Sociological Insights for Development Policy

2023 • Volume 1 • Number 1

The Racialization of Labor Pain

Julia Murphy, Camille Kroll, Sara Whetstone, Andrea Jackson and Ashish Premkumar

Labor pain has long been recognized as part of the birthing process. In the modern world of hospital deliveries, physicians-in-training are taught to see labor pain as natural but also potentially problematic (Kroll et al., 2022; Martin, 2001). Part of a clinician's (physician's, certified nurse midwife's, nurse's) role during labor is to offer and provide pain management. To assess pain in labor, clinicians ask individuals about the level of their pain– traditionally scored on a Likert scale of 1 (minimal) to 10 (severe). If available, anesthesiologists typically consult with a laboring individual to discuss goals for pain management, and recommend anesthesia and analgesia in case of unforeseen issues, such as a cesarean birth. Though this process seems benign, it harbors the potential to perpetuate inequities in eliciting laboring people's pain and recommending management options.

Due to structural racism in medical education (Willoughby, 2022), many medical students and residents believe that Black people experience less pain. One reason for such misconceptions is the belief that Black individuals have physically thicker skin, a falsehood that was used to justify slavery and obstetrical experiments on enslaved women (Hoffman et al., 2016). The structure of medical communication reinforces this. Oral case presentations and written documentation, for example, begin with identifying a patient by their age, race, and gender. This classification centers race instead of racism as a critical characteristic for the learner's framework of medical thinking. The patterns of medical practice learned in medical school and cemented during residency are then applied to medical trainees' future patients. There is an extensive and growing literature on medical racism and racial inequities in access to pain control, particularly in obstetric settings (Davis, 2019). Physicians are taught to perceive pain through a lens shaped by white supremacy and, in the case of reproductive health, misogynoir – the denigration of Black women through the intersection of sexism and racism (Bailey, 2021).

Structural racism in the vulnerable environment of the delivery room leads to the potential mismeasurement, misinterpretation and mistreatment of labor pains in those pregnant individuals least able to advocate for themselves.

Kroll et al. (2022) used grounded theory to analyze data from an obstetrics and gynecology (OB/GYN) residency in an urban academic program in the midwestern U.S. Residents were interviewed about their perceptions of patient pain with patients of different cultural, religious, or ethnic backgrounds. It was found that residents idealized laboring individuals who appear to suppress their pain. Some stated that poorer patients express less pain due to their presumed experience of previous "worse" life traumas, while others posited the opposite – that low-income individuals expressed more pain to secure medical attention. Both views minimize the birthing person's need and/or desire for pain control. Although most residents avoided directly discussing Black women's labor pain, this "quiet" or "easily controlled" ideal furthers racist misconceptions of obstetric hardiness because many residents conflated lower socioeconomic status with race. The preference for a submissive laboring individual also aligns with Sointu's (2017) description of "bad" patients as those with less cultural health capital due to low health literacy and socioeconomic status, and a consequent inability to participate in shared decision-making.

Based on our understanding of entrenched racial and classist bias in the perception and treatment of labor pain, we recommend the use of a Reproductive Justice (RJ) framework to

actively restructure all medical entities entrusted with labor care activities. The RJ movement was established in 1994 in Chicago by Sistersong, a group of Black women, to assert that all pregnancy-capable people have the right to have or not have children and to parent in safe and healthy environments (SisterSong, sistersong.net). Our long term policy recommendations include:

1.Birthing people must have a voice before, during, and after labor. Staffing on labor and delivery units should support them to request a second opinion if they feel that their pain or their goals for pain management are not being met (Carter et al., 2021).

2.The full spectrum of pain management options should be available to all laboring individuals. Doulas are experts on this spectrum of options and should be viewed as equal partners on the labor and delivery units. This would include clinicians understanding the role and expertise of doulas in the laboring process along with adequate compensation.

3.Institutions must prioritize the diversification of their faculty, trainees, and students across multiple domains. This should go beyond conventional Diversion, Equity and Inclusion approaches, to actually change pedagogy, care systems, and faculty support and development.

4.Medical schools and residency programs must actively work to identify their own structural practices that perpetuate race-based treatment. Anti-racist training must begin in medical school because many students arrive with no "critical consciousness" of racial inequality (Novak et al., 2022). Racism must be discussed explicitly and programs should employ and adequately support faculty, scholars, and community leaders to identify barriers to appropriate pain management and underlying assumptions made in the heuristics of pain management.

Labor and delivery have been wrenched from their historical place in the home attended by a midwife well known to the pregnant person. As most people now labor and deliver in the medical setting, medical professionals must practice a Reproductive-Justice based care model. Pain recognition, management, and options are currently inequitable, particularly for Black pregnant people. We must do better.

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CONTACT

Julia Murphy, Department of Family Medicine, University of Colorado,
Camille Kroll, Brown School of Public Health and Social Work, Washington University in St. Louis,
Sara Whetstone, Department of Obstetrics and Gynecology, University of California San Francisco,
Andrea Jackson, Department of Obstetrics and Gynecology, University of California San Francisco,.
Ashish Premkumar, Department of Obstetrics and Gynecology, University of Chicago,

Corresponding Author:
Julia Murphy: julia.s.murphy@cuanschutz.edu

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