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"Even if we are the caring hand": Black doctors and structural racism in the context of primary health care

Letícia Batista Silva (https://orcid.org/0000-0003-2520-2621) [1,2]
Daniel de Souza Campos (https://orcid.org/0000-0002-8937-7474) [3]
Marcos Vinícius Ribeiro de Araújo (https://orcid.org/0000-0001-5400-0207) [4]
Regimarina Soares Reis (https://orcid.org/0000-0002-2741-4380) [1]

Abstract *This study scrutinizes structural racism's influence on the training and work of Black professionals in primary health care (PHC) in Rio de Janeiro, particularly focusing on the experiences of Black female physicians. Employing a qualitative approach via a Focus Group, conducted in November 2022, we adopted symbolic interactionism to interpret racism-related experiences. Our findings encompass two primary dimensions: the manifestation of structural and institutional racism within the Unified Health System (SUS), and how racism permeates health work processes and consequences. Results highlight enduring impacts, spanning education to PHC roles, hindering healthcare process recalibration. Participants identify institutional and structural racism, from managerial neglect to territorial violence and physician scarcity, constraining comprehensive care. It is crucial to unveil and grasp racism's structural essence within healthcare, aligned with the vision of health as a fundamental right.*

Key words *Systemic racism, Physicians, Primary care, Blacks, Primary health care*

[1] Escola Politécnica de Saúde Joaquim Venâncio, Fundação Oswaldo Cruz. Av. Brasil 4365, Manguinhos. 21040-900 Rio de Janeiro RJ Brasil. leticiabatistas@gmail.com
[2] Universidade Federal Fluminense. Niterói RJ Brasil.
[3] Universidade Federal do Rio de Janeiro. Rio de Janeiro RJ Brasil.
[4] Universidade Federal da Bahia. Salvador BA Brasil.

Introduction

As discussed by Almeida[1], "racism is always structural, that is, [...] it is an element that integrates the economic and political organization of society." In Brazil, the majority (56.1%) of the population is Black – by definition from the Brazilian Institute of Geography and Statistics (IBGE), those who declare themselves Black and mixed race are considered to be Black. However, this population experiences the worst living and working conditions and access to fundamental rights.

Even though it is the largest in the workforce, in 2018 it was found that, while 34.6% of self-declared white employed people worked in informal occupations, among black and brown people this percentage was 47.3%. When looking at the average monthly income, for white employed people, it was R$2,796.00, while for black and mixed-race people it was R$1,608.00. Findings of this nature are also reflected in the illiteracy rates prevalent among black men and women; in racial iniquities in health outcomes; and in the prison system, which has a predominantly black prison population; as well as in several other spheres of sociability[2].

Therefore, since racism is socially produced and reproduced, it is present directly or indirectly in the daily lives of institutions, including the health services of the Unified Health System (SUS). Thus, it is present in the development of healthcare work, as well as in the training processes of health professionals. Werneck[3] highlights how institutional racism presents itself as a displacement of the individual's dimension and is installed in institutional and organizational structures in order to impact the subordination of subjects by their race/skin color.

According to Almeida[4], racism is a technology of power. It provides the meaning, logic, and technology for the reproduction of the forms of inequality and violence that structure social life. Regarding Brazilian formation and the structural character of racism, the author further explains:

The background that moves and changes historically are the racial ideologies that structure social relations in Brazil, on which the prejudices and discriminatory practices that give materiality to racism in the 'Brazilian' way are reaffirmed. This racism, whose material existence is recognized by the population, dialectically denies the existence of the agents, because, in Brazil, 'no one is racist'. When these agents are unknown, impunity, invisibility, silence are fostered and, consequently, the difficulties in confronting them through public policies are greater (p. 132).

Following Almeida's thoughts[4], we highlight the Brazilian State as an active agent in the annihilation of the Black population[5-7]. Through a State supported by the interests of national and international elites, a profound historical and social process is developing that denies the recognition of Black men, women, and children as subjects of law, and erases African history and culture oriented by the naturalization of Black men and women as subordinate, subaltern, and objectified individuals[6,8,9].

