Part I

Communication Fundamentals

This first section introduces key concepts that are fundamental to effective chairside communication with patients. Individuals who develop communication skills without first understanding communication or their audience may express themselves in a way that sounds insincere or even aggressive. Effective communicators understand how communication functions and can anticipate how it might function with a specific patient in context. This section provides an overview of health communication and its importance to patient-centered care (chapter 1), describes patients' perceptions of dentistry (chapter 2), and discusses cultural influences that shape patients' communication patterns (chapter 3).

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1

Understanding Communication

Why Communication Matters

This initial chapter provides a rationale for studying patient-provider communication. However, this manual is focused on skill acquisition, so we feel it is best to present the rationale as a competence to master instead of simply listing the reasons why you should read our book. The rationale-as-skill concept becomes clearer to us the longer we teach dental students. Let us explain.

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When people ask what we do, we reply that we teach patient-provider communication skills to future dentists. Usually, the responses fall into one of two categories. Some people are completely baffled and ask to know what we mean. Others make a lame attempt at humor: "It should be pretty easy to communicate with dental patients because they can't talk back!" We have heard many variations of this theme and try to smile every time.

In truth, the fact that dental patients are often restricted in their verbal expression makes instruction in communication more important, not less so. Communication is far more than rattling off the latest sports scores while manipulating dental instruments in a patient's mouth. The quality of patient-provider communication determines a wide range of outcomes, including satisfaction, treatment adherence, information comprehension and recall, and ultimately oral health.[1] For this reason, we have developed a skill of explaining and illustrating the importance of effective communication with dental patients. Those who work in a dental office—as a dentist, hygienist, assistant, or receptionist—should master this skill so that all of the practice's employees will better understand the value of effective patient communication.

The fundamental communication lesson professionals must learn is that they cannot assume that everyone understands a message in the same way. To apply this lesson to the task at hand, we will explain and explore four key concepts: *(1)* communication, *(2)* health communication, *(3)* patient-provider communication, and *(4)* patient-provider communication in dentistry. For each concept, we will define the key term and analyze its implications and associated goals.

What Communication Is

Definition of communication

People from varying disciplines have defined **communication** in vastly different ways, from the mechanical definition that relates communication to audiology and broadcast transmission, to the philosophic definition that ties it to ontology and epistemology.[2,3] Between mechanics and philosophy is a social science discipline, which acknowledges both the concrete realities of message transmission and the varied ways humans interpret the meaning of messages. A good working definition has been provided by Stoner et al[4]: "Communication can be defined as the process by which people share ideas, experiences, knowledge and feelings through the transmission of symbolic messages." Four aspects of this definition are particularly important for dental professionals to keep in mind: *(1)* communication is a process, *(2)* communication is multifunctional, *(3)* communication is multichanneled, and *(4)* communication is not always intentional.

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Communication is a process

Often, communication is understood as individual expression. However, when people view communication as a singular act of self-expression, they risk treating other individuals as mere witnesses or audience members, rather than people with whom they are building a relationship. The working definition on page 4 clarifies that communication **occurs only when two or more people are mutually involved in a process of sharing**. Dental professionals must remember that **effective communicators cannot rely on a script** to build relationships.

Communication is multifunctional

The messages shared when providers and patients communicate perform many functions, often simultaneously[5] (Table 1-1). Because communication is a process, achieving those functions depends on both the way a message is sent and the way it is received. Dental professionals must remain aware of their communication goals and listen to patients for indications that the goals are being achieved.

Table 1-1 Functions of communication

Function	Example
Psychologic	Establishing your professional role in patient introductions
Social	Cultivating patient trust through conversation
Informational	Explaining to patients the condition of their oral health
Influential	Urging patients to stop smoking

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Communication is multichanneled

Too often, people think that *communication* is synonymous with *speech*, but messages are transmitted through multiple channels, both verbal (speech and writing) and nonverbal (appearance, gesture, and facial expression, among others). Those channels usually operate simultaneously. Dental professionals must remember that some channels are better suited to certain messages than others and that messages sent through one channel should not contradict messages sent through another.

Communication is not always intentional

Another misconception is that communication is restricted to messages we intend to send. While it is true that intentional communication is valuable, any behavior can transmit a message, regardless of intent. Even complete passivity—the refusal to act—communicates, leading some to argue that humans cannot help but communicate. Further, the definition suggested by Stoner et al[4] acknowledges that we communicate with others through symbols (such as words or gestures), and symbolic messages are effective only insofar as they hold similar meaning for both sender and receiver. This is perhaps the hardest lesson: Dental professionals are constantly communicating, and they have limited control over how messages are received. However, the chance that patients will receive the intended message can be improved if dentists enhance their skills of expression and patient monitoring.

Health Communication

Definition of health communication

The study of communication contains numerous subfields. Some of those subfields are differentiated based on message context or subject matter, such as family communication and environmental communication. **Health communication** is a subfield that has expanded tremendously in recent decades, as researchers and clinicians observed its impact on patient health. Definitions of *health communication* vary widely.[6] The Centers for Disease Control and Prevention provides a useful definition: "Health communication is the crafting and delivery of messages and strategies, based on consumer research, to promote the health of individuals and communities."[7]

Health communication can be further divided based on the number of people involved in the communication: mass communication, organizational communication, small group communication, and interpersonal communication. In this manual, we will address interpersonal communication in the patient-provider dyad (or pair).

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Activity 1-1

Alone or with your peers, draft a list of qualities possessed by a competent and effective dental professional. Then, briefly survey several people who are not dental professionals and ask them what qualities they value in a dentist or dental auxiliary. Note where the two lists overlap or diverge. Pay particular attention to those qualities indicating clinical competence and those indicating communication competence.

Healthy People 2020

Healthy People is a government-sponsored initiative that uses scientific research to identify national health needs, establish benchmarks and 10-year goals, and monitor progress toward those goals.[8] Healthy People 2020 has identified numerous measurable goals in 42 topic areas. The topic area of "health communication and health information technology" includes 13 goals (Box 1-1).

Box 1-1 Health communication and health information technology goals of Healthy People 2020*

- Improve the health literacy of the population.
- Increase the proportion of persons who report that their health care providers have satisfactory communication skills.
- Increase the proportion of persons who report that their health care providers always involved them in decisions about their health care as much as they wanted.
- Increase the proportion of patients whose doctor recommends personalized health information resources to help them manage their health.
- Increase the proportion of persons who use electronic personal health management tools.
- Increase individuals' access to the Internet.
- Increase the proportion of adults who report having friends or family members whom they talk with about their health.
- Increase the proportion of quality health-related websites.
- Increase the proportion of online health information seekers who report easily accessing health information.
- Increase the proportion of medical practices that use electronic health records.
- Increase the proportion of meaningful users of health information technology.
- Increase the proportion of crisis and emergency risk messages intended to protect the public's health that demonstrate the use of best practices.
- Increase social marketing in health promotion and disease prevention.

*Reprinted from the US Department of Health and Human Services.[8]

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Patient-Provider Communication

Definition of patient-provider communication

Health communication contains numerous domains, including public health campaigns, social influences on health, and communication between medical professionals. The domain of **patient-provider communication** is communication between two people assuming the roles of patient and health care provider. Typically, it involves the face-to-face exchange of medical information. Recently, however, advances in communication technology have challenged providers to develop communication skills outside of the office through media such as email, text messages, and instant messages. As cultural emphasis shifts away from formality and privacy, providers must determine appropriate boundaries between professional and personal communication while adhering to the requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).[9]

Activity 1-2

Communication requires the participation of at least two people. Discuss with your peers whether patients have an obligation to participate in provider encounters by disclosing information and asking questions. What level of patient participation is helpful? What level of participation becomes burdensome? Do providers differ in their preferences for patient participation in health care?

The patient-centered health care delivery model has focused on the importance of patient-provider communication.[10,11] Often promoted as evidence-based medicine, the traditional model is "diseased-centered" care, emphasizing diagnosis, symptoms, and treatment, rather than the patient.[12,13] Three characteristics distinguish patient-centered care from disease-centered care.[14] First, in addition to biologic influences, patient-centered care acknowledges psychologic and social influences on health.[15] Second, patient-centered care entails decision-making that involves both the patient and the provider.[16,17] Third, patient-centered care encourages an ongoing relationship between the patient and the provider.[18,19]

Patients with a regular care provider rate provider relationships more positively than do those without consistent sources of care.[20] An ongoing relationship between a provider and a patient is associated with multiple advantages for the patient, including enhanced satisfaction, treatment plan adherence, and trust.[19,21] In turn, the health care provider benefits from long-term patient relationships because accurate diagnosis and treatment are easier to accomplish when a patient's history and behavioral habits are well known. Further, loyal patients enhance a practice's financial stability.

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Question of ethics: Patient-centered health care acknowledges the patient's right to determine treatment, but the treatment plan selected by the patient may not be the plan endorsed by an evidence-based health care approach. When such a conflict arises, what options are available to the health care provider? How does the provider proceed ethically?

American Dental Association guidelines

Patient-centered care and evidence-based care increasingly overlap in formal research studies of patient-provider communication. Innovative research designs—measuring interaction and its impact on patient health—have given rise to a large and growing evidence base of effective ways of engaging patients. Consequently, interest in this subfield is likely to increase.[22] The communication style practiced by a health care provider is now recognized to have a significant influence on patients' health outcomes. Therefore, simply assuming a lackluster "bedside (or chairside) manner" is no longer acceptable.

In 2009, the American Dental Association's Council on Ethics, Bylaws and Judicial Affairs drafted the Dental Patient Rights and Responsibilities to guide dentist-patient relationships. The statement lists 9 patient responsibilities and 13 patient rights. The statement highlights the centrality of communication to the relationship between patients and dental professionals. Of the nine patient responsibilities, the first four address communication directly: providing accurate information, providing feedback, participating in decisions, and asking about treatment options. The list of patient rights includes even more communication-related elements, indicating the high expectations for a variety of communication skills among dental professionals (Box 1-2).[23]

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Box 1-2 American Dental Association Statement of Dental Patient Rights*

1. You have a right to choose your own dentist and schedule an appointment in a timely manner.
2. You have a right to know the education and training of your dentist and the dental care team.
3. You have a right to arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.
4. You have a right to adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
5. You have a right to know what the dental team feels is the optimal treatment plan as well as a right to ask for alternative treatment options.
6. You have a right to an explanation of the purpose, probable (short- and long-term) results, alternatives, and risks involved before consenting to a proposed treatment plan.
7. You have a right to be informed of continuing health care needs.
8. You have a right to know in advance the expected cost of treatment.
9. You have a right to accept, defer, or decline any part of your treatment recommendations.
10. You have a right to reasonable arrangements for dental care and emergency treatment.
11. You have a right to receive considerate, respectful, and confidential treatment by your dentist and dental team.
12. You have a right to expect the dental team members to use appropriate infection and sterilization controls.
13. You have a right to inquire about the availability of processes to mediate disputes about your treatment.

*Adapted from the Council on Ethics, Bylaws and Judicial Affairs, American Dental Association.[23]

Patient-Provider Communication in Dentistry

Similarities to other medical contexts

Patient-provider communication in dentistry shares many similarities with patient-provider communication in other medical contexts. For instance, the primary relationship is between the dental or medical professional and the patient, although secondary relationships are sustained with others such as auxiliaries on the team, specialists, patient caregivers, and significant others. Also, the primary communication environment is the dental operatory or physician's office, although advances in communication technology are expanding the options of both time and place at which providers can communicate with patients. Finally, the primary goal of the communication is the health of the patient.

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In addition to the three similarities noted above, it is worth considering the ways in which disclosure in both dentistry and other medical contexts differs from typical dyadic (two-person) communication within social relationships. All medical professionals must become accustomed to three particular characteristics that are quite different from usual interpersonal communication. First, patient-provider communication is characterized by asymmetric disclosure. In social interactions, communicators expect to contribute equally to the conversation, but in medical encounters, patients disclose more than the provider. Second, high-level disclosure characterizes these interactions.[24,25] Doctors should be prepared for patients to reveal information to their doctors that their closest friends may not know. Third, rapid disclosure is a feature of patient-provider communication. Within minutes of meeting a provider, patients may quickly report details on their health and habits.

Question of ethics: Research indicates that provider communication influences patient satisfaction. Is it ethical for a provider to communicate poorly with challenging patients, patients with financial problems, or patients with difficult personalities in the hopes they will find another provider?

