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EXPERIENCE REPORT

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Structural racism in an urgent care unit of a northern Rio de Janeiro municipality

Racismo estrutural em uma unidade de atenção às urgências de um município do norte fluminense

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ABSTRACT

Introduction: Macaé, a municipality in Northern Rio de Janeiro marked by a history of slavery and successive processes of favela formation, presents intense socio-spatial segregation between its northern and southern regions, impacting access to healthcare for Black and peripheral populations. This article offers a racialized and intersectional analysis of medical students' practical training experiences in an urgent care unit (UCU) located in the northern region of the municipality, guided by the trajectory of a Black, peripheral medical student.

Experience Report: This is a qualitative experience report grounded in a cartographic field diary and experiential narrative frameworks. Four on-site activities were carried out at the UCU, accompanied by tutorial supervision. The scenes described revealed: racial hierarchization among health workers; incomplete and inadequate documentation of the race/color field; recurrent use of the expression "vulnerable people" and repeated association of the predominantly Black users with violence and criminality; as well as the impact of these narratives on students' construction of stereotypes, including the presumption of criminal involvement in ambiguous situations.

Discussion: In light of the concept of structural racism and literature on urban segregation, whiteness, and the hidden curriculum in medical education, the UCU is interpreted as reproducing institutional violence by erasing racial data, dehumanizing Black users, and normalizing discourses that reinforce inequities. Such practices operate as implicit pedagogical messages, shaping students' identities, perceptions, and attitudes.

Conclusion: The study highlights the persistence of structural racism in Macaé's healthcare services and underscores the need to improve the collection of racial data, strengthen racial literacy, and provide pedagogical and anti-racist training to health professionals who function as preceptors. The findings suggest the importance of further investigations into the relationship between race, healthcare organization, and the implementation of the National Policy for Comprehensive Health of the Black Population in peripheral contexts.

Keywords: Systemic Racism; Education, Medical; Health Inequities; Attitude of Health Personnel; Public Health.

RESUMO

Introdução: *Macaé, município do norte fluminense marcado por passado escravocrata e processos de favelização, apresenta intensa segregação socioespacial entre as regiões norte e sul, com impacto no acesso à saúde da população negra e periférica. Este artigo analisa, em perspectiva racializada e interseccional, a experiência de campos práticos de estudantes de Medicina em uma unidade de atenção às urgências (UAU) no norte do município, tendo como fio condutor a trajetória de uma discente negra e periférica.*

Relato de experiência: *Trata-se de um relato de experiência qualitativo, fundamentado em diário de campo cartográfico e em referenciais de narrativa experiencial. Foram realizados quatro encontros na UAU, acompanhados por tutoria. As cenas descritas evidenciaram: hierarquização racial entre profissionais; preenchimento incompleto e inadequado do quesito raça/cor; uso recorrente da expressão "pessoas vulneráveis" e associação dos usuários, majoritariamente negros, à violência e à criminalidade; além do impacto desses discursos na construção de estereótipos pelos discentes, incluindo a presunção de envolvimento criminoso em situações ambíguas.*

Discussão: *À luz do conceito de racismo estrutural e da literatura sobre segregação urbana, branquitude e currículo oculto na educação médica, interpreta-se que a UAU reproduz violências institucionais ao invisibilizar dados raciais, desumanizar usuários negros e naturalizar discursos que reforçam desigualdades. Tais práticas funcionam como mensagens pedagógicas implícitas, moldando identidades, percepções e atitudes dos discentes.*

Conclusão: *O estudo evidencia a persistência do racismo estrutural nos serviços de saúde de Macaé e aponta a necessidade de qualificar a coleta do quesito raça/cor, fortalecer o letramento sociorracial e oferecer formação pedagógica e antirracista a profissionais que atuam como preceptores. Os achados sugerem a importância de novas investigações sobre a relação entre raça, organização do cuidado e implementação da Política Nacional de Saúde Integral da População Negra em contextos periféricos.*

Palavras-chave: *Racismo Estrutural; Educação Médica; Iniquidades em Saúde; Atitude do Pessoal de Saúde; Sistema Único de Saúde.*

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INTRODUCTION

Macaé, a municipality located in the north of the state of Rio de Janeiro, has historically had its economic base structured around large slave-based agricultural plantations[1-2]. Subsequently, with the establishment of the oil industry in the region, two processes of favela formation and socio-racial segregation began to shape the configuration of the territory[2,3].

