RESEARCH

Caring for African-American patients in private practice

Disparities and similarities in dental procedures and communication

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ABSTRACT

Objective. Disparities in oral health care among racial and low socioeconomic groups have been reported. The authors compared the communication behaviors and dental services to African-American and white patients in private dental offices.

Methods and Subjects. The investigators directly observed office visits of 292 black and 1,552 white patients in 64 practices by using standardized checklists for the frequency of services provided and frequency and time of communication behaviors. From patient surveys, they constructed three communication scales and a patient satisfaction score. They examined the effects of provider-patient racial concordance on dental services and observed and perceived communication behaviors by using multiple regression analyses.

Results. Groups of black and white patients had similar demographic characteristics. Dental procedures were similar for black and white patients in offices with white providers. Compared with white patients, black patients with white providers reported lower ratings for how well the dentist knew them ($P = .001$), but patients' satisfaction with their providers was high and not affected by provider-patient racial concordance. After multivariate adjustment, odds of chatting were significantly lower between black patients and white providers than between racially concordant patients and providers (odds ratio = 0.38; $P < .001$), whereas odds of negotiation were lower among black patients regardless of the race of the provider.

Conclusions. In this study sample, the investigators did not observe overt disparities in dental services on the basis of race. They noted that some communication behaviors were influenced by dentist-patient racial concordance, which suggests the possibility of more subtle disparities than usually are considered.

Clinical Implications. Dental professionals could benefit from understanding their patients' perceptions of a range of interactions that occur during a typical dental visit.

Key Words. African-Americans; dental care; dental private practice; dentist-patient relations; office visits; communication; racial disparities.

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The Institute of Medicine report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care"[1] provides several key findings and recommendations concerning medical care in the United States. These findings state that "racial and ethnic minorities tend to receive a lower-quality of health care than nonminorities, even when access-related factors, such as patients' insurance status and income are controlled."[1(p1)] This statement is supported by findings from studies focused on racial variation in cardiac procedures[2] and colorectal surgery.[3] Investigators[4] also have considered socioeconomic, racial and ethnic disparities in quality of care.

In the dental literature, investigators have documented racial and economic disparities regarding the level of dental disease,[5] dentist's decision making[6] and effects of dental practice characteristics.[7] Investigators also have reported health disparities associated with racial variation within the Department of Veterans Affairs (VA) health care

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system,[8] a dental school clinic[9] and a prospective community-based study in Florida (the Florida Dental Care Study).[10] These studies focused on populations with socioeconomic deprivation along with racial variation, and their results support the premise that dental service disparities, like medical care disparities, occur generally among underserved populations. An examination of racial disparities in oral health care among patients in private dental practice requires a different sample of providers and patients from those studied previously.

The medical literature is extensive concerning both the cultural competence of practitioners and patients' perceptions of cultural sensitivity while receiving care.[11,12] Cultural competence affects not only patient-provider interactions but also patients' comfort and health outcomes. Investigators[13-15] have measured patients' satisfaction in family medical practices and satisfaction related to patients' interpersonal interactions with their physicians. When racial concordance exists between patient and provider, patient satisfaction increases, which can lead to improved health outcomes. The combination of patients' comfort with practitioners and satisfaction with care also may yield long-term effects on oral health, although results of such studies have not yet been reported in the dental literature.

An examination of racial disparities in oral health care among patients in private dental practice requires a different sample of providers and patients from those studied previously.

This implementation of the multimethod Direct Observation Study of Dental Practice[16] (DOS) in a practice-based dental research network in northern Ohio provided us with the opportunity to investigate one facet of the issue of disparities in health care. We sought to determine whether differences exist in services provided to white and African-American patients receiving care in the same set of private dental offices and whether these differences extend to issues of dentist-patient communication. We hypothesized that differences in services, as well as observed and perceived communication levels among white and black patients, may be associated with racial concordance between patient and provider.

METHODS AND SUBJECTS

Direct observation study. The Community Research for Oral Wellness Network was formed in 1998[16] and expanded in 2004 with funding for the DOS. Our purpose in this study was to measure, by using multiple methods, the content and context of patient-provider interactions for both dentists and hygienists with a focus on the delivery of preventive services. Study methods were described in a previous publication.[17] Briefly, we invited 2,500 private dental offices across northern Ohio to participate; we enrolled 120 of 166 responding offices from rural, urban and suburban locations, which we selected on the basis of power calculations to test the main hypotheses of the overall study. Teams of trained observers (research hygienists) visited each of these offices for three days of direct observation and one day of chart abstraction between June 2004 and September 2005. Hygienist-observers positioned themselves unobtrusively in the dental operatory so that they could see and hear visit interactions but could not participate in any way. We minimized observer variability by means of intense training and repeated standardization by using videotapes of routine dental encounters in practice situations. For interrater reliability of direct observation, we calculated multirater κ coefficients for procedures and communication behaviors, which ranged from 0.69 (good) to 0.92 (excellent).[17]

Using direct observation, we captured the behaviors of dentists and hygienists during patient visits using the Dental Davis Observation Code (DOC). The Dental DOC is a modified version of the medically oriented DOC, which prompts the recording of 24 observed practitioner behaviors at 30-second intervals.[18] Observers also recorded the occurrence of specific dental procedures using a predefined list of 65 common dental procedures. The self-administered surveys completed by dentists and hygienists collected demographic data (age, race, sex and years in practice). Patient surveys included demographic information and 15 items measuring communication with the provider and overall satisfaction with the visit. A national advisory committee consisting of experts in health services research

ABBREVIATION KEY. DOC: Davis Observation Code. **DOS:** Direct Observation Study of Dental Practice. **VA:** Veterans Affairs.

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