Eliminating Disparities in Pain Management

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Not all patients are treated equally for their pain with some therefore being undertreated. Discrepancies still exist in the way physicians treat special populations of patients such as racial minorities, women, and substance abusers. All healthcare providers need to be aware of the not so readily apparent disparities resulting from stereotyping, bias, ageism, and socioeconomic considerations. Physicians can best provide appropriate and equal care by following pain management guidelines; however, they may receive contradictory information and be apprehensive about prescribing opioids, especially to substance abusers. In this “refreshed” article, the authors describe patient encounters with patients of color and offer some goals for removing inequality and inequity from clinical settings.

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The following scenarios are anecdotal and typify how patients of ethnic and racial minorities may be treated for complaints of pain.

Case Presentations
Case 1—An African American Woman

Denise, a 32-year-old African American woman, is seen at a follow-up visit from the emergency department. During her recent move to the area, she slipped and fell, injuring her left ankle. She complains of severe left ankle pain that impairs her gait and caused a 2-day absence from work. Six months earlier, she had an open reduction with internal fixation secondary to a trimalleolar fracture. X-ray films revealed no new injury or osseous abnormalities other than the internal fixation device. Her past medical history was negative for medical problems, and her medications prior to the recent fall included ibuprofen and an oral contraceptive. She is not a smoker, she drinks less than two standard servings (14 g) of alcohol per week, and she does not use or abuse any illegal drugs.

Denise was evaluated and given a prescription for a refill of ibuprofen, 600 mg three times a day, and a revisit in 4 weeks.

Case 2—A Native American Woman

Gloria, a 56-year-old Native American, has a history of chronic low back pain. She was referred for evaluation and treatment from a colleague who refused further care because of a violation of her pain contract (Figure 1). Gloria had a positive urine drug screen for an illegal substance but maintained that she was not using any illegal drugs. It has been 2 weeks since her last opioid prescription.

Gloria does have a history of heroin abuse more than 20 years ago. She was seen by another physician but was denied narcotic analgesics as that provider thought that it would be inappropriate to treat a patient with a history of having once abused such medication in the past. As the interview progressed, Gloria admitted that besides the back pain, she also had a new complaint of vaginal bleeding. Gynecologic evaluation revealed several injection marks on the medial aspect of her thighs. She initially tried to explain these as the result of a fall into a cactus, but then tearfully admitted that she had been unable to cope with the pain. Gloria had begun injecting herself subcutaneously with heroin. She was remorseful of these actions and wanted to receive help; however, at the same time, she was hesitant to speak openly about her drug problem because she feared legal consequences.

After a complete medical and behavioral evaluation, Gloria gave consent to begin taking the buprenorphine hydrochloride—naloxone hydrochloride combination. This regimen would be effective for treating her heroin dependence and cravings. Because buprenorphine has partial μ-agonist capacity, it would also improve the low back pain. Gloria has managed to stay sober, and her back pain ratings have decreased. When she was on full μ-agonist therapy, her pain rating was 8-9 on the 0-to-10 scale in the low back; while on buprenorphine-naloxone therapy, her pain level was 3 on the 0-to-10 scale.

Discussion

Denise admitted to having substantial pain and inability to go to work for 2 days. Her physician did not think that
opioids were appropriate for her acute pain complaints.

The previous physician for Gloria was concerned that the use of opioids in a patient with a history of substance abuse is illegal based on the Drug Enforcement Administration’s Web site. This conclusion is not true.

Both women had several factors working against them. They were people of color and were seen by physicians who were uncomfortable in giving opioid analgesics to them. They were suffering from pain in a time when physicians are receiving contradictory information on how to treat patients for pain and who live in a society suspicious of opioid abuse.

Despite efforts targeted at physicians for improving the way in which they manage pain, discrepancies still abound in how certain patients are treated for such discomfort. Special populations of patients such as ethnic minorities, women, and those with a history of substance abuse are victims of deficiencies in pain management and suffer needlessly from pain.