The first occurred with the end of slavery and the emergence of wage labor, when there were no public policies to integrate black people into formal society[3]. Thus, with the rural exodus and urban expansion, the downtown spaces were occupied by those with better financial conditions and the peripheries by the new proletarian class, mostly black and poor[2]. The second occurred in the 1980s, with the installation of Petrobras (Brazilian oil and gas company) in the central region of Macaé, stimulating the allocation of business and social investments in its surroundings, leading to the accentuation of unplanned urbanization and the peripheralization of workers[2,3].

These dynamics that shaped the urban and economic development of Macaé demonstrate the presence of a deeply rooted structural racism. According to Almeida[4]:

> *Racism is a consequence of the social structure itself, that is, of the "normal" way in which political, economic, legal and even family relations are constituted, not being a social pathology or an institutional disorder. Racism is structural. Individual behaviors and institutional processes are derived from a society in which racism is the rule and not the exception[4] (p.33).*

Thus, it is understood that the patterns of territorial discrimination characteristic of the municipality express the logic of racism that built it, limiting the access of the black population to the benefits of economic growth.

Currently, this segregation is delimited by the Macaé River, which divides the city into two contrasting regions[2,3]. To the south, we find individuals with greater purchasing power, skilled workers, high-standard housing, and most of the companies associated with Petrobras[2,3,5,6]. To the north are located most of the favelas and neighborhoods historically inhabited by black and low-income populations, occupying mangrove areas and environmental protection zones, being the most affected by different forms of deprivation[2,3,5,6].

The sectors corresponding to these marginalized neighborhoods concentrate 59% of the families registered in the Unified Registry, with a high prevalence of low schooling and a predominance of informal work[5,6]. In addition, per capita income is low, with a large number living in extreme poverty. The housing, in turn, exhibits precarious conditions of construction, sanitation and access to treated water[5,6].

In this context, under the supervision of the second author, the main author carried out practical fieldwork in an urgency care unit (UCU) in northern Macaé. These activities belong to the Emergency and Urgency module of the Community Health II discipline, in the second semester of the Medicine course at the UFRJ-Macaé Multidisciplinary Center. Furthermore, it is noteworthy that the first author is a Black medical student from a marginalized community, a researcher in intersectionality, and a member of the Heteroidentification Commission at Universidade Federal do Rio de Janeiro (UFRJ).

The experience was marked by discomfort with certain actions and statements made by white professionals regarding users, who were mostly Black, which the researcher interpreted as expressions of structural racism in that service. Thus, the need arose to analyze them, especially regarding their effects on the training of other students working in that UCU. Therefore, the following questions arise: how does racism manifest itself in the daily practices of healthcare in the peripheries of Macaé, and how does this affect medical training?

Thus, this study was developed in the form of an experience report, as a qualitative research method based on the frameworks of Mussi et al. and Daltro et al.[7,8], who recognize experiential narrative as a legitimate form of scientific production. The observations and reflections were recorded in a cartographic field diary, covering explicit and subtle episodes of racism witnessed in the unit, as well as the author's feelings towards these situations. Therefore, the methodology prioritizes sensitive listening, observation, and critical analysis of the interactions between professionals, users, and students[7,8].

According to Mussi et al.[7], the report was organized into four dimensions: informative, with a description of the experience, introduced through scenes; referenced, articulating the experience with the scientific literature; dialogical, connecting experience and theory; and critical, problematizing naturalized practices of violence and their effects. Daltro et al.[8] complement this framework by valuing subjectivity as an epistemological power, understanding the report as a space for ethical, political, and affective elaboration. Therefore, this article aims to demonstrate how the author's experience can contribute to a questioning and anti-racist medical education.

