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Power and The Lens of Implicit Bias

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Black Lives Matter and Power

Events of the last few years, including the murder of George Floyd and Breonna Taylor in the United States, have heightened the endorsement of the Black Lives Matter (BLM) movement created in 2013 by three Black community organizers, Alicia Garza, Patrisse Cullors, and Opal Tometi (Black Lives Matter, 2013). Since its founding, the movement has expanded to the Black Lives Matter Global Network, with sponsored grass roots activism in Canada and the UK. Central to their efforts is their work to, "… *eradicate white supremacy and build local power*…". The movement is not focused on one, high profile leader, but instead seeks to harness the *power* of a community.

The centrality of *power* in their mission is emblematic of the expanding view among activists and others, that the movement towards greater equity and social justice in a community… in a society … requires the equitable accumulation of power and applying that power to influence the actions, beliefs, or conduct of others. Obviously, power can be used to further goals of justice and equity, but it can also be used to pursue oppression of others and constraints on the fair distribution of resources and the reinforcement of inequities.

Race and Racism in The U.S.

Individuals, groups, or communities can gain or inherit the capacity to influence beliefs and actions, as well as implement specific laws, policies, and practices. This is *power*. For example, chattel slavery in the United States was characterized by the use of power by White Americans to create laws, policies and engrained practices that maintained a system of racial inequity and White supremacy. That power created and reinforced practices that restricted Blacks from gaining agency in deciding where and who they could live with, the relationship and care of their children, and even the terms of their working conditions (*Life on a Southern Plantation, 1854*, n.d., Schermerhorn, 2018). Plantation owners, tradesmen, police, politicians, and "researchers" promulgated pseudoscience notions of the inhumanity of Blacks as a means to help solidify White supremacy. Blacks were believed to have thicker skin, less sensitive nerve endings and the inherent propensity to want to run away from the plantation where they were enslaved (Ben-Cheikh *et al*., 2021). Subtle, but powerful aspects of this pseudoscience persist up to today in the U.S. (Trawalter and Hoffman, 2015).

The formal end of the enslavement of Black people in the U.S. in 1865, marked the relaxation of some of the overtly and explicitly racist and restrictive laws, but did little to equitably distribute resources or power. President Lincoln's proposal to distribute 400,000 acres to Black families, as partial reparations for their forced enslavement, was rejected by President Johnson, who succeeded him (Oubre, 1978). One can only speculate how this allocation, if it had occurred, might have impacted the transfer of generational wealth between Southern Black families, and the ability of Black families to wield some modicum of economic power.

In the centuries since the U.S. Civil War ended, there have certainly been changes in many of the laws, policies and practices that created and supported the overt racism of the 1800's. Most forms of explicit discrimination are now prohibited by law and there is a degree of racial integration in most sectors of American life (ADL, 2019). But, an examination of racial equity that simply identifies laws and degrees of community racial integration, only counts the number of discrimination cases in American courts, or the number of African American physicians, nurses, or dentists, and neglects to interrogate the critical issues of *power*, risks perpetuating a distorted view of social justice. From the post-U.S. Civil War years up to today, formal and informal systems and structures have served to deeply stratify economic, social, and political *power* among a narrow strata of the White population in America, in spite of areas of progress. In addition, given the history of racism and colonization across the globe, this stratification clearly extends beyond the Western hemisphere (Reilly *et al*., 2015).

Implicit Bias, Systemic Inequities, and Power

An analysis of *power* must not only deconstruct who has the leverage, resources, and influence to shape policies, practices, and privilege certain norms in a field

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(i.e. dentistry), but a comprehensive analysis must also examine the more subtle, though impactful aspects of *power*, such as the dynamics of implicit bias. Implicit bias can be defined as the attitudes or stereotypes that can influence our behavior, choices, and decisions. Given the enormous amount of data our brain processes every second, we unconsciously rely on patterns or associations learned over time to make quick judgements or assessments (*Understanding Implicit Bias | Kirwan Institute for the Study of Race and Ethnicity*, n.d. 2012). The precise nature of these unconscious associations are the result of direct personal experiences, and stereotypes conveyed through the media, formal and informal education, as well as "messages" from significant figures in our environment. Manifestations of *power* are not only overt, but can be subtle, insidious, and unconscious. Implicit biases are often based on the beliefs and stereotypes promulgated by those in *power*, and negatively impact those with limited *power*.

In the months since the murder of George Floyd and the increased pronouncements of *Black Lives Matter* many healthcare facilities and academic institutions have announced plans or have implemented strategies aimed at increasing the number Black staff and employees from economically challenged communities. Additional efforts have focused on provider education and creating opportunities for enhanced dialogue within and between racially and ethnically diverse groups (Segal, n.d.). Efforts such as these are important, although sometimes short-term and under resourced. Such programmatic interventions often fail to impact embedded systems and structures that support inequities in the distribution of power, influence, and resources, and fail to impact unconscious attitudes, stereotypes and the resultant behaviors.

Hiring a few dentists from particular ethnic groups, may seem like a significant step, but it does nothing to deconstruct systems that perpetuate narrow and biased outreach efforts that often fail to surface a wide range of candidates, reflective of the community being served. One-time cultural competence or anti-racism workshops typically do not provide strategies to interrupt the *power* of individuals and systems to pass judgement on the worth of people of color or their parenting skills, or interrogate implicit bias dynamics.

