VIEWS AND CHALLENGES EXPERIENCED BY ORAL HEALTH CARE PROVIDERS PRACTICING IN A MULTICULTURAL SOCIETY: A CULTURAL COMPETENCE EDUCATIONAL NEEDS ASSESSMENT.

by

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Project Title

Views and challenges experienced by oral health care providers practicing in a multicultural society: a cultural competence educational needs assessment.

Abstract

Background: Canada is increasingly becoming more culturally diverse. Consequently, meeting the health care needs of a changing population has meant an examination of the impact of the current health care system on different cultural groups. Evidence indicates that certain cultural groups, such as new immigrants and refugees, Aboriginal people and people of low-economic status experience health, including oral health, disparities as well as unequal access to care. The health disparities are linked to social, economic, cultural and political inequities which also contribute to the marginalization of such populations. Improving cultural competence within the health care professions has been identified as a strategy to help reduce health disparities. A review of the literature indicates that in addition to a lack of awareness around the importance of cultural competence in health care, cultural competence has not been consistently taught in health care programs. Therefore, this project was undertaken to explore the challenges experienced by oral health care practitioners practicing in a multicultural society.
Methods: A one hour recorded focus group interview was conducted with a group of seven oral health practitioners to ask questions about their experiences with caring for clients of cultural backgrounds different than their own as well as what culturally competent care means to them. The conceptual framework chosen for this project was radical/critical theory through the lens of the social determinants of health.
Results: The results of the interview identified a need to increase cultural competence in oral health care practitioners. The group also identified concern for introducing bias or stereotyping when teaching about the concept of cultural competence. To avoid introducing bias, it is recommended to include cultural competence education in the informal curriculum. Additionally, a critical view of culture and multiculturalism is recommended; advocating for longer dental hygiene programs would be required to enable incorporating a critical view in the curriculum. The concept of cultural competency is quite complex; further research is required to achieve consistency in how this topic is taught and how it can be evaluated.

Purpose

The purpose of this project is to conduct a focus group interview to explore the views and challenges experienced by oral health care practitioners in Vancouver, BC to better understand their educational needs in providing care in a multicultural society.

Rationale

Canada is increasingly becoming more culturally diverse (Statistics Canada, 2006). Consequently, meeting the health care needs of a changing population has meant an examination of the impact of the current health care system on different cultural groups. Evidence indicates that certain cultural groups, such as new immigrants and refugees, Aboriginal people and people of low-economic status experience health, including oral health, disparities as well as unequal access to care (Bessiser & Stewart, 2005; Charbonneau et al., 2009). The health disparities are linked to social, economic, cultural and political inequities which also contribute to the marginalization of such populations (Adleson, 2005; Peiris et al., 2008). Additionally, problems of communication due to language barriers, culturally inappropriate language and culturally inappropriate images can contribute to the misuse of medication or to misunderstanding prevention messages and/or recommendations (Hamrosi, 2007). Moreover, the acculturation process of new Canadians is not well understood by health care providers (Dong et al., 2007). Similarly, issues with colonization of Aboriginal people are also not well understood among health care providers; it is not well understood how colonization has contributed to marginalizing Aboriginal people. Poor health outcomes experienced by Aboriginal people are viewed by health care providers as being associated with non-

compliance with health care prevention rather than related to issues of colonization (Adelson, 2005; Peiris et al., 2008).

Romanow, in his 2002 report on the future of health care in Canada, has stated that eliminating health disparities based on race and ethnicity is a goal to improve the Canadian health care system and he advocates for the development of strategies to address such disparities (Charbonneau et al., 2009; Romanow, 2002). One such strategy involves improving cultural competence[i] within the health care professions.

A review of the literature indicates that in addition to a lack of awareness around the importance of cultural competence in health care, cultural competence has not been consistently taught in health care programs (Dogra & Karnik, 2003; Weissman et al., 2005; Donate-Bartfield & Lausten, 2002; Rayman et al., 2007). Understanding that diversity exists within cultural groups and that social class, religion, region, generation, extent of urbanization, and gender can strongly influence ethnic and cultural behavior is also misunderstood and needs to be included in multicultural and diversity education (Banks et al., 2001). Additionally, systemic issues, such as time, have been shown to be factors in whether cultural competence can be effectively practiced (Weissman et al., 2005; Rayman et al., 2007).

A critical view of culture and multiculturalism by multicultural education scholars calls for a sociological approach to understanding culture where the focus is on the inequalities and power imbalances experienced by marginalized groups rather than a list of traits (May & Sleeter, 2010, p. 11). "A structural analysis via critical multiculturalism

[i] It is important to note that other terms used when referring to cultural competence are "cultural sensitivity" and more recently "cultural safety". For the purpose of this paper, the term cultural competence will be used for consistency.

frames culture in the context of how unequal power relations, lived out in daily interactions, contribute towards its production, rather than framing it primarily as an artifact of the past. Culture and identity are understood here as multilayered, fluid, complex, and encompassing multiple social categories, and at the same time as being continually reconstructed through participation in social situations" (May & Sleeter, 2010, p.10).

Consistent with the critique of multiculturalism above, cultural competency models used in health care curriculum are critiqued for their focus on "sensitivity to cultural differences between health care provider and the patient" rather than "attempting to capture the diverse fluid nature of culture and self-identity" or understanding the differences in power relations that exist between the health care provider and the client (Lee & Farrell, 2006, p.1).

Examining cultural competence within health care is an emerging trend and it is argued that increasing cultural competence may improve health outcomes and reduce health disparities (Donate-Bartfield & Lausten, 2002; Rayman et al., 2007; Horner et al., 2004). A critical perspective of culture and cultural competence in health care is recommended to better understand the contributing factors to health disparities and to improve the delivery of culturally competent care (Lee & Farrell, 2006).

Research Question

Considering that my background is in dental hygiene, my research question will thus be targeted to the dental hygiene profession. Since research surrounding cultural competence is just beginning and cultural competence has not been consistently taught in dental hygiene, dental hygienists' educational needs are unknown; therefore, the research

question underlying this project is *"what are dental hygienists' understandings of culturally competent care, and what are the challenges for dental hygienists working in a multicultural society?"*

Gaining insight into dental hygienists' needs, experiences, and understanding of cultural competence will help inform dental hygiene program planning as well as provide a better understanding of the continuing competency needs for practicing dental hygienists.