Differences from other medical contexts

Patient-provider communication in dentistry does differ from communication in other medical contexts in four important ways. First, patient encounters with dental professionals are more physically intrusive than typical medical encounters. The accepted normal amount of personal space for Americans and Europeans is about 20 inches.[26] During a routine examination, a physician may invade that space for a brief time, but a dental professional usually stands very close to—and above—a reclining patient for a substantial length of time. Second, dental examinations are routinely more invasive than most physical examinations. Physicians and medical specialists typically explore body cavities briefly, but dental professionals spend much of the appointment examining, cleaning, or repairing features of the oral cavity. Third, patients are more aggressive during dental visits than in other medical encounters in which their bodies are examined and manipulated. Inevitably, dental visits require patient activity (holding the mouth open, swishing water, spitting, etc). Often this activity can make patients feel uncomfortable and ultimately more difficult to manage. Finally, dental visits hold more potential for pain than other medical encounters. Dental professionals focus on the head and mouth, two of the most vulnerable and sensitive parts of the body. As a result, even a simple dental examination can cause pain in a way physical examinations rarely do. Taken together, these distinguishing features may explain why 1 in 10 people suffers from dental anxiety.[27]

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Criteria for training in communication skills

In 2008, the American Dental Education Association issued revised competencies for the new general dentist.[28] These 39 competencies fall into 6 domains: *(1)* critical thinking, *(2)* professionalism, *(3)* communication and interpersonal skills, *(4)* health promotion, *(5)* practice management and informatics, and *(6)* patient care. Fifteen of those competencies relate—either directly or indirectly—to communication with patients (Box 1-3). Training in communication skills is now required in all US colleges of dentistry. The Commission on Dental Accreditation[29] now includes two behavioral science standards entailing patient communication training:

- **2-15** Graduates must be competent in the application of the fundamental principles of behavioral sciences as they pertain to patient-centered approaches for promoting, improving, and maintaining oral health.
- **2-16** Graduates must be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.

Benefits and Challenges of Enhanced Communication Skills

Value of communication skills

In dentistry, how important are interpersonal skills relative to clinical skills? Given the tremendous amount of work and resources dental professionals commit to their clinical training and the significant time and skill required at a dental practice, does proficiency in patient communication justify the extra effort required to learn and implement those skills? Patients indicate that it does. Perhaps surprisingly, practicing dentists agree. A 1998 study determined that dentists rated interpersonal skills, stress tolerance, and administrative skills as the most important determinants of professional success.[30] Moreover, although dental professionals might believe patients evaluate them solely on their clinical skills, patients tend to assume professionals are clinically competent and therefore base their evaluations on communication skills.[31,32]

Measurable benefits of effective communication

Effective patient-provider communication supports patient-centered health care and is associated with specific, measurable benefits. Patient-provider communication is associated with **greater patient satisfaction with care**,[33–35] **greater patient adherence to treatment plans**,[34,36,37] and **fewer medical errors and mistakes**.[38,39] Skilled communication may even be associated with **fewer malpractice claims**.[40–44] Ultimately, effective patient-provider communication leads **to better health outcomes for the patient**.[45–47] Skilled communication yields a complementary benefit for the provider: Along with monetary reward and respect, positive patient relationships are a primary contributor to **dentists' job satisfaction**.[48,49]

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Box 1-3 Communication-related competencies for the new general dentist*

1. Critical thinking

1.3 Evaluate and integrate best research outcomes with clinical expertise and patient values for evidence-based practice.

2. Professionalism

2.1 Apply ethical and legal standards in the provision of dental care.

3. Communication and interpersonal skills

3.1 Apply appropriate interpersonal and communication skills.
3.2 Apply psychosocial and behavioral principles in patient-centered health care.
3.3 Communicate effectively with individuals from diverse populations.

4. Health promotion

4.1 Provide prevention, intervention, and educational strategies.
4.2 Participate with dental team members and other health care professionals in the management of and health promotion for all patients.
4.3 Recognize and appreciate the need to contribute to the improvement of oral health beyond those served in traditional practice settings.

5. Practice management and informatics

5.3 Apply principles of risk management, including informed consent and appropriate record keeping in patient care.
5.6 Comply with local, state, and federal regulations including OSHA and HIPAA.

6. Patient care

6.3 Obtain and interpret patient/medical data, including a thorough intraoral/extraoral examination, and use these findings to accurately assess and manage all patients.
6.6 Formulate a comprehensive diagnosis, treatment, and/or referral plan for the management of patients.
6.8 Prevent, diagnose, and manage pain and anxiety in the dental patient.
6.18 Recognize and manage patient abuse and/or neglect.
6.19 Recognize and manage substance abuse.

*Adapted from the American Dental Education Association[28] with permission.

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Activity 1-3

Measure your social style using the instrument below,* scoring each item from 1 ("poor") to 5 ("very good"). Sum your score on the subscales and the total instrument, and then compare your scores with your peers. Do your personal scores reflect the strengths and weaknesses you perceive in your communication skills? Take the test again after you have completed your communication training and note any changes.

Initiating relationships

1. How good are you at asking someone new to do things together, like go to a ball game or a movie?
2. How good are you at going out of your way to start up new relationships?
3. How good are you at carrying on conversations with new people whom you would like to know better?
4. How good are you at introducing yourself to people for the first time?
5. How good are you at calling new people on the phone to set up a time to get together to do things?
6. How good are you at going places where there are unfamiliar people in order to get to know new people?
7. How good are you at making good first impressions when getting to know new people?

Providing emotional support

8. How good are you at making someone feel better when he or she is unhappy or sad?
9. How good are you at making others feel like their problems are understood?
10. How good are you at helping people work through their thoughts and feelings about important decisions?
11. How good are you at helping people handle pressure or upsetting events?
12. How good are you at showing that you really care when someone talks about problems?
13. How good are you at helping others understand their problems better?
14. How good are you at giving suggestions and advice in ways that are received well by others?

Asserting influence

15. How good are you at getting people to go along with what you want?
16. How good are you at taking charge?
17. How good are you at sticking up for yourself?
18. How good are you at getting someone to agree with your point of view?
19. How good are you at deciding what should be done?
20. How good are you at voicing your desires and opinions?
21. How good are you at getting your way with others?

*Adapted from Buhrmester et al[50] with permission.

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Barriers to the use of evidence-based communication strategies

The many benefits of enhancing provider communication skills and using those skills when interacting with patients have already been discussed. In addition, a European study indicated that 87% of dentists and 84% of patients support the integration of communication study into dentistry coursework.[47] Yet a recent nationwide survey by the American Dental Association Survey Center found that dentists in private practice routinely engage in only 3.1 of the 7 basic communication techniques, a rate the authors of the study described as "low."[51]

Question of ethics: Patient-provider communication can determine the level of a patient's access to care. Should providers therefore strive to communicate the exact same information to every patient in the same way? Is it ethical for providers to tailor their message and its delivery to the needs of each patient? Who determines what those needs are?

Given the benefits of effective patient-provider communication and that communication training is now required in US colleges of dentistry, why would dental professionals exclude proven strategies for providing patient-centered care? Three reasons come to mind. First, training in communication skills generally involves a commitment of time and money. A 2007 study found that a single training session did not significantly improve the interpersonal skills of dental students and that a comprehensive communication curriculum was necessary to attain greater gains.[52] Although training is included in colleges of dentistry, we have observed great variation in presentation, the amount of resources and time, and faculty attention devoted to teaching of communication skills.

Second, the practice of adapting communication style to each patient's personality and needs requires a higher level of attention and effort than simply using the same approach with everyone. Patients with challenging clinical, behavioral, or personal characteristics can be particularly frustrating.[53,54] Research documents a decline in emotional empathy over the course of training in dental school, suggesting that the decline is associated with greater exposure to patients.[55,56] This negative association between patient exposure and empathy may carry into the practice. Similarly, "emotional labor" has been identified as a primary occupational stressor for dental hygienists.[57]

Third, providers may perceive that the application of effective communication skills in every encounter takes too much time and interferes with scheduling.

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Chapter Checklist

Why communication matters

- ❑ Understand that communication determines satisfaction, treatment adherence, information comprehension and recall, and oral health.
- ❑ Realize that providers cannot assume that everyone understands a message in the same way.

What communication is

- ❑ Understand that communication is the process by which people share ideas, experiences, knowledge, and feelings through the transmission of symbolic messages.
- ❑ Process: Understand that communication occurs only when two or more people are mutually involved in a process of sharing.
- ❑ Process: Acknowledge that effective communicators cannot rely on a script to build relationships.
- ❑ Multifunctional: Remain aware of your communication goals.
- ❑ Multifunctional: Listen to patients for indications that you are achieving your goals.
- ❑ Multichannel: Remember that some channels are better suited to certain messages than others.
- ❑ Multichannel: Remember that messages sent through one channel should not contradict messages sent through another.
- ❑ Intention: Realize that you are almost always communicating.
- ❑ Intention: Realize that you have limited control over how messages are received.

Health communication

- ❑ Understand that health communication is the crafting and delivery of messages and strategies, based on consumer research, to promote the health of individuals and communities.

Patient-provider communication

- ❑ Understand that patient-provider communication is communication between two people assuming the roles of patient and health care provider.
- ❑ Understand that patient-centered care acknowledges psychologic and social influences on health.
- ❑ Understand that patient-centered care entails decision-making that involves both the patient and the provider.
- ❑ Understand that patient-centered care encourages an ongoing relationship between the patient and the provider.
- ❑ Understand the 13 patient rights outlined by the American Dental Association.

Patient-provider communication in dentistry

- ❑ Understand that the primary relationship is between the dental professional and the patient.
- ❑ Understand that the primary communication environment is the dental operatory.
- ❑ Understand that the primary goal of the communication is the health of the patient.
- ❑ Understand that patient-provider communication is characterized by asymmetric, high-level, and rapid disclosure.
- ❑ Understand that patient-provider communication in a dental context differs from other medical contexts because it is more intrusive and invasive and because patients are more aggressive and more vulnerable to pain.

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Benefits and challenges of enhanced communication skills

- ❑ Benefits: Understand that communication is associated with greater patient and provider satisfaction and treatment adherence, fewer errors and malpractice claims, and better health outcomes.
- ❑ Challenges: Understand that development and implementation of communication skills demands time, money, attention, and effort, and tailoring messages may interfere with scheduling.

For More Information

Patient-provider communication

- http://www.health.gov/communication/
- http://www.patientprovidercommunication.org/
- http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PatientProviderCommunicationTools.pdf
- http://healthcarecomm.org/

Healthy People 2020

- https://www.healthypeople.gov/2020/topics-objectives/topic/health-communication-and-health-information-technology
- https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health

American Dental Education Association competencies

- http://www.adea.org/about_adea/governance/Pages/Competencies-for-the-New-General-Dentist.aspx
- http://www.adea.org/about_adea/governance/Documents/ADEA-Competencies-for-Entry-into-Alied-Dental-Professions.pdf

Commission on Dental Accreditation standards

- http://www.ada.org/en/coda/current-accreditation-standards

Health communication associations

- http://www.aachonline.org/
- http://www.hesca.org/

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2

Preparing for Patient Communication

Why Preparation Matters

Five decades of research on source credibility indicates that the way a message is received, interpreted, and recalled is influenced by variables in five domains: source, message, channel, receiver, and destination.[1,2] The source's task of crafting a message, selecting a channel, addressing a receiver, and accounting for features of the destination are complicated by the fact that the source of messages is simultaneously a receiver of messages. Although many communication guides focus on individual expression, the challenge for dental professionals is to craft appropriate messages at the same time as they are receiving messages from the patient.

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Effective message transmission depends on the source's ability and willingness to understand the perspective of the receiver. Before patients ever meet a dental professional face to face, they have formed expectations based on the role of the health care provider and the context of the dental office or practice. Those expectations guide patients' communication behavior, so an understanding of common perceptions, expectations, and responses can help dental professionals to prepare messages tailored to achieve treatment goals. This book devotes three chapters explicitly to the skills involved in understanding patients. This chapter provides guidance on anticipating the common perceptions and expectations of dental patients. Chapter 3 provides guidance on the perceptions and expectations of patients from various cultural groups. Chapter 4 advises clinicians about how to listen to and monitor patients while they are in the dental chair.

Stereotypes of Dentists

A **stereotype**, according to Davis and Palladino,[3] is "a set of socially shared beliefs that we hold about members of a particular group." Because stereotypes offer a shortcut for defining ourselves while evaluating others, they can be useful for reducing the stress of cognitive processing.[4,5] Although stereotypes are useful and often accurate, several characteristics of such categorization can lead to inaccurate assumptions. As generalizations, stereotypes describe an average or norm and work less well when applied to a specific individual within the stereotyped category. Further, stereotypes are culture specific, so stereotypes in one culture may not apply in another. Finally, stereotypes develop over time but often become outdated when they do not evolve to reflect changes in the stereotyped group.

Stereotypes are pervasive and often operate outside awareness.[6] In the United States, stereotypical characteristics of dentists tend to be negative rather than positive. Thibodeau and Mentasti[7] reviewed a century of portrayals of dentists in film and concluded that "Dentists often still are portrayed in the movies in a comedic role or as incompetent, sadistic, immoral, disturbed or corrupt." They noted that previously underrepresented groups (eg, women and racial minorities) are now cast in the role of dentist, but the negative stereotypes attaching to the role persist. Film portrayals reflect, reinforce, and shape attitudes of the audience, so in the absence of empirical research on popular stereotypes of dentists, popular films serve as useful indicators of the characteristics attributed to dentists (Box 2-1).

Six stereotypes hold particular relevance for patient-provider communication: *(1)* Dentists are rejected physicians; *(2)* dentists are sadistic; *(3)* dentists are greedy; *(4)* dentists are lecherous; *(5)* dentists are attractive; *(6)* dentists are trustworthy.

