Black skin, white coats: racism, body and ethics in anthropological fieldwork [1]

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Rosana Castro

Universidade do Estado do Rio de Janeiro | Rio de Janeiro, RJ, Brazil
rosana.rc.castro@gmail.com
https://orcid.org/0000-0002-1069-4785

ABSTRACT

During doctoral field research, I followed the work of a few White female doctors in their activities of conducting clinical research protocols. My presence in their offices was conditioned to the use of a white lab coat, which sometimes put me in a position to explain to patients that I was not a medical intern and, at other times, made explicit the limits of supposedly automatic confusions between me and a medical professional. By analyzing situations of gendered racism that I experienced during the fieldwork while wearing a white coat, I characterize medicine as a space marked by Whiteness and, extending this reflection to anthropology, I argue that ethical issues on anthropological fieldwork must necessarily take into account the racial and gender hierarchizations that make up interactions with research interlocutors – particularly those experienced by Black female ethnographers in contexts where Whiteness is normalized.

KEYWORDS

Racism, body, fieldwork, ethics, medicine

INTRODUCTION

By mid-2016, I was already attending the human pharmaceutical research center in which I had done part of the fieldwork for my PhD for a few months. I followed my daily routine arriving at the *Cronicenter*[2]: I greeted the professionals who had already arrived, left my backpack in one of the lockers, and went to the reception to talk to Maria.[3] Afterwards, I was going to follow some activity in one of the offices. Carmem, the other receptionist, was on vacation, which made me try to spend more time with Maria and offer if I could help with any task. During these conversations, I used to learn more about the Cronicenter and how the activities of the reception participated in the conduct of the clinical trials. That day I asked Maria about the new doctor who had been hired that had been accompanying the appointments of Dr. Miguel, the physician and director of the Cronicenter, as part of her training. Like the other doctors who worked there, Dr. Daniele was young, White and thin, and always wore a long white coat, high-heeled shoes and had painted fingernails.

2 | Fictitious name of the research center where I conducted the research, in a large Brazilian urban center.

3 | This and the other names mentioned are pseudonyms.

The arrival of another doctor with this complexion caught Maria's attention and, luckily for me, she shared with me her observations. She whispered to me over the reception counter: "we hardly ever see doctors of our color, do we?" I readily agreed, nodded my head in an affirmative way and asked her a question: "how many Black doctors do you know?" Maria didn't take it as a rhetorical question, and took a few seconds to consult her memory, looking for some examples. Apparently unsuccessful in her search, she answered: "that's right... it's the system, isn't it? The system already eliminates them". I told her that I agreed and that, for this reason, I saw the quotas for Black students for entry into public Brazilian universities[4] as a fundamental way to counteract this systemic inertia - a comment to which Maria finally responded, referring to affirmative actions detractors, by saying: "I think so too. Sometimes people say that Black people are diminishing themselves, but they are not".

4 | The "Quotas Law (Brasil, 2012)" was a federal law aiming to encourage the entry of Black, Indigenous and marginalized population into public universities in Brazil. According to it, all federal higher education institutions in the country had to reserve part of their places for students from public schools, with low income, and Black and Indigenous people.

Maria was about forty years old, which separated us by almost ten autumns at that time. Our dark skin, however, had very close shades. Our color allowed her to refer comparatively to the new doctor in the first-person plural: a link to a conversation whose central themes were the racism and Whiteness present in the medical field, in the research center and in our different routines in that space. Over the counter, our conversation marked the racial and gendered division of labor at the Cronicenter. The new female doctors, always passing through the center, always White and young, were *research sub-investigators*[5] , a position hierarchically subordinated to that of *Principal Investigator* (*PI*) held by the White and about seventy years old doctor, Dr. Miguel. Next to Maria worked Carmen, also Black, a few years younger. Besides the color and the counter, they shared a night shift of studies: Maria was studying law in a private college, and Carmen had just started studying again for public exams in high school level.

5 | Along the article I use italics to highlight categories, formulations, and expressions that organize the research universe and that were presented to me by my interlocutors throughout the fieldwork.

I take the first fragment of my field experience to introduce the central theme of this article. In my fieldwork, I sought to identify and understand the practices, dynamics and effects of the production of pharmaceutical evidence organized under what I called "political economies of disease and health" (Castro, 2020). By this expression, I understand the ways in which multinational pharmaceutical companies, Brazilian state institutions, research centers and clinical research professionals capitalize on systemic precariousness of the national public health system and the therapeutic itineraries of subjects in search of adequate treatment as a strategy for conducting experiments. It was by interacting in a daily and intense way with the professionals at Cronicenter, among other research efforts, that I have built these analytical categories. Also, in this process, I tried to be attentive to the ways in which racism, sexism, classism and other forms of violence were reified in the experimentation practices and, simultaneously, were a constitutive part of the conditions of possibility for the fulfillment of these scientific endeavors.

In this scenario, in which people's bodies with different diseases were a condition for pharmaceutical research, my own body - dark-skinned, curly-hair *black power* style, young, with various signs associated with the feminine - also bore the conditions of possibility for my research. I was involved in contingent relationships, probably unlikely for researchers with another gendered and racialized bodily signs. I will reflect here on some of these situations, in which my racial belonging and presumptions about the gender and sexuality that I perform pronounced themselves as fundamental elements for understanding the relations between the professionals and patients of the Cronicenter and between them and me. I thus seek to delineate how particular updates of racism and sexism in the fields of medical practice and clinical research were evident at certain moments of my research, in order to point to the centrality of the body and the ways in which it is racialized and gendered in the fieldwork realization processes (Damaceno, 2013; Albuquerque, 2017; Medeiros, 2017). I argue in this sense that scrutinizing the ways in which racism is updated in the very experiences of field research engenders important critical reflections on the operations of epidermal hierarchies in the contexts in which we work. More than that, it provides a window for theoretical and ethical reflection on the operation of similar hierarchizations in the field of anthropology itself.

