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ARQUIVOS EM ODONTOLOGIA

Camouflaged prejudice perceived by parents of pediatric dentistry patients

Larissa Kelen Moura[1] | Ivana Meyer Prado[1] | Yanna Cardoso-Santos[1] | Talyta Couto Freitas[1] Gabrielle Carvalho[1] | Junia Maria Serra-Negra[1]*

[1] Department of Pediatric Dentistry, Faculty of Dentistry, Universidade Federal de Minas Gerais, Belo Horizonte, Brazil.

Objective: To analyze the association between camouflaged prejudice expressed by parents/guardians of pediatric dentistry patients, dentist characteristics, and sociodemographic factors.

Methods: This cross-sectional study included 104 parents/guardians of patients at the pediatric dentistry clinic of a Brazilian university. The study was approved by the institutional Ethics Committee (CAAE: 05021018.7.0000.5149). Data were collected in the clinic's waiting room through a questionnaire addressing sociodemographic information (age, sex, income, education level, self-reported skin color), dentists characteristics (gender, skin color, attire, body type, education level, and patience) that most caught the attention of the parents/guardians, and the Brazilian version of the Modern Racism Scale (BR-RM). The BR-RM comprises two domains: denial of prejudice (reflecting the belief that non-white individuals already benefit from legal advantages) and affirmation of differences (reflecting the belief that white and non-white individuals differ in various abilities). Descriptive analysis and the Kruskal-Wallis test were used to assess the association between the studied variables and the total BR-RM score and its domains ($p<0.05$).

Results: Most respondents were female (74%). Higher scores in the denial of prejudice domain were observed among parents/guardians who reported caring about the dentist's gender identity ($p=0.039$). In the affirmation of differences domain, higher scores were observed among parents/guardians of female patients ($p=0.009$).

Conclusion: Camouflaged prejudice was identified among parents/guardians who considered the dentist's gender important, particularly among those whose children were girls. These individuals held stronger beliefs that white dentists differ from non-white dentists.

Uniterms: behavior; pediatric dentistry; dentists; prejudice; racism; students.

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INTRODUCTION

The Brazilian population is characterized by a racial mixture that challenges the notion of racial purity[1]. Therefore, one might assume that the problem of racial prejudice does not exist in the country. However, despite this extensive miscegenation, prejudice and discriminatory attitudes toward non-white individuals are still observed[1]. In many cases, these attitudes are expressed indirectly, as individuals attempt to avoid moral condemnation. Some people conceal their prejudice due to the influence of social desirability[1].

The Universal Declaration of Human Rights by the United Nations, in Article 2, states: "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion"[2].

***Corresponding Author**
Prof. Junia Maria Serra-Negra
Address: Av. Antonio Carlos 6627, Campus Pampulha, Belo Horizonte, Minas Gerais, Brazil. Zip code 31270901. Phone number: +553134092433.
Email: juniaserranegra@hotmail.com

Although this declaration affirms universal equality, it is well-known that human relationships are shaped by various psychosocial aspects[3]. One such factor is the importance of trust in traditional health professional-patient relationships[3]. In this context, trust is a vital asset that facilitates patient's self-care education by promoting one's health[3]. To move away from relationships based on paternalistic trust and towards a model based on patient empowerment, more and more reference is made to the importance of nurturing trust with families, ideally free from prejudice[4].

In the dentist-family-patient relationship, it is essential that prejudice is absent on both sides[3]. Any discriminatory behavior or misunderstanding between health professionals and patients can negatively impact health promotion[4]. In dentistry, missed or canceled appointments, often leading to the progression of otherwise manageable conditions, are commonly observed[5]. From educational strategies for oral hygiene at home, encouraged by parents, to more technical curative practices, successful outcomes depend on a trusting and collaborative relationship with the dental professional[6]. Racial issues in the professional-patient relationship can interfere with this complicity[7]. If camouflaged prejudice is present, interpersonal trust may be compromised[1].

In an effort to analyze the impact of racial prejudice in dentistry, a literature review have highlighted disparities in dental care related to skin color[7]. These disparities often involve treatment decisions influenced by socioeconomic status and reflect broader racial inequalities in health[7]. For example, treatment plans that prioritize tooth extractions over conservative alternatives may be rooted in underlying prejudice against non-white individuals.