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Box 2-1 Films featuring dentists

- *Laughing Gas* (1914)
- *Greed* (1924)
- *The Dentist* (1932)
- *The Strawberry Blonde* (1941)
- *The Little Shop of Horrors* (1960)
- *Rudolph the Red-Nosed Reindeer* (1964)
- *Marathon Man* (1976)
- *10* (1979)
- *The In-Laws* (1979)
- *Little Shop of Horrors* (1986)
- *Eversmile, New Jersey* (1989)
- *The Dentist* (1996)
- *Schizopolis* (1997)
- *The Secret Lives of Dentists* (2002)
- *Snow Dogs* (2002)
- *Finding Nemo* (2003)
- *Good Luck Chuck* (2007)
- *Wild Hogs* (2007)
- *Ghost Town* (2008)
- *The Spirit* (2008)
- *The Hangover* (2009)
- *Horrible Bosses* (2011)

Dentists are rejected physicians

One persistent stereotype is that dentists go into dentistry because they were unable to enter and complete medical school. Dental students indicate that they sometimes must defend the decision to pursue dentistry to people who ask why they did not instead go to medical school. Medical students do not generally report explaining why they did not pursue dentistry. The stereotype of dentists as rejected physicians likely derives from the cultural elevation of physicians in the United States and a poor understanding of the education and training required of dentists.[8] Other medical professionals (eg, pharmacists, physician assistants, and nurses) likewise are sometimes perceived as rejected physicians. This hierarchy of prestige may also persist in the research community.[9] A running joke in *The Hangover* involves the dentist's claim that he is a doctor. A physician in the film provides the typical response: "You said that several times last night, but really you're just a dentist."

When communicating with patients, dentists should remain aware that many patients do not understand the relationship between oral health and systemic health, much less where dentists and other dental professionals fit in the confusing constellation of health care delivery. Without sounding defensive or patronizing, dental professionals should make it a priority to educate patients about the significance of oral health and the role of the dentist as a doctor specializing in oral health. Through such education, patients may take more seriously both their oral health and the dentist who advises them. Dentists can further reinforce their medical qualifications in the minds of patients by consulting with patients' primary care physician and other health care providers whenever possible.

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Dentists are sadistic

Pain is a motivator for a dental visit, and dental treatments are historically associated with pain.[10] Olav[11] found that 20% to 30% of adults rated their previous visit to the dentist as "moderately painful" (or worse) and 60% reported at least one "very painful" experience. Pain and the associated anxiety are sometimes unavoidable, but in the popular imagination, some dentists inflict pain intentionally, and some even enjoy doing so. This stereotype is so pervasive that audiences quickly perceived why dentists were selected to employ "enhanced interrogation" techniques in *Marathon Man* and *The Spirit*. *Little Shop of Horrors* dropped all pretense of pain as a means to an end: The patient's torture was its own reward for that dentist.

Dental professionals should remain aware of these stereotypes, acknowledge a patient's pain, and provide accurate information about the "discomfort" a procedure will entail. Patients expect some pain and are generally willing to endure it, but they react negatively when a dentist disregards it. Clinicians should avoid laughing and appearing unconcerned when examining patients in pain or performing procedures that are causing pain. Providers who arrange a system for patients to signal when pain becomes unbearable, and then stop the procedure promptly, are unlikely to be perceived as sadistic.

Dentists are greedy

A third persistent stereotype is that dentists are motivated primarily by money. Several factors contribute to this stereotype. First, 38.2% of the US population has no dental insurance, and patients may be more aware of charges because they are more likely to pay out of pocket.[12] Second, patients often may not perceive the multiple costs involved in running a dental practice, such as training, continuing education, overhead, and insurance.[13] When patients mistakenly believe that they are paying only for appointment time, they may believe they are paying too much. Third, evidence suggests that dentists may be reluctant to serve lower-income patients, fostering the stereotype that dentists are interested mainly in collectable fees from financially secure patients.[14,15]

A testament to the endurance of the stereotype of the greedy dentist is a 1924 Erich von Stroheim film in which the main character becomes a dentist and steals his friend's girlfriend for her lottery winnings. The title? *Greed*. In communicating with patients, today's dentists must be sensitive to perceptions of greed and excessive wealth. When building rapport with patients, providers should avoid discussions of their expensive cars, upscale neighborhood, exotic trips, or private schools.

In addition, when presenting treatment plans, today's dentists must be truthful regarding the necessity and cost of services.[16] Patient-centered care allows patients to collaborate with providers in determining services and treatment, so providers should listen to patients' concerns about costs when reviewing treatment options.[17] It is un-

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ethical to pressure patients to accept an expensive treatment and then pass them off to a billing clerk to arrange payment. Even with good clinical results, patients who feel pressured to undergo an expensive treatment may thereafter suspect a dentist's motives.

Persuasion, not pressure, is simultaneously more ethical and more satisfactory for the patient. Whenever possible, patients should be provided a choice of treatments at different price points. Dental professionals can (and should) offer an opinion on the best option, given the patient's concerns (eg, cost, appearance, and durability). The patient ultimately makes the choice, however, and given that the patient will live with the results, that choice should be respected. Information on communicating treatment options is presented in chapter 9.

Dentists are lecherous

A fourth negative stereotype is that dentists are prone to take sexual advantage of patients, including sexual harassment, abuse, and assault. One possible explanation for this stereotype is the publicity surrounding high-profile cases of dentists engaging in sexual misconduct with patients.[18–20] Another explanation is the potential for misinterpretation of intrusive nonverbal behaviors (eg, proximity and touch) required in dentistry[21] (see chapter 1). A third explanation is the potential for sexual hallucinations in patients emerging from anesthesia.[22,23] Whatever the reason for the stereotype, it appears to endure, as it was a plot point in the 2011 film *Horrible Bosses*. Curiously, in that movie the sexually predatory dentist was a woman, although female dentists are rarely accused of sexual misconduct.

Dental professionals can reduce the potential for misperceptions of sexual aggressiveness by following a few communication strategies. First, social touch should be restricted to the hands and arms, and professional touch should be confined to the oral cavity as much as possible. Second, if the operatory has a door, it should be closed for privacy during the health history interview but otherwise left ajar. Third, during examinations or procedures, another professional should be in the operatory—either a dental hygienist or a dental assistant. If the patient would like a relative or friend in the operatory, and if that request can be reasonably accommodated, the request should be honored. Finally, providers should announce what they are doing and why, guiding interpretation so that the patient will be less likely to attribute proximity and touch to lecherous motives.

Question of ethics: Communication researchers have documented that flirting often is not an invitation to sexual coupling but can instead serve other functions and provide benefits such as tension reduction and relationship building. Is it ethical to flirt with patients? Does your answer change if the patient is receptive to flirting behavior? Does your answer change if the patient initiates flirting behavior?

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Dentists are attractive

A couple of positive stereotypes of dentists go far toward counteracting the negative impression of dentists as sadistic, greedy, lecherous, physician wannabes. One positive stereotype is that dentists are physically attractive. One reason for this stereotype is that—other physical characteristics notwithstanding—dentists tend to have good teeth, and good teeth are an indicator of attractiveness, particularly when evaluated by the opposite sex.[24,25] Further, physical attractiveness exhibits a halo effect in which attractive people are also assumed to be more competent.[26] Another reason is that dentists work on patient's mouths, and it has been noted that "the oral cavity has an erogenous potential."[27] Yet another reason is that arousal of fear and anxiety responses can be misinterpreted by individuals as sexual attraction.[28,29] Films often reinforce the attractiveness stereotype by casting attractive actors in the dentist role in films such as *Snow Dogs* and *Eversmile*, *New Jersey*.

Dentists can, and should, benefit from the attractiveness stereotype but also must be careful to maintain professional boundaries. Dentists' teeth and breath advertise the quality of their work, so they should be in excellent condition. Dental professionals should encourage mutual trust and liking in the patient relationship but must also sensitize themselves to indicators of danger. Dangerous dentist behaviors include consistently treating patients of one sex differently than patients of the other sex or treating one patient much differently than other patients. Dangerous patient behaviors include inappropriate verbal disclosures, questions, touching, and gift giving.

Mutual attractions sometimes do lead to relationships, but dating patients can lead to multiple practical and ethical problems, particularly if the relationship ends.[30,31] Providers who find themselves interested in a patient should refer the patient to a colleague before pursuing a romance.

Dentists are trustworthy

Seemingly incompatible with the negative stereotypes discussed is a positive stereotype that may compensate for all the negative associations: People trust dentists. In Gallup polls on the ethics and honesty of various professions, dentists consistently place in the top 10.[32] In the 2009 poll, 57% of respondents rated the honesty and ethical standards of dentists "high" or "very high."[33] This rating placed dentists sixth, behind nurses (83%), pharmacists (66%), physicians (65%), police officers (63%), and engineers (62%). The ranking is high but below the 62% rating achieved in 2006 and continues a declining trend.[34] Christensen[35] attributed that trend to several factors, relating primarily to dentists' focus on financial concerns to the neglect of patients' needs.

Even so, trust remains high, probably for the same reasons that so many of the most trusted professions are in the medical field. Patients seeking medical care are physically vulnerable, often weak and uncomfortable, and frequently do not fully understand the details of their diagnosis and treatment. As a result, they can appreciate that medical professionals hold a great deal of power to heal or harm. When professionals

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avoid harming patients or taking advantage of their vulnerability, they are rewarded with trust. The dentists in *Wild Hogs* and *Eversmile*, *New Jersey* are portraits of honesty and trustworthiness.

The primary communication strategy for fostering trust is to avoid any verbal or nonverbal messages that would undermine the honesty and fairness patients generally ascribe to the profession. Our culture typically promotes an idealistic portrait of dentistry to young children to facilitate visits and encourage lifelong dental care. Therefore, dentists are assumed to have positive qualities until personal experience indicates otherwise. The negative stereotypes are perhaps given more credibility only after a dentist causes pain (sadistic), overcharges (greedy), or makes an inappropriate comment (lecherous). Avoiding those messages is the best way to cultivate trust. The second best way is to apologize for such messages, whether they were intentional or misconstrued by the patient.

Activity 2-1

Consider portrayals of dentists in popular culture—film, television, and books. Do you think these portrayals are more likely to reflect popular attitudes about dentists or shape those attitudes? Discuss with your peers or instructors the influences on your decision to enter dentistry. Were you influenced primarily by personal experiences and relationships or by popular portrayals? Which experiences or portrayals?

Preappointment Perceptual Influences

In addition to stereotypes reinforced by the mass media, other types of influence shape patient perceptions of dentistry and dental professionals. By developing an awareness of these influences and understanding how they might affect the patient-provider relationship, providers can prepare themselves to correct misperceptions and reinforce positive perceptions. We will consider three influences on patient perceptions: *(1)* advertising and promotions, *(2)* word of mouth, and *(3)* websites and social media.

Advertising and promotions

Until the 1970s, advertising by dentists and other professionals was restricted or prohibited by professional organizations. After the US Supreme Court prohibited such restrictions, dentists began employing increasingly sophisticated advertising and marketing techniques to attract patients, and the distinction between a patient and a customer blurred. Such commercialization has remained controversial and prompted ongoing arguments about the ethics of marketing medical care.[36,37] Most dentists—particularly the older ones—initially opposed dental services advertising, but their views have moderated in the intervening years.[38,39] Consumers are generally more

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accepting of advertising than dentists are and value the information advertising provides, although patients also believe selection of a dentist should not be based on advertising.[38,40]

Advertising dental practices will continue via traditional media: television, radio, print, billboards, and direct mail. Because these are mass media, they potentially influence everyone. Whether or not a dentist chooses to advertise, patients will be exposed to the advertising of others. Only 9.2% of dentists advertise on television, but 46.7% of consumers report exposure to these advertisements.[38] Only 3.1% of dentists use billboards, but 31.7% of consumers report seeing billboard advertisements for dentists.

The public's exposure to mass media messages (including advertising) likely contributes to the high degree of agreement regarding standards of dental attractiveness.[41] Dental advertising also likely shapes patient expectations about the appointment experience and the possible results.[42,43] For instance, "pain-free dentistry" is a catchphrase often used to attract patients. Dental techniques can be less painful than they once were, and advances in pain management have further reduced the pain most procedures entail. Yet, contrary to the premise of pain-free dentistry, the potential for discomfort and pain remains. To correct misperceptions about pain-free dentistry, providers must be prepared to engage patients in an honest discussion of the pain involved and their pain threshold.

Question of ethics: List three arguments for the right of dental practices to advertise and three arguments against. Do you feel dentists should have any restrictions on their advertising? If so, what are the limits?

Dental professionals must also be prepared to respond when patients show up for appointments with photographs ripped from magazines and before-and-after dental product advertisements showing "perfect" smiles. First, providers should discuss with the patient whether the outcome portrayed is achievable, given the condition of the patient's mouth and teeth. Second, providers should discuss whether the outcome is desirable. Patients may not understand the disadvantages of some procedures (eg, the installation of tooth jewelry or "grills" or unnaturally white teeth), and the dentist should be careful to explain the drawbacks without insulting the patient's knowledge or taste. Third, if the outcome is both achievable and desirable, providers should explain whether they are willing to do the procedure and, if so, the commitment of money, discomfort, and time the procedure requires.