Literature Review

A brief literature review highlights the need for increasing cultural competence in health care providers as a means of reducing racial/ethnic disparities in health outcomes and in the utilization of health care (Horner et al., 2004). Moreover, there appears to be a lack of awareness of the importance of cultural competence among health care providers (Dogra et al., 2003). Many health care providers feel unprepared to provide cross-cultural care as they had not received formal training in this area (Weismann, 2005). This could be in part related to the fact that cultural competence education in most U.S. and Canadian medical schools is inadequate or inconsistent and lacks resources (Flores et al., 2000; Azad et al., 2002; Shapiro et al., 2006). Moreover, there is concern among the students that formal cultural competence training may result in stereotyping (Shapiro et al., 2006).

To highlight the need for increasing cultural competence in health care education and to propose interventions to improve cultural competency in health care providers, Horner et al. (2004) formed a working group at the Conference on Diversity and Communication in Health Care sponsored by the U.S. Department of Health and Human

Services. The purpose of these brainstorming sessions was to develop a set of recommendations to change health care providers' behaviors in an attempt to reduce health disparities. The working group identified several areas where improvements could be made to increase cultural competency in health care providers. Recommendations included introducing cross-cultural education before, during and after clinical training, implementation of a certificate in cultural competence for practicing health care providers, diversifying the workforce, use of culturally diverse governing boards and ongoing monitoring and evaluation of processes of care to assure that they are developed according to race, ethnicity, social classes and language.

Dogra et al. (2003), through a survey questionnaire sent to first-year medical students at the University of Illinois, collected qualitative and quantitative data on the students' attitudes toward cultural competence. Of the 153 student participants, 111 students returned the completed questionnaires. The authors concluded that although the students held open attitudes towards equity and multiculturalism, they seemed unfamiliar with key terminology and with issues of diversity.

Weissman et al. (2005) also conducted a study to assess the attitudes of final year resident physician's about cross-cultural care education. Of a random sample of 3435 resident physicians at US academic health centers, 60% returned the survey. While 96% of the respondents indicated that it was moderately to very important to address cultural issues when providing care, 58% of respondents indicated that they did not have the time and 31% indicated that they did not have the mentors to deliver cross-cultural care or evaluate their ability to do so. The authors concluded that the results of the survey indicate a need for improvement in cultural competence education.

Since little is known about the level of cultural competence education in health care programs, Flores et al. (2000) undertook a study to determine the number of U.S. and Canadian medical schools that teach cultural competence and examined the format. The authors contacted the deans and directors of 126 U.S. and 16 Canadian medical schools by telephone survey using a cross-sectional approach. Questions were asked regarding courses offered in cultural sensitivity and multicultural issues and how it was incorporated into the curriculum. The response rate was 94% with very few schools (8% in the U.S. and 0% in Canada) offering separate courses addressing cross-cultural issues. The authors concluded that most U.S. and Canadian medical schools provided inadequate cultural competence education.

Azad et al. (2002) had similar questions regarding cultural competence education in Canadian medical schools. The associate and assistant deans of undergraduate medical education of 16 Canadian medical schools were interviewed to determine what level of cultural competence was taught, by which educational methods and how the cultural competence learning was measured. Eight of the 16 schools listed criteria on cultural competence. No data was collected however on the informal teaching of cultural competence. The method of cultural competence education was inconsistent. The authors concluded that although progress seems to have been made in cultural competence education, there exists a lack of resources such as investment in faculty development and administrative staff, thus inclusion of multicultural health issues in the curriculum remains an ongoing challenge.

Shapiro et al. (2006) conducted a study to investigate the perspective of students regarding cultural competence[ii] curricula. The purpose of their study was to "qualitatively assess the views of third year medical students at a public university school of medicine regarding its cultural competence curriculum (CCC)" (p.2). To obtain this information the authors conducted focus group interviews with the students. The authors concluded that students preferred cultural competence training in the clinical setting as part of the informal training so that they could apply knowledge to practice as they learn. Many students also viewed the CCC as a "method for humanizing their medical education" (p.5). Interestingly, the students also felt they needed more assistance in addressing biases and prejudice. They felt that the CCC was helpful in recognizing expressions of bias and prejudice in others but it was less effective in providing "tools" for addressing their own biases.

Other areas of health care such as nursing, dentistry and dental hygiene have also identified the need to integrate cultural competence in their practice and improve how it is taught as a means of improving health outcomes and to provide "client-centered" care (Foster, 2006; Donate-Bartfield & Lausten, 2006; Rayman & Almas, 2007; DeWald & Solomon, 2009). In the field of dental hygiene, DeWald and Solomon (2009) conducted a study to determine if the level of cultural competence of dental hygiene students had increased over the course of the two-year program. They used a universal assessment tool, the Cross-Cultural Adaptability Inventory (CCAI), which was administered at the

[ii] The authors of this study use the terms cultural competence, cross-cultural competency, cross-cultural communication and training, and diversity training interchangeably. For the purpose of this literature review, I have chosen to use the term "cultural competence" for consistency.

beginning of the program, at the end of the first year and again at the end of the second year. The CCAI assessed four skill areas: Emotional Resilience, Flexibility/Openness, Perceptual Acuity, and Personal Autonomy. The entire class of 26 students was assessed. The authors found no significant changes in the level of cultural competence after all three assessments were completed indicating that the method of teaching and assessing cross-cultural care needs to be improved. Suggestions made by the authors included sharing the results of the CCAI score with students so that they can identify strengths and weaknesses and thus use the information to improve their skills.

The literature review indicates that cultural competence has not been consistently taught nor is key terminology familiar to most health care practitioners. Additionally, although students perceive a strong need to include cultural competence in the curriculum, there appears to be a lack of understanding as to what the students' needs are. Additionally, there appears to be a gap in the literature in understanding the perspective of practicing dental hygienists in working in a multicultural society. Thus, I felt it was important to conduct a focus group interview to obtain insight into the needs and challenges of practicing dental hygienists to better understand the educational needs of dental hygiene students.

Conceptual Framework

The conceptual paradigms primarily used in health care research include the positivist, interpretive and critical theory paradigms. According to Gephart (1999), the positivist paradigm assumes an objective view of the world and is concerned with facts provided by rigorous scientific data. From a positivist perspective, one assumes that reality exists and can be observed, measured and understood (Giddings, 2007). The

interpretive paradigm is concerned with meaning and understanding views and beliefs (Gephart, 1999). The critical theory paradigm seeks to understand and uncover social inequalities and injustice to transform society into a "more democratic institution" (Gephart, 1999). Critical theory asks us to look at power imbalances in order to include the marginalized in social programs.