This study was approved by the Research Ethics Committee, as per Opinion n. 5,527,563, respecting the ethical principles of research with human beings.

EXPERIENCE REPORT

In total, four days of practical fieldwork were conducted, on Tuesdays, from October 17th to November 7th, 2023, from 2:00 PM to 4:00 PM. During these days, 14 students, divided into pairs, observed the reception, risk classification, adult and pediatric

consultation and observation areas, the red room, the laboratory, and the pharmacy. Concurrently, six tutorial meetings were held for the pedagogical monitoring of the activities.

Scene 1

On the first day, we immediately noticed the precarious structure of the unit. There was visual and noise pollution caused by renovations, many air conditioning units were not working, and most of the service was based on manually filled-out forms. When phenotypically analyzing the patients at the reception, it was noticeable that they were mostly Black women, with darker skin tones, curly or kinky hair, among other Black phenotypic characteristics.

This perception of inequality extended to the unit's professional staff. Based on their phenotypes: three of the four doctors were white, as well as all the management, reception, and pharmacy staff. On the other hand, all the cleaning staff, most of the construction workers, as well as the nursing technician and the integrative therapist I observed, were Black.

However, precise confirmation of the racial profile of the served public could not be obtained through the unit's records. On the third day, while observing the reception area, I noticed that the "color/race" field on the forms was filled out by the employees using only the terms "white," "brown," and "Black," without the patients' self-declaration. Furthermore, the receptionists informed me that this section was always filled out on all forms. However, on the fourth day, in one of the consulting rooms, I noticed that none of the several forms contained the patients' racial information. When I questioned the doctor about the situation, he stated that it was a common occurrence.

Scene 2

At the beginning of the first visit, the staff constantly referred to the patients as "vulnerable people" without detailing why. Throughout the day, this pattern was repeated, and several professionals—always phenotypically white—gave accounts of frequent conflicts generated by the users, especially involving verbal violence. The impression formed up to that point by us, the students, suggested that their main, if not only, markers were dangerousness, subservience, and aggressiveness.

At the end of that day, we participated in a round table discussion with some professionals, whose objective was to present us with the patients' socioeconomic context. However, the accounts of episodes of violence continued, still without any in-depth look at the reasons, histories, or negligence that affected them.

During the other visits, we continued to be exposed to similar discourses: superficial statements that generalize and homogenize the profile of a historically neglected entire population. Consequently, especially considering that most of the students were not accustomed to the challenges of communities in Rio de Janeiro, I had the perception that we were induced to form a stereotype of those users. This included aspects such as residing in favelas with high crime rates, involvement with criminal organizations, not having the free right to come and go from their neighborhoods, and difficulty in dealing with disagreements.

However, it is worth noting that, during the four meetings, I did not witness any violent incidents. The closest situation was the verbal dissatisfaction of some individuals with the delay in care and communication difficulties.

Scene 3

On the fourth day, the doctor we were accompanying asked us to call a patient who, according to the reception, had already left the unit. Upon checking his file, we noticed that it said, "Resident of the Fronteira" (one of the favelas in the region) in the field for the CPF (Brazilian taxpayer ID) and "Special" in the field for the address. However, instead of considering that this information might be incorrect—given the manual completion of the forms and the inconsistencies observed in the "color/race" field—I inferred that the individual would fit the stereotype of a user with criminal involvement—repeated several times throughout the visits. However, I quickly realized that I should have considered more plausible alternatives.

Shortly afterward, along with other students, we visited the unit's pharmacy. The administrative technician responsible for the sector demonstrated how current operations were carried out and shared episodes from previous months, when the section also functioned as a Municipal Pharmacy. She mentioned the long lines and frequent conflicts, highlighting that many patients tried to obtain medications without presenting identification. In response, one of the students—white and from an upper-middle-class background—asked: "Were they doing this because they were involved in something?"

