

## ETHICS FORUM

### Disparities in Pain: Ethical Issues

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*Note from editor: The following is the report and newest recommendations from the AAPM Council on Ethics, which are now included in the "AAPM Ethics Charter." All comments are welcome.*

The American Academy of Pain Medicine (AAPM) endorses the World Health Organization declaration that pain relief is a human right. The Academy advocates strongly for access to high-quality pain care for all persons, seeking to overcome any and all inequities that exist. The AAPM embraces the American Medical Association's statement on disparities, affirming that "disparities in medical care based on immutable characteristics such as race must be avoided. Whether such disparities in health care are caused by treatment decisions, differences in income and education, sociocultural factors, or failures by the medical profession, they are unjustifiable and must be eliminated. Physicians should examine their own practices to ensure that racial prejudice does not affect clinical judgment in medical care" [1]. While federal agencies have paid increasing attention to health care disparities in recent years [2], the impact of pain on individual patient's lives, their families, and society are notably absent in most federal research agency's strategic plans and position statements. The reality today is that there has been little impetus or effort among agencies of influence to promote, no less uphold, an acceptable standard of pain care among all groups of patients.

There continue to be major disparities based on patient sociodemographic factors (e.g., race, ethnicity, socioeconomic status [SES], age, gender) for all types of pain (i.e., nociceptive and neuropathic pain) and across all settings (i.e., inpatient and outpatient settings) [3]. Overall, minorities report significantly more psychological and phys-

ical morbidity (e.g., post-traumatic stress disorder and disability) than non-Hispanic whites across the age continuum [4,5]. Respondents of an American Pain Society (APS) and AAPM survey on ethical concerns in pain care identified pain management at the end of life and the general undertreatment of pain (particularly in the elderly and children) as the major ethical dilemmas confronting the practice of pain [6]. Neither racial nor ethnic disparities in pain care were identified as a concern. Although "lack of patient access to pain services" was identified as the sixth most significant ethical dilemma in pain, the qualitative comments referred to lack of 24-hour coverage and lack of certified practitioners rather than insufficient access due to race, ethnicity, or SES.

Several ethical and health care policy considerations must be addressed to optimize pain assessment and treatment for those at particular risk for substandard pain care [7]. There are many predictors of pain care disparities: SES, race and ethnicity, language, geography, extremes of age, gender differences, health literacy, specific types of pain-related conditions (e.g., HIV/AIDS), specific comorbidities (e.g., substance use disorders), and others. The AAPM ethics charter identifies many of these, but this document will focus on those that affect people most commonly: race and ethnicity, SES, and geographic location.

#### Socioeconomic Disparities

Access to health care is strongly influenced by financial status [7]. Research suggests that pain medicine physicians give preferential treatment to more profitable patients [7]. The principle of distributive justice would dictate that all patients under similar clinical circumstances would receive equal access to all necessary and indicated treat-

ment modalities. Prevailing economic forces coupled with insensible and even discriminatory policies within our health care system proscribe against fair treatment for many patients in pain. Low SES is broadly associated with poor access to care, fewer community health care resources, and higher overall morbidity and mortality rates [8–10]. Overall, minority persons are much more likely to be poor than non-Hispanic whites. Health insurance has allowed improved access and health but 15% of U.S. non-Hispanic whites are uninsured compared with 18% of Asians and Pacific Islanders, 20% of African Americans, and 32% of Hispanics [11]. Minority persons without insurance are half as likely to have a regular physician when compared with insured African Americans limiting their access to specialty care such as pain medicine [12].

### **Recommendation**

As pain is a universal experience, with substantial health impact, all physicians should support efforts to ensure access to high-quality pain care for all, without regard to patients' financial means. Advocating for reforms in public policy to remove barriers to access to care through the provision of some form of health care coverage (insurance or its equivalent) for all persons is an ethical imperative. Successful implementation of such policy reform will lessen health disparities in general and disparities in pain care in particular.

### **Geographic Disparities**

It has been well demonstrated that a person's place of residence strongly influences access to health-related services [13]. Overall, locations with relatively poor health care resources, especially for specialist-level pain care, tend to correlate with percentage of minority inhabitants, although there is substantial variation in racial and ethnic disparities across geographic lines. Perhaps the only consistent pattern is that pain specialists tend to practice in urban areas. There is an insufficient number of pain specialists overall, requiring that primary care physicians provide care even for patients with complex pain management needs, particularly in rural settings.