Current evidence indicates the dominance of the positivist paradigm in dental hygiene. Cobban (2004) describes the movement towards an evidence-based practice (EBP) paradigm model in dental hygiene. The definition for evidence-based medicine (EBM) includes "the collection, interpretation, and integration of valid, important and applicable patient-reported, clinician observed, and research-derived evidence" (Cobban, 2004) which implies the use of a combination of the positivist paradigm and the interpretive paradigm. However, the focus of EBM is on the strong scientific evidence used for decision making of which data from randomized-control trials (RCT) are viewed as the "gold standard" due to their rigid design (Cobban, 2004). It is felt that a movement towards an EBM model of practice and its focus on scientific methodology is an attribute to professionalization; thus, there is strong advocacy in dental hygiene research and education to promote the EBM paradigm model. Cobban wisely warns that the focus on the EBM model and the "gold standard" of evidence can potentially exclude important qualitative data which addresses client preferences and feelings about various forms of treatment. In other words, although RCT are indeed viewed to be rigid in their design and useful in collecting statistical data, RCT do not address the social determinants of health or the power imbalances that exist in society which have a greater impact on health outcomes (Raphael, 2009, p.2).

In addition to the EBM model, dental hygiene also relies on the behavioral sciences to guide research and practice (Cobban et al., 2007). Within the behavioural sciences, models of care which have been primarily observed in dental hygiene are the Human Needs Model, the Oral Health-Related Quality of Life Model and the Client Self-Care Commitment Model (Cobban et al., 2007). These three models address meeting the needs of the client through motivation and encouraging behavioural change, thus emphasizing individual behaviour risk factors as central in health outcomes rather than the social determinants of health. Raphael and Curry-Stevens (2009) describe this issue as "individualism" in health care and wisely state that "it [individualism] places the locus of responsibility for one's health status within the individual's motivations and behaviours rather than recognizing that health status is a result of how a society organizes its distribution of a variety of resources" (p.365).

In my view, the reliance on EBM and the behavioural change models in dental hygiene play important roles in contributing to the oral health disparities that presently exist in society. Acquiring a broader understanding of the social determinants of health and the power imbalances that exist in health care would be beneficial in preparing dental hygienists to provide culturally competent care. Thus, in exploring the challenges experienced by dental hygienists working in a multicultural society, the conceptual framework chosen for this project is the radical/critical theory through the lens of the social determinants of health.

Within this framework, the work of Michel Foucault will aid in understanding the impact of power imbalances between dental hygienists (health care provider) and the health care service recipient (client). Additionally, work by Ron Labonté will be used to

frame the understanding of the social determinants of health through a critical theoretical paradigm. The critical theoretical paradigm is also recommended in Aboriginal health care which will be highlighted in writings by Adelson et al. (2005) and Peiris et al. (2008).

Fenwick, Nesbit and Spencer (2006) in their book titled *Contexts of Adult Education* explain that the radical/critical orientation is based on the humanist tradition and that "the radical orientation suggests that true humanization develops only when people understand how they are situated in society (their classed, raced, or gendered positions) and how their thoughts and behaviours are shaped by the position they hold and how society regards them" (p. 100). The authors add that "through powerful analysis of society, individuals can learn to critique inequality in society and recognize their human agency for creating personal and social transformation *within* these historical constraints" (p.101).

This philosophy is evident in the writings of Ron Labonté, an adult education scholar who has written and published extensively on issues of health inequity, population health, globalization and the social determinants of health. In a paper written by Labonté et al. (2005), the authors explore the term "population health" and provide a solid critique of how population health research provides a simplistic view of the health care/economy relationship and how little attention is placed on the physical environment and the absence of human agency. The authors conclude with recommendations for future population health researchers to emphasize in their research the importance of reducing inequalities rather than emphasizing the importance of improving economic prosperity (to thus improve health). They argue for a more critical approach to

population health research and encourage a "reflective cycle of action informed by theory/evidence/values" (p.15). In other words, the authors are suggesting rather than focusing on prevention messages to improve health and thus reduce health care costs, it would be more effective for health care researchers to focus their research on how they could take action to improve the physical environment/living conditions of those who experience the greatest health disparities.

This radical/critical orientation is also evident in other writings by Labonté (2009), such as in a chapter he wrote titled "Social Inclusion/Exclusion and Health: Dancing the Dialect" in the book by Raphael (2009). In this chapter Labonté challenges the reader to think of the social determinants of health in terms of who is excluded and who is included in health policies. He asks, "how can one include people and groups into structured systems that systematically exclude them unless the structures of exclusion are themselves altered?" (p. 269). By focusing on the concept of social inclusion/exclusion he attempts to challenge the reader to think more critically about the social determinants of health, emphasizing the need to change policies to include all of society in health care rather than simply looking at behavioural factors that affect health outcomes in society.

The concept of Foucauldian poststructuralism is also evident in Labonté's writings. Fenwick et al. (2006) state that Foucauldian poststructuralism "offers a far more comprehensive notion of power as exercised (used) rather than held (owned) by all people" (p.109). In Labonté's (2009) chapter, he makes reference to Foucault's essays on the positive practices of power (p. 271). He quotes Foucault in asking "to what extent do efforts at social inclusion *accommodate* people to relative powerlessness rather than challenge the hierarchies that create it?" (p.271). He states that Foucault describes the

positive practice of power as "the gaze of authority that judges what it sees and , in so judging, controls the choices of those who are gazed upon" (p.271). According to Foucault, the only way to challenge this power is to resist the judging gaze of authority or conceal one's life from authority which, in turn, is a deliberate form of *social exclusion*. Labonté also warns the reader not to misuse the term "social exclusion" as there may be a tendency to view the concept in terms of categorizing people rather than in terms of the relations of power that categorize people (p. 272). In this sense, he is meshing concepts of radical/critical theory with concepts of Foucauldian poststructuralism; he is essentially saying look at what is wrong with society that is causing these issues of power relations and thus social inequalities. Labonté encourages health and social service organizations to pay more attention to the power-culture dynamics in programme planning and evaluation to better assist marginalized migrant communities in their own empowerment process which will thus lead to better health (Williams & Labonté, 2007).