DISCUSSION

In light of the concept of structural racism, it becomes necessary to consider Macaé's slave-owning past and the subsequent processes of favela formation in the analysis of the reported experiences. Historically, the dynamics of the municipality have been based on the geographical, social, economic, cultural, and racial segregation of Black individuals. That being said, it is impossible to understand the current structure of Macaé and, consequently, of its public health units, without considering the racist tools on which they are anchored.

Scene 1 and socio-racial segregation: "the cheapest meat on the market is black meat"

In that UCU, the majority of professionals with greater social power were phenotypically white, while the majority of those in more subordinate positions were black. That is, despite everyone working in a place with a precarious structure, Black people were still the ones with the worst payment, consistent with the Brazilian reality[9,10].

Furthermore, receptionists did not fill in racial information on all forms, and when they did, it was done inadequately. Patients were not questioned about their self-declarations, and only the terms "white," "brown," and "black" were used in a completely subjective way, without proper phenotypic analysis. This goes against Article 1 of Ordinance N. 344 of February 1, 2017[11] — which provides for the completion of the race/color question in the forms of health information systems — which states:

> *The collection of the color question and the completion of the field called race/color will be mandatory for professionals working in health services, in order to respect the self-declaration criterion of the health user, within the standards used by the Brazilian Institute of Geography and Statistics (IBGE) and which appear in the forms of health information systems as white, black, yellow, brown or indigenous[11] (p. 1).*

Thus, it is understood that the yellow and indigenous populations were excluded from documents. Concomitantly, the Black population was erroneously classified, since the term "Black" was used synonymously with "of color," contradicting the National Policy for Comprehensive Health of the Black Population (PNSIPN), which considers the Black population as the sum of black and brown individuals[12].

Such attitudes not only deny the right of non-white citizens to self-determine before the State but also render their existence invisible. In this scenario, institutional violence manifests itself in the neglect of the use of racial data as a tool for equity. As a unit that primarily serves a black and marginalized public, the racial data collected could be useful for confronting historically established inequalities in health care and other social spheres. As Nery et al.[13] point out, although Social Determinants of Health are extensively addressed in the epidemiological literature, the discussion based on racial aspects is still incipient, which hinders public management and the fight against inequities.

This situation also fits into the concept of 'convergence of interests' described by Delgado et al.[14], because, as racism promotes both the material interests of white elites and the psychological interests of working-class whites — such as UCU professionals —, both segments have little incentive to eradicate it. Therefore, the erasure and inadequate collection of race/color data go beyond the bureaucratic character, revealing the institutionalization of racism in health[13].

Scene 2, racism and aporophobia: the dehumanization of black bodies

In this scene, the generalization of objective and subjective aspects of the served population was observed — such as the use of terms like "vulnerable people" without contextualization and the recurring association of users with violence. This brings to mind the expression "White Savior Syndrome," understood by Julio[15] as the reproduction of racism by whiteness even when there is an intention to benefit other races or ethnicities, sustained by an implicit sense of social superiority. Thus, in the context of the UCU, the welcoming and care were accompanied by discourses that dehumanize a predominantly Black and poor group[2,3,5].

Even so, it is important to recognize that the tensions mentioned by the professionals refer to real dynamics in peripheral territories, although this does not validate stigmatizing interpretations. According to Ribeiro[16], the historical-structural character of socio-spatial segregation and the abandonment of the peripheries by the State — as observed in the north of Macaé[2,3] — favors the advancement of urban violence and the war between the State and criminals for the control of these areas. This results in the neglect of basic rights, such as decent housing and freedom of movement.

Several materials discuss violence in favelas in Rio de Janeiro, such as the dissertation 'Human rights violations and collective struggles in the favelas of Rio de Janeiro — the joint case of the Maré favelas', by Borges[17], and the report "Penalties for women who disrespect the rules of drug traffickers and militiamen range from haircuts to death in Rio", by Globo TV network[18]. In this report, the account of a resident stands out: "The division is very clear. And the residents are held hostage. When you live in a community controlled by a rival criminal organization, you can't go to the other side to catch a bus to go to work. It's enemy territory, and you're very exposed to that"[18].

