

# DISCURSOS

PRONUNCIADOS EN EL ACTO DE  
INVESTIDURA DE DOCTOR *HONORIS CAUSA*  
DEL EXCELENTÍSIMO SEÑOR

D. CRISPIAN SCULLY

PRESENTADO POR

D. MIGUEL ÁNGEL GONZÁLEZ MOLES



UNIVERSIDAD DE GRANADA

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PHK/10/10/10

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C-62-16(9)

b19689524  
i21242112

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DISCURSOS DEL ACTO DE INVESTIDURA DE DOCTOR  
HONORIS CAUSA DE D. CRISPAN SCULLY.  
Depósito Legal: GR. 2342-2009  
Edita: Universidad de Granada  
Imprime: Gráficas La Madraza

*Printed in Spain*

*Impreso en España*

DISCURSO DE PRESENTACIÓN PRONUNCIADO POR  
EL DOCTOR DON MIGUEL ÁNGEL GONZÁLEZ MOLES  
CON MOTIVO DE LA INVESTIDURA DEL DOCTOR  
D. CRISPAN SCULLY

SEÑOR RECTOR MAGNÍFICO DE LA UNIVERSIDAD DE GRANADA,  
EXCELENTÍSIMAS E ILUSTRÍSIMAS AUTORIDADES,  
MIEMBROS DE LA JUNTA DE GOBIERNO DE LA UNIVERSIDAD DE  
GRANADA,  
CLAUSTRO DE PROFESORES  
SEÑORAS Y SEÑORES

Comparezco ante las autoridades académicas y el claustro de profesores de la Universidad de Granada para solicitar la concesión del grado de Doctor *Honoris Causa* al Profesor Crispian Scully, el más alto grado académico que conceden las universidades como reconocimiento al mérito y a la valía científica o profesional. Este acto constituye para mí un altísimo honor que desempeño con enorme satisfacción personal, con agradecimiento hacia el Departamento de Estomatología que me encomendó esta misión y hacía todas las personas que lo han hecho posible. Mi agradecimiento debe ser especial para el Rector de la Universidad de Granada, el profesor Francisco González Lodeiro, y para su antecesor en el cargo, el profesor David Aguilar Peña. Ambos han mostrado la máxima sensibilidad hacia la propuesta formulada por nuestro Departamento. La solicitud que cursé recibí inmediatamente el máximo entusiasmo por parte del Departamento de Estomatología, lo que igualmente ocurrió en la Junta de Centro de la Facultad de Odontología y en el resto de los centros y departamentos que han dado su apoyo a esta propuesta. Igualmente hemos recibido muestras

de adhesión de otras universidades como la Universidad Complutense de Madrid, la Universidad de Valencia, la Universidad de Santiago de Compostela y la Universidad del País Vasco, en las que desarrollan su actividad grupos de investigación que mantienen estrechas y fructíferas relaciones con Crispian Scully. El Departamento de Estomatología de la Universidad de Granada realiza esta petición bajo el convencimiento de que se trata de un acto de justicia hacia una de las personalidades más relevantes del mundo en la Odontología de los últimos veinte años. Para nosotros representa además un doble motivo de satisfacción por cuanto Crispian Scully será el primer dentista Doctor *Honoris Causa* de la Universidad Española, lo que en alguna medida refleja la importancia científica que ha adquirido la Odontología y en particular, la repercusión internacional y el enorme incremento del nivel científico de la actual Odontología española.

La idea de proponer al Prof. Scully como Doctor *Honoris Causa* por nuestra Universidad se gestó hace algunos años, cuando dirigí mi línea principal de investigación hacia algunos aspectos de la etiopatogenia del carcinoma oral de células escamosas. Comprobé entonces que las aportaciones de Crispian Scully en este campo fueron determinantes y posteriormente, a lo largo de mi formación académica y de mi vida investigadora, he podido constatar que sus contribuciones científicas han cambiado y modernizado las bases de la Odontología en las ramas de la Medicina Oral, la Cirugía Oral, la Patología Oral y especialmente de la Odontología para Pacientes Discapacitados y Médicamente Comprometidos.