A set of camouflaged discriminatory beliefs is referred to as modern racism, in which racism is framed as a problem of the past. For individuals who hold such views (typically white), non-white individuals are seen as beneficiaries of legal advantages, and inherently different from white people. Under this framework, racist statements are disguised as neutral observations about differences in ability between white and non-white individuals. When camouflaged prejudice arises in dentist-family-patient relationships, trust in the professional may be undermined. Given these considerations, this study aimed to evaluate camouflaged prejudice, through modern racism scores, among parents/guardians of pediatric patients at the Universidade Federal de Minas Gerais's pediatric dentistry clinic, in association with the dentist characteristics that drew their attention and various sociodemographic factors.

METHODS

Study scenario and participant recruitment

A cross-sectional epidemiological study was conducted at the School of Dentistry of the Universidade Federal de Minas Gerais. The study was approved by the institutional Ethics Committee (protocol CAAE: 05021018.7.0000.5149). The university is located in the southeastern region of Brazil and is one of the most prestigious higher education institutions in the country. The undergraduate dentistry program lasts five years and is divided into ten semesters. Students start to provide dental care to patients in the third semester. Patients are treated through the Brazilian Unified Health System (Sistema Único de Saúde - SUS), which means that all dental treatments are provided free of charge.

Parents/guardians of patients attending the institution's pediatric dental clinic were approached while waiting for the dentistry student to call their child for treatment. Those who agreed to participate and signed the informed consent form completed a sociodemographic questionnaire that included questions on sex, age, education level, monthly family income, and self-reported skin color. A numeric analog scale ranging from zero to ten (where zero meant "I don't like it" and ten meant "I like it a lot") was used to measure preferences regarding dentist's gender, whether the dentist's gender influenced the trust placed in their competence, as well as physical and behavioral characteristics of the dentist. Parents' self-declared skin color (white, black, brown, yellow, or indigenous) was dichotomized into white and non-white for analysis.

To assess camouflaged prejudice, the BR-RM was applied[1]. All participants completed the study instruments before knowing which dental student would be assigned to their child. The sample size was directly related to the number of patients recruited to the institutional pediatric dental clinic during the second half of 2023.

Brazilian version of the Modern Racism Scale (BR-RM)

Modern racism reflects camouflaged prejudice. This scale highlights racist statements and attitudes that may go unnoticed, even by the individuals who express them. The BR-RM consists of ten statements rated on a seven-

point Likert scale, with anchors ranging from 1 = Totally disagree to 7 = Totally agree. Total scores range from 10 to 70 points, with higher score indicating greater levels of modern racism. The scale comprises two domains: denial of prejudice (scoring between 7 and 24) and affirmation of differences (scoring between 3 and 21).

The denial of prejudice domain includes statements suggesting that non-white individuals use their racial background to gain legal advantages. The affirmation of differences domain reflects the belief that white and non-white individuals are inherently different, with race-linked abilities and talents[1].

Eligibility criteria

Included participants were parents/ guardians aged 18 years or older, literate in Brazilian Portuguese, in good general health, non-syndromic, and with no cognitive impairments. These information were assessed based on participants' self-reports regarding health conditions, syndromes, and cognitive issues.

Pilot Study

A pilot study involving ten parents/ guardians was conducted with the aim of testing the research methodology. It was found that no modifications were necessary. Participants in the pilot study were not included in the main sample.

Statistical Analysis

The dependent variable was the total BR-RM score and the scores from its two domains[1]. Independent sociodemographic variables included sex, age, monthly family income (in Brazilian minimum wage, converted into U.S. dollars: up to U$242.40 and above U$242.40), education level (less than 8 years and 8 years or more), and self-reported skin color (categorized as white and non-white).

Confounding independent variables included ratings on a scale from 0 to 10 (0 = I don't like it and 10 = I like it a lot) for preferences regarding the dentist's gender (whether it was female, male, or LGBT+), whether the dentist's gender influenced perceived professional competence (mattered or did not matter), physical and behavioral characteristics of the dentist (attire, body type, education level, and patience) that drew the participant's attention, and the level of trust in the dentist (not reliable, reliable, and very reliable).

Statistical analysis was conducted using the SPSS software (Version 21.0). Descriptive statistics were first performed, followed by the Kolmogorov-Smirnov normality test, to verify the BR-RM score distribution according to the categories of the sample's independent variables. As the data did not follow a normal distribution, the Kruskal Wallis test was performed to compare groups ($p<0.05$).

