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INVISIBILIZED PAIN: THE MYTH OF PAIN RESISTANCE AND MEDICAL NEGLECT OF BLACK WOMEN

DOR INVISIBILIZADA: O MITO DA RESISTÊNCIA À DOR E A NEGLIGÊNCIA MÉDICA COM MULHERES NEGRAS

DOLOR INVISIBLE: EL MITO DE LA RESISTENCIA AL DOLOR Y LA NEGLIGENCIA MÉDICA DE LAS MUJERES NEGRAS

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ABSTRACT

Throughout history, Black women have been victims of medical neglect driven by racist stereotypes, including the myth of pain resistance, which suggests, without any scientific basis, that Black women experience less pain than white women. This myth has historical roots in scientific racism and continues to influence contemporary medical practice, resulting in the underestimation of these patients' pain, reduced prescription of analgesics, and neglect in essential medical procedures. The analysis seeks to address the folowing central question: What measures are necessary to deconstruct the myth of pain resistance and promote more equitable and humanized medical care for Black women? Using a hypothetical-deductive methodological approach, through documentary and bibliographic research techniques, special attention is given to the myth of pain resistance in Black women. The research aims to examine, from an evidence-based perspective and with recognition of the intersectionality of race and gender, the importance of anti-racist education in the training of healthcare professionals, as well as the need for public policies that promote respect and dignity in the care of these patients.

Keywords: Invisibilized Pain. Myth of Resistance. Medical Neglect. Black Women.

RESUMO

Ao longo da história, mulheres negras têm sido vítimas da negligência médica impulsionada por estereótipos racistas, entre eles o mito da resistência à dor, que sugere, sem qualquer embasamento científico, que mulheres negras sentem menos dor que mulheres brancas. Esse mito tem raízes históricas no racismo científico e continua a influenciar a prática médica contemporânea, resultando na subestimação da dor dessas pacientes, na menor prescrição de analgésicos e na negligência em procedimentos médicos fundamentais. Deste modo, através da presente pesquisa, pretende-se responder a seguinte questão: Quais atitudes são necessárias para desconstruir o mito da resistência à dor e promover um atendimento médico mais equitativo e humanizado para mulheres negras? Utilizando-se da abordagem metodológica hipotético-dedutiva, através de técnicas de pesquisa documental e bibliográfica, confere-se especial atenção ao mito de resistência à dor nas mulheres negras. A pesquisa visa examinar, a partir de uma abordagem baseada em evidências e no

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reconhecimento da interseccionalidade entre raça e gênero e destacar a importância da educação antirracista na formação de profissionais de saúde, bem como a necessidade de políticas públicas que promovam o respeito e a dignidade no cuidado dessas pacientes.

Palavras-chave: Dor Invisibilizada. Mito da Resistência. Negligência Médica. Mulheres Negras.

RESUMEN

A lo largo de la historia, las mujeres negras han sido víctimas de negligencia médica impulsada por estereotipos racistas, incluyendo el mito de la resistencia al dolor, que sugiere, sin fundamento científico, que las mujeres negras sienten menos dolor que las blancas. Este mito tiene raíces históricas en el racismo científico y continúa influyendo en la práctica médica contemporánea, resultando en la subestimación del dolor de estas pacientes, la prescripción insuficiente de analgésicos y el descuido de procedimientos médicos esenciales. Por lo tanto, esta investigación busca responder a la siguiente pregunta: ¿Qué acciones son necesarias para deconstruir el mito de la resistencia al dolor y promover una atención médica más equitativa y humana para las mujeres negras? Mediante un enfoque metodológico hipotético-deductivo, mediante técnicas de investigación documental y bibliográfica, se presta especial atención al mito de la resistencia al dolor entre las mujeres negras. La investigación busca examinar, desde un enfoque basado en la evidencia y reconociendo la interseccionalidad entre raza y género, y destacar la importancia de la educación antirracista en la formación de profesionales de la salud, así como la necesidad de políticas públicas que promuevan el respeto y la dignidad en la atención de estas pacientes.

Palabras clave: Dolor Invisible. Mito de la Resistencia. Negligencia Médica. Mujeres Negras.

1 INTRODUCTION

The relationship between race and health is marked by deep inequalities that disproportionately affect the black population. In Brazil, black women face specific challenges in accessing and quality of medical care, often impacted by racial stereotypes that compromise the recognition and treatment of their health conditions. One of the most persistent and damaging among these stereotypes is the myth of pain resistance, which suggests, without any scientific basis, that black women feel less pain than white women.