Crispian Scully nació en el Reino Unido en 1945, y su vida profesional ha estado siempre presidida por el trabajo incansable y excelente. Se licenció en Odontología por la Universidad de Londres en el año 1968 y posteriormente se especializó en Cirugía Dental, en Bioquímica y en Cirugía. Finalmente se graduó en Medicina en 1974. Es Doctor en Patología desde 1974 y Doctor en Medicina desde 1987. Crispian Scully es catedrático de la disciplina Odontología en Pacientes Especiales y catedrático en la disciplina de Medicina, Patología, y

Microbiología Oral. Ha impartido docencia inicialmente en la Universidad de Bristol y actualmente en el Eastman Dental Institute y en la Facultad de Odontología de la Universidad de Londres. El Eastman Dental Institute es un centro dependiente del University College of London, que constituye el mayor centro de postgrado de Europa y que, con más de 50 años de experiencia, es actualmente sin duda un líder mundial en educación posgraduada y en investigación relacionada con ciencias de la salud oral. En él perfeccionan su formación cientos de odontólogos de todo el mundo y también numerosos odontólogos españoles. Crispian Scully ha sido el decano de este centro durante 15 años, desde 1993 hasta 2008, y actualmente dirige su Departamento de Proyectos Especiales. Durante su gestión, el Eastman Dental Institute mejoró de forma espectacular sus niveles de investigación y enseñanza postgraduada alcanzando el rango de Centro Internacional para la Excelencia en Odontología a través del premio Queens Award for Higher Education en 2002. Asimismo, entre otras distinciones ha recibido el reconocimiento como Centro colaborador de la Organización Mundial de la Salud, y del Instituto Nacional para la Salud de Estados Unidos. Scully ha desarrollado también su labor docente como profesor visitante en 39 Universidades de todo el mundo entre las que se encuentran Las Universidades de California, Ámsterdam, Atenas, Burdeos, Berna, Lisboa, Helsinki, Ankara, Buenos Aires, Valencia, y un largo etc. En opinión de muchos de los que lo conocemos, Crispian Scully tiene una capacidad especial para transmitir de forma sencilla sus enormes conocimientos, lo que hace con gran entusiasmo y dedicación. Pero si hubiera que resaltar alguna de sus facetas de enseñanza, esta debería ser, desde mi punto de vista, la relacionada con los cuidados de la salud oral en pacientes discapacitados y médicamente comprometidos. En este campo, el autor ha realizado una actualización de las vías de tratamiento de este grupo especial de pacientes que hasta hace pocos años eran infratratados o tratados en condiciones que ponían en riesgo su salud. Su preocupación por enseñar en profundidad como ha de ser atendido este sector de la población es una muestra más de su espíritu generoso

y bondadoso. Su repercusión docente en este y otros campos es, sencillamente, espectacular. Sirva como ejemplo que ha publicado 41 libros de los que 11 son libros de texto. Uno de ellos, "Medical Problems in Dentistry", del que ya ha aparecido su quinta edición, ha recibido el premio Doody por ser uno de los libros de Medicina más vendidos del mundo. Podría decirse sin temor a equivocarnos, que a partir de la figura del Profesor Scully hay un antes y un después en el tratamiento odontológico de los pacientes discapacitados.

