Transcultural Oral Health Care and the Chinese – An Invisible Community

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Abstract: The Chinese, a 'silent minority', are the most scattered, but neglected, community in the UK. Most dentists will have at least a few Chinese people in their community. This paper describes the health beliefs, dental knowledge, attitudes and behaviours of the Chinese. Implications for general dental practitioners are discussed.

***Dent Update* 2000; 27: 296-299**

Clinical Relevance: This group tends to have a poor understanding of dental health; instead, they hold strong traditional health beliefs, and have low awareness and fatalistic attitudes toward oral health and dental care. General dental practitioners need to be aware of the problems these beliefs can cause in treatment.

The Chinese people are often stereotyped as hardworking and law-abiding with a preference for self-help and self-sufficiency, an image that has resulted in their being labelled as the United Kingdom's *invisible community.*[1] Before the 1991 census, estimates of the size of the UK's Chinese population were based on figures from local councils, or from the country of birth of the head of household figures given in the census.[1-2] The total number of Chinese people has increased from 400 in 1900 to 156,938 in 1991.[1–2] The current size of the population is likely to be higher still, particularly as a consequence of the transfer of Hong Kong back to China in 1997. Despite the dramatic rise in population over the century, this group remains one of the smallest of all minority ethnic groups identified in the 1991 census.

As with many minority ethnic groups, the Chinese community is a relatively young group, the average Chinese person in Britain being 29 years old (9 years younger than the average White person). About 28% were born in the UK.

The largest sub-group within this population are from Hong Kong (34%), with Malaysia and Singapore together supplying another 13%, as did China (including Taiwan). Six per cent migrated from Vietnam.

Unlike many of the other ethnic groups, the Chinese are scattered across the UK:[2] 53% live in the south-east, but the rest are widely dispersed throughout the country. Interestingly, the distribution of the Chinese community varies with the country of origin. The Hong Kong Chinese are the most widely dispersed group, which may be a reflection of the fact that they work predominantly in the catering trade[2,3] and economic migration to small towns and villages has occurred to meet the growing demand for Chinese food/restaurants. The Chinese from South-east Asia have their highest level of concentration in the south-east of England, which could be explained by the fact that this sub-group have a high proportion of technical and professional skills.

As genetic make-up affects disease susceptibility, cultural beliefs shape the perception and understanding of health and illness, and therefore influence health behaviours. An awareness of these influences is essential for delivering culturally sensitive services. This paper describes the health beliefs, oral health knowledge, attitudes and behaviours of Chinese people in the UK, and discusses their implications for general dental practitioners.

HEALTH BELIEFS

Chinese health beliefs are based on a holistic or macrocosmic view, which takes into account the mental, physical and social factors conducive to health and emphasizes the importance of environmental factors in increasing risk of disease. Much of the traditional teaching about health is based on the doctrine of two opposite but complementary forces, *yin* and *yang* (*yin* represents earth, moon, night, cold, female and interior; *yang* represents heaven, sun, day, and heat, male and exterior). Imbalance of these two forces results in illness. For example, 'rheumatism' is caused by the exposure to 'wet' and 'cold' in the afflicted part. The flow of *qi*, vital energy, must also be in balance between the individual and the environment, in order to maintain a state of health. *Qi* protects the body

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from invasion of outside factors such as cold, damp, wind and other environmental excesses that can cause disease. Therefore by taking into account the various seasons and other environmental conditions, herbal medicine and acupuncture can be used to alter the balance and flow of *qi*.

Given that some local symptoms may be only the external manifestations of disease of the viscera, in Chinese medicine much emphasis is placed on examination of the tongue and palpation of the pulse, together with a careful observation of the patient's face and skin colour, during clinical diagnosis. For instance, bleeding gums may be interpreted as an imbalance of the body humour that influences the host response to plaque. Dietary modification and herbal medicines may be needed to redress this balance.[4] These traditional beliefs continue to have a strong influence, and have obvious implications for those involved in health promotion and the provision of health care.[5]

ORAL HEALTH BELIEFS

Regardless of age and gender, Chinese people believe that they are susceptible to dental disease, that one should expect to lose teeth in old age and that nothing can be done to prevent it[6,7] – although tooth loss is considered undesirable in all except elderly people. On the other hand, elderly people believe that having teeth in old age will 'eat away their children's fortune', bringing bad luck to the family. Presence of a neonatal tooth may also be seen as bad luck, a sign of retribution.[8]

The fear of blood loss, a cultural concept involving 'weakening of the body', is also deeply ingrained. The timing of dental treatment, and dental extractions in particular, is important. For instance, extractions that take place in late evening may result in non-stop bleeding. Everyone is considered to possess a 'blood tooth', a tooth that will result in prolonged bleeding following extraction, which is significant to some Chinese. The consequences of this are seen as serious if that particular tooth is causing 'pain'. Unfortunately, nobody knows which tooth is the 'blood tooth'.