This discussion is basted by sewing overlapping layers of skin and clothing tensioned in my research experience. To ethnographically follow the activities of the medical offices, privileged spaces in the interactions between doctors and patients at Cronicenter, Dr. Miguel demanded that I wore a white lab coat. At first, I was concerned that the patients at the Cronicenter might mistake me for one of the doctors, and thus assume that their contributions to my research would be associated with the authority imbued in the coat or the provision of medical care. But in fact, the confusion between me and a doctor was not immediate or recurrent, given the presumed dissociation

between the color of my skin, the color of my coat, and that of whom used to wear it. The tensions of chromatic overlap proved themselves even more intense when, even while wearing the white coat, I had my presence in the office sexualized by doctors and patients, an evident situation of gendered racism (Gonzalez, 1983; Kilomba, 2019; Pereira, 2018) in which they sought to allocate me in another position - neither a doctor nor a researcher. From this place of "outsider within" (Collins, 2016) - that of a Black researcher in direct contact with White doctors - I will reflect on how these experiences, in association with the whispers I exchanged with Maria at the reception counter, indicate fundamental questions about the organization and functioning of the biomedical field.

Stretching the thread to anthropology, I discuss racial and gender tensions interposed between the acts of "putting on the ethnologist's cape" (DaMatta, 1978: 3) and "putting on the white coat" (Chazán, 2005). Thus, I emphasize the importance of considering the analytical and ethical status of the bodily and "aesth-ethical" crossings that make up the positions our interlocutors assume among themselves and, in turn, those we assume (or not) in front of our interlocutors. I am particularly interested in the intersectionalities (Krenshaw, 2002; Collins, 2019) that constitute and configure the different research contexts, considering not only the relationships between ethnographers and interlocutors, but the very theoretical *corpus* that informs our investigations. By thus approximating the Whiteness shared between medicine and anthropology in Brazil, I reflect on the problems of de-racializing reflections on ethnographic work and its implications on ethical dilemmas that may emerge in Black female ethnographer's experiences during fieldwork. Finally, recovering the initial reflection of Maria about affirmative action, I insist on the urgency of incorporating in anthropological canons the references and experiences of fieldwork in which the corporality is pronounced from the differential markings of racial belonging and identification, especially those recorded by Black anthropologists in research contexts marked by Whiteness.

WHITE SKIN, WHITE COATS: WHITENESS AND RACISM IN BRAZILIAN MEDICINE

In August 2013, a striking image was spread out in TV news, portals, and social medias in Brazil. The arrival of Cuban doctors into the Northeastern city of Fortaleza, to reinforce the *Mais Médicos* Program (PMM, in Portuguese),[6] received a hostile reception from Brazilian doctors, who protested at the exit of the building that housed the professionals' training course. Dressed in white lab coats, Brazilian physicians booed and shouted against their Cuban colleagues, calling them "slaves". In a picture on the cover of a large circulation newspaper, a visibly embarrassed Black Cuban doctor passed by a corridor of White male and female doctors, who shouted shrilly in his direction.[7] The protests gained national proportions, with support from professional organizations

6 | The PMM was launched in 2013 during Dilma Rousseff's government and aimed at filling the shortage of doctors in certain Brazilian regions through several actions such as hiring professionals and expanding vacancies in undergraduate medical courses (Gomes and Mehry, 2017).

7 | Image available at: https://acervo.folha.com.br/leitor.do?numero=19599&anchor=5890629&origem=busca&originURL=. Accessed on 13 Dec 2020.

such as the Federal Council of Medicine and the Brazilian Medical Association, and marked resistance and conflicts related to different aspects of the implementation of the Program that aimed at increasing the distribution of doctors throughout the country. Among the points of disagreement were the low adherence of Brazilian professionals to the idea of working outside large urban centers and their consequent replacement by foreigners; the exemption of revalidation of foreign medical records to practice in Brazil and the accusation by professional organizations that foreigners would incur in illegal exercise of the profession; and allegations that Cuban doctors would be subjected to a regime of "semi-slavery" due to their precarious work relationship and the retention of part of their payment by the Cuban government (Gomes & Mehry, 2017).

The insidious and repeated recourse to the idea of slavery makes explicit a significant racial tension between Brazilian and Cuban doctors. In general, the term seems to have been used in two ways. On the one hand, as an articulator of a denunciation of the Cubans' work regime, as a supposed measure of protection of their labor rights (Jesus et. al., 2017). On the other, the word "slavery" emerged as a category of accusation that, directed in screams at the newly arrived doctors, would have the potential to denounce their disqualification to the medical practice. In this case, "slave" emerged as an attempted insult, which points to the perception of those Brazilian doctors that the history of enslavement of Black people is configured as a condition of these subjects, updated and identifiable by the dark skin of Cuban doctors - a movement that, according to the writer Toni Morrison, characterizes the particular way of updating racism in the post-slavery context in the Americas.

> What is "peculiar" about New World slavery is not its existence but its conversion into the tenacity of racism. The dishonor associated with having been enslaved does not inevitably doom one's heirs to vilification, demonization, or crucifixion. What sustains these latter is racism. [..] The ease, therefore, of moving from the dishonor associated with the slavebody to the contempt in which the freed blackbody was held became almost seamless because the intervening years of the Enlightenment saw a marriage of aesthetics and science and a move toward transcendent whiteness. In this racism the slavebody disappears but the blackbody remains and is morphed into a synonym for poor people, a synonym for criminalism and a flash point for public policy (Morrison, 2019: s/p).

The disqualifications of the Cuban doctors were also accompanied by similar manifestations on the internet. One of the cases with greatest repercussion was the comment made by journalist Micheline Borges, who posted the following on her profile on a social network in August 2013: "Excuse me if it is prejudice, but these Cuban [female] doctors look like housemaids. Are they really doctors??? Gosh, that's terrible. Doctors generally have a posture, they look like doctors, they impose themselves based

on their look... Poor our population" [sic]. According to the G1 portal, the publication was shared more than five thousand times, and, in consequence of the wide exposure, the journalist canceled her account (G1, 2013). The statement was widely criticized because it expressed the assumption of a double association between skin color and the profession of White and Black people. Black skin and the female gender were associated with domestic work, understood as occupations characterized by subalternity; while at the same time it was stated that White skin would concern the posture and appearance necessary to the authority characteristic of medical professionals.

In this context of protests and racist manifestations, there was a strong public perception among Brazilian professionals that Cuban male and female doctors were out of place to practice their profession in Brazil. Identified as deviants or outsiders, in the sense proposed by Howard Becker (2008), many Brazilian doctors understood that their Cuban colleagues were displaced, because Black people should not be in a profession of such technical and social prestige. Thus, the very expression of the supposed inadequacy of Black men and women to the medical profession had as a counterpart the affirmation of White raciality as a condition for the adequate incarnation of medicine.

