   a. White/Hispanic
   b. White/Black
   c. Black/Asian
   d. American Indian/Black

8. Nonphysical traits, such as values, beliefs, attitudes, and customs that are shared by a group of people and passed from one generation to the next is a general term used to define:
   a. Ethnicity
   b. Race
   c. Ethnocentric
   d. Culture

9. The concept of dividing people into populations or groups on the basis of visible traits and beliefs about common ancestry refers to:
   a. Ethnicity
   b. Race
   c. Culture
   d. Acculturation

10. The classification of large groups of people according to common racial, national, tribal, religious, linguistic, or cultural origin or background refers to:
    a. Ethnicity
    b. Race
    c. Culture
    d. Acculturation

11. The process of adapting to another culture and/or acquiring the majority group’s culture is termed:
    a. Ethnocentrism
    b. Cultural competence
    c. Collectivism
    d. Acculturation

12. The belief that one’s culture is superior to that of another is termed:
    a. Ethnocentrism
    b. Cultural competence
    c. Collectivism
    d. Acculturation

13. The ability to interact effectively with people of different cultures utilizing a knowledge of congruent behaviors, attitudes, structures and policies in intercultural situations is termed:
    a. Ethnocentrism
    b. Cultural competence
    c. Collectivism
    d. Acculturation

14. A very important aspect of acquiring cultural competence is the realization that:
    a. All cultural groups are basically the same
    b. No one culture is superior to another
    c. There is as much variation within cultures as there is between them
    d. Cultural care is not important in dentistry

15. The manner in which people of diverse cultures view health and illness has to do with:
    a. Their overall world view
    b. The delivery of care
    c. Beliefs, values and attitudes of their culture
    d. A and C

16. A set of criteria to assist health-care providers in delivering culturally appropriate services, developed by the Office of Minority Health in the US Department of Health and Human Services is:
    a. The Healthy People 2020 objectives
    b. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
    c. The Cultural Competence Continuum
    d. The Purnell model for cultural competence

17. Dental and dental hygiene schools are charged with providing cultural competence training in their curricula by:
    a. The Commission on Dental Accreditation
    b. The Centers for Disease Control and Prevention
    c. Individual dental and dental hygiene programs
    d. The Institute of Medicine

18. The concept of each person having a personal responsibility for him- or herself with value placed on independence, uniqueness and competition refers to:
    a. Collectivism
    b. Individualism
    c. Acculturation
    d. Ethnocentrism

19. The concept of group dynamics and valuing the needs and interests of the group over a single member refers to:
    a. Collectivism
    b. Individualism
    c. Acculturation
    d. Ethnocentrism

20. When utilizing interpreters for verbal communication, the health-care provider should:
    a. Use family members whenever possible
    b. Use trained interpreters over ad hoc interpreters
    c. Use professional medical terminology to describe conditions
    d. All of the above

21. Gestures, physical touch, eye contact and personal appearance are all forms of:
    a. Pain expression
    b. Collectivism
    c. Nonverbal communication
    d. Personal space

22. Examples of nonconventional practices and treatments that are different from mainstream health-care practices and treatments is/are:
    a. The miswak stick
    b. Home remedies
    c. The use of folk healers
    d. All of the above

23. All of the following are true of the miswak or chewstick except:
    a. Used as an alternative to the mainstream toothbrush
    b. Can cause abrasion and gingival recession if used improperly
    c. Is a product of the Salvadora persica tree
    d. Has no recognized antibacterial properties

24. Though direct eye contact is often encouraged and valued by Westerners, in some cultures it is a sign of:
    a. Embrassment
    b. Anger
    c. Disrespect
    d. Emotional pain

25. Yarrow tea, ground lichens, and bayberry tea are all substances that diverse cultures may use in home remedies for:
    a. Tooth pain
    b. Dental Caries
    c. Oral lesions
    d. Gingivitis/periodontitis

26. Submucous fibrosis, oral cancer, tooth attrition and staining, and periodontal disease can all be consequences of the use of:
    a. Betel Nut
    b. The miswak
    c. Licorice root
    d. Echinacea