RESULTS

A total of 104 parents/ guardians of pediatric dental patients at a university clinic participated in this study. The sample predominantly consisted of female guardians (74.0%), most of whom were the mothers of pediatric dentistry patients (63.5%). The mean age of the parents/guardians was 40.6 years (± 10.7), while the mean age of the children was 8.2 years (± 02.7). A high percentage of participants self-identified as "non-white" (76.9%), had more than eight years of formal education (74.0%), and reported a monthly family income above US$242.40 (65.4%). Regarding their children, the majority reported that the child's skin color was non-white (62.5%). As for the characteristics of the dentist that caught the attention of parents/ guardians, physical traits stood out (64.4%). Most participants stated that the gender of the dentist treating their child did not matter (90.4%) (Table 1).

Table 1. Descriptive analysis of the sociodemographic characteristics of the sample.

(continues)

Variables	N (%)
Parents'/Guardians' sex	
Male	26 (25.0)
Female	77 (74.0)
Parents'/Guardians' age	
Average [±SD]	40.6 [10.7]
Median [Min – Max]	10.5 [17 – 72]

(conclusion)

Kinship with the child	
Mother	66 (63.5)
Father	23 (22.1)
Grandmother/Grandfather	08 (07.7)
Other	07 (06.7)
Parents'/Guardians' self-reported skin color	
Non-white	80 (76.9)
White	24 (23.1)
Parents'/Guardians' Level of Education	
< 8 years of study	27 (26.0)
> 8 years of study	77 (74.0)
Household income	
Up to U$242.40	34 (32.7)
Above U$242.40	68 (65.4)
Child's sex	
Female	57 (54.8)
Male	47 (45.2)
Child's age	
Average [±SD]	08.2 [02.7]
Median [Min – Max]	08.0 [02 – 15]
Child's self-reported skin color	
Non-white	65 (62.5)
White	39 (37.5)
Characteristics of the dentist that called attention	
Behavioral	26 (25.0)
Physical	67 (64.4)
Didn't notice	11 (10.6)
For me, the dentist's gender does not matter	
The dentist's gender doesn't matter	94 (90.4)
The dentist's gender matters	05 (04.8)
Trust in the dentist	
Unreliable	02 (01.9)
Reliable	42 (40.4)
Very reliable	59 (56.7)

N = Number; SD = Standard Deviation; Min = minimum; Max = maximum.
Note: Not all of the participants answered all of the questions of the questionnaire.

Table 2 presents the analysis of associations between sociodemographic variables, the total scores of the BR-RM, and its two domains: "denial of prejudice" and "affirmation of differences". No statistically significant associations were found between the total BR-RM score and the analyzed variables. However, parents/guardians who expressed concern about the gender identification of the dentist treating their child had significantly higher scores in the denial of prejudice domain ($p = 0.039$). Additionally, in the affirmation of differences domain, higher scores were observed among parents/guardians of girls ($p = 0.009$) (Table 2).

Table 2. Association between total score of the Brazilian version of the Modern Racism scale, its domains and independent variables.

(continues)