> As Hughes points out, in our society a doctor is also informally expected to have a number of auxiliary traits: most people expect him to be upper middle' class, white, male, and Protestant. When he is not there is a sense that he has in some way failed to fill the bill. Similarly, though skin color is the master status trait determining who is [Black] and who is white, [Black people] are informally expected to have certain status traits and not to have others; people are surprised and find it anomalous if a [Black person] turns out to be a doctor or a college professor. (Becker, 1963: 32)

The White male racial profile as a bodily, moral, and symbolic norm for medical practice in Brazil is still accompanied by the maintenance of the predominance of self-declared White professionals in the field. According to the 2018 Medical Demography (Scheffer et.al., 2018), a national census of the profession, the field has been expanding significantly in the country, due to a series of policies to expand vacancies in medical university courses - including by the implementation of the PMM. However, the White racial prevalence is persistent in contrast with the gender transformations of the medical field. In a study of recent graduates, it was estimated that, although the proportional difference between men and women has been reducing quite significantly, the racial gap remains constant in medical education in Brazil. "A total of 77.2% of those interviewed declared themselves White, a percentage that rises to 89.5% in the South region, 80.9% in the Southeast, and falls to about 54% in the Northeast and Northern regions. Only 1.8% declared themselves Black and 16.2%, *Pardos*" (Scheffer et. al., 2018: 65).[8]

8 | I take here into account the medical census whose study covered the period closest to that of my field research. Data from the Medical Demography published in late 2020 point out that, despite the persistence of a profile of White graduates in medical courses (67.1%) in the country, between 2017 and 2019 it was possible to identify a reduction in the disproportion between them and Black students (27.7%), especially among those who studied medicine in public universities (Scheffer et. al, 2020). According to the authors of the study, "the inclusion seen in medicine can be attributed to the measures that have been adopted since 2000 to reduce inequalities in access to higher education in Brazil" (ibid.:116)

Considering such elements, especially the advances of the "feminization of medicine" (ibid.) in Brazil, the medical field can be characterized, in general terms, by its double articulation of racism and Whiteness. Black participation is reduced, and the practice of the profession is socially considered inadequate or inappropriate for Black people; at the same time the career is established as an occupation not only mostly White, but symbolically pre-destined exclusively to this racial group. In face of this configuration, both the systematic exclusion of the former and "the interference of Whiteness as a silent guardian of privileges" (Bento, 2002) are made explicit. In this scenario - in which Black subjects are marked by a negativity that supports the positivization of White ones (Carneiro, 2005; Mbembe, 2014) -, it is remarkable the continuous mobilization and updating of medicine as a space for the exercise of authority and racially oriented subalternization.

The observations that Maria and I shared at the counter of the Cronicenter, described at the beginning of this article, resonate with this configuration of the medical field in Brazil. The turnover of doctors at the clinical research center was relatively high, something noticeable by the renewal of the sub-investigators staff with young White graduate women. During my field research, in only one situation did I see a young Black woman under the white lab coat. Dalila, shy and with straightened hair, was finishing her medical school at a private college in the city and attended the center for a few weeks to get to know the place and see if she liked the work experience. She once told me that she was only able to take the course because she was a *ReUni* beneficiary, a federal program that fully funded the exorbitant medical school tuition. The experience at the Cronicenter was a training course for her, after which there would be the possibility of being hired - which did not happen. The feminine and White conformation of wearing a white coat at the Cronicenter was only relatively disturbed when, exceptionally, I had to wear the lab coat to observe the consultations in which the clinical records of the participants of the experiments were made. In the next section, I will proceed to describe situations experienced by Dalila and me in the clinic, in order to make explicit the ways in which our presences were absorbed as "out of place" and to identify the places to which we were repositioned in these moments.

"WILL YOU WORK HERE?": DILEMMAS OF IDENTITY (NON)CONFUSIONS

Right during the first months of field research at the Cronicenter, I noticed the centrality of the consultations the happened in the doctor's office for understanding the dynamics of interaction between the female doctors and patients during the experiments. Given the importance of this space for my research, I asked Dr. Miguel if I could go around the doctors' offices, follow their appointments, take notes of the dialogues that took place there, and record the processes of production of primary information about the performance of the medications tested at the center. It seemed

more interesting to me to start at Dr. Helena's office, the most experienced physician at the Cronicenter, who was getting ready to move to another city after working there for a few years. As her departure was only in a few weeks, I had little time to get to know her work. She herself had suggested that I accompany some of her consultations during an interview I had done with her, so I already had her authorization to be close to her office.

However, I feared that her word could be insufficient, so I planned a conversation with Dr. Miguel for the day after the interview with Dr. Helena. I arrived very early at the Cronicenter that day. As soon as he arrived and before he started working, I quickly asked him about his authorization to accompany Dr. Helena's office. The director consented, on the condition that I wore a white lab coat. His authorization was of great value, as it signaled that he continued to renew his confidence in my presence at the center, as well as opening up the possibility of deepening my description of experimental processes. However, I felt rather frustrated by his request. Even though the reading of some ethnographies had cautioned me for this possibility (Chazán, 2005; Gomes; Menezes, 2008), I was not fully prepared to deal with this demand. At first, I did not want to wear the garment for ethical reasons. I feared that the lab coat could imply the reinforcement of an asymmetry between me and the patients of the research center, who could mistake me for a doctor and, therefore, feel embarrassed to grant or deny me conversations, interviews, and observations by the symbolic authority interwoven in the fabric of the white coat.

The lab coat I was supposed to wear belonged to Fátima, Dr. Miguel's "right-hand woman". Like Dalila, Fátima had less dark skin than mine, and her hair was clearly straightened. However, she was not young nor shy; on the contrary, it was precisely her approximately fifty years of age, her experience, and her ability for conversation that made her a professional that transited with excellence between technical and logistic attributions and the direct contact with patients. The white coat hung in the employees' bathroom was worn by Fátima sporadically, when she taught patients how to use experimental injectable medications. Dr. Miguel asked me to borrow the coat and I went to her to request it. As I watched Fátima approach me with it in her hands, I began to deal not only with my old dilemmas, but with new concerns about wearing that particular coat. It was a huge piece, as if made for a person much taller and wider than me or Fátima - who was shorter and slimmer than me. Also, it was not only white; it had thin gray stripes, and some stains all over the fabric.