Similarly in Aboriginal health care, a critical perspective in research is recommended. Adelson (2005), an Aboriginal health scholar, encourages researchers to include "the wider social and historical contexts and the individual effects of inequity" (p.S46) with an emphasis on the colonial history of Aboriginal people and the resulting impact on their health outcomes. She recommends more emphasis on case studies and the "voices of the individual" in research rather than merely stating statistics as statistical data can only tell us the degree of health disparities not the cause. Moreover, she emphasizes the importance of recognizing that the health disparities experienced by Aboriginal people are "related to economic, political and social disparities and not to any inherent Aboriginal trait" (p.S45).

The recommendations suggested by Adelson comply with the concept of "cultural safety" as described by Peiris et al. (2008). Peiris and colleagues describe cultural safety as a concept which "shifts the role of culture away from a check-list approach based on a person's ethnic background and toward a critical examination of the power imbalances in health care encounters between indigenous patients and non-indigenous health care providers". This concept requires using the critical paradigm to construct knowledge as opposed to relying on the biomedical model, which is based in the positivist paradigm. A non-biomedical model of care as outlined in the cultural safety concept emphasizes achieving mutual trust through reciprocity and shared decision making to balance the power relations which, in turn, will help reduce the health inequities (Peiris et al., 2008). This philosophy is in contrast to the biomedical model which focuses on the individual and holds the individual responsible for preventing unfavourable health outcomes.

By participating in the interview, I hope that dental hygienists will become more aware of the value of the critical theory paradigm in dental hygiene and how the social determinants of health impact health outcomes, thus, encouraging a paradigm shift to better understand how to provide care in a multicultural society.

Methodology

I conducted a one hour recorded focus group interview with a group of seven oral health practitioners, five dental hygienists and two dental assistants, to ask questions about their experiences with caring for clients of cultural backgrounds different than their own as well as what culturally competent care means to them (see appendix B for list of questions). The intention of the focus group interview was to generate discussion about their educational needs to be better prepared to care for a diverse client base.

One of the members of the group was contacted to ask permission to conduct this interview. Once permission was granted, a list of questions (Appendix B) was forwarded along with a copy of a paper that I co-wrote and recently published in the Canadian Journal of Dental Hygiene, titled "*Increasing Cultural Competence in the Dental Hygiene Profession*", for pre-reading. The intention with the pre-reading was to familiarize the group with my meaning of cultural competence and to generate discussion about what it might mean to them. I also felt that since cultural competence is an emerging concept in health care, it was possible that members of the group might not be familiar with the topic and providing the pre-reading might be informative to them to generate more discussion during the interview. Additionally, the consent form (approved by UBC Behavioural Research Ethics Board) was forwarded to the group along with the questionnaire and pre-reading to obtain their consent for my interview.

A digital recorder was used to record the interview and notes were taken during the discussion. Field notes were taken of the environment and mood that was created during the discussion. My transcriptions, field notes and tape recordings were given to my course instructor Dr Shauna Butterwick, the principal investigator for this project, for her review and assessment.

Results

The focus group consisted of seven members, five Registered Dental Hygienists and two Certified Dental Assistants with varying years of experience ranging from 3 to 29 years. One member of the group had previous medical training and one member had dentistry training in their countries of origin. Using my questions as a guide, discussion

was generated allowing for the conversation to be relaxed and flow freely. The following topics were derived from the questions asked during the interview.

Diversity of Client Base

The group recognized ethnic diversity in their client base and one member included physically challenged individuals as well. The group was unsure if the term "diversity" meant diversity in ethnicity exclusively rather than diversity in client's needs, values and beliefs such as with physically and mentally challenged individuals. The group was also uncertain about the inclusion of First Nations individuals in their client base as many indicated that they had difficulty recognizing their First Nations clients as they were educated so "it was difficult to tell". Some discussion occurred around forgetting that "European Caucasian is a culture". This led to the revelation that culture is not only skin deep but that some cultural groups might have shared values, needs and beliefs but may not all have the same skin colour. However, there was a missed opportunity to direct the discussion towards White dominance in society.

Meaning of Culturally Competent Care

For the most part, the group felt that cultural competence meant being non-judgmental, open-minded and sensitive to others' values and beliefs. One participant felt quite strongly that if the client kept coming back then they "were happy with you". It had not occurred to the group that in some cultures, it might be considered rude or impolite to question the health care practitioner. They may not necessarily be "happy" to return to their dental office, but they don't feel it is their place to challenge their health care practitioner. When asked if the group felt that the clients' values and beliefs also included how they approach health care, the group responded "yes". This led to a discussion of the

fact that in some countries dental hygiene programs were relatively non-existent until recent years, thus, as a result, the population had little access or knowledge of preventive dentistry. This led others to understand that perhaps this is why some clients approach a dental office only when they have symptoms such as a toothache or a broken tooth.

Views on Practicing Culturally Competent Care in the Oral Health Care Field

A pre-reading was provided of a paper I co-wrote on the topic of cultural competency in the dental hygiene profession; a definition for cultural competency and culture was also provided (see definitions in Appendix A). I asked the group how they viewed this paper and if they agreed or disagreed with the concepts mentioned in the paper in order to generate discussion about their views and opinions on the topic.

The group felt it was very important and timely to become more familiar with cultural competence, seeing that Canada is becoming increasingly diverse. One group member described how meaningful it was to her to have attended a seminar led by someone in a wheelchair from "her point of view". It seemed quite important to have people from their own culture discussing how they would like to be cared for in a dental office, rather than learning from a dental hygiene instructor to avoid misunderstandings.

Another participant touched on the issue of political correctness and the problem with not being certain about what is acceptable to ask or discuss with clients about their culture and what is not. This led to a discussion of the risk of teaching about cultures can lead to creating generalizations and stereotyping. The group felt quite strongly about this potential risk. For instance, one participant expressed how her own father who is of Chinese decent but was born in Canada felt offended when a physician he had recently seen asked him if he could speak English. The group felt that the physician made

assumptions about her father based on his ethnicity which could have been avoided had the physician made an attempt to get to know his client by making small talk and asking a few simple questions.