As in the case of bleeding gums, the role of body humour, *yin* and *yang* and *qi* are important in the aetiology of dental disease. The presence of plaque deposit on the tongue may also be interpreted as a sign of disease for another part of the body. Halitosis may be attributed to 'hot humour', and not necessarily related to plaque.

KNOWLEDGE OF ORAL HEALTH

The causes of dental caries, periodontal disease and tooth loss are poorly understood, particularly among adults and elderly people.[7] The role of sugar in the aetiology of dental caries is not generally recognized, although 'hot humour' and 'toothworms' are considered as contributory factors. Periodontal disease is prevalent among the Chinese[9] but many do not know what causes it; understanding of this concept is in inverse relationship to age. Similar findings have also been reported in Hong Kong.[10]

ATTITUDES TOWARDS ORAL HEALTH

Attitudes Towards Dentists

In general, the Chinese believe that Western dentists are clinically competent but many adults and elderly people feel that their patient management lacks cultural sensitivity:[3] only one in four Chinese consider that Western dentists respect their culture or take their feelings into account. Not surprisingly, older people place less faith in their dentists and prefer a Chinese dentist who, they believe, has better cultural empathy.

Issues regarding consent for treatment are significant for the Chinese. Many feel that their dentists do not take time to explain the proposed treatment plan and to obtain positive consent. This perception is exacerbated by communication and cultural barriers.

Attitudes Towards Dental Health Services

Older Chinese people have problems in finding a dentist, and this is compounded by language difficulties. For individuals with unsociable working hours, such as those working in the catering industry, normal dental surgery hours are considered unsuitable, as taking time off for dental (or medical) treatment is not culturally acceptable, far less a social norm.

Different expectations can cause problems in prosthetic treatment. If new dentures fit poorly, the person may not wear them – but neither will they return to the dentist for adjustment, instead having a new set constructed by another dentist. Routine adjustment of new dentures is not a norm in their country of origin. Experience with the general attitude of dentists in their own country leads many to believe that dentists in the UK would not welcome patients returning for denture adjustment. Some, particularly elderly, people also find it embarrassing to keep returning for follow-up prosthetic treatments, and are afraid of troubling the dentist and becoming an 'unpopular' patient. Meanwhile, the first dentist, and indeed Western dentistry as a whole, is seen as inadequate, a belief that will be reinforced throughout the community.

Contrasting cultural norms and expectations may result in misunderstanding and conflicts. In China, appointment systems are not always implemented: dentist or doctor 'shopping' is prevalent. Hence, some Chinese adults and elderly people may find the UK system, where registration and an appointment are needed for dental or medical treatment, perplexing. Similar conflicts may also arise during dental treatment, for instance there are differences between the UK and China in the routine use of local anaesthetics during simple restorative treatment.

Many Chinese people are not aware

of the emergency services offered by their dentists, and this can lead to the mistaken belief that their dentist is not available when needed. This will, undoubtedly, further compromise their trust in dentists.

ORAL HEALTH BEHAVIOUR

Oral Hygiene

While toothbrushing is practised habitually by most Chinese, a small proportion of elderly people do not brush their teeth at all. Flossing and the use of mouthrinses are uncommon among the Chinese, particularly the elderly, who may have no awareness of these dental products. The use of toothpicks, in contrast, is more prevalent, although this is primarily intended to indicate or express their appreciation of the meal. Some believe that adequate rest and no smoking are important for good oral health.

Dietary Control

Fruit is an integral part of the Chinese diet, and is perceived as beneficial to both general and oral health. Interestingly, although the younger generations recognize the harmful effect of sugar and carbonated drinks on dental health, they consume more sugary snacks and drinks than previous generations, a habit which is adopted during acculturation to the UK.

Dental Attendance

While the majority of the UK Chinese have visited the dentist, regular dental attendance is uncommon and is not perceived as a cultural norm. Many, notably the older generations, have a symptomatic approach to dental care, even in their country of origin.[11] For many adults, choice of dentist will depend on recommendations from friends and family and, if necessary, they will 'shop around' for the most suitable dental practitioner (this is also true of their choice of general medical practitioner). The teenagers, having been educated in the UK, appear to have adopted prevailing UK customs and are more aware of the National Health Service.[6]

Use of Traditional Remedies

The use of traditional remedies is common for both preventive and therapeutic purposes.[6,7] The most common conditions for which traditional remedies are used are toothache, abscess and swelling. There is an overall trend towards an increased use of these remedies with age, and among females. Herbal tea, Tiger Balm, salt water, toothache solution, Japanese medical plaster, rum, kerosene, White Flower Oil, Melon Cream and other available Chinese medicines are all used for dental problems.