Before putting it on, I inquired Dr. Miguel about the necessity of the white coat one last time, "is the lab coat really necessary?" "Absolutely!" - he answered me in a very serious, assertive tone, with no apparent room for a rejoinder. The situation in which I found myself was to choose between accepting the condition of wearing the coat or, if not, not to know the Cronicenter's main space for the production of pharmaceutical evidence. I had little time to deal with the situation. Dr. Helena, who I imagined was

still to arrive, came walking from one of the corridors to the reception to get the chart of her first *protocol appointment* of the day—situation that focused on the clinical record of variables related to the performance of experimental drugs. The time I had to decide was thus further reduced. Luckily for me, she stopped to chat a bit with Dr. Miguel at the reception desk, which gave me a few more minutes. I took a breath. And I remembered again the ethnographies, which faced such dilemmas with different strategies to clarify the researcher's position under the lab coat. I thought that maybe eventual confusions could be undone. Maybe they could even be avoided. Still hesitant, I decided to wear the coat, using the garment itself as a way to try to remain suspicious of the possibility of confusion between the identities of researcher and physician.

Saying goodbye to Carmen, who was following her work at the counter, I went to the office after putting on the coat as it was: with the sleeves loosely folded at elbow height - probably with the marks of Fatima's last use. I did not button it either, leaving my clothes apparent, markedly different from those worn by the doctors at the center. I usually wore jeans, an unprinted T-shirt, and sneakers. The doctors, on the other hand, were in the habit of wearing slacks or dresses, high heels or flat shoes, and formal blouses. Moreover, the very contrast between my coat and those of the professionals at the center was evident. Their jackets were very neat, well pressed, neatly lined, with their names embroidered on the left side of the chest and a seam at shoulder height with the emblem of the university where they had graduated. The one I was wearing had no personal or institutional identifiers. Somehow, this nonconformity of my coat made me less uncomfortable with that biomedical symbol. So I wore it, not only that morning, but for the 48 *protocol consultations* I followed during the field research.

Contrary to my initial concerns, in my visits to the offices I was never really mistaken for a doctor. I was not called "doctor", I was not invited to give opinions on clinical cases, nor was I asked to sign any documents. Considering, also, some specific duties of the doctors at the Cronicenter that might escape the more daily set of clinical research tasks, I was not asked by patients to renew the validity of prescriptions, hand out free samples, or write referrals or medical reports either. However, I don't think that the lack of confusion occurred because I was wearing a folded, loose, disjointed lab coat - at least not in itself. On the contrary, the absence of immediate association between me and a doctor was due to a dissonance between the whiteness of the coat and the darkness of my skin, which contributed to a distancing from the full medical identity and, in certain moments, to a somewhat astonishing sexualization of my presence in the office.

In certain consultations, some patients asked me if I was a medical intern or if I was about to start working at the center. When they saw me sitting next to the doctor's table, they sometimes asked me: "are you *going to* work here?" I took such opportunities to introduce myself, to say that I was a researcher and that I was there to follow the consultations and other procedures carried out for the conduction of the experiments.

Usually, the conversation also played a role for the proposition of an oral consent to observe the consultations, a procedure always received openly or indifferently by the patients and their eventual companions.[9] Despite these questions, I consider that such situations did not configure a confusion between me and a doctor. On the contrary, they showed a first dislocation in relation to my initial expectation of immediate confusion of identities. Given the high turnover of these professionals at the Cronicenter, the patients had already seen many doctors starting to work at the center in a spatial position similar to the one I placed myself in the office during my observations: I was always next to the doctor, a little bit behind her chair, so that I could follow her notes and activities and not be in the middle of the way when she needed to get up. Somehow my own arrangement in the space contributed to my being absorbed as a professional in training, in the process of becoming a physician, a quasi-doctor.

These were the situations in which I came closest to a confusion with a medical identity during the research. Thus, the ethical issues that gripped me at the beginning of the white lab coat incursions proved to be quite different from what I expected. If, on the one hand, my concerns were associated with the reinforcement of asymmetries between researcher and interlocutors through the use of the coat, an insignia of additional authority in the research context; on the other hand, issues arising from both the positions I took in the field and those I did not take in front of my interlocutors' deserve ethical reflection. Particularly, I am interested in reflecting on how, as occurred with Janaína Damaceno in her doctoral field research, "the problem was not to be confused, but not to confuse" (2013: 15). For the anthropologist, paying attention to this issue was related, in turn, to the recognition that "[the] problem is still the way they look at you, racialize you, order you" (*idem*). In my case, as I will detail below, my presence in the doctor's office had its non-medical rank associated with the emergence of another status, best specified in particularly sensitive moments of the consultations, in which I was redescribed by doctors and patients in sexualizing terms.

9 | The only exception to this general picture of openness or indifference to my presence in the office was that of a gentleman who, upon learning that I was a PhD candidate at a federal university, criticized Brazilian public higher education and its "Marxist" tendency, in his terms.

"HE LIKED YOU": GENDERED RACISM ON THE FIELDWORK

The *protocol consultations* followed a certain rite, in which scripted elements were associated with a conduct of relative openness of the doctors when facing specific challenges on the conduction of the experiments. In general, it was necessary to guide the clinical encounter with a *template*, a form prepared by the Cronicenter coordination professionals with all the elements included in the *protocols* of the studies in progress.[10] The *template* guided the physicians in the office, indicated what was of indispensable recording, and triggered the information whose collection justified the presence of the patients in the center at a certain moment. These consultations also had the purpose of operationalizing the clinical management of *adverse events*[11] , as well as providing the physicians with the necessary information for what they called patient *follow-up*. At

10 | Protocols were documents produced by the pharmaceutical laboratories sponsoring the researches or by *Contract Research Organizations* (CROs) contracted by them to conduct the experiments. They contained the steps and procedures to be followed by all the research centers designated for the execution of a trial.