Crispian Scully ha dedicado también un gran esfuerzo a la gestión universitaria y de organismos y sociedades científicas. Ha sido Jefe del Departamento de Medicina, Cirugía y Patología Oral de la Universidad de Bristol, Decano de la Facultad de Odontología de la Universidad de Bristol, Decano del Eastman Dental Institute, y Jefe de Estudios e Investigación de este centro. Ha sido presidente de la Federación Internacional de Medicina Oral, Presidente de la Academia Internacional de Oncología Oral, Presidente de la Asociación Europea de Medicina Oral y Presidente de la Sociedad Británica de Medicina Oral. Actualmente, en el Reino Unido es miembro del Grupo de Trabajo sobre Cáncer del Centro Nacional para la Salud y Excelencia Clínica; desde 1998 es codirector del Centro Colaborador de la Organización Mundial de la Salud para la Salud Oral, Discapacidad y Cultura, entre otros puestos de relevancia. En todos ellos ha desempeñado sus funciones con gran eficacia y dedicación.

Scully ha desarrollado además con brillantez y autoridad una fructífera actividad clínica, tanto en el campo de la medicina hospitalaria como en asistencia primaria. Se ha dedicado especialmente a la medicina, cirugía y patología oral, así como a la odontología para pacientes discapacitados y médicamente comprometidos. Ha sido director clínico del Eastman Dental Institute y del Grupo de Quimioprevención de la organización Europea para Investigación y Tratamiento del Cáncer. Es consultor honorario de numerosos hospitales, entre los que se encuentran el Glasgow Dental Hospital, Bristol Royal Dental Hospital y Royal London Hospital, así como de los hospitales universitarios NHS

Foundations Trust, Great Ormond Street Hospital y del Instituto Europeo de Oncología de Milán.

Finalmente, si bien en todos los campos mencionados ha brillado con intensidad, probablemente sus mayores logros y aportaciones corresponden a su faceta investigadora. El interés principal de su investigación se ha centrado esencialmente en el estudio de enfermedades graves y potencialmente letales como el cáncer y precáncer oral, SIDA, enfermedades autoinmunes, etc. Fue el primero en alertar sobre el aumento de la incidencia de cáncer oral en el Reino Unido, y el primero en señalar las relaciones del carcinoma orofaríngeo con los papilomavirus humanos de alto riesgo, asociaciones que hoy están plenamente reconocidas por la comunidad científica internacional. Además comunicó por primera vez la presencia de un nuevo tipo de virus del papiloma humano en cáncer oral. Su grupo ha puesto de manifiesto también por primera vez evidencias de RNA complementario del virus del herpes en cáncer oral. Sus estudios han demostrado mutaciones del oncogen *ras* y cambios en algunos genes supresores tumorales relacionados con el cromosoma 3p. Ha desarrollado igualmente investigación de gran nivel sobre las repercusiones orales de algunas enfermedades autoinmunes, su clasificación y su tratamiento. En este sentido, su trabajo más referenciado, con más de 1000 citas, propone una clasificación y criterios diagnósticos del síndrome de Sjögren. Algunos de sus trabajos en el campo de las lesiones orales erosivas severas de origen autoinmune han sido realizados en colaboración con miembros del Departamento de Estomatología de nuestra Universidad. Junto a él hemos propuesto pautas de uso de corticoides tópicos en patología oral severa y hemos alertado por primera vez sobre algunos de sus efectos adversos más importantes. Además, en nuestra investigación también hemos señalado el potencial premaligno del liquen plano, una frecuentísima enfermedad que afecta prioritariamente a la mucosa oral. En el campo de la infección por el VIH, ha realizado aportaciones muy relevantes, con trabajos que superan las 200 citas, sobre las infecciones orales oportunistas de los pacientes con SIDA y sobre el papel de los virus en el sarcoma de Kaposi.