In addition to advertising, dentists sometimes resort to marketing promotions to draw clients, and these strategies can distort a patient's perceptions of the cost of dental care. Garretson and Clow[44] found that coupons for dental care did increase the intention to purchase but at the expense of negative impacts on perceived quality and risk. Raghubir and Corfman[45] found that negative associations are more likely in service industries (such as dentistry) in which price promotions are traditionally un-

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common. Whether those negative effects extend beyond the dental practice offering the discount or free trial is unknown.

What is known is that price promotions often list rates for specific procedures (eg, "$495 porcelain crown"), and these rates likely influence what patients expect to pay their own dentist. Therefore, dentists should remain aware of current local pricing levels for standard procedures. They should also be prepared to account for discrepancies between the lower rates advertised by other dentists and their own rates. Clinicians should explain to patients if procedures or materials differ or if a higher price includes more service.

Word of mouth

A 2009 study identified the implicit communication deriving from successful dental treatment as the key communication factor determining patient satisfaction.[46] The secondary factors, however, were the dentist-provider relationship and referrals by previous patients. Word-of-mouth referrals by patients are the most cost-effective form of marketing a dental practice.[47] A 2008 survey asked about the influences on respondents' selection of an orthodontist.[48] Fifty percent noted recommendations by family and friends, and 57% noted professional referrals. Very few respondents were influenced by Yellow Pages advertising (4%) or websites (1%). Dentists believe lay referral is the major source of new patients.[49]

Word of mouth can also negatively influence a practice. Reichheld[50] suggested that several positive comments would be necessary to overcome a single negative evaluation a patient disclosed. Other researchers, however, dispute this claim, although they acknowledge that negative word of mouth can drive away potential patients.[51,52]

Question of ethics: Assume the role of a patient instead of a health care provider. Is it ethical for patients to tell family and friends of negative experiences with a health care provider? Is it ethical to post such experiences on the Internet?

Dental professionals have limited control over what is said to whom after patients leave the office. Yet the reputation of a practice is largely built—or destroyed—by social network communication, which is now magnified by the availability of digital communication and social media. Dental professionals should realize that new patients may already have formed a strong opinion of them before ever sitting in the chair.

Developing an awareness of your reputation is essential to strengthening it or defending it. Satisfied patients can be explicitly encouraged to refer friends and family members to the practice. All patients should be encouraged to express any dissatisfaction to their dentist first, to offer an opportunity to fix problems. If they make a good-faith effort to address patient dissatisfaction and a patient continues to complain to others about service, providers have few options beyond referring the patient to a colleague. Such providers might console themselves with the assumption that the friends and family of the former patient are accustomed to hearing his or her complaints and therefore discount the evaluation.

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Websites and social media

As an influence on patient perceptions, digital communication bridges mass media advertising and word of mouth. It also remains a frontier. A 2007 study found that 71.5% of dentists market their practice using a website, but only 11.7% of consumers reported viewing their dentist's website.[38] These numbers may increase, however, as more practices make use of Internet portals to schedule appointments, document a patient's health history, and provide information and follow-up for procedures.

Practices increasingly use the Internet for promotional purposes. For instance, dental practices have begun offering discounts through Internet sites such as Groupon and LivingSocial. Some professional organizations suggest that these promotions should be prohibited because they represent compensation for referral.[53] The Internet will continue to raise provocative issues that the entire dental profession must confront.

Even those practitioners who do not have a website or market themselves via the Internet must contend with two particular influences. First, patients now have access to an enormous amount of information on dental health and the latest developments in dental care. The Internet has simultaneously expanded access to information and democratized information flow, allowing anyone to attract an audience. A second important development is the rise of social media such as Facebook and Twitter, which permit real-time interaction with enormous networks. As a result of these two influences, before they arrive for an appointment, patients may have formed strong beliefs and attitudes regarding dental health (eg, mercury in restorations), dental procedures (eg, tooth whitening), and even specific dentists.

Not all of these beliefs may be accurate, nor may all the attitudes be justified. Dental professionals, however, have an obligation to listen to patients and validate their concerns. Dentists should always begin by praising the initiative patients have shown in researching or investigating an issue. When patients are misinformed, providers should use patients' misperceptions as an opportunity to educate them. Clinicians should encourage patients to pursue their interest in dental care but suggest some specific, credible resources—perhaps their own practice's website or the American Dental Association's excellent site, which includes an enormous amount of information in its Public Programs section (http://www.ada.org/en/public-programs).

Social media may be a source for information and misinformation, but it serves an additional function in allowing patients to disseminate opinions about their recent procedure or provider encounter. An increasing number of patients are taking to the Internet to air complaints against medical professionals.[54] However, unlike nonmedical service providers, medical professionals are typically prohibited by federal law (Health Insurance Portability and Accountability Act of 1996[55]) from disclosing patient information, thus preventing response to a patient's complaint in an online forum. Dentists should periodically conduct an Internet search of their name to ensure that no such complaints are floating around. If such complaints are found, the complaining patient can be contacted directly to arrange a resolution involving the removal of the online complaint. In some cases, legal action may be necessary.

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Dental Anxiety

Odontophobia, **dental phobia**, **dental fear**, and **dental anxiety** are defined differently by various researchers. We refer to both **dental fear** and **dental anxiety** to describe the negative reactions of some patients toward dental treatment. Those reactions may be cognitive and emotional or they may be behavioral, but every dentist will encounter patients who are dentally anxious; interacting with such patients usually induces stress in the dentist.[56]

Poor anxiety management may lead patients to change dentists.[49] As with patient-provider communication in general, no single approach works best in every circumstance, so concurrent treatment of dental anxiety must be tailored to the patient.[57,58] To accomplish this, providers should understand what causes dental anxiety and what types of treatment are effective.

Causes of dental anxiety

An extensive research literature has developed around the causes and treatment of dental anxiety. Older patients and women are more likely to exhibit dental anxiety, which is often a consequence of a negative experience.[59] A 1996 study found more than three-quarters of the population reports direct negative dental experiences: painful (71%), frightening (23%), or embarrassing (9%).[60] Further, the relationship between dental anxiety and such experiences is strong. Patients can also develop dental anxiety vicariously through the experience of others—anxious parents or friends who had a painful procedure.[61] A more recent study by Armfield[62] found that previous negative dental experiences are weaker predictors of anxiety than are perceptions of uncontrollability, unpredictability, dangerousness, and disgustingness.

Regardless of cause, anxiety can have clinical consequences. For instance, anxious patients are significantly more likely to have caries lesions and to be edentulous.[63,64] Dental anxiety is also related to reductions in oral health–related quality of life.[65]

Diagnosis of dental anxiety

Although validated instruments have been developed to diagnose dental anxiety and dental fear, they are inconvenient in a clinical setting.[66–69] Recently, Jaakkola et al[70] developed a one-question screening tool that can be used chairside and has shown promise in determining the level of a patient's fear (Table 2-1). If a screening instrument is used, we advise against revealing a diagnosis of "anxious" or "fearful," which could label the patient with a condition that may be situational or temporary.

Of course, the provider can always simply ask, perhaps during the health history interview, whether the patient has delayed or canceled previous appointments or is worried about the present appointment.[71] The goal is to identify specific fears so they can be addressed.

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Table 2-1 The Short Dental Fear Question and clinical classification*

Question: The last time you visited your dentist, how did it go?	Classification of fear
1. I was totally relaxed during the treatment.	Relaxed
2. I was nervous, but the treatment was carried out successfully.	Slightly frightened
3. I was nervous; the treatment could only just be carried out.	Moderately frightened
4. I was so frightened and nervous that…	
a. Treatment was difficult.	Severely frightened
b. The treatment didn't succeed.	Severely frightened
c. I totally missed my appointment.	Severely frightened

*Reprinted from Jaakkola et al[70] with permission.

The four anxiety classifications identified in the study by Jaakkola et al[70] are similar to the four types of anxious patient described in a study by De Jongh et al[72]:

1. Patients with mild anxiety
2. Patients fearful of specific dental procedures or situations
3. Patients with psychiatric symptoms
4. Patients with a high treatment need

Communication strategies with anxious patients

The De Jongh et al[72] study identified three chairside approaches effective in reducing anxiety. First, the progress of the appointment should be highly predictable for the patient. At the beginning, providers should preview the agenda by describing the goals of the appointment and the procedures required to meet those goals. Predictability can be enhanced by previewing and narrating the procedures as they occur.

Second, the teaching of coping skills to anxious patients reduces their anxiety. Such skills can include thought-stopping, deep breathing, meditating on positive affirmations, imagery, and holding a comforting object.[73] Milgrom and Weinstein[61] indicated that the acquisition of coping skills can enhance trust and feelings of control. A meta-analysis of behavioral interventions to reduce dental fear indicated a medium to large effect, and the results seem to be long-lasting.[74]

Third, desensitization to stimuli is an effective way to reduce anxiety. A European study ranked 67 stimuli by the degree of patient anxiety that they evoked.[75] Stimuli that scored higher included seeing the needle and other dental instruments, hearing the handpiece, and several sensations—the needle, the handpiece, and cold air on a tooth. Anxious patients who are prepared for these stimuli through a show-and-tell approach may become desensitized to the objects and experiences that they associate with anxiety.

In their review of psychologic (nonpharmaceutical) techniques for treating dental anxiety, Jerjes et al[76] included the suggestions made by De Jongh et al[72] and added

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a few more. A few of the communication strategies warrant emphasis. Ultimately, the dentist should aim to create a positive dental experience to counteract anxiety that has resulted from previous painful and negative dental experiences. To this end, a dental professional should never ignore dental anxiety, treat it as irrational, or try to argue a patient out of anxiety.

One easy strategy is to distract the anxious patient during a procedure by talking, playing music, or allowing the patient to listen to an MP3 player (such as an iPod or smartphone) on low volume.[73,77] The provider can allow the patient to select the type of music he or she wishes to hear during the appointment. To accomplish this, the provider can keep a variety of compact discs on hand, sort music by genre on an MP3 player, or select a type of streaming music from an online service such as Pandora.

Another easy strategy to alleviate anxiety is to allow the patient to pause the procedure by signaling when a break is needed. This approach enhances an anxious patient's perceived sense of control.

Patient Preferences

A growing body of research documents patient preferences and patient perceptions of the ideal dentist. Despite broad agreement across various demographic categories, however, patients often differ from one another in their preferences for many attributes and behaviors.[78] Furthermore, patients often differ from their provider in their expectations. Zimmerman[79] found a strong positive relationship between patient satisfaction and patient-provider agreement on expectations for interaction during an appointment.[80] Thus, providers should remain aware of the trends in patient preferences but should always clarify with specific patients their expectations for the consultation.[80]

The following sections discuss communication-relevant preferences that have emerged in the literature, supplemented by anecdotal and observational reports that have emerged in our discussions with students and patients.

Communicative and honest

A research team led by Lahti[81,82] reported strong preferences among Finnish patients for communicative and informative dentists. Behaviors associated with this attribute include telling patients why procedures are being done, asking if patients have specific concerns, encouraging patient questions, and telling what procedures are included in the treatment. A follow-up study indicated that patients prefer that dentists give accurate information regarding pain.[83]

A survey by Rankin and Harris[78] likewise found that patients want accurate information regarding pain and discomfort. Those patients also preferred full explanations of treatment, equipment, and behavioral expectations of the patient.

A study of patient loyalty found that patients indicate that the primary reason they remain with a dental practice is the honesty of their dentist.[84] In that study, quality of

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work and knowledge of dentistry were noted but were secondary to honesty, suggesting the importance of trust. A 1994 study found that 61% of patients indicated that explanations of procedures are very important, but only 39% of dentists agreed.[85]

Patients also tell us that they prefer being informed about the wait time for appointments and about the progress of the consultation. Regarding language use, they report a preference for explanations in lay terminology that they can understand rather than medical or dental jargon. Patients dislike the tendency of providers to leave the operatory without any explanation or estimated time they will be gone.

Activity 2-2

This chapter references film portrayals of dentists, but several television shows have also featured dentists prominently: *Friends*, *The Bob Newhart Show*, *The Carol Burnett Show*, *Seinfeld*, *Beverly Hills 90210*, *M*A*S*H*, *The Swan*, *Extreme Makeover*, and *John and Kate Plus 8*. Can you think of others? How do TV dentists compare to movie dentists? Discuss with your peers whether any of these portrayals reinforce the negative and positive stereotypes mentioned in this chapter.

Sensitive

A 1993 study found that sensitivity is considered by patients as the most important attribute when selecting a dental practice.[86] Specifically, patients prefer providers who are responsive to their pain and willing to discuss and overcome their fears. A survey of dentists indicates that they believe patients most frequently leave a practice due to external circumstances (such as relocation), but they also noted that patient turnover increases when patients are dissatisfied with the way they are treated and with quality of care.[49] Patients do not like being blamed by their dentist, criticized for the condition of their teeth, or scolded for poor oral hygiene.[78,82,83] In addition, 53% of patients say it is very important that providers not rush through an appointment, but only 32% of dentists agreed.[85]

Our own research confirms these findings and indicates that patients dislike negativity in general and alarming comments in particular. We have also been told repeatedly that patients dislike being neglected or ignored, as when members of the dental team converse as if the patient were not there. Perhaps because it interferes with their ability to perceive the progress of the appointment, patients also dislike reclining so far that their feet are above their head.