11 | In the context of clinical research, *adverse events* refer to any clinical changes detected in tests or complaints brought by patients, whether presumably resulting from the experimental drugs or not.

the Cronicenter, the *follow-up* had several functions, such as monitoring *adverse events* over time and *controlling* indicators related to chronic diseases, which included the measurement of vital signs and guidance on physical exercise and diet. In this section, I will focus on the moments of blood pressure measurement, a routine activity in any type of consultation, being performed in all patients regardless of their participation in a research study or whether their protocol requested this procedure.

At the end of the morning of my first incursion to Dr. Helena's office, I was accompanying her last patient of the day. The White female doctor, who was around forty years old, had blonde highlights in her hair and always wore high heels, saw Mr. Emerson, who was a Black, tall, thin man, around sixty years old, with curly hair that was beginning to gray. The appointment didn't seem to differ much from the two I had seen that day, except for Dr. Helena's assessment of Mr. Emerson's reaction to my presence. She told me in a relaxed tone, as I was leaving the office: "He liked you". At that moment I did not understand exactly what her suggestion regarding Mr. Emerson's taste was all about. I could not recall any interaction between me and him that would allow such an inference. The occurring repeated itself a few times during my field research. During the review of my field diaries for writing the doctoral dissertation, the recollection of these situations allowed me to evaluate them as episodes of genderized racism (Kilomba, 2019), moments in which racism and sexism operated in articulated ways (Gonzalez, 1983; Pereira, 2018). I will resume two of such moments.

Having already followed Dr. Helena's appointments for some weeks and with her departure date approaching, Dr. Dalila and I were watching one day her appointments. With Dalila's arrival at the Cronicenter, my office arrangements had to be reorganized. There was no room for two chairs next to Dr. Helena, so Dr. Dalila took that seat and I followed the consultations sitting on the stretcher, which was not often used. In one of the appointments on that day, the senior doctor was finishing the consultation with Mr. José - a White, thin patient, about seventy years old. Dr. Helena asked Dr. Dalila to help her by taking José's blood pressure. She did so and, after checking the result on the display, Dr. Helena exclaimed: "Whoa, Mr. José! It is high!" He replied, somewhat strangely, that his blood pressure was not usually high, and justified: "It's this *morenaiada* audience,[12] I get nervous!". "That's right, that's right" - replied Dr. Helena, subtly laughing and agreeing. Dr. Dalila and I did nothing, we just went about our work: she took the cuff off the patient's arm and I wrote everything down in my little notebook, with a certain discomfort. The consultation ended a little after this passage, and, at that moment, I was left with only a diffuse discomfort with the term "*morenaiada*", directed at me and Dr. Dalila, which I did not manage to elaborate deeply at that point. In any case, I intuitively decided to record this moment in my field notes.

I only realized what happened in those situations when, upon reviewing my complete records, I connected this episode to another, which occurred when Dr. Helena had already left the Cronicenter. I was following the appointments of Dr.

12 | The term used by the patient is a neologism to refer to a gathering of Black women. "*Morenaiada*" is composed of the word "morena" – a historically charged word that points to a linguistic strategy to refer to Black women, especially those with lesser dark skin, by emphasizing their bodily attributes and suggesting sexual availability –; and the ending "-ada", which conveys the idea of a large group of people. Following Lélia Gonzalez (1983) critical thought, the use of the term "morenaiada" could be seen as sophisticated form of denegation of racism, similar to the one that works through the use of the word "*mulata*" to refer to Black women.

meaning a brown skinned female, and the ending "-ada", which conveys the idea of a large group of people. The term is used, in this case, in a humorous attempt by the patient."

Carolina, a young, White woman, and a recent medical graduate who, after a period of training, was hired as a *sub-investigator* at the Cronicenter. In her third appointment of a particular morning, the patient was Mr. Carlos, a Black, thin, slightly bald man, who appeared to be around fifty years old. Dr. Carolina called him to the office door and led him inside. She introduced herself by name and then introduced me to Mr. Carlos, who reacted to seeing me sitting next to the doctor's desk: "You're pretty, huh, *morena*!". "Thanks, nice to meet you" - I said to him, surprised and smiling. He followed, still looking at me with wide eyes, apparently surprised, pointing at his own skin with his fingers: "look!" It is hard to know for sure what he was referring to with that gesture and that exclamation; what seemed minimally certain to me was that he was running his fingers on his forearm signaling the similarity of the darkness of his skin with mine.

At the end of the appointment, Dr. Carolina measured Mr. Carlos' blood pressure. Surprised with the result, she preferred to repeat the procedure: "Let's measure this pressure again? It's too high!" The result was the same, which made her give him a pill immediately. The doctor opened the drawer on the left side of the desk and took out a crumpled blister pack, with some pills missing. She then quickly left, saying that she was going to get a glass of water to give him the medication. Meanwhile, Mr. Carlos told me, somewhat dismayed, that he had found the results of the measurements strange and that he was worried. His face, cheerful during the whole consultation, was now apprehensive and frowning. On the way back, Dr. Carolina gave Mr. Carlos the pill, and he took it right there. The consultation was concluded shortly after, with the doctor making several recommendations regarding diet, exercise, and smoking, and asking him to return in a few days for a reevaluation.

After one more visit, the consultations for that day were over. At the end of the morning, Dr. Carolina commented on Mr. Carlos' consultation. She said, jokingly, that I was responsible for the sudden increase in his blood pressure. She repeated, to my surprise, the phrase said a few weeks before by Dr. Helena: "he liked you". I replied by telling her that Dr. Helena had already told me that unexpected blood pressure results in certain male patients had the same reason. I did not associate any of these comments with concrete sexual approaches from patients – although, as a matter of fact, Mr. Carlos' way of addressing me at the beginning of the consultation had caused me some embarrassment. As I recorded in my diary, I reflected at that moment that it was possible that the lab coat I was wearing was bringing unexpected elements to the clinical encounter. I was then willing to evaluate to what extent my research brought unexpected risks to the patients; not because of the confusion of identities *per se*, but because of the possible nervousness caused by yet another supposedly coat-wearing authority in the office, an additional "pressure".[13]

However, to understand these situations as a whole, it took some time and a retrospective look at my records and my own sensations. As I re-examined these experiences, it became evident that the use of the coat, when put to the test in the daily

13 | Such hypothesis would bring evident tensions to the ethical debate of anthropology with biomedicine, in the terms proposed by Cardoso de Oliveira (2004). This is because the author assumes that in anthropological research "*with* human beings" the interlocutors are "subjects of interlocution", unlike the biomedical context in which subjects are "objects of intervention". Such sense assumes that anthropological research would not bring physiological risks to the interlocutors, whereas in biomedical studies, performed "*in* human beings", the risks come fundamentally from interventions on the body.

interactions in the offices; in the mediations articulated by procedures and equipment; in the daily routines and clinical diagnoses of the doctors; and in the ways in which patients interacted with professionals and with me, resulted in episodes of gendered racism at several times. Such situations were characterized, above all, by the re-reading of my attendance at the doctor's office as a researcher as a sexualizing factor of the therapeutic encounter, a potentially silent and imperceptible disruption if it were not for the denunciation of the blood pressure gauging device.