In Brazil, medical students are mostly white, both during graduation and during residency[10], which is an expression of the racial division present in the medical workforce in the country. This is a reflection of the exclusion of the Black population from functions of greater recognition and social prestige and better remuneration, as well as representing an important analytical key to understanding the production of health in care spaces based on the experience of workers who break this historically constructed profile of the figure of the medical student and doctor in Brazil.

The historic struggle of Black movements organized throughout the 20th century produced tension and participated strongly in political disputes with a view to overcoming the aforementioned scenario. In particular, in the field of health from the 1990s onwards, it was able to chart a path that resulted in the elaboration of the National Policy for Comprehensive Health of the Black Population (*Política Nacional de Saúde Integral da População Negra* – PNSIPN)[11] in 2009, elevated to the status of law in the chapter on the Right to Health of the Racial Equality Statute in 2010[12]. In effect, as a law, what became mandatory throughout the national territory, among other issues, was "the inclusion of the health content of the Black population in the training and permanent education processes of health workers" (p. 15)[12].

In this way, gaps were created to advance the workers' ability to deepen the analysis of the health situation experienced by the Black population. With the National Curricular Guidelines (*Diretrizes Curriculares Nacionais* – DCNs) for the 2014 Medicine course, a transversal approach becomes mandatory that "always considers the dimensions of biological, subjective, ethnic-racial, gender, sexual orientation, socioeconomic, political, environmental diversity, cultural, ethics, and other aspects that make up the spectrum of human diversity" (p. 1-2).[13]

Despite formal regulatory advances, constituting a favorable scenario for new curricular frameworks, little is known about how training processes in health have been incorporating policy guidelines aimed at promoting racial equality. There is a lack of knowledge of Law 10,639/03, which establishes the DCNs for the Education of Ethnic-Race Relations and for the Teaching of Afro-Brazilian and African History and Culture (DCN ERER), and the PNSIPN; as well as the incipient offer of courses, subjects, and curricular activities that address the health of the black population and the education of race relations, according to Monteiro et al.[14].

Although there is an explicit racist structure of the Brazilian State and society, "the myth of racial democracy" predominates in the country as an ideology. Based on this, the explanation of ethnic-race differences in Brazil has its roots in a supposed racial harmony; hides the antagonisms; and does not reveal the agents, determinants, and consequences of racism, which, in addition to fleecing Black women and Black men, privileges whiteness[15].

Taking the characteristics of disease and dying as their object of study, Batista et al.[16] developed the study entitled, "The color of death: causes of death according to race characteristics in the State of São Paulo, 1999 to 2001". According to the authors: "There is a white death caused by diseases, which, although of different types, are nothing more than diseases. There is a black death that has no cause in diseases: it consists of external causes, complications of pregnancy and childbirth, mental disorders, and ill-defined causes [...]" (p. 630).

In addition to their central contribution to normative advances, Black social movements have undertaken a permanent struggle in the production of anti-racist projects and experiences that have an impact on overcoming racial inequities in the conditions of birth, life, disease, and death. The Negrex Collective – made up of Black medical students and doctors - triggers this process in the area of Family and Community Medicine (*Medicina de Família e Comunidade* – MFC), based on the accumulation of experiences and theoretical-practical production in a critical and emancipatory perspective about the effects of racism on health, and clinical and social specificities of the Black population[17].

Critically approaching racism and anti-racism in health policy requires that elements that permeate the daily life of health services, as well as the perspective of Black men and women as workers, be incorporated into the analysis. Therefore, based on the recognition of racism as structural and a structuring of social relations in the Brazilian scenario, our objective in this article is to analyze the training and health work experiences of Black doctors who work in the Unified Health System (SUS), especially in primary health care (PHC), from two axes of analysis: the manifestation of structural and institutional racism within SUS and how racism permeates health work processes and its repercussions.