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Collaborative

A study of decision-making preferences found that most patients prefer collaboration between provider and patient, although patients perceive that they play a passive role.[87] A minority of patients preferred a more passive role, citing their lack of knowledge, trust in their provider, and time constraints as reasons to place decisions in the provider's hands. A recent systematic review of decision-making in physician-patient relationships found that 50% of studies completed before 2000 reported a preference for shared decision-making compared with 71% after 2000, suggesting a generational shift toward collaboration.[88] When asked what dentist behaviors they dislike, patients in Rankin and Harris's survey[78] said that they did not like dentists who began treatment without a full explanation.

Our research indicates that patients prefer to have treatment options presented to them but also like knowing which option the dentist advocates. They report a strong dislike for feeling pressured to make a treatment decision.

Supportive

One study found that, in addition to professional skill, patients believe that the ideal dentist should be friendly and able to put patients at ease.[89] However, there are limits to supportive behaviors. Patients prefer that providers refrain from excessive touch, especially patting or caressing.[83] Patients dislike the failure of providers to comment on patient cooperation.[78]

Our research reveals a patient preference for compliments and positive reinforcement. They also like to be greeted by name, and they like it when the provider recalls personal details about them. Patients report a strong preference for eye contact. Patients dislike a lack of tact—as when providers take a condescending tone or curtly command, "Open!" Although patients like providers to be friendly and supportive, more than a few have reported that they dislike flirting.

Professional in appearance

Patients also report preferences regarding their provider's appearance. Actually, the strongest appearance-related preferences relate to smell rather than looks or dress. Patients prefer that their providers not smell of smoke or perfume.[83] They also prefer that their dentist not have bad breath.[90]

Our research confirms these preferences, and our patients also report liking their providers to have a nice appearance and clean clothes. A few reported disliking beards, but our dental students indicate that most patients likely have no beard preference, and in some cultures beards might actually be preferred.

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Chapter Checklist

Addressing stereotypes

- ❑ Failed-doctor stereotype: Prioritize education of the patient.
- ❑ Failed-doctor stereotype: Emphasize the role of dentist as a doctor specializing in oral health.
- ❑ Failed-doctor stereotype: Coordinate care with the patient's other health care providers.
- ❑ Sadistic stereotype: Remain aware of the stereotype.
- ❑ Sadistic stereotype: Acknowledge a patient's pain.
- ❑ Sadistic stereotype: Provide accurate information about the nature of discomfort a procedure will entail.
- ❑ Sadistic stereotype: Avoid laughing or appearing unconcerned when a patient is in pain.
- ❑ Sadistic stereotype: Arrange a signaling system for a patient in pain.
- ❑ Sadistic stereotype: Stop when a patient requests a break.
- ❑ Greedy stereotype: Remain sensitive to perceptions of greed and excessive wealth.
- ❑ Greedy stereotype: Avoid discussions of expensive cars, homes, etc.
- ❑ Greedy stereotype: Be truthful regarding the necessity and cost of services.
- ❑ Greedy stereotype: Listen to the patient's concerns about costs.
- ❑ Greedy stereotype: Do not pressure the patient to accept expensive treatments.
- ❑ Greedy stereotype: Provide a range of treatments at different price points.
- ❑ Greedy stereotype: Offer an expert opinion, but respect the patient's choice.
- ❑ Lecherous stereotype: Restrict social touch to the patient's hands and arms.
- ❑ Lecherous stereotype: Restrict professional touch to the oral cavity.
- ❑ Lecherous stereotype: Leave the operatory door ajar after the health history interview and update.
- ❑ Lecherous stereotype: Announce what is happening and why, to prevent misinterpretation.
- ❑ Attractive stereotype: Maintain professional boundaries with the patient.
- ❑ Attractive stereotype: Maintain your teeth and breath in excellent condition.
- ❑ Attractive stereotype: Encourage mutual trust and liking, but be sensitive to indicators of danger, such as treating one sex or one patient differently than others.
- ❑ Attractive stereotype: Refer patients to a colleague before pursuing a romance.
- ❑ Trustworthy stereotype: Avoid messages that would undermine perceptions of honesty.
- ❑ Trustworthy stereotype: Apologize for intentional or unintentional messages that undermine patient trust.

Addressing preappointment influences

- ❑ Pain: Prepare to discuss pain and the patient's pain threshold.
- ❑ Patient requests: Discuss whether the outcome is achievable and desirable.
- ❑ Patient requests: Explain commitments of money, discomfort, and time required to achieve results.
- ❑ Local promotions: Remain aware of local pricing levels for standard procedures.
- ❑ Local promotions: Address pricing discrepancies, noting differences in procedures, materials, and included services.
- ❑ Word of mouth: Realize that the patient may have well-formed opinions before a face-to-face meeting.
- ❑ Word of mouth: Encourage the patient to express any dissatisfaction to you first.
- ❑ Websites and social media: Listen to the patient and validate his or her concerns.
- ❑ Websites and social media: Praise the patient's initiative in researching oral health.

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- ❑ Websites and social media: Use misinformation as an opportunity for education, referring the patient to credible sources of online information.
- ❑ Websites and social media: Periodically conduct an Internet search to identify online complaints against your practice.
- ❑ Websites and social media: Contact any complaining patient directly to resolve the source of dissatisfaction.

Addressing dental anxiety

- ❑ Understand the causes of dental anxiety: negative experiences; vicarious experiences; and perceptions of uncontrollability, unpredictability, dangerousness, and disgustingness.
- ❑ Diagnose dental anxiety through a validated instrument or by asking about dental fear during the health history interview.
- ❑ Make the appointment predictable by previewing and narrating procedures.
- ❑ Teach coping skills, such as thought-stopping, deep breathing, meditating on positive affirmations, imagery, and holding a comforting object.
- ❑ Desensitize the patient to stimuli through a show-and-tell approach.
- ❑ Create a positive dental experience to counteract negative past experiences.
- ❑ Never ignore anxiety, treat it as irrational, or argue over the rationality of anxiety.
- ❑ Use distractions such as talking and playing music.
- ❑ Allow the patient to pause procedures by signaling.

Accommodating patient preferences

- ❑ Communicative and honest: Tell the patient why procedures are being done, ask if the patient has specific concerns, encourage questions by the patient, and tell what procedures are included in the treatment.
- ❑ Communicative and honest: Using lay terms, provide full explanations of treatment, equipment, and behavioral expectations of the patient.
- ❑ Communicative and honest: Inform the patient of the wait time for appointments and the progress of the consultation.
- ❑ Communicative and honest: Avoid leaving the operatory without explaining or estimating the length of the absence.
- ❑ Sensitive: Respond to the patient's pain and show willingness to discuss dental fears.
- ❑ Sensitive: Avoid negativity; alarming comments; and blaming, criticizing, and scolding the patient.
- ❑ Sensitive: Avoid rushing through appointments or giving the appearance of rushing.
- ❑ Sensitive: Avoid neglecting or ignoring the patient.
- ❑ Sensitive: Avoid over-reclining the patient in the chair.
- ❑ Collaborative: Exhibit a willingness to collaborate.
- ❑ Collaborative: Begin treatment with a preview of the appointment.
- ❑ Collaborative: Provide treatment options and a professional recommendation, but avoid pressure.
- ❑ Supportive: Put the patient at ease.
- ❑ Supportive: Refrain from excessive touch.
- ❑ Supportive: Greet the patient by name, recall personal details, and make eye contact.
- ❑ Supportive: Compliment the patient and comment on his or her cooperation.
- ❑ Supportive: Show tact and avoid flirting.
- ❑ Professional appearance: Maintain a nice appearance with clean clothes.
- ❑ Professional appearance: Avoid bad smells such as smoke, perfume, and bad breath.

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For More Information

Professional codes of ethics

- http://www.ada.org/en/about-the-ada/principles-of-ethics-code-of-professional-conduct/
- http://www.adha.org/bylaws-ethics

Questions patients ask

- http://www.ahrq.gov/questions
- http://www.ihs.gov/healthcommunications/index.cfm?module=dsp_hc_toolkit
- http://www.mouthhealthy.org/en/dental-care-concerns/questions-about-going-to-the-dentist
- http://www.npsf.org/?page=askme3

Dental advertising

- http://www.crookedbrains.net/2009/10/advertising.html
- http://www.healthpromotionsnow.com/browse/Dental-Promotions-and-Practice-Marketing_149/default.aspx

The Joint Commission's Speak Up Program

- http://www.jointcommission.org/speakup.aspx

Dental anxiety

- http://www.sitalchauhan.pwp.blueyonder.co.uk/dentalanxietyassessment/Index.htm
- http://www.dentalfearcentral.org
- http://www.dentalphobia.co.uk
- http://www.hatedentists.com/1112/fear-dentists-dental-anxiety

Lists of films featuring dentists

- http://www.amazon.com/ (search "Dentists in movies")
- http://www.classicfilmguide.com/index2f36.html
- http://www.chiprowe.com/videorev/dentist.html
- http://www.listal.com/list/movie-dentists

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3

Developing Cultural Competence

Why Cultural Competence Matters

Chapter 2 explored stereotypes and media influences that shape societal perceptions of dentistry. This chapter takes a different approach, examining how perceptions and preferences are influenced within a society by the cultural background of a patient. The American Dental Education Association's (ADEA's) *Competencies for the New General Dentist* include the ability to "communicate effectively with individuals from diverse populations."[1] The ADEA[2] also requires that new dental hygienists be able to "initiate a collaborative approach with all patients when developing individualized care plans that are specialized, comprehensive, culturally sensitive, and acceptable to all parties involved in care planning." The core competence requirement for dental assistants uses similar wording. The current

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emphasis on developing communication skills with patients from diverse backgrounds reflects a broader movement in health care toward cultural competence among providers.[3–5] The Commission on Dental Accreditation[6] defines **cultural competence** as follows:

> Having the ability to provide care to patients with diverse backgrounds, values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Cultural competence training includes the development of a skill set for more effective provider-patient communication and stresses the importance of providers understanding the relationship between diversity of culture, values, beliefs, behavior and language and the needs of patients.

Cultural competence contributes to a patient-centered approach to health care and therefore seems like a nice way to treat patients, but it is more than that. A growing body of research suggests at least four advantages associated with culturally competent providers. First, the United States is becoming ever more diverse. By 2042, the aggregate ethnic "minority" population will become the majority.[7] This diversity is reflected not only among patients but also among providers, suggesting that patients and providers increasingly will come from different cultural backgrounds.

Second, cultural competence may reduce disparities in health care access. Differential access to oral health care is associated with a range of demographic and cultural variables.[8,9] Yet, even after controlling for income, education, age, and dental insurance, data indicate significant disparities in access that may relate to cultural barriers.[10] Deliberate efforts by dental professionals to overcome those barriers could enhance access to care.[11,12]

Third, by reducing communication barriers, culturally competent providers can provide better care. Most explicitly when accommodating patients' language limitations, culturally competent providers hold an advantage in understanding patients' chief complaint and desired outcome.[13]

Fourth, providers who are culturally competent diversify their patient base and enhance patient satisfaction. Patient satisfaction with dental care varies significantly by patient ethnicity and income.[14,15] Because technical competence does not vary by patient ethnicity and income, it can be assumed that patients from different backgrounds perceive their treatment differently. Development of skills in culturally competent communication is a step toward minimizing these perceived differences.

Culture and Context

Definition of culture

Culture is commonly understood in concrete terms—as the collection of symbols that characterize a given population. In other words, culture comprises a people's customs, dress, music, literature, rituals, and so on. This conceptualization is flawed in at least

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two ways. First, it portrays culture as rigid and unchanging rather than dynamic and evolving. For this reason, some Americans visit the Netherlands expecting the Dutch to wear wooden shoes. Second, this rigid understanding of culture is likewise very narrow, so it fails to account for the wide variation in behaviors among those sharing a given culture. For this reason, many international visitors expect all Americans to carry handguns. Unfortunately, cultural research and education often reflect this flawed approach to culture. Even formal measures of cultural competence often equate culture with possessed traits (usually race and ethnicity) and assume that health care providers are white and Western.[16]

We prefer Wood's communication-oriented definition,[17] which reflects the dynamism and variability of culture by emphasizing meaning rather than artifacts: **Culture** is "the beliefs, understandings, practices, and ways of interpreting experience that are shared by a group of people." Simply put, culture is the worldview of a group of people, which is expressed in communicative behavior. Dental professionals, however, do not treat groups of people; they treat individual patients. Therefore, professionals must bear in mind two points. First, no given patient perfectly represents the culture of a group to which he or she belongs. We all have individual preferences for enacting or rejecting various aspects of the culture to which we belong.