Como consecuencia de su actividad investigadora, Crispian Scully ha publicado más de 800 trabajos recogidos en MEDLINE, 352 en revistas de impacto. Ha publicado en *New England Journal of Medicine*, *Lancet*, *British Medical Journal*, etc. Se trata prioritariamente de investigación básica, aunque también ha publicado investigación clínica y trabajos de revisión que han tenido una gran repercusión internacional. Sus publicaciones han recibido un total de 8348 citas, y cuarenta de sus publicaciones han sido citadas al menos en cuarenta ocasiones, lo que como saben le otorga un índice H de 40. Crispian Scully ha colaborado en proyectos de investigación con Universidades de 40 países del mundo. En relación a la frecuencia de sus colaboraciones, las Universidades españolas ocupan el tercer lugar, y entre ellas destaca la Universidad de Granada. Los que hacemos investigación en campos relacionados con los aspectos médicos de la Odontología y hemos tenido el privilegio de investigar y publicar junto a Crispian Scully, sabemos que esto es una garantía absoluta de perfección en el trabajo y en alguna medida nos vemos recompensados y disfrutamos de un estatus algo especial derivado del halo de prestigio que emana su figura. Su disposición a trabajar con investigadores de todo el mundo refleja una vez más su espíritu generoso, su capacidad para compartir sus conocimientos y su esfuerzo, y para aceptar las naturales limitaciones que conlleva trabajar con personas de dispar altura científica. No obstante, Crispian Scully sabe exigir a sus colaboradores nivel científico y esfuerzo personal. Junto a él no hay demora en el trabajo, no hay cabos sueltos, no hay investigación de segunda categoría. Por ello, que el Departamento de Estomatología de la Universidad de Granada mantenga una línea fructífera de trabajo investigador en colaboración con Scully refleja en alguna medida el nivel que en poco tiempo hemos alcanzado, lo que queda patente en un análisis realizado por el Departamento de Biliotecnomía y Documentación de nuestra Universidad que nos sitúa a la cabeza de los departamentos de la Universidad de Granada pertenecientes estrictamente al ámbito de la Medicina, cuando se consideran indicadores de excelencia investigadora como porcentaje de trabajos publicados en el

primer cuartil o número de proyectos financiados en planes nacionales o por la Junta de Andalucía, etc. Este análisis también nos sitúa a la cabeza de todos los departamentos odontológicos de nuestro país. Puesto que estos datos obran en poder de nuestras autoridades académicas, humildemente he querido hacerlos públicos aquí para resaltar que las relaciones internacionales de nuestro Departamento son también en parte fruto de su actual nivel.

La relevancia científica del profesor Crispian Scully también se plasma en aspectos relacionados con su actividad editorial. Él es el fundador y el editor de la revista *Oral Oncology* que, con un elevado factor de impacto y situada en los primeros puestos de su categoría, es considerada actualmente como la revista de oncología oral más importante del mundo. Además es coeditor de la revista *Oral Diseases*, igualmente ubicada en posiciones preferentes de la categoría, y es coeditor de la revista *Medicina Oral, Patología Oral, Cirugía Bucal*, la única revista odontológica española indexada y con factor de impacto, en este caso compartiendo sus funciones con el Profesor Bagán Sebastián, catedrático de la Universidad de Valencia. Asimismo, forma parte del comité editorial de múltiples revistas con impacto como *Journal of Oral Pathology*, *European Journal of Cancer*, *International Journal of Oncology*, *Archives of Oral Biology*, *Journal of Oral Pathology and Medicine*, etc.

El conjunto de su actividad docente, clínica e investigadora ha dado lugar al *currículum vitae* que les he expuesto resumidamente. La solidez de su trayectoria ha sido reconocida por numerosas asociaciones, instituciones y organismos a través de la concesión de múltiples premios y distinciones; más de 50 según figura en una reciente actualización de su currículum. Entre ellos destacan el habersele otorgado la medalla de honor de la Universidad de Helsinki, así como el grado de Doctor *Honoris Causa* por la Universidad de Atenas en 2005, y por la Universidad de Pretoria en 2008. Ha sido además reconocido por el Instituto Biográfico Americano en 2009, por su proyección internacional, como hombre del año del Reino Unido. Por último, probablemente el reconocimiento que personalmente más le honra, es el haber sido nombra-