Grada Kilomba makes use of the concept of gendered racism to emphasize that in the discriminatory and dehumanizing experiences of Black women it is impossible to explain such situations as updates of racism *or* sexism. By describing a medical appointment in which she was asked by a White doctor if she would like to work as a housemaid for his family during vacation, Kilomba reflects that "'race' can neither be separated from gender nor can gender be separated from 'race.' The experience involves both because racist constructions are based on gender roles and vice-versa, and gender has an impact on the construction of 'race' and the experience of racism" (Kilomba, 2010: 54). In this scenario, certain racially and sexually characterized attributes are updated in diverse contexts in ways that are also diverse, so that gender and race constitute each other in the operationalization of multiple processes of dehumanization. In this sense, according to sociologist Bruna Pereira

> [...] both are always active in the social contexts in which they participate, and with which they interact in a complex way: sometimes they heckle each other, sometimes they reinforce each other; here they potentiate each other, there one is strengthened to the detriment of the other; sometimes one seems invisible, but constitutes the basis for the operation of the other, and so on. (Pereira, 2018: 186)

The phrase "he liked you", an insidious and irresistible comment repeated a few times by different doctors, did not synthesize speculations of affection from patients to the doctors, but only to me. The enunciation of this diagnosis by the authority figures in the office operated different functions, in the sense of localizing the doctors themselves and other social actors linked in the therapeutic encounter in different positions. By issuing the cause of the increased pressure, the doctors performed the ultimate act of truth production, declaring that there was a health disorder in the patients. The case, however, is that their diagnosis was double-edged: on one hand, it alerted the patients that a new and potentially harmful fact about their health had been discovered; on the other hand, it immediately pointed the disturbance cause by performing a presumed invasion of the patient's intimacy, exposing their alleged feeling of attraction toward me. In this scenario, I would be the provocateur of unacknowledged desires, the transmitter of stimuli promptly received by the patients who, unintentionally, experienced the unexpected and silent increase of blood flow in their veins.

The white coat, taken in isolation, was not the central element in the distribution of hierarchically arranged positions among doctors, patients, and me. It could not even be isolated, since other factors acted upon it and, in turn, implied different intersubjective constitutions in that therapeutic-experimental-ethnographic context. Only when considered in its interaction with the spatial arrangements of the actors in the office; with the medical equipment activated in the therapeutic scene; with the actualizations of differential perceptions of gender of the people engaged there; and, above all, with the racial classifications intersected by such factors, it becomes possible to understand their place in the complex arrangement of conjugation of authorities and subordinations. While White doctors in white coats issued utterances that diagnosed pressures, impressions, and assumptions, patients and I assumed sexualized and racialized positions. Male patients were urged to respond for their increased pressures as arising from supposed responses to the sexual appeals of my presence. My Black and mistakenly taken as heterosexual and available body, managed as a risk factor for supposed sexualizing effects, was figuratively exposed under a coat, virtually turned invisible.

BLACK SKIN, WHITE COATS: BETWEEN MEDICAL AND ANTHROPOLOGICAL WHITENESS

The physician, philosopher, and activist Frantz Fanon thematizes medicine in several passages of his work, framing it as a fundamental field for understanding the relations of exploitation in the colonial context (Bernardino-Costa, 2016). In a chapter of the book "A dying colonialism" (1965: 121), Fanon reflects that "with medicine we come to one of the most tragic features of the colonial situation", understanding that, in the context of colonization and the Algerian liberation struggle, the ambivalent attitudes of Algerians towards French doctors had a direct relation to the participation of medicine in the violent process of territorial domination. In the book "Black Skin, White Masks" (1967), Fanon theorizes about racism as an element that fixates hierarchical positions, in which Black subjects are constituted in their condition of non-being, while White people are recognized as the very form of being for humanity. In this reasoning, the racial, gender and class tensions that constitute medicine are, for the author, examples and participants in the production and actualization of racial boundaries not only professionally, but ontologically.

Addressing the issue of language, Fanon (1967) alludes to two situations in which a White doctor uses "*petit-nègre*" to speak with a Black patient, an inflected form of French that adds marks of the presumption of a language misuse by a Black interlocutor. This speech act assumed by the White doctor as a good approaching action is identified by Fanon as fundamentally derogatory, for "it is just this absence of wish, this lack of interest, this indifference, this automatic manner of classifying him, imprisioning

him, primitivizing him, decivilizing him, that makes him angry" (1967: 32). Fanon describes the doctor as a subject who is constituted by the act of authority instituted in each appointment, being the more authorized the more he subjugates a patient, more so if the patient is a subject to whom physical and intellectual deficiencies are judged as natural attributes – in an inverse reflection of the one who treats him. In this sense, Fanon argues that "a white man addressing a Negro behaves exactly like an adult with a child and starts smirking, whispering, patronizing, cozening" (Fanon, 1967: 31).

> "G'morning, pal. Where's it hurt? Huh? Lemme see – belly ache? Heart pain? With that indefinable tone that the hacks in the free clinics have mastered so well. One feels perfectly justified when the patient answers in the same fashion. 'You see? I wasn't kidding you. That's just the way they are.' When the opposite occurs, one must retract one's pseudopodia and behave like a man. The whole structure crumbles. A black man who says to you: 'I am in no sense your boy, Monsieur...' Something new under the sun." (Fanon, 1967: 33)

The identification of the intersubjective tension that marks the continuous update of racism in medicine is more explicit in Fanon's thought if we take into account his reflection on a situation in which the doctor is a Black person. Faced with the reaction of White interlocutors to the supposed contradiction between his color and his profession, suspicions emerged about his competence. Being a doctor, White people assumed that a Black man was naturally unsuited to medical practice.