Ethical Issues

When asked if the group had encountered ethical issues when providing care for a client of a different cultural background other than their own, the group responded "yes" as a whole. There was much discussion around the importance of making sure that the client understood the information given in order to ensure informed consent. The group discussed how they would ask the help of a family member who could speak English to translate the information.

One member told a story of a client who came to the office where she was practicing dental hygiene several years ago in Toronto. The client was seeking dental care but could not speak English. After unsuccessfully attempting to complete a medical and dental history with the client, the dentist "just sent him away" because they could not communicate. This was upsetting to the group which was highlighted by the commentator's comments: "I mean he got no dental care. That wasn't good. This guy (referring to the dentist) was bewildered, so, you know what if he had a toothache? He just didn't get any attention". The group expressed sympathy for the client because he was not able to receive dental services nor was he able to communicate his dental concern to the dentist. The group felt that the client should have been referred to another dental office where the client's language was spoken.

The group also felt that it was important for the staff to be multicultural and multilingual to accommodate clients of various cultures and who speak various languages.

Communication with Non-English Speaking Clients

When asked if there had been any misunderstandings when using a family member as an interpreter, the group initially responded that there was no problem however, once I gave an example of how problematic it could be to use a family member as an interpreter, the group changed their opinion. I explained to the group that it is not desirable to use family members to translate medical information because family members may not interpret the entire information depending on their own views of health care, or on the family's financial situation, or on their comprehension of the information being translated.

This inspired one member to share a story about one elderly client who was living in a residential care facility for whom she recommended dental hygiene aids as well as dental treatment. The client's son had rejected the recommendations because he felt the father would not need his teeth for much longer so "what's the point". It was stated that a language barrier wasn't an issue in this case, but that there were differences in values, which made the group wonder how more problematic this scenario could have been if there was a language barrier as well.

Cultural Interpreters

In general, the group felt that a cultural interpreter's services might be beneficial; however, dentists would likely not be willing to pay for this service. When I pointed out that perhaps clients might welcome this service because some might feel uncomfortable

having a family member translate their dental health information, the group agreed. The group felt that if the client was willing to pay the interpreter fee, they would be more open to using cultural interpreters rather than family members.

The group felt that it would also be helpful to have translated pamphlets and brochures to offer their clients. They thought it might be problematic to offer many languages in written translation but the "major ones" would be useful. One member pointed out that having translated material wouldn't address the fact that some may not be able to afford further treatment, as new immigrants often do not have dental benefits when they first arrive to Canada. "It's not an easy question. Even if you have a visual and the patient wants it but they can't because they have no money to pay and they have no insurance coverage".

Acculturation Process

The acculturation process was a new concept for the group; they asked for further clarification on the definition. After providing a brief definition (see definition in Appendix A), the group felt it was so important to learn and understand the process that new immigrants undergo when they first arrive to a foreign country that it should not only be taught in dental hygiene, it should be taught in elementary schools as well. They seemed to feel more comfortable about learning about this process than learning about different cultures as they felt learning about different cultures might introduce bias and stereotyping.

Socio-Political Environment

When asked about their views of learning about the socio-political environment of the countries of origin of Canada's new immigrants, the group was less enthusiastic.

Again, the group felt that learning about the socio-political environment might introduce bias and stereotyping, and that it would be "too difficult to learn about all these countries". One group member felt that not all new immigrants are poor and some come to Canada with quite a bit of financial wealth, so we should not assume that all new immigrants are poor and uneducated. Initially, the group felt that the easiest way to learn about new immigrants' situation is to ask them why they immigrated here. When I discussed how problematic this could be, as some new immigrants might feel very passionate about discussing the socio-political environment of their country of origin and, thus, feel they should enlighten the dental hygienist with a lengthy response and some might be offended by being asked such a question, their opinion began to change somewhat.

One group member mentioned that she saw the benefit in learning about the socio-political environment but understood that some people might not be "politically minded" and might have difficulty wanting to learn this topic. There was also concern about the content of a socio-political course being biased and needing to get the point of view of the inhabitants of the countries themselves rather than relying on a "western point of view". Yet one member felt learning much more than just the generalities would be "too difficult, too dangerous".

Primarily, the group wanted to be given tools they could use in, as one member put it, "how to deal with the situation not the people". When asked to give an example, one group member responded that acquiring skills in how to "deal with someone who doesn't speak English" would be beneficial. The respondent provided a story of her experience in working in a dental clinic in a hospital in New York City. She explained

that she treated clients of many cultures and how difficult it was to communicate with them. She and her dental hygienist colleagues had access to interpreters and translated pamphlets but admitted that interpreters were seldom called upon because, as she explained, “they just wanted to get the work done”. One group member asked how they got consent for treatment, and the response was that it was implied consent. “If they open their mouth, they come to your office, then obviously they are giving consent”.

This discussion triggered one member to describe a course she took titled “Multiculturalism” as part of her dental hygiene education. She spoke very favourably about this course, describing that because the students in the class were from many different cultures, the instructor was able to form working groups with the students so they could discuss their own cultural backgrounds and the socio-political environment of their country of origin. This group member felt the informal format in which the content was delivered, coupled with the fact that the class was multicultural, was very helpful to her learning because it allowed students to learn from each other. She then proceeded to describe another useful course titled “Community Health” where the students were asked to attend an ESL (English as a second language) class and discuss the process of gum disease in “very basic terms” to the class. She felt that in this class the students learned much about immigration and the “multiculturalism process”.

Cultural Competency in Oral Health Care Programs

Without having to ask if cultural competency had been part of their oral health care programs, the discussion from the previous question led another group member to describe how she learned about the British dental health care system from a dental hygienist colleague who had worked in Britain for a couple of years. She explained to the

group that to us it appears that British people do not value oral health as we do, but in reality they have a two-tiered dental health system where many only have access to the public dental plan in which the government sets the fees and time allowance for dental hygiene procedures. Thus, even though the clients might want a thorough dental hygiene treatment they are restricted by what their public dental plan allows and, due to a lack of financial resources, they are forced to go without the thorough treatment.

This led another group member to observe that learning about international health care systems in her dental hygiene degree completion program helped her better understand the health care beliefs and views of many of Canada's new immigrants. Aside from this group member and the group member who described the Multiculturalism and Community Health courses she took, none of the other members remembered having aspects of cultural competency taught in their oral health care programs.