This myth has historical roots in scientific racism and continues to influence contemporary medical practice, resulting in the underestimation of these patients' pain, lower prescription of painkillers, and neglect of fundamental medical procedures. The impact of this discrimination can be observed in several areas of health, such as obstetrics, the treatment of chronic diseases, and the management of acute pain, contributing to worse clinical outcomes and a higher maternal mortality rate among black women.

Therefore, through the hypothetical-deductive method, qualitative and quantitative research, as well as bibliographic reviews and clinical studies in the area, it is intended to answer the following question: What measures are necessary to deconstruct the myth of resistance to pain and promote more equitable and humanized medical care for black women?

It is intended to examine, from an evidence-based approach and the recognition of the intersectionality between race and gender, and to highlight the importance of anti-racist education in the training of health professionals, as well as the need for public policies that promote respect and dignity in the care of these patients.

2 THE MYTH OF PAIN RESISTANCE: HISTORICAL ROOTS AND STRUCTURAL RACISM

The history of Brazil is usually divided into very unequal periods in chronological terms, which today reflect the transformations and behaviors of society. According to the historical scope, in the pre-Cabral period, before the arrival of Europeans on Brazilian soil in 1500, indigenous populations already inhabited the region, having customs and ways of life typical of the culture. However, due to colonization, they were subjected to forced labor.[13]

In the period of empire (1822-1889), the economy was supported by African slave labor, and, although there was progress in abolitionist discussions, abolition only occurred in 1888, with the enactment of the Golden Law.[13,9] This intense period of enslavement was

directly linked to the long transatlantic slave trade, a moment that brought approximately five million Africans to Brazil for more than 350 years.[26]

In the first decades of the twentieth century, because there was a high number of immigrants, the jobs performed were subdivided by gender. The female population of former slaves was admitted to laundries, as sellers of medicinal herbs and blessings, and the male population was concentrated in the fields and in the urban market. These sectors have the lowest salaries and unfavorable working conditions.[20.16]

In Brazil, unlike the explicit segregation that occurred in the United States and South Africa, the thesis of the policy of whitening and the myth of racial democracy hindered the development of an ethnic-racial identity, which contributed to the denial of racism.[15]

Due to historical formation and dehumanization, structural racism - a system that favors certain groups to the detriment of others - happens in practice in an explicit and implicit way. When thinking about the field of health, the racial conflict is clear, when in mid-1855, the *cholerae morbus* epidemic that devastated Rio de Janeiro generated panic and social disorder, a moment in which the mortality rate rose drastically, especially among blacks. Due to the historical construction, there was a high population density in marginalized regions and the etiological agents of yellow fever, smallpox and tuberculosis were mostly found in tenement regions due to the precarious conditions of basic sanitation.[10]

One of the most pernicious aspects of this collective memory is the belief that black people feel less pain than white people. In the nineteenth century, the American physician Samuel Cartwright, known for his racist theories in order to justify slavery, published in *the New Orleans Medical and Surgical Journal* the *"Report on the Diseases and Physical Peculiarities of the Negro Race",* claiming that blacks had a less developed nervous system compared to whites, as a consequence, making them less sensitive to pain.[12,19] Ideas widely used at the time to perpetuate racist stereotypes.

Another event of important analysis concerns James Marion Sims, a doctor known as the "father of gynecology", responsible for developing various surgical techniques and treatments for gynecological conditions. Although Sims made a significant contribution to the advancement of gynecology, his controversial practices consisted of experimental surgeries, without the use of anesthesia, on enslaved African-American women, among them Anarcha, Betsy, and Lucy, who suffered from vesicovaginal fistulas. Marion justified her actions with the belief that black people were more resistant to pain than white people.[24]

In the course of scientific and technological advancement, medicine has gone through several events that often reflected thoughts, practices currently seen as inappropriate, defenses of points of view and values not respected. In addition, in addition to the historical heritage, erroneous behaviors of some health professionals are still observed, as a remnant of old approaches, which compromise the quality of care, as well as contempt for the pain of black women, a theme to be addressed in the next topic.

3 CONTEMPT FOR BLACK WOMEN'S PAIN AND HEALTH CONSEQUENCES

The persistence of racist behavior in health services undermines the universal, integral, and equitable access of the black population to the Unified Health System (SUS).