Methodology

This is a qualitative study, using a focus group (FG), conducted with three doctors who self-report themselves as Black, all between 30 and 35 years of age, working in PHC in the city of Rio de Janeiro in November 2022. The script included open questions focusing on the experiences of these Black workers and the issue of racism in in the field of health care. In relation to the interpretation of the data, we searched for references in symbolic interactionism[18] in order to interpret the situations that make up the experiences of racism. In the analysis of Kanter[19] and Hall[20], symbolic interactionism is potentially one of the most appropriate approaches for analyzing processes of trajectories and experiences and, above all, for studying the mobilization of changes in opinions, social behaviors, expectations, oppression, and social demands.

Thus, during the pre-analysis, the statements were transcribed in full, allowing an open reading of the collection, after which all the transcribed material was read and the empirical material was organized. The second coding stage consisted of a detailed analysis of the selected material and data coding based on thematic units, enabling the description of manifest and latent content. Next, the grouping was performed based on symbolic internationalism[18-20], for the interpretation related to the situations that make up the experiences of structural racism in the training and work of Black workers working in PHC. These were gathered into two axes: (1) manifestation of structural and institutional racism within SUS and (2) work and health processes, racism, and its repercussions.

This study fully met the ethical requirements of Resolutions CNS 466/2012 and CNS 510/2016, approved and logged under CAAE registration no. 57976322.0.0000.5241. The participants' speeches were identified by the names of black

personalities indicated by the interviewees so as to preserve their anonymity.

Results and discussion

Manifestation of structural and institutional racism within SUS

Racism is a (re)producer of the denial of rights, the lack of access to health services, the production of death, and the non-effectiveness of good living for black bodies, and this has been implemented through the production and reproduction of a dark, morbid dimension, permeated by contexts of suffering, violence, and structural racism in its most diverse expressions in the trajectory and experience of Black professionals and PHC user.

Therefore, the recognition of racism as a problem of public interest requires the involvement of the entire society to reduce its incidence in certain forms of existence. In this sense, it is through the political organization of Black Movements that anti-black racism, organized and perpetrated by the State and its institutions, will be denounced[21].

For Almeida[4], everyday racism presents itself not only as the revitalization of a colonial past, but also as a cruel reality, which spreads within social relations, producing a series of structured discriminations, constituting itself as a process through which circumstances of privilege differentiate between racial groups and manifest themselves across economic, political, and institutional spaces.

Considering racism as structural means contemplating it in the multiple dimensions that structure society and how it manifests itself in sociability, in the naturalization of inequalities, and in violence as a component of contemporary social life[4].

Structural racism permeates the subjects' conception of the world and structures institutional relationships, which are reproduced in different spaces, including PHC services and professional training. Therefore, in order to guarantee health as a right for all people, especially black bodies, it is urgent that SUS begins to consider the racial issue through actions to promote, protect, and recover subjects.

Racism is produced and reproduced socially; therefore, it is present directly or indirectly in the daily lives of institutions, including health care and training institutions, primarily expressing itself in health care, iniquities in access to services, and differences in care for diseases prevalent among black people. "So racism exists in SUS, it is in the structure of SUS, and it turns out that our work maintains a lot of this structure" (Tituba), as well as in the training of health professionals, "I think that in addition to us not having had it, we also had to be the ones that made the content happen. So, at the university, we even brought the three of them together here, to create a space about the health of the Black population" (Conceição).

The participants' reports suggest that medical training has not effectively contributed to reducing racial iniquities in health. Higher education institutions, in addition to not knowing or incorporating the objectives of PNSIPN into the subject syllabi, end up reproducing the thinking of the universal user. This reveals the historical (in)visibility regarding the racial diversity of SUS users, disregarding equity in services, making it impossible to discuss broad and integrated care, and making it difficult to reduce the impacts of racism in their lives. Coupled with this, it is necessary to reinforce that the field of health, strictly speaking, has an extremely technical and biological training perspective, characterized by the focus on the disease and not on the subject and their interaction with social structures. This is an unsustainable contradiction with the concept of health as an expression of the ways in which people live and work, which is assumed in the political-health scope of SUS.