Variables	Modern Racism Total Score		p	Prejudice denial domain		p	Affirmation of differences Domain		p
	Average (±SD)	Median [Min – Max]		Average (±SD)	Median [Min – Max]		Average (±SD)	Median [Min – Max]	
Parents'/Guardians' sex									
Masculine	41.5 (14.4)	40.0 [14 – 77]	0.190*	17.4 (08.4)	17.0 [05 – 35]	**0.**159*	24.5 (09.5)	24.5 [09 – 44]	0.277*
Feminine	40.1 (20.1)	36.0 [14 – 98]		15.3 (09.3)	13.0 [05 – 35]		24.3 (13.4)	19.0 [08 – 63]	
Parents'/Guardians' skin color/race									
Non-white	42.1 (19.5)	38.0 [14 – 98]	0.228*	16.8 (09.4)	16.0 [05 – 35]	0.077*	24.7 (12.7)	20.0 [09 – 63]	0.562*
Whites	36.0 (15.2)	38.5 [14 – 66]		12.9 (07.4)	12.0 [05 – 30]		28.5 (11.6)	19.5 [08 – 48]	
Parents'/Guardians' level of education									
< 8 years of study	48.3 (23.8)	43.0 [20 – 98]	0.061*	18.8 (10.6)	16.5 [05 – 35]	0.110*	29.2 (15.2)	25.0 [09 – 63]	0.054*
≥ 8 years of study	37.8 (15.6)	36.5 [14 – 78]		14.8 (08.3)	14.0 [05 – 35]		22.7 (10.9)	19.5 [08 – 51]	
Family income									
Up to 1 minimum wage	45.5 (24.5)	38.5 [16 – 98]	0.359*	18.4 (11.1)	15.0 [05 – 35]	0.102*	25.7 (15.9)	18.5 [09 – 63]	0.779*
More than 1 minimum wage	38.2 (14.7)	38.0 [14 – 77]		14.6 (07.6)	15.0 [05 – 33]		23.8 (10.4)	20.0 [08 – 48]	
Child's sex									
Masculine	36.5 (16.5)	35.0 [14 – 80]	0.068*	15.4 (08.7)	14.0 [05 – 35]	**0.7**78*	21.1 (10.8)	18.0 [08 – 45]	**0.009***
Feminine	43.8 (19.7)	38.5 [15 – 98]		16.3 (09.5)	16.5 [05 – 35]		27.1 (13.1)	24.5 [09 – 63]	
Child's color/race									
Non-white	40.3 (19.0)	37.0 [14 – 98]	0.344*	16.1 (09.6)	16.0 [05 – 35]	0.780*	23.3 (12.3)	19.0 [08 – 63]	0.081*
Whites	41.0 (18.2)	39.0 [14 – 90]		15.5 (08.3)	14.0 [05 – 35]		26.0 (12.6)	22.5 [09 – 61]	
Child's collaboration level									
Non-collaborator	66.0 (33.9)	66.0 [39 – 56]	0.187=	21.5 (10.6)	21.5 [14 – 29]	0.051=	44.5 (23.3)	44.5 [28 – 61]	0.930=
Mild collaborator	46.3 (08.7)	44.0 [39 – 56]		26.2 (06.8)	26.5 [19 – 33]		17.6 (07.0)	17.0 [11 – 25]	
Collaborator	37.6 (13.9)	36.5 [14 – 67]		14.8 (07.3)	12.5 [05 – 28]		23.4 (09.6)	19.5 [09 – 42]	
Good collaborator	41.1 (20.6)	36.5 [14 – 98]		15.6 (09.8)	14.0 [05 – 35]		24.6 (13.4)	20.5 [08 – 63]	
First impression of the dentist									
Behavioral	42.7 (16.7)	40.5 [21 – 78]	0.611=	15.0 (09.4)	11.0 [05 – 35]	0.784=	26.4 (10.9)	25.0 [13 – 51]	0.404=
Physical	39.6 (18.4)	37.5 [14 – 98]		16.2 (09.2)	16.0 [05 – 35]		23.4 (12.1)	19.5 [08 – 63]	
Didn't notice	41.8 (25.0)	35.0 [14 – 90]		16.0 (07.9)	14.0 [05 – 29]		26.2 (17.2)	19.0 [09 – 61]	

(conclusion)

Dentist's gender									
Dentist's gender doesn't matter	40.1 (18.5)	38.0 [14 – 98]	0.236*	15.4 (08.9)	14.0 [05 – 35]	**0.039***	24.3 (12.5)	20.0 [08 – 63]	0.404*
Dentist's gender matters	50.5 (20.2)	43.5 [35 – 80]		24.4 (08.2)	27.0 [15 – 35]		26.5 (12.5)	22.0 [18 – 45]	
Trust in the dentist									
Not reliable	57.5 (31.8)	57.5 [35 – 80]	0.612=	21.0 (19.0)	21.0 [07 – 35]		36.5 (12.0)	36.5 [28 – 45]	0.291=
Reliable	37.4 (14.0)	36.0 [14 – 67]		15.3 (07.9)	16.5 [05 – 35]	0.898=	21.8 (09.2)	18.0 [09 – 42]	
Very reliable	41.9 (20.6)	39.0 [14 – 98]		16.1 (09.7)	14.0 [05 – 35]		25.6 (13.8)	23.0 [08 – 63]	

P = Probability value; SD = Standard deviation; Min = Minimum; Max = Maximum
Values in bold represent statistical significance.
*Mann-Whitney U test; =Kruskal-Wallis test