do por la Reina de Inglaterra en el año 2000 Comandante de la Orden del Imperio Británico. La pertenencia a esta orden, por otra parte muy exclusiva, es otorgada por la Reina a aquellos que contribuyen de forma muy significativa al prestigio internacional del Reino Unido, y se concede a personalidades del mundo de la cultura, del deporte, de la música, de la política, etc. Crispian Scully comparte este honor por ejemplo con Agata Christie, Margaret Thatcher, Julie Andrews, Michael Cain, Elton John, Paul McCartney, Bill Gates o David Beckham. Él recibió esta importante distinción como reconocimiento a la repercusión de su trabajo en el cuidado de la salud oral, especialmente de los pacientes discapacitados y médicamente comprometidos.

Por todo lo expuesto, creo, en representación del Departamento de Estomatología, que concurren en el Profesor Scully todos los atributos necesarios para alcanzar el grado académico máximo de Doctor *Honoris Causa* por la Universidad de Granada. Creo sinceramente que el Profesor Scully lo merece por su compromiso con la Docencia y la Investigación, por el interés que ha demostrado durante toda su vida por mejorar la salud oral de la población, en particular en las enfermedades graves que la atenazan y especialmente de los enfermos con discapacidad física o psíquica, y por su afán permanente por incrementar el potencial investigador de otros países diferentes al suyo, entre los que España ocupa un lugar muy significativo.

Para finalizar, quiero referirme a ti, querido Crispian, para agradecerte que me hayas permitido pertenecer a tu círculo de colaboradores y amigos, aprender tus enseñanzas y tu ejemplo, demostrándome cómo trabajan las personas excelentes, y sobre todo para agradecerte todo lo que has hecho por mi Departamento y por mi Universidad.

Señor Rector, quiero terminar dando las gracias a la comunidad universitaria y especialmente a usted por el entusiasmo demostrado hacia la candidatura de Crispian Scully. Nosotros entendemos que esto también demuestra una sensibilidad especial por las inquietudes y los problemas del Departamento de Estomatología y de la Facultad de Odontología.

Así pues, considerados y expuestos todos estos hechos, dignísimas autoridades y claustrales, solicito con toda consideración y encarecidamente ruego que se otorgue y confiera al profesor Scully el supremo grado de Doctor *Honoris Causa* por la Universidad de Granada.

DISCURSO PRONUNCIADO POR EL DOCTOR  
DON CRISPIAN SCULLY  
CON MOTIVO DE SU INVESTIDURA COMO  
DOCTOR *HONORIS CAUSA*

## ORAL HEALTH CARE IN A CHANGING WORLD

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

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

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

History shows centuries of conflict and movement of populations in many, if not most parts, of the world. Colonization and the subsequent decolonization; wars, natural disasters; competition for limited re-

sources; and the natural desire of human beings to explore new worlds, has resulted in enormous changes, especially in the last and this century. The world is also shrinking with globalization following the tremendous technological advances facilitating travel and communication.

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

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

Culture is a term used to refer to shared patterns, meanings and behaviors of a social group. Understanding and respecting the differing cultures, religions, ethnicities and values within society is increasingly recognized as critical to good quality healthcare provision. Some

healthcare providers have been tardy in appreciating the importance and the improved quality of care that comes from patient-centred care. Each patient is of course, an individual with personal views about their illness and health-views which may not always concur with those of the HCP. Patients have personal wishes, needs and concerns that demand the understanding and respect of the healthcare providers. Patients increasingly and rightly expect to be offered choice not just about when and where they receive treatment, but also about what kind of treatment they receive, how it will be delivered and by whom. Extending choice is particularly important in responding to the needs and preferences of an increasingly diverse population. At the same time, it is increasingly recognised that involving patients as full partners in decisions about treatment leads to better health outcomes.