Just like the capital, Macaé is also plagued by disputes between rival criminal organizations for territorial control. Amigos dos Amigos and Comando Vermelho exert influence in several neighborhoods in the north of the municipality served by the analyzed UCU[6,19-22]. That being said, it is reasonable to assume that their patients face similar challenges.

However, the narratives show divergent perspectives. The texts by Borges and Globo network rely on residents' accounts and highlight the limitations during periods of conflict[17,18]. In contrast, the employees' statements presuppose a permanent restriction on free movement, producing a

stereotypical narrative that associates poverty and blackness with dangerousness.

Scene 3 and the doctors of the future: violence that reproduces itself

It becomes evident that constant exposure to racist speech impacted the students' perception of the served population, demonstrating a lack of knowledge about the peripheral reality and/or an erasure of their critical judgment capabilities.

This phenomenon, especially considering the students' limited experience in the early stages of their undergraduate studies, can be understood in light of the power relations established between health professionals and students, which, in practice, have taken on the character of an educator-learner relationship. As Freire points out, relationships of this nature tend to be narrative and vertical, in which the educator positions themselves as the exclusive agent of knowledge, depositing messages in the learners, who classically receive them in a passive and uncritical manner[23].

In this context, it becomes crucial to understand that such interactions are not merely isolated episodes, but rather a broader phenomenon in medical education: the 'hidden curriculum'. It corresponds to the set of dominant norms, values, discourses, and practices — those in positions of authority — transmitted implicitly in the daily life of training, being naturalized and incorporated by students, shaping their professional identities[24-26].

In the analyzed case, the negligence regarding the socio-racial intersections of users and the normalization of prejudices act as elements of this hidden curriculum. When incorporated into the routine of training practices, these mechanisms tend to reinforce the distance between students and users, hindering the construction of culturally sensitive and racially conscious clinical practices.

Therefore, health professionals at the UCU — when directly or indirectly occupying a training position — have a concrete pedagogical responsibility for the explicit and implicit messages transmitted to students. As Santos et al.[24] emphasize, combating the negative effects of the hidden curriculum requires recognizing that routine interactions shape ethics, empathy, identity, and future practices. In this sense, it becomes urgent that preceptors and other health unit workers receive adequate training to perform their pedagogical functions, including communication skills and anti-racist education.

FINAL CONSIDERATIONS

This experience report makes evident the persistence of structural racism in the health services of Macaé. The observed scenes demonstrate that the practices, attitudes, and discourse shared at the UCU reflect the violence historically suffered by the Black population of the municipality, as they function as implicit pedagogical messages, shaping medical training.

This scenario highlights the urgency of incorporating racial literacy and pedagogical preparation among health professionals who act as preceptors—even informally—in practice settings. It is urgent that universities and administrators recognize that medical training is profoundly impacted by power dynamics and the way individuals are viewed and treated in healthcare services.

However, this article represents only a snapshot of ethnic-racial relations in medical education and healthcare services. Nevertheless, it is hoped that this study will stimulate future research focused on other units—including those in other municipalities in the interior of the state of Rio de Janeiro—on causality and intervention. Research investigating the relationship between the collection of race/color/ethnicity data and the quality of care, as well as the implementation of the National Policy for the Comprehensive Health of the Black Population (PNSIPN) in units in the interior, is considered especially fundamental.

Finally, this experience reinforces the need to strengthen educational practices that promote historical reparations and racial equity. It is hoped that these reflections will contribute to a medical profession that trains more critical, humanized professionals aligned with the principles of social justice and, above all, anti-racist principles.

AUTHORS' CONTRIBUTION

Raisa Soares Estevão da Graça contributed with Conceptualization; Data Curation; Research; Writing - Original Manuscript; Writing - Review and Editing. Kathleen Tereza da Cruz contributed with Conceptualization; Data Curation; Research; Methodology; Project Management; Supervision; Validation; Writing - Review and Editing.

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

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DATA AVAILABILITY DECLARATION

Research data are available in the body of the document.

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