A study guided by Resolution No. 196/1996 of the National Health Council and filed by the Oswaldo Cruz Foundation, carried out a comparative analysis of gestational risks, considering the period from prenatal to puerperium, of about 6,689 black and white pregnant women. The analysis showed that there is a great disparity in medical care with black and brown women, which is why they receive fewer obstetric interventions during childbirth than white women (less local anesthesia when submitted to episiotomy), less guidance and support, prevalence of postpartum depression (associated with experiences of racial discrimination and physical stress), absence of follow-up during childbirth, and higher maternal mortality rate, being 2.5 times higher for black women compared to white women in Brazil.[18]

Sickle cell anemia, hypertension and diabetes mellitus are the three most frequent pathologies during pregnancy and are predominant among Afro-descendant women.[2,11,30]

Anemia is caused by a mutation of the beta-globin gene of hemoglobin, giving rise to an abnormal hemoglobin (hemoglobin S), in which it determines the change in the shape of red blood cells. Under certain circumstances, especially during deoxygenation, the molecules of this hemoglobin S can polymerize (deformation/stiffening), causing vascular occlusion with the risk of infarction, lesions in various sites and episodes of pain.[30] When a black patient arrives at the hospital with a pain crisis resulting from the hereditary condition, they are mostly stereotyped, as professionals assume that black women are naturally stronger,6 impairing the prescription of opioids for pain control and the comprehensive care they need.[27] The impact of this hemoglobin gap is extremely important during pregnancy, since fetuses depend on maternal oxygen transport to meet their needs.[2] In addition, it is important to highlight the reports of patients who denounce the lack of effective care for their demands, given that

medical recklessness impacts hospital transfer in search of support and a possible late diagnosis, considered one of the biggest problems for the control of the pathology.[8]

Arterial hypertension (SAH) and diabetes mellitus are common complications of pregnancy intensified by the prolonged use of immunosuppressants, hormonal, metabolic and physical factors. With the significant increase in the levels of hormones such as prolactin and progesterone, the changes can compromise the thickness of the blood vessels, causing constrictions or an increase in blood pressure, resulting in changes in the cardiovascular system, preeclampsia (among the most frequent causes of death in black puerperal women)[17] and gestational growth restriction.[30,6] Diabetes, a metabolic condition that is characterized by high blood sugar levels, has an implication with metabolic changes, increased body fat, insulin resistance, and can lead to complications in the heart and adjunct organs, in addition to the risk of maternal morbidity.[4]

According to the epidemiological bulletin of the Ministry of Health, there are several socially determined diseases. This tool is for monitoring health indicators among black people and an important collaborator for the application of public policies to combat racism and comprehensive health promotion. In Brazil, the number of HIV cases detected in black pregnant women (brown and black) increased, from 62.4% to 67.7%, from 2020 to 2021. The same happens with the case of death from AIDS (representing almost two-thirds of the total deaths in relation to white people) and from acquired syphilis (proportion of cases to 64.6% of blacks).[5]

In 2022, about 78 thousand people were diagnosed with tuberculosis, and among the new occurrences, 49,381 were brown and black, indicating that they were 63.3% of the cases. This scenario of inequality has a direct impact on the rates of socially determined diseases, because despite having free treatment by the Unified Health System (SUS), there is an abyss in the destination of this care when color/race is considered.[5]

In contemporary times, there is much discussion about the interruption of pregnancy, whether it is performed as a spontaneous or induced abortion, legal or clandestine. Given this scenario, according to the World Health Organization – WHO, there are several women who resort to the practice of abortion in unsafe conditions, estimating, annually, 73 million induced abortions performed worldwide. Of the data presented, six out of ten unplanned pregnancies result in abortion, of which 45% are not carried out in a safe way.[21.1] According to data released by Agência Brasil, in 2023, black women are 46% more likely to have an abortion, regardless of age group, when compared to white women. This implies that for every

10 white women who have an abortion, there will be 15 black women going through the same situation.[29]

Black women, when compared to white women, are more vulnerable in society because they mostly have inequality of race, class, educational disadvantages and precarious access to health services, being more exposed to institutional barriers to access to preventive care.[8,14,28] Thus, the practice of unsafe abortion is a major factor of inequality, because as recorded, the rate of women who undergo this procedure is predominantly black. When they do not get adequate follow-up in clinics and private offices, women seek medication obtained clandestinely, and after the bleeding begins, they go in search of public hospital assistance to complete the process and evaluate possible complications.[25] However, systemic discrimination, stereotypes that associate black women with the practice of abortion, a controversial subject because it involves moral and religious aspects of the population, contribute to the dehumanization of medical care.

This dissatisfaction is one of the reasons why black women avoid seeking the health system. All the characteristics presented show structural racism and how the contempt for the pain of black women significantly impacts the health and well-being of the population, which is only a reflection of the dimension of barriers imposed in society.