BARRIERS TO DENTAL CARE

Although the Chinese have settled in the UK for many years, English still presents difficulties, both in the spoken and written forms, particularly among women and elderly people. Many feel that dentists fail to understand what they are saying.[3] In addition to language difficulties, poor awareness of the available services and working long and unsociable hours lead to the under-utilization of service; this is compounded by the cultural beliefs in self-help and self-sufficiency.

Cost could also be a barrier to regular dental care, reflecting the relatively low priority UK Chinese people place on oral health. The fear of 'losing face' if perceived as not being able to afford the treatment may deter some from visiting a dentist. Dental treatment is often considered a painful experience, financially as well as physically.

Low awareness of dental problems, cultural differences and poor access are all major barriers to dental care, as are anxiety over dental treatment and distrust of dentists. Uncertainty concerning the type of treatment received, and the fear of misunderstanding and conflicts arising during dental treatment, may all discourage the Chinese from visiting the dentist. The cultural characteristic of personal reserve may aggravate the misunderstanding if the individual is too embarrassed to ask a question.

IMPLICATIONS FOR GENERAL DENTAL PRACTITIONERS

Compared with other populations in the UK, Chinese children have poor dental health, and among adults periodontal disease is more prevalent. The poor dental attendance may conceal a high treatment need, which may lead to unpleasant dental experience, further reinforcing the negative attitude towards dental care. To facilitate regular preventive dental attendance, attempts should be made to minimize barriers to dental care – for example, re-organization of surgery hours may be needed to cater for those who work unsociable hours.[3]

The implications for health promotion are considerable. Attitude towards, and respect for, dentists could be improved through good communication and cultural awareness. Dental practices should adopt the ethos of a 'health-promoting dental surgery'. Collaboration with local Chinese community associations helps to bridge the cultural and communication gap, at least alleviating problems concerning informed consent.

The strength of traditional Chinese beliefs poses a tremendous challenge for dentists trying to deliver a culturally acceptable service. The strong sense of self-sufficiency, self-control and self-reliance of this population may mask the pressing health needs of this 'silent minority'. Most dentists in the UK will have at least a few Chinese people resident in their locality, and the issues raised here highlight the need for further training in cultural awareness when delivering patient care.

CONCLUSION

Traditional cultural beliefs are deeply ingrained among older Chinese people, who also have poor dental knowledge and low dental awareness. Cost, communication problems, anxiety and cultural differences are the major barriers

to dental care. In order to deliver effective health promotion and treatment services, dental practitioners should take into account the extent of cultural beliefs and needs of their Chinese patients.

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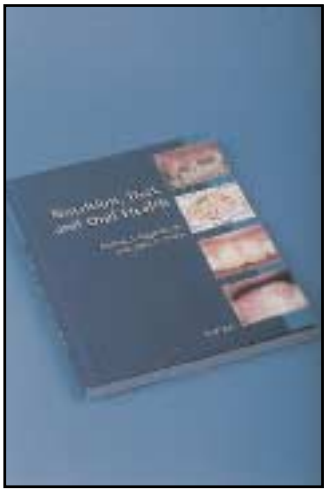
BOOK REVIEW

Nutrition, Diet and Oral Health. By Andrew J. Rugg-Gunn and June H. Nunn. Oxford University Press, Oxford, 1999 (198pp., £29.95) ISBN 0-19-262937-9.

This extremely comprehensive book examines the interrelationship between oral health, diet and nutrition. It brings together a variety of information relating to dietary components and oral health, general nutritional advice for children and adults and the influence of national and community food policies on diet.

The book is well laid out with effective use of boxes and tables to demonstrate key points, which allows easy access to relevant information. The text is clearly illustrated with excellent clinical photographs. The use of case reports also highlights the clinical relevance of the subject matter. Each chapter concludes with a summary section and advice for further reading.

The introductory section examines the influence of nutrition on tooth formation, identifying causes of dental



enamel defects and highlighting the importance of fluoride in the prevention of dental caries.

The following three chapters consider the effects of diet on dental caries, dental erosion and the soft tissues of the oral cavity. Evidence is presented for the role of carbohydrates in dental caries, followed by a comprehensive review of alternative non-cariogenic sweeteners; dietary factors that have a protective effect against caries are also discussed. Evidence for the cause and prevalence of erosion is presented along with practical advice for its prevention. The potential for a dramatic reduction in the incidence of oral cancer through dietary change is highlighted.

The importance of nutrition as a determinant of health and disease is outlined. Chapter six considers how the quality of the dentition may affect this relationship. Specific dietary advice for children and adults, both for oral and general health is covered in the following two chapters.

The penultimate chapter deals with national factors that influence diet. Government policies and food legislation are examined along with the role of the food industry, professionals and other groups in influencing this.

The book concludes with some practical guidance on giving dietary advice to patients in the dental surgery. This takes into account the difficulty of changing behaviour and the importance of tailoring advice to each patient's circumstances.

Overall, this book is recommended as an essential text for dental students. However, established practitioners wishing to refresh their knowledge in this important subject area will also find it useful.

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