At the same time, when the participants report that they were responsible for facilitating the discussion on the health of the Black population, they corroborate the need for reflection on the qualification of health professionals for a convergent action with health as an expression of ways of life and work, about welcoming Black users, and, more specifically, about the search for comprehensive care. The reports bring to light the character of a resistance and emancipatory initiative, but localized and which holds a group of Black women responsible for responding to a highly complex social problem, instead of appearing as an institutional movement for the management of health education and of curricular reform from an anti-racist perspective.

These aspects reveal the gaps in medical training and for a comprehensive teaching-learning process as recommended by the National Curricular Guidelines[22], mainly with regard to theoretical discussions and the development of skills and competencies of the medical profes-

sional for comprehensive care in the promotion, protection, and recovery of the health of the Black population[23].

This context of erasure of ethnic-racial issues from health training makes up a broader historical mosaic, with points of contact and intersections between race theories and health interventions, since eugenics policies tend to seek support in racist theories based on medical-scientific knowledge. This is how, for example, medicine provided an important contribution to the construction of scientific racism as a carrier of discourse capable of influencing the most diverse spheres of sociability[3].

Despite the absence of curricular components in the medical course that directly address the health issue of the black population, the interviewees informed the initiative to create the NegreX Collective, which is nationally based and was founded in 2017. One of its main educational interventions is the holding of Seminars on the Health of the Black Population, in which workshops are held in partnership with teachers from the Family and Community Medicine axis and discussions on the Health of the Black Population.

The workshops are offered by students from the collective from different undergraduate periods for medical students studying the disciplines of Comprehensive Health Care (3rd period), Medical Psychology (6th period), and Integrated Internship in Family and Community Medicine and Mental Health (9th period). There is a moment of achievement in each of these periods, with different programmatic contents and dynamics. This initiative seeks to dialogue with the contents of the discipline and the specific challenges of what a clinical practice with a racialized perspective would mean in the context of that training period[24].

Eurico[25] points out that the democratization of the Black population's access to public policies requires a reflection on the concept of institutional racism, given that, when it permeates the daily lives of institutions, the situation becomes even more complex and crystallized. For the author, it is expressed in access to education, access to the job market, the creation and implementation of public policies that disregard racial specificities, and the reproduction of discriminatory practices rooted in institutions. Werneck[3] points out that institutional racism presents itself as a displacement of the individual's dimension and is installed in institutional and organizational structures in order to affect the subordination of subjects according to their race/skin color.

To identify the expressions of institutional racism, we chose to use the analyses developed by Eurico[25] to qualify the two interdependent and correlated dimensions of institutional racism: "the political-programmatic, and that of interpersonal relationships" (p. 299). In relation to the political-programmatic dimension, the author informs that it consists of the actions that hinder the formulation, implementation, and evaluation of efficient, effective, and efficacious public policies in combating racism, as well as the visibility of racism in everyday practices and administrative routines. In turn, the dimension of interpersonal relationships covers the relationships established between managers and workers, between workers and workers, and between workers and users, always based on discriminatory attitudes. "That's what we see between the lines, right? It is in the teams in the most vulnerable areas with the greatest vacancy of doctors, with fewer resources to encourage the retention of doctors in those units" (Conceição). This behavior is the result of institutional racism.

The obstetric violence reported by one of the FG participants also qualifies the institutional racism experienced within the PHC.

I saw a patient this week, she suffered obstetric and gender-based violence. Then call the ombudsman, but, if she gets pregnant again, her reference maternity ward remains the same, so why am I changing any structure in relation to this? And then I want to know what will happen with the complaint she made, will they send something to me to continue with an investigation? No, they won't (Luana Tereza).

In view of the above, it is possible to assume the existence of racial bias in the care provided to Black women in the pregnancy and puerperal period, making it necessary to recognize the value of the race/skin color aspect for the analysis of referrals made to complaints made by Black women about obstetric violence in PHC.

