

Provider Racial Concordance and Medical Mistrust in Pediatric Dentistry

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Purpose

- Studies have drawn varying conclusions on the importance of a racially concordant patient provider relationship.
- Medical mistrust has continued to garner attention as healthcare enterprises thread equity, diversity and inclusion throughout their organizational policies, practices and system
- The goal is to evaluate racial concordance hypothesis and gauge level of medical mistrust in Pediatric Dentistry.

Background

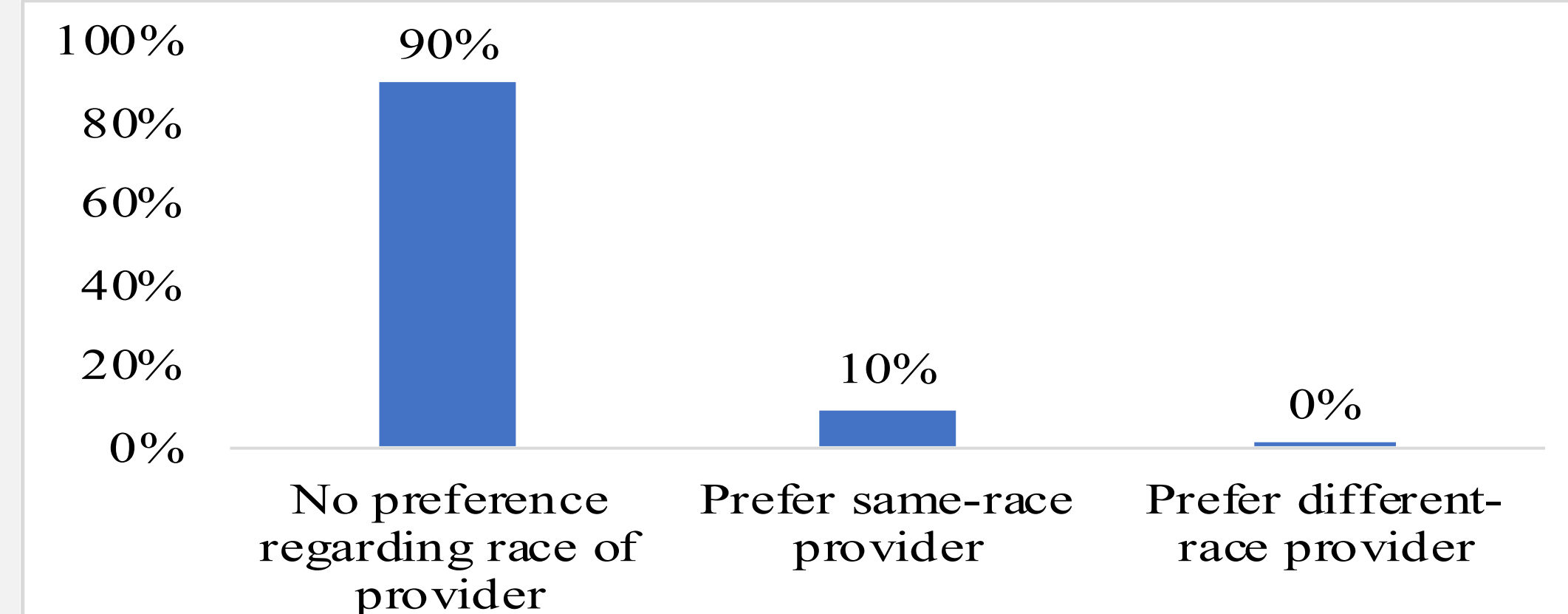
- There is a lack of underrepresented minorities in pediatric dentistry to serve the needs of growing minority populations who have less access to care, use fewer healthcare resources and are less satisfied with care they receive than the majority white population.
- Research on race and health care has documented that race affects the doctor-patient relationship but has not addressed parental preference for race concordant provider and medical mistrust within pediatric dentistry and how a pediatric dentist's national origin affects parental view of dependent's oral healthcare.
- Since children from minoritized groups were more likely to report poorer health status than were White children, with Black and Hispanic children faring worse than White children on many sociodemographic and health system measures, it is crucial to explore parental/caregiver preference for a race concordant home for dependents, gauge the level of medical mistrust and explore the concept that an increase in race concordant providers in the field of pediatric dentistry may contribute to better oral health outcome amongst minoritized groups.

Methods

- This study has been modeled as descriptive survey-based research and approved as exempt by the Institutional Review Board of Virginia Commonwealth University with the study ID number HM20023856
- Parents/caregivers of pediatric patients at VCU Pediatric Dentistry were invited to participate. Surveys included questions about demographics, racial concordance, language preference, and the validated Group-Based Medical Mistrust Scale.
- Inclusion criteria: To be included in this survey, participants had to be English or Spanish speaking.
- Exclusion criteria: All non-English and non-Spanish speaking parents/caregivers were excluded from the study.
- Responses were summarized using descriptive statistics (counts, percentages for categorical variables and mean, standard deviation for continuous).
- Bivariate associations between various demographic characteristics and preferences for provider's race and language spoken were assessed with chi-squared or Fisher's exact tests.
- Variables that were marginally or significantly associated with the preference were considered for the multivariable logistic regression models. Backwards elimination was used to determine a parsimonious model. SAS EG v8.2 (SAS Institute, Cary, NC) was used for all analyses. Significance level was set at 0.05.

Results

- A total of 256 individuals participated in the survey. 42% indicated the child was Black or AA, 30% Hispanic, and 15% Caucasian.
- 10% indicated they preferred a provider with the same race as their child, 57% prefer the provider speak to the child in the primary language spoken at home, and 56% prefer the provider speak to them in the primary language spoken at home. Preference for same-race providers was not significantly associated with guardian race.
- An increase in the Group-Based Medical Mistrust Scale was significantly associated with preference for same-race providers for children



Conclusion

While race was shown to be a nominal factor in provider selection, those parents/guardians who expressed a higher degree of medical mistrust, were significantly more likely to desire a racially concordant provider relationship. Mitigating systemic barriers in healthcare should include a focus on embracing language differences and acknowledging historical lapses in ethics, cultivating trust in the healthcare system.