DISCUSSION

Identifying the presence of modern racism in dentistry and understanding its influence on the health professional-patient and/or health professional-guardian relationship is of great importance in confronting and addressing these expressions. The findings of this study showed no significant association between sociodemographic variables and the total score on the BR-RM. However, an association was found between parents/guardians who expressed concern or discomfort with the dentist's gender identity and higher scores in the "denial of prejudice" domain. In a study by Barbabela et al[9], no preference was found among children concerning the pediatric dentist's skin color. However, skin color may still influence parents/guardians when choosing a healthcare professional for their child. That study did not employ validated scales to assess racial bias, relying instead on a single question about preference.

Lima and Vala[10] discuss new forms of expressing prejudice and racism, including theories of modern racism, symbolic racism, aversive racism, ambivalent racism, subtle prejudice, and cordial racism. According to these authors, there is an open social condemnation of more traditional forms of racism; however, new camouflaged expressions have emerged, showing that racism continues to be a serious and current problem. Modern racism, in particular, is marked by the expression of negative stereotypes toward non-white individuals in ways that do not openly violate social norms.

Despite its subtle presentation, modern racism is just as serious and harmful as more traditional forms, affecting society in all its spheres and professions. In pediatric dental care, a good relationship between the dentist and the parents/guardians, based on trust, understanding, and empathy, is essential for effective care and better oral health outcomes.

This study's findings pointed to a gender-based association, with parents/guardians of girls scoring higher in the "affirmation of differences" domain, and participants who reported caring about the dentist's gender scoring higher in the "denial of prejudice" domain. A Mexican study analyzing children's cartoon characters on TV, using content and correlational analysis, focusing on the association between violence and race, found that white and male characters were portrayed as more violent than other characters, leading to the conclusion that modern racism was represented in race-gender portrayals[11]. Brazilian and Latin American research highlights both explicitly and implicitly violence against non-white populations[12]. In a Swedish study evaluating differences in gender behavior and implicit/explicit racial prejudices through facial photographs of white and non-white individuals, researchers found that women scored higher in implicit prejudice, while men showed higher scores in explicit prejudice[13]. These findings may help contextualize the gender-related influence observed in this study, which warrant future investigation, especially through qualitative approaches that can better elucidate gendered responses to camouflaged prejudice.

A Brazilian study highlighted the distinction between racism in Brazil and in the United States, which is explicit and supported by segregationist laws, while among Brazilians racist behavior is

camouflaged[14]. This silenced form of racism reflects the outdated myth of racial democracy, the belief that Brazil's mixed-race population lives in harmony, without conflicts, thus denying the historical impact of colonization and racism. As a result, exclusionary and discriminatory practices continue to hinder the social advancement of non-white Brazilians[14]. The social vulnerability of the population in this study also deserves reflection. It is important to note that dental care at the university clinic is offered through an agreement with the SUS, which serves primarily vulnerable populations[15]. Dental treatment is provided free of charge, and most patients are non-white, explaining the high percentage of non-white participants in this research[8,15]. The presence of camouflaged prejudice in this population may reflect psychosocial dynamics in which the oppressed may become the oppressor[14-17]. A systematic review with meta-analysis on racial disparities in children's oral health found that untreated dental caries were more prevalent among racially minoritized children compared to privileged groups[16]. In addition to these issues of social vulnerability, it is also important to evaluate the influence of gender on prejudiced attitudes[18]. A noteworthy aspect of the university clinic's service model is that, prior to the dental appointment, neither the parent/guardian nor the child receives any information about the dental student assigned to the care. The integrated public administration system from Brazil refers patients to the university, which is responsible for the patients' schedule and randomly assigns them to students. Only the appointment date and time is provided to families. This practice has the potential to trigger preexisting unconscious biases regarding the professional's gender or appearance, which could jeopardize the development of trust and treatment commitment. These dynamics are not limited to the clinical contexts; rather, they reflect broader societal patterns in which gender and racial expectations influence how authority, competence, and trust are affected. By addressing these perceptions, the present study opens paths for critical education not only in dental clinics but also in other public service environments.