Cultural Competency as Continuing Competence Credits

The group in general responded that study clubs[iii] would be the best options for learning more about cultural competence. There was also some discussion about an "on-line" option, but the group displayed preference for the study club option in the form of a discussion much like what we had just done in the focus group interview with a facilitator who is knowledgeable on the topic. The group felt they learned much about cultural competence through participating in the focus group through sharing ideas and stories with each other. One group member mentioned workshops at a conference would also be a suitable option.

[iii] Study clubs are a common form of continuing competency for dental hygienists. They are organized monthly with a different topic and speaker each month to provide information on emerging topics in the field of dental hygiene. See definition of Dental Hygiene Continuing Competency (Appendix A) for further explanation.

Barriers to Practicing Cultural Competence

The "boss's" attitude towards the concept was very important to the group in enabling them to practice culturally competent care. They felt that if the dentist was open-minded and supportive, they would have more freedom in how much time they took with their clients to assure culturally competent care. The group felt that although dental health is part of health care, it is also a business and the practitioner needs to bill for his/her time to justify paying their hourly salary.

Additional/Closing Comments

The group felt that the topic was important and it was essential to "get it to a conference". They expressed that although they had never heard the term before, they had an awareness of practicing culturally competent care. They felt that there is a need for more awareness around this topic.

The group also reinforced the importance of being "authentic" when working with multicultural clients. "I think if you truly don't understand a person's situation, their emotions, how they're feeling, that person's experience, don't lie to them that you're totally sympathetic and you totally understand them. I find it's kind of condescending". Another member reinforced the need to have a better understanding of the acculturation process. "I didn't think of how difficult it would be to adapt". This member also felt that if there was more awareness of the socio-political environments that some of our new immigrants came from this might help in avoiding "putting our foot in our mouth".

Experience with Being Interviewed

The group expressed that they felt very comfortable participating in the focus group and that they not only learned much about cultural competence in the process but

they learned much about each other's cultural background as well. One member said that she felt she was afraid to speak over everyone else at times and that she wanted to hear what everyone had to say before speaking.

Analysis

The group clearly identified a need for cultural competence education to better prepare them to provide oral health care in a multicultural society. There seemed to be an urgency to learn more about this topic considering the current diverse makeup of the Canadian population. The group identified the ethnic diversity even among themselves and how little awareness they had of each other's cultural background. Additionally, consistent with the study by Dogra and colleagues the group felt that they were aware of practicing culturally competent care; however, key terminology was unfamiliar to them.

Although the group recognized the difference between culture and ethnicity, there was very little discussion regarding diversity within cultural groups or the power relations that exist in society. The group, however, was very cautious about generalizing and stereotyping, indicating some awareness of diversity within cultures and the issue of making assumptions based on ethnicity. The concern with stereotyping was evident throughout the interview, which aligns with the study by Shapiro and colleagues, where the authors discovered that the medical students preferred cultural competence to be taught as part of the informal curriculum as it was felt that formally teaching about cultural issues could introduce bias and stereotyping.

The group also alluded to the need for "tools" to help with providing care in a diverse society. It was felt that learning about cultural issues might expose biases and stereotyping when they needed to learn how to interact and care for clients of a different

cultural background than their own. This realization also aligns with the study by Shapiro and colleagues where the medical students felt the cultural competence curriculum helped in recognizing their own biases but was less helpful in providing "tools" for addressing their own biases. The desire to acquire tools or instructions on how to address certain issues possibly stems from how dental hygiene is taught at the diploma level. Due to the shorter duration of the program and a very full curriculum, the diploma program is very focused on the clinical skills needed to perform dental hygiene services. Additionally, as described by Cobban (2004), the positivist paradigm is dominant in dental hygiene, leaving little time in a two-year diploma program to allow for in-depth analysis of the critical theory paradigm or a broader understanding of how the social determinants of health impact health outcomes. Thus, having access to "tools" or a list of instructions would be viewed as a time saver by most dental hygienists.

Another theme that was evident in the focus group, and consistent with the critique by Lee & Farrell (2006), was the idea that culturally competent care meant being non-judgmental, open-minded and sensitive to others' values and beliefs. Missing from the discussion was a more critical view of cultural competency displaying an understanding of how power imbalances between client and practitioner and societal factors can affect patient care and health outcomes. Acquiring an understanding of international dental and health care systems was important to the group in understanding how some of our new immigrants value health care and how they approach dental and health care in Canada. Although it was not discussed in depth, it is my impression that it was felt that understanding international health and dental care systems would help in reducing judgmental attitudes towards new immigrants' views of health care and

prevention, thus removing the blame from the client and understanding how the structure of various health care systems can interfere with individuals' health and wellbeing. Only one member discussed being taught about international health care systems in her dental hygiene program; however, this was at the baccalaureate level.

Another dominant theme in this focus group interview was the issue of language barriers. The group felt there was a need to obtain better skills in how to communicate with clients who do not speak English or a language that the oral health care practitioner spoke. The presence of a language barrier appeared to pose ethical issues with the group. It was felt that consent for treatment could not be properly achieved if language barriers existed. Systemic issues such as time and fees needed for translations posed as barriers to addressing language issues. The group identified that although dentistry and dental hygiene are based in health care, it is also a business and the time required to address language barriers could not be billed for. Currently in Canada, dentistry is privatized and most dental hygienists are paid hourly by the dentist employer. The dental hygienist is thus expected to justify his/her hourly wage by the services that he/she bills. Incorporating dental care or at least dental hygiene care in the universal health care system might help in removing this barrier; however, a paradigm shift in how dental hygiene is delivered will also be required. As one member described, even when she had access to interpreters, they were not well utilized, as the dental hygienists "just wanted to get the work done". As previously mentioned, there is a strong focus on clinical skills in the diploma level dental hygiene programs, and students are taught to manage their time with clients as this will be expected in private practice. Removing the time barrier might

help both teacher and student to focus on the needs of the client rather than on the need to receive payment for the time spent with the client.

A new concept for the group was the understanding of the acculturation process that our new immigrants experience when they first arrive to Canada. The group seemed very open to learning more about this concept and associated it less with introducing bias and stereotypes than learning about specific cultures. It was felt that learning about the acculturation process would help with feelings of sensitivity and understanding.