**Terminology**

A disparity in healthcare has been defined as a “difference in treatment provided to members of different groups that is not justified by underlying health conditions or treatment preferences of patients.”1 This definition has three parts:

- **Differences in treatment**
- **Need for treatment, which takes into consideration:**
  - Patient’s health status
  - Patient’s preferences
- **Disparity**

The Institute of Medicine (IOM)1 finds that one of the first steps to fight inequalities in healthcare, including pain management, is to acknowledge the inconsistencies: “Health care providers should be made aware of racial and ethnic disparities in health care, and the fact that these disparities exist, often despite providers’ best intentions.”1

Variations exist in terminology:

- **Disparity**—differences or inequalities in health and healthcare based on observed differences (eg, race, ethnicity, socioeconomic status).
- **Inequity**—inequities in health are based on ethical judgments about those differences (ie, Is it fair that...?) It is about the fairness of those differences.2

**Differences**

**Race and Ethnicity**

Ethnic minorities suffer from undertreatment of pain in the emergency department as compared with their white counterparts.3 Physicians have been guilty of inadequately managing pain in racial and ethnic minorities regardless of the type, eg, acute and chronic, cancerous, end-of-life, and healthcare setting, eg, surgical, emergency, postoperative, outpatient.4 Even when income, insurance, and access to care are controlled, minorities are not as likely as white patients to receive the care that is needed, including medically necessary procedures.1 Todd et al5 reviewed University of California, Los Angeles Emergency Medical Center records of analgesia therapy for isolated extremity fractures and found that Hispanics were often undertreated for pain. Although there were no differences in pain assessment of Hispanics and non-Hispanic white patients with long-bone fractures, Hispanics were two times more likely not to receive pain medication than non-Hispanic whites.6 Blacks also received the same inadequate therapy. Bernabei et al7 illustrated how black Americans residing in nursing homes were assessed and treated less often than whites. Asian, black, and Hispanic women were less likely to relieve epidural analgesia than white women in a study of patients with identical Medicaid insurance coverage.8

**Gender**

Gender disparities have also been reported in pain management. Differences exist between men and women in frequency of pain reports, severity of pain perceived, and analgesic treatment.9 Women complain of pain to their healthcare provider more frequently than men do and also report greater sensitivities to pain than men.9 However, the way in which physicians respond to pain reported by women varies from how they respond to men. Green and Wheeler10 surveyed Michigan physicians to find out how they would manage cancer pain and postoperative pain. Cases were presented as clinical vignettes followed by treatment options in a multiple choice answer format. Physicians more often chose better pain management options for men following prostatectomy than for women after myomectomy. They also chose intervention strategies with improved outcomes more frequently for men with metastatic prostate cancer than for women with metastatic breast cancer.10

While women may be given pain medication more frequently and receive higher dosages and more potent analgesics, women are less likely than men to be referred for cardiac catheterization.3,9 This inequity has resulted in the misdiagnosis of cardiac events in women compared with men.
History of Substance Abuse

Patients with a history of substance abuse also often receive inadequate treatment for pain. Feelings of frustration by both patient and provider often precede a patient-physician encounter. Patients may have already had bad experiences from providers and be distrustful of healthcare systems. Providers may have legitimate concerns regarding scientific evidence of opioid addiction as compared with the moral judgments and stigma of patients who have used illegal drugs.11 Patients who admit to using drugs may be seen as drug-seeking despite the fact that about a third of the US population at some time has used illegal substances.12

It is important for providers to remember that even though patients may abuse drugs, they may still be in quite a bit of pain for which they need to be treated. It is well understood that individual variations exist in how people perceive pain.13 There are even differences between how opioid-dependent patients feel pain compared with those who are not so dependent. Prolonged use of opioids creates pharmacologic tolerance and consequent neurophysiologic changes that result in less analgesia and a decreased ability to withstand pain,14 which is further magnified in patients undergoing withdrawal. Osteopathic physicians need to recognize that patients with a history of substance abuse have pain, and these patients need to be treated for it.

Assessment of Pain

With discrepancies existing in how patients are treated for pain, careful assessment of patients becomes even more important. James N. Campbell, MD, thought that the American Pain Society should declare pain, “The Fifth Vital Sign,” and he made this the theme of his presidential address in 1994.15 The American Pain Society (APS) has promoted the phrase “Pain as the fifth vital sign.” In his presidential address to the APS, Campbell stated:

Vital signs are taken seriously. If pain were assessed with the same zeal as other vital signs are, it would have a much better chance of being treated properly. We need to train doctors and nurses to treat pain as a vital sign. Quality care means that pain is measured and treated.