Activity 3-1

What are the elements that distinguish the culture of dentistry? To help you answer this question, imagine that you are asked to educate members of an isolated tribe about their first visit to a US dental practice. Make a list of 10 things they should know so their appointment will be successful. Consider from their point of view which things will seem the most unexpected.

Second, the culture to which we belong is not a single monoculture but rather the overlap of various co-cultures. Wood's definition[17] relates culture to a group of people, but we all belong to various groups simultaneously: nation, school, workplace, religion, service organization, sports team, and so on. The list of overlapping groups is large, and each has its own culture. Therefore, an individual's cultural background is a mix of cultures reflecting the various groups to which he or she belongs.

Further complicating matters, the expression of culture is shaped by individual preferences and the context in which a person is situated. The dental practice is a specific context that can affect a patient's cultural expression; dental professionals should therefore consider the ways they and their environment might be perceived differently, depending on a patient's cultural background.

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Patient-provider context

Culture cannot exist in a vacuum, because a person's ways of interpreting experience—or ways they do not interpret experience—take on meaning only when they are compared to alternatives. As a result, the degree of contrast between two cultures suggests how challenging the communication between members of those cultures will be. For instance, health care in the United States has developed a culture of its own. Those who operate within this culture take for granted assumptions about germ theory, the roles of physicians and nurses, the quality of hospital food, and a host of other characteristics that were internalized long ago. In advanced Western societies, even adults who have never been inside a clinic can quickly figure out how the culture works because they are familiar with other bureaucratic institutions. Adults from cultures that are less bureaucratic or practice other types of healing will struggle to understand the US health care system. If dental professionals aim to deliver patient-centered care, they must be culturally competent enough to determine whose cultural background could make the dental practice seem foreign and how to reconcile one culture to another.

The patient-provider dyad is fundamental to the dental context. From a clinical standpoint, the provider can operate only within narrow parameters supported by evidence-based practice. Patients whose cultural background makes them unfamiliar with clinical procedures involved in examination and treatment should be educated because the procedures themselves cannot be changed significantly. On the other hand, nonclinical interaction often can be modified to accommodate cultural expectations and individual preferences.

First, however, providers must gain a full understanding of their own appearance, behavior, and cultural background so they can better understand how patients perceive them. Communication challenges can result from differences between patient and provider, but such challenges are not inevitable. Rather, the challenges tend to emerge when the provider does not meet the patient's cultural expectations about who should be a provider and how they should behave.

Male and female dentists are remarkably similar in the way they approach and practice their profession.[18–20] Yet, research on gender stereotypes indicates that patients believe female dentists are more likely to ensure that patients are relaxed and to take time to discuss symptoms.[21] Patients believe that male dentists are more likely to expect the patient to endure pain without complaint. When presented with photographs of general dentists, participants in one study[22] indicated that female dentists are more caring than their male counterparts, whereas males are more competent, and the participants would more likely choose a male as their dentist in the absence of other information. On the other hand, a study of British patients found that they prefer female dentists to male dentists.[23] These perception studies were conducted with small, nonrepresentative samples, but for that reason they suggest how a patient's cultural background can shape perceptions of the provider based on characteristics unrelated to clinical skill.

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Activity 3-2

Interview a dental professional who does not fit cultural or traditional expectations for the role. For instance, talk to a male dental hygienist or a black female dentist. Ask if patients respond to the provider differently than they do to colleagues who match cultural expectations. What sorts of responses has the provider gotten? How has he or she handled such reactions?

Concordance

Concordance is simply the degree of similarity or agreement between two individuals on a given measure. Because culture is variable and dynamic, validated measures are difficult to construct, so researchers have instead attempted to measure the degree of patient-provider concordance on cultural proxies such as race and sex to identify how concordant dyads may differ from nonconcordant dyads on such outcomes as treatment planning and adherence. Such research is important, given that 76.3% of dentists, 88.9% of hygienists, and 69.2% of dental assistants in the United States are white.[24] In each profession, whites are overrepresented relative to their proportion of the US population. Further, 77.8% of dentists are male, and 99% of dental hygienists are female.[25,26] From a communication perspective, such skewed representation is not a problem if the professionals are comfortable and if patients are satisfied and receiving equal treatment. The evidence, however, suggests room for improvement.[27]

A lack of cultural competence could be responsible for some of the frustrations experienced by providers. Milgrom et al[28] developed a measure for frustrating patient visits. Three of the four factors identified are related to frustrations that could have cultural explanations: unpleasant feelings (eg, "The patient was too controlling."), lack of communication (eg, "The patient and I seemed to come from different worlds."), and compliance (eg, "The patient did not accept responsibility for his or her dental health.").

The cultural explanation is supported by a study by Rouse and Hamilton,[29] who found that dentists evaluate patients on three culturally relevant dimensions: compliance, tractability, and likability. Some evidence suggests that more cooperative patients receive higher-quality restorative treatment.[30] Given that knowledge of cultural groups among dental students is low, the potential for frustration and treatment disparities is high.[31]

One solution is for providers simply to treat patients whom they feel comfortable treating. In 1981, Ayer[32] suggested that the patient-provider relationship reflects a mutual selection process in which individuals of similar backgrounds and values are more satisfied than dissimilar dyads. Presumably, patients and, to a lesser degree, providers continue to be drawn to those with whom they feel comfortable. However,

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in the three decades since the study by Ayer,[32] demographics and expectations have changed among both patients and providers.

The implications of these changes are not entirely clear. A 2007 study by Bender[33] found that most patients report no preference for a dentist of the same race or sex, but among subgroups some differences emerged. Hispanic females expressed a marked preference for both a race- and sex-concordant dentist. A proportion of black and Hispanic patients may prefer a racially concordant dentist, and a proportion of female patients may prefer a female dentist.

Black and white patients report similar satisfaction with white providers, but black patients give lower ratings for how well the white dentist got to know them.[34] Another study found that black dentists are significantly more likely to treat underserved populations, but the reasons for this are unclear.[35] Bare and Dundes[36] discovered that anxious patients preferred male dentists to female dentists, and this tendency was most pronounced among anxious male patients, 91% of whom preferred a male dentist.

Studies from the broader health care environment offer additional insights. A 2009 review of the literature found that 33% of studies documented positive health outcomes for minorities in race-concordant patient-provider dyads.[37] An additional 37% found mixed results. Another report was more conclusive, linking racial and ethnic concordance with greater patient satisfaction and improved health care processes.[38] The authors of that study explicitly called for efforts to recruit minority providers while improving the cultural competence of current providers. A study of patient-provider communication found that, in racially concordant consultations, physicians visited longer and patients rated them as more participatory.[39]

Question of ethics: Practicing dentistry requires a degree of intimacy between patient and provider. Appointments involve questions about health history and personal habits, followed by a physically intrusive examination. Given the sensitivity of these procedures, patients from conservative cultural backgrounds may prefer providers of the same sex. Should you accommodate these cultural preferences? What if the request is for a provider of the same religion or ethnicity? What are your limits for accommodating cultural differences?

Cultural Influences

Because culture is dynamic and variable, instructions on communicating with individuals from specific cultures are prone to error and quickly become outdated. Because such guidelines assume that everyone affiliated with a given culture is identical, they are also offensive. Consider your reaction to instructions on "How to talk to girls" or "How to marry a millionaire." Furthermore, individuals belong to multiple social groups and therefore hold overlapping cultural identities. Some of these identities may be more salient to dental care (eg, Somalian or mixed martial artist) and others less so (eg, Apple user or geocacher). In short, no one can provide worthwhile in-

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struction on how to communicate effectively with people from every culture on earth. Even if such a resource existed, providers could ignore most of it, because the cultural diversity they will encounter in their practice is likely to be limited to the number of cultural groups that populate the community they serve.

What is possible, and far more useful, is sensitizing dental care providers to the ways culture can influence oral health care so they can quickly identify and accommodate challenges and opportunities when they arise. Training for a career in dentistry helps students develop cultural sensitivity in that dental colleges and training institutions often attract a diversity of patients and typically require service learning outreach to underserved populations.[40,41] As noted, however, cultural barriers persist in dental care. For a more comprehensive understanding of health care issues related to diversity, we recommend that providers review some of the excellent books on intercultural communication in health care.[42–46] We also recommend that providers research the cultural beliefs and practices of cultural groups within their practice area. Some resources are listed at the end of this chapter. The final section of this book also includes chapters on intercultural communication with patients likely to visit any practice (eg, the deaf and hard of hearing, those with limited English language skills, and young and old patients).

In addition, there are components of culture that dental providers can notice easily to determine whether a patient's culture might influence care (Box 3-1). Providers should be careful not to stereotype, however, because physical characteristics do not always signify that the patient is a member of a particular culture. For instance, patients with Latino features might claim American heritage stretching back centuries. Patients with Asian features might have been adopted into a non-Asian family and have very little cultural knowledge of Asia, despite the irritating assumptions of others.

In addition, providers should remain aware that many multicultural patients are adept at **code switching**, meaning they are proficient at communicating fluently in at least two different cultures. Refugee and immigrant children, for instance, often behave and speak the "old country way" at home and the "American way" at school or work. Given these cautions, the following discussion will consider the cultural implications of a patient's language, nationality, and ethnicity.

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Box 3-1 Ways to determine the cultural background of patients

- **Observe the patient's dress:** A patient who is visiting from another country or a recent immigrant is less likely to buy and wear Americanized clothing.
- **Read the patient's forms:** Lack of response, awkward phrasing, and incorrect spelling can suggest that the patient is not familiar with English.
- **Review the patient's information:** The information the patient provides could yield clues to his or her cultural background.
- **Listen to the patient's language:** If the patient speaks another language with family or friends in the waiting room, he or she may have limited English skills.
- **Listen to the patient's vocabulary:** If the patient uses strange English phrasing or addresses people more formally than native-born Americans usually do, he or she may speak English as a second language or come from a former British colony.
- **Observe the patient's interaction:** If the patient appears uncertain how to respond to the receptionist, he or she may not understand English or appointment procedures.
- **Observe the patient's behavior:** If standard appointment procedures seem foreign to the patient, he or she may not have visited a Western dentist (or any dentist).
- **Consider the community:** Determine whether the community includes social or religious gathering places for people of different cultures.
- **Ask the patient:** The question, "Are you foreign?" is both intrusive and offensive. However, you can often elicit cultural information through polite rapport: "Have you always lived in Springfield?" If communication is not going well, you can ask the patient for help: "I am worried I am not doing what you wanted. Can you tell me what your previous dental visits were like?"

Language

Language and culture are inseparable because language reflects culture, shapes culture, and determines which individuals can verbally interact with a social group. Regarding language, dental professionals have three primary concerns. First, the patient must be able to provide an accurate health history. Second, the patient must be able to understand diagnoses and treatment options. Third, the patient must be able to understand and grant informed consent.

These are ethical concerns, but they are also legal concerns. Title VI of the Civil Rights Act of 1964[47] requires health care providers who accept federal financial assistance such as Medicaid and the State Children's Health Insurance Program to provide and pay for "meaningful access" for patients with limited English proficiency. For deaf patients, the Americans with Disabilities Act[48] requires providers to ensure communication equivalent to that with a hearing patient, regardless of federal financial assistance.

Language barriers are associated with cultural barriers but can present a separate set of challenges. The challenges of delivering care to deaf patients and patients with

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limited English proficiency (LEP) are complex enough to merit a separate chapter in the final section of this book (see chapter 11). LEP is associated with poorer oral health and fewer preventive dental visits.[49–51] Further, health literacy is a problem for English speakers as well as patients with LEP, and it is addressed in the chapter on verbal skills (see chapter 11).

Nearly every provider can expect to treat patients with LEP. Unfortunately, such treatment can take longer, and some providers alter their treatment recommendations and treatment provided to these patients.[52] Providers perceive that patients with LEP are more difficult to treat, so providers must be on guard to provide adequate care to such patients.[53]

Nationality

Culture is not defined by national boundaries, but prior to the widespread availability of telecommunication technology, culture was necessarily localized and spread by interpersonal contact. Furthermore, nationality frequently is an important component of a group's cultural identity, even when the groups relocate. Consider Americans of Irish or Italian heritage who identify with Ireland and Italy for generations after an ancestor emigrated.

Geert Hofstede[54] is a Dutch social psychologist who developed a theory of cultural dimensions to provide a framework for analyzing cultures across modern nations. Hofstede's analyses are used extensively as resources by international businesses seeking research on cultural preferences of a given nation's population. A consulting website based on his work offers cultural analyses of more than 50 nations: http://geert-hofstede.com/countries.html.

Briefly, the cultural dimensions Hofstede[54] isolates are power distance, individualism, masculinity, uncertainty avoidance, and long-term orientation. These dimensions are presented here as cultural influences for the dental provider to consider when treating someone from a different country. **Power distance** is the degree to which members of a culture accept imbalances of power and authority. Patients from countries where power distance is high might expect those in authority (eg, the dentist or the head of the family) to make treatment decisions for them. **Individualism** is the degree to which members of a culture accept independent (versus collective) action. Patients from less individualistic cultures may wish to confer with family members before making treatment decisions. **Masculinity** is the rigidity or fluidity of gender roles in a society, with implications for the value placed on traditionally masculine traits such as aggression and competitiveness. Patients from less masculine cultures might embrace the relational aspects of patient-provider interaction more than patients from more masculine cultures. **Uncertainty avoidance** is a culture's tolerance for ambiguity. Patients from cultures high in uncertainty avoidance may request more specific information regarding diagnosis, treatment outcomes, and cost. Finally, **long-term orientation** refers to a culture's time horizon. Patients from cultures with a long-term orientation might be more accepting of treatments that require multiple visits and more gradual results.