This study has some limitations. Its cross-sectional design does not allow cause-effect analysis. Moreover, a larger sample size might reveal other results that did not appear in this analysis. Although the BR-RM is a validated instrument[1] and has been used in other populations[8,20], no prior studies were identified in the literature that evaluated prejudice among parents/guardians of pediatric dental patients. This makes the current article a pioneering contribution to literature. However, the absence of similar studies limits the possibility of direct comparisons and highlights a research gap. Based on the findings, awareness-raising initiatives have already been implemented in the clinic's waiting rooms to encourage caregivers to reflect on their perceptions and reduce the influence of implicit bias in the professional-patient-family relationship. The BR-RM was chosen as a suitable instrument for measuring camouflaged prejudice in epidemiological surveys[1,19]. Any attempt to change this reality implies framing anti-racism as a priority in health education. For this to happen, it is essential to first acknowledge that racism exists, even in the form of camouflaged prejudice, and that it negatively impacts health promotion[20]. Emphasizing empathy in both clinical and educational settings could encourage a reduction in prejudicial attitudes, enabling the dismantling of racism[21]. Discussions about racism in universities is essential[22]. Other study designs should be encouraged, including qualitative as well as quantitative approaches. Therefore, future studies should be promoted.

CONCLUSION

Gender was the most relevant variable associated with camouflaged prejudice among parents/guardians of pediatric dentistry patients in this sample. Parents who expressed concern about the gender of the dentist treating their child at the dental clinic, as well as those who were parents/guardians of female patients, showed higher scores in the denial of prejudice and affirmation of differences domains.

AUTHORS' CONTRIBUTIONS

All authors have made substantial contributions: to conception and design (JMCSN, IMP); acquisition of data (LKM, YCCS, TCF); analysis and interpretation of data (IMP, GC); drafting the manuscript (LKM, YCCS, TCF, GC); revising it critically for important intellectual content (IMP, JMCSN); financial support (JMCSN); final approval of the version to be published (all authors).

CONFLICTS OF INTEREST

The authors declare no conflicts of interest regarding the publication of this paper.

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ORCID

Larissa Kelen Moura https://orcid.org/0009-0009-4757-1496
Ivana Meyer Prado https://orcid.org/0000-0002-3233-5927
Yanna Carolina Cardoso-Santos https://orcid.org/0000-0001-7869-854X
Talyta Couto Freitas https://orcid.org/0009-0009-1130-269X
Gabrielle Carvalho https://orcid.org/0000-0002-6971-3282
Junia Maria Serra-Negra https://orcid.org/0000-0001-6098-3027

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Preconceito camuflado percebido por pais de pacientes odontopediátricos

Objetivo: Analisar a associação entre preconceito camuflado entre pais/responsáveis de pacientes de odontopediatria, características do dentista e fatores sociodemográficos.

Métodos: Participaram deste estudo transversal 104 pais/responsáveis de pacientes atendidos na clínica de odontopediatria de uma universidade brasileira. Houve aprovação do Comitê de Ética institucional (CAAE: 05021018.7.0000.5149). A coleta de dados ocorreu na sala de espera da clínica, por meio da aplicação de questionário sobre informações sociodemográficas (idade, sexo, renda, escolaridade, cor da pele autodeclarada), características do dentista (gênero, cor da pele, vestuário, característica corporal, escolaridade e paciência) que mais chamaram a atenção dos pais/responsáveis e a versão brasileira da escala moderna de racismo (BR-RM). O BR-RM possui dois domínios: a negação do preconceito (que representa o sentimento de que os não-brancos já recebem vantagens legais) e a afirmação das diferenças (representa o sentimento de que brancos e não-brancos são diferentes em diversas habilidades). A análise descritiva e o teste de Kruskal-Wallis foram utilizados para avaliar a associação entre as variáveis estudadas e o escore total do BR-RM e seus domínios ($p<0,05$).

Resultados: A maioria dos pais/responsáveis era do sexo feminino (74%). Maiores escores no domínio negação do preconceito foram observados entre os pais/responsáveis que relataram se preocupar com a identificação do gênero do dentista ($p=0,039$). No domínio afirmação de diferenças, foram observados maiores escores entre pais/responsáveis de meninas ($p=0,009$).

Conclusão: Foi detectado preconceito camuflado entre pais/responsáveis que se preocupavam com o gênero do dentista, principalmente entre pais de meninas, com a convicção de que dentistas brancos são diferentes de dentistas não brancos.

Descritores: comportamento; odontopediatria; odontólogos; preconceito; racismo; estudantes.