Such emphasis has promoted changes in hospital care such that pain is now formally recorded; failure to establish such a policy may interfere with accreditation.

Assessing pain in any patient requires looking at the entire person. The osteopathic physician, by being trained to think about a patient as a whole, has an advantage over other healthcare providers. Because this discomfort affects so many aspects of one’s life, pain assessment requires a multidisciplinary approach examining the physiologic, psychological, social, and economic impact on the patient’s life.16

Pain is often accompanied by depression, sleep disturbances, job loss, and disability, which may then only add to this condition. Early, effective treatment of patients for pain could break this cycle. This concept is especially important in minorities and drug abusers who may already be facing socioeconomic difficulties.

Patient education is an important part of pain management. Figure 2 provides a list of patient-centered Web-based resources. Consideration may be given to consulting a pain management specialist. Nonopioids and adjuvant analgesics could be tried before using opioids. Nonpharmacologic approaches may also be used. Osteopathic manipulative treatment may be especially helpful for those suffering from low back pain. It has been shown to decrease use of medications in patients suffering from low back pain.17

Physicians face several barriers when it comes to treating pain effectively. Vilensky18 recognized several obstacles that physicians face when it comes to properly prescribing opioids: lack of formal education about managing pain in medical schools; fear of opioids causing dependence or respiratory depression; lack of patient education; lack of understanding that pain management is a vital portion of patient care; and poor history taking. Beginning on page ES27, Wyatt and Dekker review recommendations for improving physician and medical student education in substance use disorders, knowledge of which, in turn, will impart to physicians greater confidence and skills in treating patients in pain.

Educating healthcare providers as well as patients is the key to adequate pain management. Few medical schools have formal instruction in pain management. In a study by Green et al19 30% of the physicians studied in Michigan in 2001 received no formal education in pain management during medical school, residency training, or through continuing medical education. Without formal training, physicians may feel that they lack the experience in effectively treating pain, especially in a patient who has abused drugs in the past. Communication is a critical factor in patient assessment and education (Figure 3).

Healthcare providers are receiving mixed signals on how to manage pain. Some states are now requiring physicians to evaluate and treat patients for pain, yet do not define the monitoring specifics such as urine drug testing, dosage counts, or behavioral assessments to identify misuse.

Comment

It is clear that disparities exist in how certain patients are treated for their pain. Physicians need to be aware of them to provide proper care to their patients.

Figure 2. Web sites for patient education.
especially minorities, women, and substance abusers. Organizations that wish to remove inequality and inequity from their clinical settings need to have a plan and set the following goals:

- Promote public awareness of pain and the need to properly evaluate and treat patient for this condition.
- Continue to develop, disseminate, and implement scientifically proven prevention and treatment services with respect to pain.
- Improve assessment and recognition of pain.
- Eliminate racial/ethnic, gender, and socioeconomic disparities in accessing adequate analgesia by education and monitoring.
- Improve the infrastructure for reporting pain, including support for scientifically proven interventions across professions.
- Increase access to and coordination of quality pain management services.
- Train frontline providers and identify champions to recognize and manage pain, and educate providers about scientifically proven prevention and treatment services. Offer technical assistance to those providers and programs that are not able to eliminate inequity in the treatment of pain.
- Monitor access to and coordination of quality pain care.
- Establish a close working relationship with the addiction medicine staff to enhance timely and appropriate referrals for those patients who are unable to control their use/misuse of opioids.

Unequal treatment based on race, ethnicity, socioeconomic status, gender, religious beliefs, geographic location, sexual orientation, and/or education should not exist in a society that claims equality.

References


Figure 3. Minority adults who have one or more communication problems such as understanding the physician, feeling that the physician listened, and not asking any questions they had compared with white adult patients who had the same communication problems. (Source: Chart 10. In Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans: Findings from the Commonwealth Fund 2001 Health Care Quality Survey. Charts. March 2002. Available at: http://www.commonwealthfund.org/usr_doc/collins_commonconcerns_survey_charts.pdf?section=4056.) Photos © Dreamstime.com