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

The knowledge base to be culturally sensitive to all the different peoples is enormous and lists of cultural traits and religious customs and beliefs can help but inevitably give a very false impression of uniformity. Thus, it is crucial to remember that there is considerable variation within every cultural and religious group and to avoid stereotyping. Guidance applies only to certain patients and is not a recipe for all solutions and is simply a starting point for individualizing dental healthcare. Individual's views, practices, needs and wishes vary widely and can be influenced by religion, ethnicity, educational, socioeconomic, acculturational and other factors.

*Culture* (Latin *colere*; to inhabit, to cultivate, or to honour), is a term that refers to patterns of human activity and the symbolic structures that give such activity significance. Culture can be seen as consisting of three elements:

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

*Cultural differences* are based on combinations of the above three elements but, apart from religion, a key difference between non-Anglo-American and Anglo-American cultures is that the latter stress the independence of the individual while the former emphasize the individual's dependence on the family. This has many implications for healthcare.

*Cultures are often based on some sort of religion or faith*, or similar basis developed for inculcating and preserving established or "correct" cultural behavior. Groups of immigrants, exiles, or minorities often also form cultural associations or clubs to preserve their own cultural roots in the face of a surrounding (generally more locally-dominant) culture.

*Cultural changes can and do occur* particularly due to the environment (including education and socioeconomic status), to inventions (and other internal influences), and to contact with other cultures. When this affects an individual or groups of people, it is often termed *acculturation*. *The health manifestations of culture are significant and determine patient behaviors*. Immigration is not a new phenomenon and is unlikely to cease. Migrants from diverse social, economic and educational backgrounds arrive and have arrived for centuries in other countries for a variety of reasons. Many are refugees fleeing war, political upheaval, persecution, natural disasters or deprivation in their home countries. Some are joining families from which they have been separated for years. Yet

others come seeking education or financial advantage, or to provide or seek work. All the evidence suggests that the desire or need to emigrate from various places around the world is unlikely to diminish.

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

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

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

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

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

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

Social exclusion and barriers to healthcare are often present and prevent access to care. Immigrants may also run into conflict with aspects of their new life, because of different views and values. For example, few immigrant groups have flexible attitudes towards issues such as women's equality.

In terms of health and health care, new immigrants may lack full understanding of the new health care system in which they find themselves; lack awareness of preventive practices and screening; have some reliance on traditional (folk) medicine and have views on consent issues unaligned to westernized thoughts and practice.

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

Those coming from, in particular, countries in upheaval can also suffer from a variety of health problems and post-traumatic stress syndrome. Some suffer from psychiatric disorders consequent on persecu-

tion, racism or perceived racism. Depression and anxiety are common, related to these factors and to the stress of emigration and adapting to a new life. Such factors, combined with the stigma associated with ill health in their home countries and being cut off from traditional family support networks, may prevent many from seeking healthcare.

Some immigrant groups also suffer social deprivation and have related medical problems such as accidents and high perinatal mortality rates.

In places where dentists have not been available, and branded toothpastes hardly affordable, people may still practice traditional toothbrushing with for example, salt or a Miswak. A lack of understanding of the healthcare system can dissuade newcomers from attending to their health needs. Newcomers are confronted with understanding the complexity of health care in developed countries—the decentralized structure, the principle of choice regarding health care providers and insurance plans, the need for health insurance, the emphasis on preventive health, and more. They may well lack understanding of the existence or roles of the various health care professionals.

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

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

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

In the transitional phase, communicable diseases prevalent in the first stage of resettlement are generally brought under control, but conditions such as hypertension, diabetes and ischaemic heart disease become more prevalent from lifestyle factors such as lack of exercise, smoking and diet. Psychological disorders, including conversion reactions, seizures and other post-traumatic stress sequelae also typically become more prevalent. The latter may arise from the stress of adjustment to a new culture, the burden of the past and separation from traditional family and cultural support systems, intergenerational conflict, and conflict with other cultures (sometimes originating from conflicts in the home country), domestic violence, gambling and substance abuse. Other problems which may arise with acculturation include the sequelae of changing name; some members adopt a western style surname, which can lead at the very least to confusion and family strife.