Clearly all individuals, regardless of their gender, ethnicity, race, or cultural background are subject to implicit bias (Banaji and Greenwald, 2016). The process is part of the human condition. Our judgements and decisions are both explicit and implicit. But, the implicit bias of those with *power* can be critical in creating narratives that further equity within a country or subtly shape and reinforce negative stereotypes about particular groups. For example, explicit programs designed to hire more Black dentists, might not account for unconscious schemas by those in *power*, and may result in only a small number of dentists being selected for prestigious senior level positions or noteworthy awards (Sensoy and DiAngelo, 2017; Shore *et al*., 2020). Those newly hired dentists might find their careers stalled, in spite of their efforts at advancement. Unconscious bias can contribute to what types of research proposals are eventually funded, as well as influencing who gets to teach and provide leadership within our academic institutions (Head *et al*., 2013; Rogus-Pulia *et al*., 2018). In addition, research indicates that the conscious beliefs of individuals, frequently differ from their unconscious attitudes and behavior. Consequently, a person might consciously endorse values of social justice, fairness, and equity, but those beliefs might not align with that individual's actual behavior.

The subtle nature of implicit bias is demonstrated in research that indicates that individuals not demonstrating *conscious* racial bias, can show negative associations towards darker-skinned vs. lighter skinned-African Americans (Ben-Zeev *et al*., 2014). This apparent unconscious bias shows up in the courtroom sentencing of African Americans of different complexions, as well as in discipline inequities in many secondary schools (Blake *et al*., 2017; Kizer, 2017). Darker-skinned African American students experience more negative outcomes for their behavior. In healthcare, White physicians' decisions about treatment have been shown to be influenced by the race of the patient, in spite of surveys not indicating conscious racial bias by those doctors (Sabin and Greenwald, 2012) Given pseudoscience beliefs in the 19th century, such as the notion of Blacks having fewer nerve endings, it is noteworthy that 21st century research shows racial disparities in prescribing medication for pain. Hoffman (2016) found that medical students and residents who endorsed false beliefs about biological differences between African Americans and Whites, rated their pain as lower, and made inappropriate recommendations. In another study, utilizing the race Implicit Association Test (IAT), a test measuring the strength of an individual's unconscious racial bias, White oncologists' racial bias was associated with shorter interactions with Black patients (Penner *et al*, 2016). Recordings of the encounters with those patients also revealed providers' exhibiting less patient-centered communication, as well as less supportive statements. In addition, those patients experienced difficulty in remembering the interaction and had less confidence in the recommended treatment. In research by Patel (2018), White dentists, demonstrating pro-White bias on the IAT, were significantly more likely to recommend root canals for White patients and more likely to recommend extractions for their Black patients. Thus, research indicates that healthcare providers, like the general population, exhibit implicit biases that can result in behaviors that negatively impact African Americans and other underrepresented groups during the healthcare encounter (FitzGerald and Hurst, 2017).

Mitigating Implicit Bias

Although educational workshops to increase knowledge about the development and impact of implicit bias, increased self-awareness regarding personal "blind spots", mindfulness practice, and deliberately "slowing down" to consciously focus on equitable, non-biased behavior, are useful strategies for short-term bias reduction, they tend not to significantly impact structural inequities of *power* engrained in cultures over centuries. Further, the impact of these short-term strategies appears to dissipate over time. Keith Payne, a noted implicit bias researcher in the U.S., found that states and counties more dependent on slavery before 1865, displayed higher levels of pro-White implicit bias among their White residents than areas less

dependent on slavery (Payne, *et al*., 2019). This finding suggests that although implicit bias shows up in *individual* cognitions and behavior, its foundation is in the *environment*. Structural inequities and the distribution of power and resources are interrelated with individual and group racial implicit bias. Long term mitigation of implicit bias requires not only individual interventions, but must include structural shifts in the distribution of power in a community and re-distribution of resources (Payne *et al*., 2017).

A Way Forward

Although one must use caution in applying dynamics of structural racism and *power* in the U.S. to other locations in the world, but there is less dispute about some of the foundational tenets of *power*. Those groups with greater *power* can shape norms, promulgate perceptions, harness political and social influence, accumulate resources, and structure key elements of a society or healthcare system. This can occur both in conscious and deliberate ways, as well as in implicit or unconscious beliefs, attitudes, and behavior. If we are to move more rapidly towards a society, and specifically the field of dentistry, that is characterized by justice and the equitable distribution of power, then we have to augment programmatic and interpersonal initiatives with systemic and structural change. We must attend to both explicit and implicit bias, and view all of us as being responsibility for this work. We have to move beyond viewing "diversity leaders," or "diversity researchers" as being responsible for moving us forward. Virtually everyone accepts the premise that *every* practitioner and researcher is expected to operate in alignment with the highest ethical principles. We see this as a foundational principle of most every field, including dentistry. Why shouldn't *everyone* be required to actively demonstrate work towards a more just field of dentistry and the equitable distribution of *power*? Schools of dentistry should not only *teach about* healthcare disparities, but require students to show a level of proficiency in *recognizing systems* that reinforce inequities in their practice or research. For example, implicit bias education might be a requirement within schools of dentistry, as well as being a requirement for licensure or re-licensure, affording the opportunity for learners to understand how powerful individuals and systems can perpetuate unconscious or implicit bias. Of course there is no way of insuring the actual use of implicit bias mitigation skills, but taking action to codify this educational component is an actionable and important step. Let's take action … now.

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