27. The primary effect sought from the use of betel nut and combination products such as paan and gutka is for:
    a. Tooth cleaning
    b. Dental pain relief
    c. Psychostimulation
    d. Gingival health

28. The reason for health disparities among racial and ethnic minority groups is:
    a. The lack of diversity of the health-care provider workforce
    b. Values and beliefs of cultural groups
    c. Negative health behaviors
    d. There is not just one reason; it is multifactorial

29. Strategies for increasing cultural competence among health-care providers to address health disparities and reduce barriers to care include:
    a. Increasing the diversity of the health-care workforce
    b. Building the cultural knowledge base of health-care providers by offering cultural competence training
    c. Assuring culturally and linguistically appropriate interpreter and health education services and materials
    d. All of the above

30. A well trained oral health provider should:
    a. Assist patients in adhering to the values, beliefs, and practices of the mainstream culture
    b. Seek to understand the patient’s cultural parameters and look for ways to incorporate cultural differences into the process of care
    c. Treat all patients the same regardless of cultural factors
    d. Be ethnocentric in delivering services

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Cultural Competence for the Dental Provider

Educational Objectives

At the conclusion of this educational activity participants will be able to:
1. Describe key trends in the demographics of culturally diverse populations
2. Discuss the evolution of cultural competence in health care and dentistry
3. Define cultural competence terms and ideas about health and wellness
4. Describe communication issues associated with working with diverse populations
5. Explain oral practices and oral health disparities of diverse populations

Course Evaluation

1. Were the individual course objectives met?
   Objective #1: Yes No
   Objective #2: Yes No
   Objective #3: Yes No
   Objective #4: Yes No
   Objective #5: Yes No

Please evaluate this course by responding to the following statements, using a scale of Excellent = 5 to Poor = 0.

2. To what extent were the course objectives accomplished overall? 5 4 3 2 1 0
3. Please rate your personal mastery of the course objectives. 5 4 3 2 1 0
4. How would you rate the objectives and educational methods? 5 4 3 2 1 0
5. How do you rate the author's grasp of the topic? 5 4 3 2 1 0
6. Please rate the instructor's effectiveness. 5 4 3 2 1 0
7. Was the overall administration of the course effective? 5 4 3 2 1 0
8. Please rate the usefulness and clinical applicability of this course. 5 4 3 2 1 0
9. Please rate the usefulness of the supplemental webliography. 5 4 3 2 1 0
10. Do you feel that the references were adequate? Yes No
11. Would you participate in a similar program on a different topic? Yes No
12. If any of the continuing education questions were unclear or ambiguous, please list them.
13. What additional continuing dental education topics would you like to see?

If not taking online, mail completed answer sheet to
PennWell Corp.
Attn: Dental Division,
1421 S. Sheridan Rd, Tulsa, OK, 74112
or fax to: 918-831-9804

For IMMEDIATE results, go to www.ineedce.com to take tests online.
Answer sheets can be faxed or credit card payment to 918-831-9804.

If paying by credit card, please complete the following:

Payment of $59.00 is enclosed.
(Checks and credit cards are accepted.)

Acct. Number: _______________________
Exp. Date: _______________________

Charges on your statement will show up as PennWell

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COURSE EVALUATION and PARTICIPANT FEEDBACK

We encourage participant feedback pertaining to all courses. Please be sure to complete the survey included with the course. Please e-mail all questions to hhodges@pennwell.com.

All questions should have only one answer. Answering the examination is done manually. Participants will receive confirmation of passing by receipt of a verification form. Certification of Participation forms will be mailed within two weeks after taking the examination.

CANCELLATION/REFUND POLICY

Any participant who is not 100% satisfied with this course can request a full refund by contacting PennWell in writing. Any participant who is not 100% satisfied with this course can request a full refund by contacting PennWell in writing.

PennWell maintains records of your successful completion of any exam for a minimum of six years. Please contact our offices for a copy of your continuing education credits report. This report, which will list all credits earned to date, will be provided and mailed to you within five business days of receipt.

Completing a single continuing education course does not provide enough information to give the participant the feeling that s/he is an expert in the fieldrelated to the course topic. It is a combination of many educational courses and clinical experience that allows the participant to develop skills and expertise.

Please photocopy answer sheet for additional participants.