In these terms, for Assis[26], obstetric violence needs to be understood as the appropriation of women's bodies and reproductive processes by health professionals, and is expressed through dehumanized relationships, abuse of medicalization, and the pathologization of natural processes, thus limiting the autonomy of women and their capacity to decide. The author is emphatic in explaining that the effects of obstetric violence with a racial bias tend to have more intense contours.

SUS, in its universal character, guided by PHC as the first instance of preferential contact,

organizer of the care network, and coordinator of care, has the Black population as the majority of its users. This constitutes a privileged space for the exercise and construction of racial consciousness as a critical reflexive instrument for the production of health. This can act on the determinations and implications of health work processes, thus producing the potential capacity to qualify, in a critical sense, the practices shared among users, workers in care roles, and workers in managerial roles; but also being able to influence the training processes for/at work in SUS, more precisely, in the relationship among students, workers, users, and political-sanitary-pedagogical projects of teaching organizations and health services.

Work and health processes, racism, and their repercussions

We also assume that healthcare work is an essential activity in the lives of men and women, and falls within the sphere of non-material production[27]. We understand that the purpose of healthcare work carried out at SUS is to meet health needs, which are understood as needs that are socially and historically constituted and manifest themselves in individual and/or collective dimensions.

In this logic, contemplating healthcare work from a social, historical, and critical perspective requires reflecting on the movements of this process, including racism in all its dimensions, and the experiences of Black workers in SUS, as discussed in one of the excerpts "even if we are the hand that takes care of it, right, the structure is in place for things not to work; there has to be an absurd effort for you to be able to provide more care to a black child *[…]*" (Tituba).

In terms of totality, health is integral to broader social processes that are correlated. This means that Brazilian health policy and, within it, healthcare work and training, are crisscrossed by specific interests, historical, social and subjective constructions that operate in the daily lives of institutions, whether training or healthcare work. In our conception of contemplating racism, training and work in health imply the understanding that these dimensions – historical, social, and subjective – intertwine and appear in the daily life of health policy, making it impossible to analyze the topic without understanding it in dialectical movement. In the wake of Kosik's[28] studies, "dialectics is critical thinking that sets out to understand the 'thing in itself' and systematically asks how it is possible to understand reality. Therefore, it is the opposite of doctrinal systematization or the romanticizing of common representations" (p. 20).

Thus, even in the face of Black doctors who are aware of their racial responsibility, the structural character of racism is capable of demobilizing individual initiatives, putting the health of these workers themselves at risk, forcing them to want to leave these spaces.

The dialectic appears here when we locate health work as collective health work, as it is made explicit in the construction and meanings of health policy and in the interaction of large groups of workers, such as those who represent the so-called health professions (according to CNS Resolution No. 287/1998, including: Biomedicine, Biological Sciences, Physical Education, Nursing, Pharmacy, Physiotherapy, Speech Therapy, Medicine, Veterinary Medicine, Nutrition, Dentistry, Psychology, Social Work, and Occupational Therapy), as well as workers with technical training and those who carry out predominantly administrative activities and who do not necessarily interact with users; among many others. In this sense, the interviewees contrast the individual effort by drawing attention to management's responsibility: "I think that it is very important for us to have these statements coming from management, because otherwise there is only one statement about our individual struggle" (Conceição).

Therefore, it is important to highlight that healthcare work takes place in activities within the scope of planning and management, health education, and care itself, or even that we can scrutinize healthcare work through the articulation of different levels of care, based, for example, on the particularity of action within the scope of PHC, the so-called medium or high complexity of SUS. These articulations and many others are present in daily healthcare work[29].

Professions and occupations that work in health are inserted in the social and technical division of work, constituting socially useful practices that contribute to the process of social reproduction. The health field presents itself as the locus where these practices develop from the mediations established with society, with the notion of social rights, with health policy, with institutions and services, with other workers, and with users. In this sense, healthcare work itself makes up a complex totality formed by several elements, including structural racism, which is reflected in particular in the experiences of Black health professionals with regard to work processes. "How

does management manage to make a team work that must deal with absolutely anything? But we are faced with a situation that doesn't count, the math doesn't add up, so it´s like this: I know that the indicators are worse for Black women, and yet we do nothing different" (Tituba).