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

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

Drug abuse may be seen in some groups. Intergenerational conflicts can arise, with exclusion of older people and breakdown of family structures and values. Occasionally the consequences can be as dramatic as gang conflicts.

Immigrants in the third phase thus tend to have gained access to, and make use of healthcare services, increasingly using the locally dominant culture language, and following westernized health practices but, concurrently, acquire the lifestyles, habits and diseases of the culturally locally dominant community, often associated with breakdown of the extended family and intergenerational conflicts. In contrast, some individuals and groups may choose to retain or even accentuate their ancestral heritage.

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

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

- *Non-White groups are more likely than White people to be living in poor quality housing.*
- *There are variations in school performance between cultures.* Black Caribbean children perform less well than most other Black and Minority Ethnic Minority (BME) children at school. Gypsy/Roma children and those of Travelers of Irish Heritage have the lowest attainment in schools. In contrast, Chinese and Indian children perform better than others in school
- *Non-White groups are twice as likely as White people to be unemployed.* Bangladeshis have 4 times the rate of unemployment (20%) compared to White British (5%). Black groups have the highest unemployment rates for the under-25s and Bangladeshi households also have the lowest gross hourly earnings and incomes.



- *There are variations in type of employment.* Asians account by far for most recruits to the medical, dental and pharmacist professions. Chinese and Indian people are as, or more likely, to be in professional and managerial positions as Whites. People in BME groups who have qualifications are far more likely to be in employment than are those without. Whites, Indians and Chinese people are more likely than other BME groups to have parents who are salaried.
- *There are significant health problems in, and barriers to health care for, BME populations.* Health care services, and primary care, NHS Direct, and walk-in centres are underused by the BME population. One in 6 refugees has a health problem severe enough to affect their lives.

As to oral diseases, many of the risk factors are modifiable, and thus all patients need to be aware of the risk factors and have access to effective strategies to reduce them. Some patients of all cultures may have limited knowledge of the risk factors for common oral disease such as dental caries and periodontal disease, as well as serious conditions such as cancer, especially those who have not had the luxury of a good education or a high level of socioeconomic support. This can apply to immigrant groups many of whom are unlikely in the early stages of acculturation, to routinely visit a dentist or other healthcare provider. Furthermore, the perception of health and disease may vary in different groups; for example, whilst older Chinese subjects perceive themselves as being at lower risk for periodontitis they actually have more objective signs of periodontitis than subjects of European descent but comparable age. The importance of oral hygiene is often appreciated by people from or who have had contact with such Anglo-American cultures, but this is not always the case in some other cultures. The miswak - a stick made from the roots or twigs of various trees - is used commonly in Muslim countries as an effective and inexpensive tool for oral hygiene. The plaque removing properties of the miswak and conventional toothbrush are similar and, in some studies,

the miswak has even been superior. Miswaks may also have some anti-caries activity by virtue of fluoride contained. Miswak users however, develop significantly more gingival recession and occlusal wear than do toothbrush users, and the teeth may develop a distinctive yellow stain. Teeth are also cleaned in some cultures using tooth powders derived from a variety of sources, such as charcoal, ash, silica or tobacco. Tongue cleaning is another ancient habit used in some cultural groups such as Hindus and Chinese, while in others (including most westerners) it is a novel concept. It can however, help reduce oral malodor. Racial and socioeconomic status disparities in oral health are also strong determinants of tooth loss. Children from deprived backgrounds in most cultures, have more caries (tooth decay). For example, in the USA, African Americans and lower socioeconomic status adults have relatively fewer remaining teeth and are more likely to receive a dental extraction once they enter the dental care system, given the same disease extent and severity, than are other groups.