> It was always the Negro teacher, the Negro doctor; brittle as I was becoming, I shivered at the slightest pretext. I knew, for instance, that if the physician made a mistake it would be the end of him and of all those who came after him. What could one expect, after all, from a Negro physician? As long as everything went well, he was praised to the skies, but look out, no nonsense, under any conditions! The black physician can never be sure how close he is to disgrace. I tell you, I was walled in: No exception was made for my refined manners, or my knowledge of literature, or my understanding or quantum theory. (Fanon, 1967: 117)

In contexts such as the one described above, the negative perception that medicine is a field whose professionals should not be Black is articulated to the positive association between medicine and Whiteness (Gonçalves, 2017). In these scenarios, Black people in white coats are *outsiders* (Becker, 2008) and, if they are within the field of medicine, they should be ready to be put in their supposedly proper place. From a historical perspective, this place can be found, in multiple contexts, in the positions of patients, research and medical training subjects, for example (Fanon, 1965; Washington, 2006; Lima, 2011; Castro, 2020) – positions in which Black people are managed as objects of medical action rather than their subjects of knowledge and professional performance and public respect associated with such positions. The experience of racism, in this

sense, can be understood as the fixing element of hierarchized positions. In this hierarchy, Black subjects constitute their conditioning according to the particular attributes that mediate their dehumanization, in a movement that simultaneously associates to White people the positivized symbols of Western medicality.

The racism and Whiteness of the medical field became particularly actualized in my fieldwork. At first, it was remarkable that in contrast to the White composition of the medical research team at the Cronicenter, most of the patients were Black. Seeking health treatments for different chronic diseases, such patients found at the center partial and fragile solutions to the precariousness of their therapeutic trajectories in the local public and private health care systems (Castro, 2020). On the other hand, my own body was assimilated in several situations as a sexualizing factor of the therapeutic scene - in approximation with common processes of racist and sexist stereotypes attribution to Black women in the Brazilian context (Gonzalez, 1983) and of estrangement with the authority status associated with medical professionals. The lab coat only allowed the delineation of hypotheses about a supposed training phase, a moment in which the medical practice was restricted to assisting the doctors in performing simple procedures during the consultation. The direction of the consultations remained the exclusive authority of the trained, White, hired physicians.

To revisit the ways with which I was redescribed in sexualizing terms also points to the extent of how the assumptions of the ethical reflections I carried to incursions at the Cronicenter also had anthropological Whiteness as a fundamental mark. The reflections that guided me, coming from the field of Anthropology of Health, took into account a relationship between female ethnographers and female medical interlocutors that assumed, on the one hand, a hierarchical tension between the fields of knowledge of medicine and anthropology, and on the other, a potential symmetrization between female doctors and anthropologists during fieldwork through the use of lab coats. Regarding the first aspect, I emphasize the recognition of biomedicine as a hegemonic field in the production of discourses, values, and practices about the body and emotions. In face of the physicalist, rationalist and interventionist tendencies of biomedicine, it would be up to anthropology to locate diverse and adverse knowledges and practices to biomedicine professionals and, while recognizing its complexity, establish a critical dialogue and an alternative theoretical grammar for understanding processes of illness and suffering (Duarte, 1998; Sarti, 2010).[14]

On the other hand, ethical reflections on fieldwork with male and female doctors denote, in several moments, the use of the lab coat as a moment in which such diverse fields of knowledge and practice could be confused, even if temporarily.[15] Elaborations in this direction are particularly sensitive in the work of ethnographers who are, in fact, trained in medicine. Lílian Chazán (2005), for example, reflected on how, even being a doctor, she felt as if she was covered up in the doctor's office because she was asked to wear a white coat during her field research in an ultrasound clinic in the outskirts of

14 | This tension is yet accompanied by a second and deeper one, characterized by the critique of modern Western thought that references not only medicine, but anthropology itself. In this sense, Sarti (2010: 88) reflects: "It is thus, in the constitutive tension of being inside and simultaneously confronting itself with being outside Western rationality - in which biomedicine is based and sustained -, in a relationship of alterity, that anthropology moves in the scientific field that studies body, health and disease. Tension that is tributary to the fact that, if anthropology was born under the aegis of Western universalist thought, it also criticizes the ethnocentrism and rationalism implicit in this thought."

15 | Ethical reflections around possible confusion between fields of knowledge are also important in Brazilian Anthropology of Health, as it points out, above all, to the risks of biomedical logic encapsulating anthropological reflection. "The overwhelming strength of the biomedical discourse on the conceptions and practices involving body, health and disease in our society cannot elude the responsibility of health anthropologists in face of the fact that they do, above all, anthropology, and then they are guided by its epistemological references and by the debates that animate. This position places them, amongst the health disciplines field, by definition, in a place of resistance" (Sarti, 2010: 88).

Rio de Janeiro: "The discomfort I experienced pointed to the questioning of the explicitness of my position in the field, in ethical terms. Wearing a lab coat, I was 'disguised' as a doctor, and the ethnographic observation was impregnated by an untruth [...]" (2005: 26). Chazán explains that, after a while without answers to deal with the unease, she decided to approach the women treated at the clinic at the waiting room, before their entrance to the office, to introduce herself and ask them if they would allow her to accompany their examination.

Rachel Menezes (2004), in the same direction, relates how the realization of her ethnography in an oncologic hospital would be impossible, were it not for her medical degree. When submitting documentation to the hospital's Ethics Review Board, her ethnographic attendance to the hospital was accommodated under the denomination of "observation visit," a type of transit only allowed to certified health professionals. Additionally, her research was conditioned to the use of a white lab coat and badge with a photo, nominal identification and registration number at the Regional Medical Council (Menezes, 2008: 10). According to the author, these elements caused her to be mistaken for a professional of the institution several times by patients and professionals, reason why she was even asked to perform certain procedures, provide information and sign documents.