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Question of ethics: The health care culture in the United States places the highest value on curing and symptom relief. Other cultures, however, are more accepting of chronic health problems and pain. If one of your patients refuses a simple restorative treatment, should you feel obligated to find out why? If the reasons are cultural or religious, is it ethical to attempt to persuade the patient to change his or her mind?

Ethnicity

A 2006 review of the research on health care barriers related to ethnicity identified potential barriers at the patient, provider, and system levels.[55] Potential patient-level barriers included health beliefs and attitudes, perceptions of illness, health practices, and social variables and resources. Potential provider-level barriers included provider skills and attitudes. System-level variables related primarily to organization. The multiple variables determining access to and quality of care led the authors to conclude what we previously asserted[55]: "The barriers are all tied to the particular situation of the individual patient and subject to constant adjustment. In other words, generalizations should not be made."

Although providers should tailor communication to individual patients, they should also remain aware of health disparities between ethnic groups and consider the possible cultural reasons for those disparities. Books and online resources provide information on myriad ethnic groups and their health practices. The following is an example of the type of research that is conducted and how it can be applied. Black and Hispanic Americans tend to have poorer oral health than white Americans.[56] Manski and Magder[10] found significant and large differences between dental care utilization between whites and their black and Hispanic counterparts. Those differences in oral health and dental care utilization persisted even after the data were controlled for income and dental insurance, suggesting the influence of other variables.

One cultural explanation is that patient ethnicity seems related to attitudes toward prevention. Whites are more likely to believe in the benefits of preventive dental practices (perhaps as a result of greater access to preventive dental care), and some ethnic groups perceive dental visits in terms of problem solving rather than prevention.[57,58] Other possible explanations for differences include diet and acculturation, although the impact of these cultural factors on oral health has not been adequately studied.[59–61] Detailed information on ethnic disparities in oral health is presented in the 2009 National Healthcare Disparities Report.[24] Research on the oral health beliefs of four ethnic minorities in the United States was discussed in a 2008 review by Butani et al.[62]

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Activity 3-3

Culture is context based. The way a group of people view the world attains meaning only if it can be described as different from another way of viewing the world. Often, minority groups are perceived in cultural terms because their worldview and behaviors are different from those of the majority, whose worldview and behaviors are considered "normal" and therefore not seen in cultural terms. The blog http://stuffwhitepeoplelike.com/full-list-of-stuff-white-people-like/ explores this idea by making the majority culture seem different and worthy of comment. Read some of these entries and discuss with your colleagues whether the observations are accurate and what they say about cultures in our society.

Providers can and should inform themselves about these and other cultural influences on oral health, including education, socioeconomic status, sexual orientation, and even age and sex. In applying such knowledge, however, caution should be emphasized. In a multicultural society, a patient's cultural background can be impossible to determine based on appearances. Even when a provider has accurate information regarding a patient's ethnicity, the patient's health-related values, beliefs, attitudes, and practices may differ markedly from those that are generally associated with his or her cultural heritage.

Furthermore, cultural imperialism can lead Western health care providers to believe in the superiority of evidence-based practice over faith healing, folk remedies, prayer, and refusal of treatment. As members of a distinct health care culture, providers are often perceived as detached and condescending, particularly to patients who do not share their native language, nationality, or ethnicity. To provide patient-centered care, dental professionals must determine a patient's values and goals for care and sensitively collaborate with the patient to deliver the best evidence-based care acceptable to the patient. Developing and sustaining empathy with patients, despite their differences, are crucial aspects of this process.[63,64]

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Activity 3-4

The questions below are adapted from The Jefferson Scale of Physician Empathy.* Respond to each statement with a number from 1 ("strongly disagree") to 7 ("strongly agree") and total your points. Compare your score with those of your peers. Discuss those items that seem to generate the most variability in scores.

1. Dental professionals should try to imagine themselves in their patients' shoes when providing care to them.
2. Dental professionals' understanding of their patients' feelings gives the patients a sense of validation that is therapeutic in its own right.
3. An important component of the patient relationship is the dental professional's understanding of the emotional status of patients and their families.
4. Dental professionals should try to understand what is going on in their patients' minds by paying attention to their nonverbal cues and body language.
5. Dental professionals should try to think like their patients in order to render better care.
6. I believe that empathy is an important therapeutic factor in dental treatment.
7. Empathy is a therapeutic skill without which success as a dental professional would be limited.
8. Patients' problems can be cured by medical treatment, but emotional ties to patients cannot have a significant place in this endeavor.
9. Dental professionals should allow themselves to be touched by intense emotional relationships between patients and their family members.
10. I believe that emotion has no place in the treatment of dental problems.
11. Because people are different, it is almost impossible for dental professionals to see things from their patients' perspectives.
12. Attentiveness to patients' personal experiences is irrelevant to treatment effectiveness.
13. Patients feel better when the dental professional understands their feelings.
14. Dental professionals should have a good sense of humor because I think it contributes to a better clinical outcome.
15. I consider understanding patients' body language as important as verbal communication in patient-provider relationships.
16. Dental professionals should try to pay attention to patients' emotions in interviewing and history taking.

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Activity 3-4 *(cont)*

17. I consider asking patients about what is happening in their lives as an important factor in understanding their physical complaints.
18. It is easy for me to view things from patients' perspectives.
19. I enjoy reading nondental literature and the arts.
20. A dental professional's understanding of how patients and their families feel is a relevant factor in dental treatment.

*Adapted from Hojat et al[63] with permission.

Culturally Competent Communication Strategies

Even without training, health care providers with a natural inclination toward empathy can instinctually understand patients and often know the best way to respond. Balancing empathy with the clinical detachment necessary for effective care, however, can be challenging, particularly when the patient is from a different culture. Box 3-2 lists several adjustments to your standard communication style that may be appropriate when interacting with patients from diverse cultures. These suggestions integrate our own experience with the work of Teal and Street.[65] In addition to these adjustments, this section will present a brief overview of language use, the LEARN model,[66] and the Kleinman questions.[67]

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Box 3-2 Communication adjustments for patients from diverse cultures*

- **Greeting:** Always smile and say hello while looking at the patient. A smile is a universal expression of good will.
- **Address:** Always call the patient by his or her title (Mr, Ms, Dr, etc) until granted permission to call the patient something else. Many cultures retain a formality the US culture is rapidly shedding.
- **Patient chaperones:** Patients from some cultures are more likely to bring someone with them to a dental appointment. If this happens, greet the chaperone. If the chaperone wants to observe, attempt to accommodate him or her in the operatory if it will not interfere with procedures.
- **Nonclinical touch:** A handshake is generally appropriate, but in some cultures male-female touching is disapproved, so note the patient's reaction when you extend your hand. Refrain from other nonclinical touch (on arms or the back) until you are certain it will not offend.
- **Rapport:** In some cultures, medical professionals are expected to act authoritarian and detached. If the patient seems unresponsive to friendly rapport building, do not persist in attempting to draw out personal information.
- **Speech:** Speak slowly, facing the patient, to enhance understanding if the patient's first language is not English.
- **Patient response time:** Allow extra time for the patient to respond so he or she can interpret or process what you have asked and formulate a reply.
- **Patient responses:** As you present information and listen to replies, look for signs of incomprehension, such as blank eyes, furrowed brow, shifting gaze, and silence. If the patient appears not to understand, repeat the information with simpler wording, use presentation aids, or enlist the help of the chaperone.
- **Treatment decisions:** In some cultures, decisions regarding treatment are made by someone other than the patient (eg, the health care provider or the head of the family). If the patient seems unwilling to make a treatment decision, clarify which treatment you recommend and ask whether the patient would like to discuss treatment options with someone at home. Send the patient home with written information outlining the treatment options.

*Adapted from Teal and Street[65] with permission.

Vocabulary

Culture is a primary means of identifying and distinguishing social groups. It has therefore been misused for millennia as a way for members of one social group to insult, provoke, and minimize the worth and accomplishments of other social groups. A healthier expression of this human tendency is observable in modern school and sports team rivalries. More malignant expressions remain observable in some of the language that is used to reference social and cultural groups.

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Although progress has been made on this front in recent years, changes in language use and preferences stated by social and cultural groups can leave some adults using an outdated or offensive term. Table 3-1 presents several such terms, along with more acceptable alternatives. This information is presented with two cautions. First, providers who commonly refer to a patient's social group may be in danger of placing too much emphasis on affiliation and not enough on the patient's individuality. There are few occasions when dental care providers would be called on to refer to a patient's sexuality or ethnicity, for example. Second, patients should always have the last word in how others refer to them. If a patient corrects the provider, the provider should thank the patient and make a note of this preference in the patient's file.

Table 3-1 Culturally sensitive vocabulary

Insensitive term	More sensitive term	Most sensitive term
Oriental	Asian	Japanese, Korean, etc
American Indian	Native American	Cherokee, Navaho, etc
Chicano	Latino or Hispanic	Mexican, Puerto Rican, Colombian, etc
Colored	Black	African American
Hybrid or mulatto	Mixed race	Multiracial
Hearing impaired	Hard of hearing	Deaf or person with hearing loss
Queer	Homosexual	Gay or lesbian
Midget		Dwarf or little person
Retarded	Developmentally disabled	Person with an intellectual disability
Crippled or handicapped	Disabled	Person with a physical disability
Old	Elderly	Senior
Junkie or drunk	Addict or alcoholic	Substance-dependent person
Crazy		Person with a mental illness
Senile		Person with Alzheimer disease or dementia

The LEARN model

A 1983 report by Berlin and Fowkes[66] presented a framework for cross-cultural communication in family practice. That framework is the **LEARN model**, referring to the actions a provider should take when interacting with a patient from a different culture: **listen**, **explain**, **acknowledge**, **recommend**, and **negotiate**. That model applies equally to the dental setting.

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Listening seems an obvious and intuitive activity, but clinical tasks can be distracting, and the routine of interviewing can deceive a provider into thinking he or she is listening when that is not the case, even with a concordant patient. A culturally or linguistically different patient can be even more challenging to listen to, as he or she may be reticent or difficult to understand. Active and reflective listening are crucial.

Explaining the diagnosis and treatment is perhaps even more important with a patient from a different culture. Providers can assume that a patient familiar with Western medicine comprehends examination procedures, typical diagnoses, and standard treatments. A patient from another culture may not understand the words or the concepts that underlie these procedures, so gauging the patient's comprehension level and addressing the patient at that level is very important, particularly with preventive care. If the patient does not understand why the provider wants something done, the patient is unlikely to do it.

Acknowledging when a patient has a different conception of illness and health is as important as explaining the Western model of medicine. The Kleinman questions,[67] discussed in the next section, suggest ways to elicit the patient's model.

Recommending the most appropriate treatment follows learning how a patient perceives health problems and solutions. By integrating the patient's model with the medical model, the provider can address unhealthy practices and encourage appropriate treatment.

Negotiating the final treatment is important, because the provider must not impose a treatment if a patient is unwilling or unable to carry out any part of it. The provider should remain aware that some cultures value harmony and authority, so patience and persistence may be required to elicit a patient's concerns. When such concerns are articulated, the provider should avoid refuting or discrediting them, a sure way to shut down dialogue. The provider should be willing to negotiate the treatment recommendations.

Kleinman questions

A 1978 study by Kleinman et al[67] used anthropologic methods to explore how diverse cultures understand clinical experiences. One outcome was a series of questions providers can ask in order to understand the patient's cultural framework for health and illness. The Kleinman questions (Box 3-3) are therefore a way to address the acknowledging step in the LEARN model. The authors emphasize, however, that question wording should vary based on patient and problem characteristics. They also urge patience and persistence, as patients from other cultures may be hesitant to disclose their cultural frameworks for illness.

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Box 3-3 The Kleinman questions for eliciting patient illness frameworks*

Questions related to diagnosis
1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness? Will it have a short or long course?

Questions related to treatment and therapeutic goals
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your sickness has caused for you?
8. What do you fear most about your sickness?

*Adapted from Kleinman et al.[67]

Stigma

Although **stigma** originally referred to body modifications intended to signify something bad or wrong about the bearer, stigma is now better understood in relational terms as a failure to meet normative social expectations.[68] Because those expectations are social, they are profoundly cultural and therefore variable over time and across cultures. For instance, in the United States, crooked, broken, and rotted teeth are increasingly marks of stigma that alter perceptions about the person the teeth belong to—or do not belong to, in the case of missing teeth. In earlier times and in other cultures, lack of preventive dental care and fluoridated water resulted in a higher prevalence of poor oral health, and less stigma was attached to the appearance of teeth.