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

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

dysplasia and cancer, and impaired healing after exodontia, surgery, implant and periodontal treatment.

Areca or betel nut chewing is another lifestyle habit, especially common in people from South and South East Asia. Around 20% of the world population use betel. Following migration from these countries to developed countries, predominantly to inner city areas, the habit has remained prevalent amongst its practitioners. Common effects of betel use are brown or black tooth and mucosal staining, and possibly increased periodontal disease but some protection against dental caries. Oral submucous fibrosis is also related to the use of betel and has a malignant potential if mouth cancer develops possibly in up to 8%. The carcinogenic effects of the betel quid also extend to cause pancreatic cancer. Chewing khat (qat) from the leaves of a cultivated, alkaloid shrub (*Catha edulis*), a habit mainly seen in the Arabian Peninsula and eastern Africa is another stimulant which produces oral effects including cancers. Shammah may have similar effect. Traditional practices which persist today in various cultures include deliberate mutilation of hard or soft tissues. Tooth mutilation or tooth evulsion is seen especially in the developing world, particularly Africa. A number of cultures deliberately chip or reshape teeth. In parts of Uganda, Tanzania and Nigeria the operation of ebino, or "false teeth", refers to the extraction of deciduous canine tooth buds when gingival swellings appear during the eruption of the primary canine teeth in infants. A similar practice in Somalia is 'Ilko dacowo.'

Tooth staining is another practice in some indigenous African people and in Peru and Ecuador, Vietnam, Laos, Thailand, Indonesia, and the Philippines.

Temporary mutilation by facial piercing is seen in Hindus as part of the religious ceremony Thapasyam. Facial or oral piercing is of course now common in westernized societies but also seen elsewhere, mainly in Africa and South America.

Facial scarring is seen in many tribes in tropical Africa. Tattoos are also not uncommonly seen in some cultures. Tattoos on the face or

elsewhere on the head and neck are seen in Maori, Nigeria and Cameroon, some Bedouins, and in some western cultures. Lip tattooing is seen mainly in North Africa. In Nigeria some people have the lip or gingivae tattooed before marriage. Maxillary blue-black gingival tattooing is seen in some female Muslims in North Africa and the Middle East. In some East African groups, children have uvulectomy in the belief that their health will be improved.

Traditional healers are commonplace in some cultures, especially in the developing world and associated with particular religions, particularly those of African or Chinese background. Traditional healers are also found in the West. Indeed, the concept of healthcare providers may be quite alien to such peoples, or they can be used along with traditional healing. Untrained or partly trained dentists provide oral health care, at least to some degree, in many cultures where healthcare providers are unregulated. Traditional Chinese Medicine for example, is increasingly commonly used and not just by people from that culture, not least because here are clear barriers to conventional or westernised oral health care in some BME and other communities.

Many people attend for emergency care only; for example, UK studies have shown that 40% of Vietnamese attended only when in pain and 30% of Bangladeshi children had never visited a dentist.

Efforts to address these disparities include public education and community screening efforts, dental curriculum development, professional education, intensive research efforts, and significant dental-medical collaborations, oral health education/awareness programs, specifically customized to the various dental-medical professionals/trainees and to populations at risk.

It is imperative therefore, that all dental healthcare providers acquire the knowledge and communication skills that will make them attentive to the cultural differences of their patients and one of the best ways are to become more involved in the relevant communities. Furthermore, if healthcare providers are more exposed during their training to primary care and community health centers, not only will

they have an opportunity to participate in service-learning for underserved and disadvantaged patients, but they may also be more willing to establish practices in and for these communities.

A workforce of more diversity that can address the disparities in oral health problems based on race and ethnicity is also needed. Affirmative action has thereby been introduced into academic dental institutions at least in the USA. This will more fairly assesses candidates' qualifications and increase the diversity of the dental student population, and ultimately will achieve a body of more diverse healthcare providers, with an improvement in culturally sensitive health care.

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