4 BREAKING BARRIERS: HOW MEDICINE CAN COMBAT STRUCTURAL RACISM AND RECOGNIZE THE PAIN OF BLACK WOMEN

Due to the present scenario, it is known that there are several problems that place the black population in a different position from the others. In addition, associating blacks with situations of violence, marginality, addictions and the impossibility of guaranteeing their rights is a challenge that the white population does not witness.[3]

Before promoting comprehensiveness, universality and equity in health services, it is first necessary to recognize racism as an attitude present in all environments. Medicine, an extremely elite area, is already markedly occupied by the white population, and within the educational environment, violence, racism, social and economic difference are issues addressed that demarcate and contribute to the perpetuation of the racist stereotype.[3]

In order to break individual and institutional barriers, health professionals must recognize as an objective the application of norms and principles resulting in humanized treatment. The human being is a single species, differing in some physical and psychological characteristics,28 we share the same fears, the same diseases and the same rights.

Anti-racist education is an education that does not ignore the narratives of black culture, clarifies historical factors, their results, invests in elements and reconstructs social consciousness. It is a training that concerns human dignity, promotion of values and the search for equality. This plurality demystifies, strengthens and enriches our culture.[28]

Considering the need to address ethnic-racial issues and the history of Afro-Brazilian and indigenous cultures in professional training, the Ministry of Education establishes National Curriculum Guidelines for the Undergraduate Course in Medicine, that is, a set of rules and principles that define how the training of doctors in the country should be.[7] This conquest, which leads to unanimous, humanized and ethical care.

The anti-racist struggle is everyone's responsibility, and the commitment to ensure human rights must be defended in all environments, especially in the area of health, as it is of great importance as a welcoming space and provider of care.[22]

According to the historical aspect, the need to build anti-racist strategies, practices and policies aimed at combating inequalities related to race and ensuring health was intensified.[3] And when analyzing the dignity and citizenship of black women, the duty of health professionals is to pay attention to behaviors that do not violate the autonomy of their decisions, since the power relations that exist in the hospital environment, such as racism and sexism, already imply greater vulnerability to them.[6.23]

Medicine that can recognize the pain of black women when in the presence of structural racism, deconstructs false beliefs, implements anti-racist education with health professionals, ensures that complaints are taken seriously, applies active listening and, above all, offers humanized care. To this end, it is necessary to combat the structural racism that permeates medical and social practices, given that women need to have their pain fully recognized. Their sufferings must be validated and treated without stereotypies or historical inequalities, deeply rooted in social behavior.

5 FINAL CONSIDERATIONS

Throughout history, black women have been victims of medical negligence driven by racist stereotypes, including the myth of resistance to pain. This belief, rooted in structural racism, holds that black people feel less pain than white people, resulting in less attention to the complaints of these patients and inadequate or insufficient treatment. The impact of this negligence is evident in several areas of health, especially in obstetric care, in the

management of chronic pain, and in the treatment of diseases prevalent in the black population.

Deconstructing the fabulation of resistance to pain in black women is essential to promote more equitable and humanized medical care, considering that undertreatment, negligence in requests, and adverse outcomes are reflections of a health system that fails to guarantee comprehensive care to the black population.

To this extent, what attitudes are necessary to deconstruct the myth of resistance to pain and promote more equitable and humanized medical care for black women?

In order to answer this question, it was found that the epidemiological bulletin of the Ministry of Health shows that socially determined diseases disproportionately affect the black population. In 2021, HIV cases in black pregnant women increased from 62.4% to 67.7%, and the mortality rate from AIDS and syphilis was also higher among this population. In 2022, of the 78 thousand tuberculosis diagnoses, 63.3% occurred in brown and black people, reflecting inequalities in access to treatment. In addition, according to the WHO, 73 million induced abortions occur annually, 45% of which are unsafe. In Brazil, black women are 46% more likely to resort to abortion compared to white women, evidencing social and racial vulnerabilities in access to health.

The disparities faced are reflections of a broad system of social and racial inequality. By recognizing and eliminating the mistaken belief about the supposed greater resistance of black women, medicine can ensure that these patients receive appropriate treatment for their pain and clinical conditions, promoting an approach based on evidence and not on stereotypes. Respecting the dignity and autonomy of black women ensures equal access to health services and, consequently, improves the health indicators of this population.

To ensure fairer care, it is imperative that health professionals adopt a proactive stance towards intersectionality education, implement active listening practices, and validate pain complaints, regardless of skin color.

Thus, facing the myth of pain resistance is not only a clinical necessity, but an ethical and social commitment. Only by recognizing and correcting these historical flaws will it be possible to build a truly universal health system, where all patients are cared for with dignity, respect, and equity.

Therefore, awareness and action regarding pain and racism are fundamental steps to transform medical practice and ensure that all women, regardless of their color, receive the appropriate, respectful, and humanized care they deserve.

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