Learning about the socio-political environments of new immigrants, however, was viewed less favourably by some group members as it was felt it might in fact introduce bias and stereotypes and it would simply be "too difficult" to learn about so many countries. Some group members felt that learning about the socio-political environments would not provide the tools they needed to actually provide oral health care to these individuals. One group member described how beneficial it had been to her to learn about her classmates socio-political backgrounds as part of a Multiculturalism course she took while completing her dental hygiene diploma. It was felt that learning from each other in this manner was less problematic than learning about countries in general. Thus, diversity in the classroom appeared to be beneficial in understanding how socio-political backgrounds can influence one's values and views.

Overall, the group felt that cultural competency should be part of oral health care education but with caution not to introduce bias. The group appeared to be more comfortable with aspects of cultural competency being taught informally such as was described with the Multiculturalism course by one group member. It was also strongly felt that cultural competency education be available as continuing competency credit

either through conference workshops or as study club subjects or even as online/distance learning.

Recommendations

Considering the evidence from the literature review regarding concerns with introducing bias and stereotypes when teaching about cultural issues as well as the concerns of the focus group members, I recommend incorporating cultural competence education in the informal curriculum. Encouraging diversity in the classroom and allowing students to learn from each other and then applying their cultural knowledge to practice appears to be the most accepted method of introducing this complex topic.

Additionally, advocating for longer dental hygiene programs at the baccalaureate level would allow more time to incorporate the critical theory paradigm with an emphasis on the social determinants of health, which would be beneficial in applying culturally competent care. As critiqued by Lee and Farrell (2006) and May & Sleeter (2010), a critical view of culture, multiculturalism and cultural competency is required in health care education to reduce the risk of introducing bias and stereotyping; and longer dental hygiene programs would be required to enable incorporating a critical view in the curriculum. Currently, the requirement for entry-to-practice in dental hygiene is a diploma and registration in dental hygiene; however, there is advocacy at the governing level that a baccalaureate degree in dental hygiene would contribute to the advancement of the dental hygiene profession.

The concept of cultural safety and issues with Aboriginal clients was not discussed in this interview, primarily because the group felt they had few Aboriginal clients in their practice. However, considering the evidence from the literature review, the

concept of cultural safety in the critical theory paradigm would be beneficial to oral health care practitioners in understanding how their own values, beliefs, and behaviour can influence the oral health outcomes of their clients. Although the opportunity was missed to ask further clarifying questions regarding the groups views and beliefs about Aboriginal clients, it appeared by their comments that they predominately view Aboriginal people as being uneducated; thus judging Aboriginal people by their appearance. Cultural safety not only asks the health care provider to look at their own views and attitudes towards Aboriginal people, it also provides a deeper understanding of the pre-colonial and colonial history of Aboriginal people and how this history has impacted their lives and contributed to the health challenges experienced in their communities today (Cultural Safety: Module 1).

Devising an evaluation plan for the cultural competence curriculum would be advisable in generating consistency in how cultural competence is taught and how well it is understood. Furthermore, advocating for dental hygiene care to be incorporated in the universal health care system might help in addressing systemic issues such as time and fees, which are viewed as barriers in practicing culturally competent care.

Cultural Competency (CC) in Education Summary of Recommendations	
CC in Informal Curriculum	Allow for students to learn about cultural issues through informal discussions and to apply the new knowledge to practice in the clinical setting to address concerns with generalizations and stereotyping, rather than teaching about specific cultures.
Diversity in Classroom	Diversify the classroom to allow for students to learn about each other's culture and to explore the socio-political environments of each other's country of origin in an informal manner.
Longer Dental Hygiene Programs	Lengthen dental hygiene programs and advocate for a baccalaureate degree as a requirement for entry-to-practice to allow for more time to incorporate and analyze the critical theory paradigm and the social determinants of health in which the concept of cultural safety and issues of health care providers' biases and behaviours can be explored.
Evaluation	Devise a standardized evaluation plan to create consistency in how cc is taught and understood.
Dental Hygiene and Universal Health care	Advocate for dental hygiene to be incorporated in the universal health care system to help address systemic barriers, such as time and fees, to practicing culturally competent care.

Limitations

One of the limitations of a focus group interview is that of confidentiality. In a focus group, the researcher cannot control what the participants might say outside of the interview. This might create a certain level of stress among the participants which might ultimately influence how much participants might want to disclose during the interview. Although the group members appeared to be relaxed and comfortable discussing cultural competence issues, it is unknown if members of this focus group felt they should withhold opinions for fear it might be repeated outside of the interview.

Additionally, according to Vaughn et al. (1996) researchers should not assume that results from a focus group interview can be generalized to a larger population. The

intent of the focus group interview is to report the views of the participants; not to find solutions that can be generalized to a larger population. I must, therefore, be cognizant that the data I have collected in the focus group interview are the views and experiences of the oral health care practitioners I interviewed and that other dental hygienists in Vancouver might not share these same views, challenges or experiences.

Furthermore, the transcripts were not reviewed by the group members to assure correct interpretation of their discussion. However, a copy of this report will be forwarded to all participants upon completion.

Conclusion

The evidence indicates that there is a need to increase cultural competence education amongst students in health care programs, including dental hygiene programs, as well as to review health care policies and program planning. By analyzing the views and challenges experienced by oral health practitioners working in a multicultural society, this project has identified the current level of interest in practicing culturally competent care and the potential cultural competence educational needs in this group of oral health care practitioners.

The focus group interview has identified a concern that the concept of cultural competence might be misinterpreted and thus introduce stereotyping and generalizations about cultural groups rather than promote individualized care. To avoid introducing bias and stereotyping in teaching about cultural competency, a critical view of culture, multiculturalism and cultural competency is required to highlight the unequal power relations that marginalized groups' experience, rather than focusing on cultural traits and characteristics. In short, a focus on how society, policies, and power imbalances play key

roles in health outcomes and the role dental hygienists can take in advocating for policy change to reduce health disparities would be beneficial in teaching about culturally competent care as opposed to focusing on teaching about specific cultures.

Furthermore, it is essential that a cultural competence course promote awareness that diversity exists within cultures and that looking at one's own biases and stereotypes is important in providing culturally competent care. Additionally, making a distinction between race/ethnicity and culture is essential in highlighting the fact that the concept of culture does not only imply skin colour but it also implies the sharing of common interests, values, traditions and beliefs.