Despite legal advances in the field of health, such as the institution of PNSIPN/2009, which has as its general objective: "to promote the integral health of the Black population, prioritizing the reduction of ethnic-racial inequalities, the fight against racism, and discrimination in SUS institutions and services", what can be observed are small advances compared to the social reality and health needs of the black population at the present time.

When we look at Brazilian social indicators, in any field related to living conditions, work, and access to social rights, there is an expression of racial inequality in the country.

We know that Black children also die more often, even from infectious parasitic diseases and diarrhea. But what do we do differently in relation to these children? Nothing. And in the end, it also falls into the lap of those on the team, so is the surveillance keeping an eye on this too? Is it only primary care that has to be there solving problems? I think we can signal it, but surveillance has to be attentive to this (Tituba).

A fact that puts pressure on and questions the purpose of health work by placing health production as an objective-image that organizes the entire work process:

How do you say 'go walk, go walk, go do yoga, go relax', where? In the crack house? She is going to go out, and the field she has there to do physical activity is the field where several people have already been murdered, it is at the entrance where the police will enter (Conceição).

A report by the Center for Security and Citizenship Studies, entitled "Health on the firing line: impacts of the war on drugs on health in Rio de Janeiro"[30], published in 2023, points out that police operations in favelas, under the justification of "a war on drugs", is an obstacle to regular access to health services for residents of these locations, given the successive closures of health establishments due to shootings. This problem, inserted in an arc of limitations on the movement of residents and health workers to work, studies, leisure, and other activities of daily life, results in an increase in the risk and prevalence of high blood pressure, prolonged insomnia, depression, and anxiety. Furthermore, there is the increase in individual monetary costs, coupled with the loss of income for residents, at the level of health services, with the interruption of health services and treatments, with medications for treatment and insomnia, for example.

Thus, in these territories, with a Black majority, marked by racial violence, in the predominant form of war conflicts, the lack of working conditions and, therefore, the extreme difficulty in offering adequate care, as well as the illnesses of these professionals, are indicative elements of structural racism and are part of the daily work experience of these Black doctors.

In other words, they are not exceptional events, and, combined with the lack of actions to combat health management, they end up establishing limits to work. This is how the reorganization of the healthcare work process in PHC is structured, favoring the exchange of the territorial logic of care for the logic of demands, based on complaints and behaviors, increasingly restricted to the inner sectors of health establishments.

Final considerations

The present study demonstrated how racism permeates the healthcare work experience of Black women, doctors, family health team workers in PHC in the city of Rio de Janeiro in *favela* regions, territories that are mostly Black. From the denial of anti-racist content in health in their respective training processes, to the organization of care flows, to the terrible conditions to develop work, these elements were identified by the participants as a result of institutional and structural racism operating within SUS. Furthermore, the limits of isolated individual action in an attempt to act in the face of the consequences of racism in health care became evident, since the complexity of these issues demands committed, intersectoral actions at all levels of health management in order to address them.

As a limitation, this study did not focus on an in-depth analysis of the effects of the intersectionality of gender and race on work experiences, nor did it discuss the participants' perception of relationships between professionals, between users, and between users and black and white professionals, that is, in the interpersonal expressions of racism in their experiences.

However, it was evident that the experiences discussed here, although they cannot be generalized, reveal meanings produced by racism for the development of healthcare work in relationships with the subjects involved.

Thus, it is necessary to consider that racism – as an element that promotes illness, combining explicit and implicit moments, rooted in management structures, institutional culture, and the naturalization of racial violence – becomes the main obstacle in the reorganization of the healthcare work process, especially in PHC in racialized territories.

Collaborations

LB Silva participated in the conception and design of the article; development of the methodology, literature review, data analysis, and interpretation; and the final write-up and critical review of the article in its various stages. DS Campos participated in the conception and design of the article; the development of the methodology, analysis, and interpretation of data; and the final write-up of the article. MV Araújo participated in the conception and design of the article and in the final write-up. RS Reis participated in the review of the article.

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