What is true of teeth is true of other individual characteristics: The patient, the provider, or both may perceive a given characteristic as stigmatized. Such situations call for cultural competence on the part of the provider to reduce the stigmatized patient's shame, defensiveness, or unwillingness to disclose medically relevant information. Too often, dental professionals report unwillingness or discomfort in addressing patients' stigmatized conditions. Chapter 12 explores stigmatized conditions in more depth, but this section considers two stigmatized conditions that dental professionals may encounter and offers suggestions for dialogue.

Eating disorders

Lifetime prevalence of anorexia nervosa is 0.9% among women and 0.3% among men.[69] Lifetime prevalence of bulimia nervosa is 1.5% among women and 0.5% among men. Symptoms of an eating disorder may appear as erosion of a patient's hard or soft tissue. Groups at elevated risk for these two eating disorders are females, whites, and

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perhaps Hispanics as they are acculturated.[70] Eating disorders are often accompanied by an inordinate focus on diet and are most prevalent during adolescence and early adulthood. They also tend to occur with comorbid psychiatric disorders.

Burkhart et al[71] researched provider communication with dental patients who have an eating disorder (Box 3-4). As with other forms of stigma, patients may be unwilling to acknowledge a problem. Several organizations, such as the Academy for Eating Disorders and the National Association of Anorexia Nervosa and Associated Disorders, offer information about eating disorders. An online screening program for eating disorders is available through Screening for Mental Health (http://www.mentalhealthscreening.org). These and other online resources, including brochures, are listed at the end of the chapter.

Box 3-4 Communicating with patients with suspected bulimia nervosa*

- **Timing:** Planning the discussion early or late in the day may allow adequate time to explore concerns.
- **Location:** Choose a location that is comfortable for both patient and provider. Ensure that the location is private enough that the discussion will not be overheard. The dental chair may be appropriate.
- **Nonverbal behavior:** Maintain an adequate distance (2.5 to 3.5 feet) and comfortable eye contact. Do not encroach on the patient's personal space or lean so far forward that the patient feels trapped.
- **Slow beginning:** *(1)* Express concern. *(2)* Describe changes you have noticed in the patient's mouth and teeth. *(3)* Ask if the patient knows what might be causing the damage.
- **Possible causes:** If the patient does not volunteer information, suggest various possible causes (eg, gastric reflux, pregnancy, frequent self-induced vomiting, restrictive diets) and ask whether any apply.
- **Food relationship:** Ask whether you can explore the patient's relationship with food. The patient's answer should indicate his or her readiness for change.
- **Body image:** Ask open-ended screening questions such as, "How do you feel about your eating behavior in general?" or "How do you feel about your weight?"
- **Eating behaviors:** State that you will ask some direct questions about eating to determine the cause of the changes you have noticed. For instance, "Do you ever make yourself throw up?" or "Has anyone expressed concern about your eating habits?"
- **Summarize:** Thank the patient, provide literature on eating disorders and local treatment resources, and ask permission to coordinate care with the primary physician.

*Adapted from Burkhart et al[71] with permission.

HIV/AIDS and other sexually transmitted infections

Sexually transmitted infections (STIs) remain highly stigmatized. Estimating the prevalence of STIs is difficult, given that stigma suppresses reporting and that some STIs

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are curable. In the United States, an estimated 65 million people live with at least one viral STI, most commonly genital herpes.[72,73] Nineteen million new STIs occur annually, and about half of these occur among young people aged 15 to 24.[74]

Perhaps because it is associated with racial and sexual minorities and because it is potentially fatal, HIV is stigmatized more than other STIs. At present, an estimated 1 million people in the United States are living with HIV, and 21% are unaware of their infection.[75] More than 56,000 new infections occur annually. Groups at higher risk for HIV include gay, bisexual, and other men who have sex with men. Although white men who have sex with other men constitute the majority of new infections each year, black Americans represent 46% of those living with HIV and 45% of new infections. Hispanics are also disproportionately infected; the infection rate of Hispanic men is more than double that of white men, and the rate among Hispanic women is more than double that among white women.

In the 1980s and 1990s, a substantial body of research addressed infection control practices and professional attitudes of dental professionals toward patients with HIV and AIDS.[76,77] Fear of infection and differential treatment of infected patients was documented, with some practices refusing altogether to treat patients with HIV/AIDS.[78–80] The past decade has seen a shift in society's attitudes toward those living with HIV/AIDS, as medications have reduced the mortality of HIV. Yet the attitude of dental professionals and HIV/AIDS patients toward each other can reflect the fear and misperceptions cultivated in a previous era.

A 2005 study of hygienists found that 53.9% believed that treating HIV/AIDS patients increased their risk of contracting HIV, and 65.8% would not use an ultrasonic scaler on such patients, indicating differential treatment.[81] More recent studies showed that dentists and hygienists are comfortable treating HIV/AIDS patients and confident in their ability to do so.[41,82] Explicit training in interaction with HIV/AIDS patients is effective.[83] In one study, training-enhanced empathic themes expressed by providers included the importance of maintaining health, reassurance, and hope.[84]

Perhaps as a result of real or perceived stigma from health care professionals, some HIV-positive patients likely remain cautious about seeking care and disclosing their status. A Canadian survey from the mid-1990s found that only 54% of HIV-positive patients always disclosed their status to their dentist, and a significant predictor of disclosure was trust in the dentist's confidentiality.[85] A 2008 UK study indicated that 34.6% of HIV-positive patients who had revealed their status to a dentist believed it negatively influenced the care they received; 6.2% were refused treatment.[86] A study of HIV-positive men documented the communication behaviors of health care professionals that patients perceive as stigmatized (Box 3-5).[87] A participant in this study told of an encounter in which a dental assistant learned the patient had AIDS[87]:

> As I'm sitting there and [the dentist and I were] talking, [the assistant] comes running over. I could tell it was a big emergency. He says, "Wait a minute!" and grabs the manila folder. Because he's writing it so large, I can tell what he's writing across the front of this manila folder on the side that I can't see, and he's writing the word "AIDS!"

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Box 3-5 Health care provider behaviors that patients associate with stigma*

- Avoiding eye contact
- Speaking in clipped, flat, or brusque tones
- Standing too far away from the patient
- Expressing irritation or anger
- Displaying nervousness or fear
- Panicking
- Shifting demeanor on learning HIV status
- Taking excessive precautions
- Taking different precautions than usual
- Labeling patient files, rooms, specimens, etc
- Scaring the patient with diagnoses
- Mocking the patient (eg, for sexual practices)
- Blaming the patient (eg, for sexual practices)

*Information compiled and adapted from Rintamaki et al.[87]

Standard infection-control procedures such as labeling biologic specimens and wearing eye protection and masks may be perceived as excessive and stigmatizing by patients with HIV. Providers should therefore good-naturedly explain that these precautions are taken with every patient.

Chapter Checklist

Developing cultural competence

- ❑ Examine your own appearance, behavior, and cultural background to understand how the patient may perceive those things.
- ❑ Understand how culture can influence oral health care in order to identify and accommodate challenges and opportunities.
- ❑ Read books on intercultural communication in health care.
- ❑ Research beliefs and practices of cultural groups within the practice's market area.
- ❑ Avoid cultural stereotyping based on physical or behavioral characteristics.
- ❑ Remain aware that the multicultural patient may be adept at code switching.

Determining cultural background

- ❑ Observe the patient's dress, behavior, and interactions.
- ❑ Read the patient's forms and review the information they contain.
- ❑ Listen to the patient's language and vocabulary.
- ❑ Consider which cultural communities are nearby.
- ❑ Inquire politely.

Addressing cultural barriers

- ❑ Language: Overcome reluctance to treat a patient with limited English proficiency or hearing problems.
- ❑ Nationality: When developing intercultural communication strategies, consider power distance, individualism, masculinity, uncertainty avoidance, and long-term orientation of the patient's country of origin.

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- ❑ Ethnicity: Avoid generalizations and tailor communication to the individual patient.
- ❑ Ethnicity: Remain aware of health disparities and possible reasons for those disparities among people of different cultures, education levels, socioeconomic status, sexual orientations, age, and sex.
- ❑ Ethnicity: Avoid basing cultural assumptions on appearance alone.
- ❑ Ethnicity: Acknowledge that health-related values, beliefs, attitudes, and practices may vary widely even among patients who share a common culture.
- ❑ Ethnicity: Determine a patient's values and goals for care and sensitively collaborate with the patient to deliver the best evidence-based care acceptable to the patient.
- ❑ Ethnicity: Avoid the detached and condescending behavior often associated with the health care culture.
- ❑ Ethnicity: Develop and sustain empathy with the patient.
- ❑ Vocabulary: Use culturally sensitive terminology when referring to a patient's background or characteristics.
- ❑ Vocabulary: Avoid placing too much emphasis on a patient's background or characteristics.
- ❑ Vocabulary: Honor the patient's preferences in what he or she is called and how he or she is referred to.

Conversing with patients from other cultures

- ❑ Greet the patient with a smile, verbal greeting, and eye contact.
- ❑ Use a title with the patient's name until the patient says otherwise.
- ❑ Welcome a patient's chaperones.
- ❑ Minimize nonclinical touch.
- ❑ If the patient is unresponsive to rapport building, take a more detached approach.
- ❑ Speak slowly and face the patient.
- ❑ Allow extra time for responses and monitor the patient for signs of incomprehension.
- ❑ If the patient seems unwilling to commit to treatment, encourage consultation with the family.

LEARN model

- ❑ Listen: Employ active and reflexive listening.
- ❑ Explain: Gauge the patient's comprehension and address the patient at his or her level of comprehension.
- ❑ Acknowledge: Explore the patient's illness frameworks using the Kleinman questions.
- ❑ Recommend: Integrate the patient's model with the medical model when suggesting the most appropriate treatment.
- ❑ Negotiate: Elicit the patient's concerns, address those concerns respectfully, and remain willing to negotiate the treatment recommendation.

Kleinman questions to elicit illness framework

- ❑ Diagnosis: What do you think has caused your problem?
- ❑ Diagnosis: Why do you think it started when it did?
- ❑ Diagnosis: What do you think your sickness does to you?

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- ❑ Diagnosis: How severe is your sickness? Will it have a short or long course?
- ❑ Treatment: What kind of treatment do you think you should receive?
- ❑ Treatment: What are the most important results you hope to receive from this treatment?
- ❑ Treatment: What are the chief problems your sickness has caused for you?
- ❑ Treatment: What do you fear most about your sickness?

Addressing the stigma of eating disorders

- ❑ Plan the discussion for early or late in the day.
- ❑ Hold the conversation in a comfortable and private place.
- ❑ Maintain adequate distance and comfortable eye contact.
- ❑ Begin slowly by expressing concern about symptoms and asking the patient if he or she knows what may be causing the problems.
- ❑ Suggest possible causes.
- ❑ Ask about the patient's relationship with food, body image, and eating behaviors.
- ❑ Summarize what was said, thank the patient, provide literature, and ask if you can coordinate care to address the eating disorder.

Addressing the stigma of HIV/AIDS and other STIs

- ❑ Make eye contact.
- ❑ Take normal infection-control precautions and explain that the precautions are routine with all patients.
- ❑ Avoid brusque or clipped speech.
- ❑ Avoid displaying irritation, anger, nervousness, fear, or panic.
- ❑ Avoid changes in demeanor on learning a patient's infection status.
- ❑ Avoid obvious labeling of the patient's files, rooms, specimens, etc.
- ❑ Never scare, mock, or blame the patient.

For More Information

Health and culture

- https://www.thinkculturalhealth.hhs.gov
- http://nccc.georgetown.edu
- http://www.xculture.org
- http://www.diversityrx.org
- http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English
- http://wps.prenhall.com/chet_spector_cultural_7/94/24263/6211431.cw/index.html
- http://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6

Cultural competence assessments

- http://www.aafp.org/fpm/2000/1000/p58.html
- http://nccc.georgetown.edu/resources/assessments.html

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Effective and ineffective cultural communication

- http://www.youtube.com/watch?v=pY8QsvAzBcw
- http://www.youtube.com/watch?v=OwmhZNd9uQE&feature=relmfu
- http://www.mdanderson.org/education-and-research/resources-for-professionals/professional-educational-resources/i-care/ICAREguide_CultComp.pdf

Health care disparities

- http://www.ahrq.gov/research/findings/nhqrdr
- http://www.biomedcentral.com/content/pdf/1472-6831-8-26.pdf

Communicating with specific cultures

- http://depts.washington.edu/pfes/CultureClues.htm
- http://www.mckinley.illinois.edu/multiculturalhealth/index.htm
- http://www.hrsa.gov/culturalcompetence/index.html
- http://www.cvahec.org/resources/cultural-competency
- http://www.deaflinx.com/Services/health.html
- http://www.hispanichealth.org
- http://americanindianhealth.nlm.nih.gov

Sensitive terminology

- http://en.wiktionary.org/wiki/Category:English_politically_correct_terms
- http://www.unh.edu/inclusive/bias-free-language-guide

Screening for eating disorders

- www.mentalhealthscreening.org

Information and brochures on eating disorders

- www.gurze.com
- www.aedweb.org
- www.anad.org

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