It is my hope that this project will provide some preliminary qualitative data to help guide dental hygiene educational planning as well as highlight the importance and value the critical paradigm can bring to the dental hygiene profession. Additionally highlighting how the social determinants of health impact health outcomes, rather than solely focusing on individual behavioural risk factors, would be beneficial to the practice of dental hygiene. The concept of cultural competency is quite complex; further research is required to achieve consistency in how this topic is taught and how it can be evaluated.

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APPENDIX A

Definitions

Acculturation: Acculturation refers to a cultural change that results from contact between autonomous cultural groups (i.e. the process new immigrants experience when they come to Canada). Although change generally occurs in both groups, more change occurs in the non-dominant group than in the dominant group. This process requires members of both cultural groups to engage in new attitudes and behaviours, and to develop new forms of relationships in their daily lives (Racher & Annis, 2007).

Colonialism: Colonialism "refers to the policies, laws, and systems associated with controlling people or geographic areas which has been characterized by both cultural and population loss". Aboriginal people feel that this process needs to be better understood in health care to better provide care to this population (Cultural Safety: Module 1).

Culture: The concept of culture does not encompass ethnicity entirely; it is much more complex, and extends to beliefs, values, common interests and common needs shared by a group (Schim et al., 2007).

Cultural Competence: "Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations" (Cross et al., 1989). "It is a process in which an understanding of cultural attitudes, values, beliefs, and practices is used to help guide care for an individual, taking into consideration specific history and needs, and avoiding the use of stereotypes and personal biases" (Charbonneau et al., 2009).

Cultural Safety: Cultural safety is a concept developed by Aboriginal people to assist health care providers in providing care to their population. It "involves the recognition that we are all bearers of culture and we need to be aware of and challenge unequal power relations at the individual, family, community, and societal level" (Cultural Safety: Module 1).

Cultural Sensitivity: According to the Encyclopedia of Nursing and Allied Health, "cultural sensitivity begins with recognition that there are differences between cultures. These differences are reflected in the ways that different groups communicate and relate to one another, and they carry over into interactions with health care providers" (http://www.enotes.com/nursing-encyclopedia/cultural-sensitivity).

Dental Hygiene Continuing Competency: The Continuing Competency Program has been implemented in dental hygiene because "health professions are constantly changing through advances in technology, research, innovations in health care delivery and procedures, and increasing social awareness. Continual change accentuates the need for dental hygiene registrants to pursue educational opportunities that enhance their professional practice. It is a registrant's responsibility to determine his/her specific

Continuing Competency needs and to pursue activities that enable the registrant to maintain competency in dental hygiene practice" (College of Dental Hygienists of BC). Thus, the Continuing Competency Program in dental hygiene consists of any additional education a dental hygienists pursues to enhance his/her professional practice.

Ethnic Background: Although an official definition for ethnic background is unavailable, a following definition for ethnicity includes "the social group a person belongs to based on shared culture" (Dein, 2006). Statistics Canada (2006) describes ethnic origin (also known as ethnic ancestry) as follows "Ethnic origin refers to the ethnic or cultural origins of the respondent's ancestors. An ancestor is someone from whom a person is descended and is usually more distant than a grandparent. Ethnic origin should not be confused with language, place of birth or citizenship. For example, a person of Haitian origin may speak French, be born in Canada and have Canadian citizenship".

Health/Oral Health Disparities: A number of definitions of health disparities are available; the most appropriate definition for the purpose of this paper is as follows: "differences in health outcomes in the population, determined by factors that affect an individual or a group's environment, and predispose them to disease" (Lawrence & Leake, 2001).

Multicultural Society: Statistics Canada (2003) describes Canada's multicultural society as follows: "Canada is a multicultural society whose ethno-cultural composition has been shaped over time by different waves of immigrants and their descendents, as well as by the Aboriginal Peoples of the country. Each new wave of immigrants has added to its diversity". In other words, a multicultural society in Canada refers to the diversity of people from various areas of the world as well as the Aboriginal Peoples who make up the population of Canada.

Social Determinants of Health: The social determinants of health are defined by the World Health Organization (WHO) as "the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between populations" (CSDH, 2008).

APPENDIX B

Focus Group Interview Questions

Thank you for agreeing to let me interview you about cultural competence in oral health care. I realize it might seem odd to have me interview you about a need that I've predetermined that you might have. I am making this assumption because studies indicate that cultural competence has not been consistently taught in health care programs. Keep in mind that this interview is about determining what experiences you might have had with cultural competence in your oral health care practice. I hope that through exploring your experiences with caring for clients of cultural backgrounds different than your own that together we might determine if you have any needs that might better prepare you to care for a culturally and ethnically diverse population. There are no right or wrong answers and alternate critical views will also be informative to my project. If there are questions that make you feel uncomfortable or you prefer not to answer, you are in no obligation to answer.

1. How many years of experience do you have in providing oral health care?

2. How diverse is your client base? Which cultural or ethnic groups are represented?

3. What does culturally competent care mean to you?

4. If you have had a chance to read the paper I co-wrote and published in the Nov. /Dec. edition of the Canadian Journal of Dental Hygiene titled "*Increasing cultural competence in the dental hygiene profession*", how do you feel about it? Can you relate to any of the issues that were presented in the paper? Do you disagree with any of the issues or concepts mentioned?

5. What are your views about practicing culturally competent care in the oral health care field?

6. In a survey that I undertook with health care providers of various disciplines last semester, I asked them to provide experiences they had encountered when providing care for clients of a cultural background different than their own. Some of the responses included important ethical issues. For example: One respondent said: "Decision to intervene or send someone for tests without proper informed consent due to language barriers and no family member or interpreter available to communicate". How do you feel about this? Have you had similar or different experiences that you would like to share with me?

7. How do you presently communicate with clients who do not speak English or other language that you know? If the response is: "I ask a family member to translate". What has your experience been with a family member interpreting? Have there been any misunderstandings?

8. What are your views about having access to a cultural interpreter in your practice?

9. What do you think about the idea of learning about the acculturation process that new immigrants experience? What would you need to know about the country of origin of some new Canadians?

10. How has your dental hygiene or dental assisting program prepared you to practice culturally competent care?

11. What was missing from your program that might help in practicing culturally competent care? What was beneficial?

12. If a cultural competence course were offered to practicing oral health care providers for continuing competence credits, what format would best meet your needs?

13. Is there anything else you would like to add that wasn't mentioned in this interview?

14. What has been your experience of being interviewed; how does it feel to respond to these questions? What changes might you suggest for future interviews?

Thank you for your time!