> On several occasions, nursing assistants or nurses asked me to sign and stamp prescriptions for controlled medications, which was not possible due to my observer status. Until the reason for my presence in the hospital became clear my refusal elicited reactions, such as: "but aren't you a doctor? What's the problem then?" (Menezes, 2008: 10)

For both ethnographers, the fact that they were doctors doing ethnography in medical facilities mobilized them to reflect on the dilemmas of their dual training and on the need to maintain a certain distance to assume the identities of ethnographers - and not doctors - on the field. Chazán (2005) and Menezes (2004) also argue that the white coat and other accessories used during the research could or, in fact, did lead their interlocutors to identify them as doctors - a not necessarily wrong perception, since they actually were. However, what seems fundamental to me to understand the dynamics of such confusions and profusions of identities during the ethnographic research is to recognize that, over and above the wearing of the coat, they were both White. Thus, the fact that they were absorbed by medical professionals as "colleagues" is not only due to their training and professional records, but also to the approximations that their bodies allow between medical and anthropological Whitenesses. The instrumental or involuntary transit between the identities of doctor and anthropologist presupposes a shared ground, recognizable precisely in the Whiteness of both fields of knowledge.

Therefore, confusions of identity with authority figures during field research are necessarily enacted through corporality and, more precisely, raciality. Stella Paterniani

(2016), in this sense, reflects on how, during her fieldwork, a participant of a right-to-housing movement in São Paulo handed her certain documents, mistakenly assuming that she was an agent of the State, exemplifies a situation that articulates her Whiteness to the Whiteness of Brazilian State: "by recognizing me as White, equating me to the State and handing me the documents, there is also the recognition that the State also operates racially" (2016: 5). Similarly, ethnographers mistaken for doctors in ethnographic fieldwork would denote the Whiteness of medicine. Additionally, I argue that to presume or perform transits through such authoritative positions in fieldwork, as if they worked regardless the racialized bodies of female ethnographers, points to the ways Whiteness configures anthropology itself. By locating the anthropological field and the possible confusions of identity in the field related to authority figures, I seek to make explicit the insufficiency of the actuation of a clothing accessory for Black female ethnographers to assume their corresponding relative attributes. In this sense, it is of fundamental pertinence to analyze how identity confusions and non-confusions in fieldwork are made explicit through racialized and gendered relations, articulated in each ethnographic context in different ways and with the participation of varied and even unusual elements, such as objects. Our possible and impossible identifications in the field, in face of our interlocutors, emerge through diverse updates of the modes of racialized ordering of bodies and subjects in different positions.

A CONCLUSION: "WE" WHO? "THEY" WHO?

Maria's whispering comments at the reception counter, described at the beginning of this article, ended with a mention to the affirmative policies for the admission in higher education public institutions. In fact, we don't see many doctors of our color in Brazil, a fact that, unfortunately, little has changed over the past years that conform the racial quota policies era (Scheffer et.al., 2020). Historically attacked with virulence and put under threat by the current government, the affirmative quotas have had limited impacts on the medical field. The 2018 Medical Demography's research branch, dedicated to delineating the profile of recent medical graduates in Brazil in the year 2017, identified the persistence of the training of mostly White young physicians.[16]

> Admission to medical school in Brazil still favors White individuals and those with better socioeconomic status. Educational policies of inclusion, quotas, and affirmative actions that aim to promote equity in access to higher education have has, so far, timid repercussions in medical schools. Thus, medical education remains elitist and inaccessible to strata of the population, revealing the challenge of making the expansion of undergraduate opportunities compatible with the democratization of access to medical education. (Scheffer et.al., 2018: 140)

16 | In the 2020 Medical Demography, it is again stated that, "despite of the changes, which reveal greater social inclusion in medical majoring, medical courses are still attended mostly by White, high-income family students who attended private high schools" (Scheffer et al., 2020: 115).

In anthropology, on the other hand, there has been an important change in the profile of undergraduate students after the emerging of racial quotas. With the advance of affirmative actions in graduate programs, Black and Indigenous scholars have also gradually begun to compose the bodies of researchers in the area (Nascimento; Cruz, 2017). The still recent Black and Indigenous occupancy of these spaces of professionalization and knowledge production, from a historical point of view, also presents challenges for the anthropology field. In recent years, we have followed demands from undergraduate and graduate students for the inclusion of Black theoretical references in the classes syllabi they study, as well as the organization of academic events by Black and Indigenous anthropologists, and even the creation of a Committee of Black Anthropologists in the Brazilian Association of Anthropology (ABA). Initiatives in this direction have also resulted in courses with syllabi composed entirely of Black authors, evidencing not only the existence of a thriving Black anthropological production, but also its amplitude and diversity.

Actions such as these have repercussions in the qualification of analyses of how Whiteness marks the Brazilian anthropology, empowering questionings of the ways in which "a pretended 'racial neutrality' is maintained within the academy" (Pereira, 2020: 11). Also, such remarkable changes collaborate to the refinement of the reflections that locate the research and theoretical contributions of Black men and women to the field. These are, therefore, theoretical-analytical contributions with an ethical content, for they simultaneously question the paths designed and projected for anthropology and launch transformative proposals for the future by tensioning naturalized positions among anthropologists and interlocutors. Through the reflections presented in this article, I sought to contribute to the thickening of productions in this direction.

During the fieldwork, my anticipations about the possibilities of establishing relationships with my interlocutors proved to be mistaken, since they were disembodied and de-racialized, and tended to universalize what was, in fact, absolutely specific. Irretrievably and doubly positioned as an *outsider within* (Collins, 2016) - in medicine and anthropology, I was forced to deviate from that first presumed place and locate myself with reference in the intersections of gender and race embodied in relationships with doctors, patients, receptionists, and machineries. Understanding the identities I had and those I had not in the field necessarily involved reflecting on how gendered racism composed my fieldwork, pharmaceutical research, medicine, and anthropology.

On the other hand, on the reception counter with Maria and as I came to read about experiences similar to mine in the anthropological literature (Albuquerque, 2017; Damaceno, 2013; Medeiros, 2017), I was patiently taught to understand how such displacement did not preclude the composition of a certain "we". We still see few anthropologists of our color in graduate programs and university faculty, as well as there are still few of us who are read in the formative theoretical chairs of our discipline. In this sense, amongst the challenges for the future are the recording of and investigation

on the ways in which our bodies experience and produce anthropologies, from undergraduate studies to teaching, from the classroom to field research. Gradually, we deepen our understanding of the intricacies of the ethical task of, from the experiences of these multiples "we", also making anthropology ours.

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Rosana Castro is a professor at the Institute of Social Medicine of the Rio de Janeiro State University (UERJ).

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