Although pain complaints are one of the most common reasons that people seek medical care, studies consistently report that physicians receive very little education specifically directed at managing pain. Patients requiring specialized pain care may need to travel long distances for evalua-

tion and treatment. In addition, the availability of essential medications required for the treatment of pain varies geographically, even within metropolitan areas and across a state [14,15]. Pharmacies located in minority and low-income neighborhoods are less likely to carry opioid analgesics than those in nonminority neighborhoods. Reluctance to prescribe and decreased ability to obtain pain medications complicate appropriate pain management for racial and ethnic minority persons and impairs their overall health and well-being.

### **Recommendations**

1. Pain medicine physicians in concert with pain management advocacy groups should identify regional variations in the quality and availability of pain care and promote the development of training programs and public policy initiatives to fill the need of underserved areas.
2. Pain medicine physicians must work in concert with pain management advocacy groups and regulatory agencies to eliminate barriers both to prescribing and to obtaining indicated analgesics.
3. Pain medicine physicians must advocate for and help organize improved pain management education to primary care physicians and other health care professionals practicing in areas with limited access to specialized pain care.

### **Racial and Ethnic Disparities**

The bioethical principle of "justice" is severely strained when there are racial and ethnic disparities in treating individuals with pain. A recent Institute of Medicine (IOM) report identified consistent and overwhelming racial and ethnic disparities in health and health care for a wide variety of illness and health care services but only briefly addressed pain care [16]. The IOM clearly documented the disparities in providing pain care for acute pain problems in the emergency room and for cancer pain. More recent reviews further document racial and ethnic differences in a variety of settings (e.g., emergency departments, inpatient, and nursing homes) and conditions (e.g., nociceptive, neuropathic, and experimental pain) [4,5].

These reports conclude that racial and ethnic minorities are at risk for poor pain assessment compared with non-Hispanic whites. The pain complaints of racial and ethnic minorities, the elderly, and women often are handled less

aggressively by physicians than those of non-Hispanic white men. Minority persons often report increased pain and pain-related sequelae while being at increased risk for undertreatment. These differences in pain assessment and treatment by physicians are based on patients' demographic characteristics regardless of type or cause of pain.

Studies in the emergency department found a twofold increase in the amount of analgesics administered to white patients with acute pain due to long bone fractures compared with comparably injured racial minorities. Differences were not accounted for by other patient sociodemographic, substance use, or medical characteristics [3]. In another study using black and white actors presenting with acute chest pain, women, and minorities received inferior pain care. A survey of 13,625 elderly nursing home residents with cancer pain showed that blacks were less likely to have their pain assessed and were 63% more likely than whites not to receive any pain medications [17]. Additionally, minorities carry a higher disease burden than non-Hispanic whites, adding to the diminished physical, social, and emotional health imposed by persistent pain. Recent work reveals that there are generational differences in pain reports and pain-related sequelae among blacks, with younger patients reporting more distress than their older counterparts. The cultural reasons for this are not completely clear but over time, this has significant implications for an increasingly aging society.

In addition, minority patients are prescribed less potent analgesics and are significantly undertreated using World Health Organization pain management guidelines. African Americans were significantly less likely to receive a prescription for a cyclooxygenase-2 inhibitor than Caucasians [18]. Emanuel [19] has noted that even in end-of-life care, services such as hospice are more available for the "well-heeled white sectors of society than others." The Worker's Compensation literature provides additional evidence for disparate pain care with racial and ethnic minorities receiving less treatment and lower disability ratings while being twice as likely to be disabled 6 months following occupational back injuries.

#### **Recommendation**

Ongoing research and monitoring of disparities related to ethnic or racial background are required in order to inform public policies that can reme-

diate inequities in pain care. Pain medicine physicians have an ethical obligation to advocate for research funding and policy changes to eliminate disparities and optimize pain care among all patients.

#### **Access to Pain Care**

Racial and ethnic minorities have less access to primary care, resulting in fewer referrals to pain management specialists and they are at increased risk of having their pain complaints discounted and undertreated. Many minority patients with pain complaints believe that they should have been referred to specialty pain care sooner, feel that ethnicity influenced pain care, and reported that persistent pain is a major financial burden more so than whites.

Racial and ethnic disparities in pain care may result from patient- and clinician-level factors. Minority patients are more likely to refuse recommended therapies, adhere poorly to treatment regimens, and delay seeking medical care [20,21]. These behaviors are the consequence of patients' mistrust in physicians (lack of identification with and empathy from mostly white practitioners), past negative experiences with the health care system, and limited health literacy [22]. Physician sources of racial and ethnic disparities may result from bias or prejudice, stereotyping, poor cross-cultural communication skills ("cultural competency"), and greater clinical uncertainty when treating minority patients [23,24]. Physician-patient congruence has been shown to improve compliance. However, physicians from racially and ethnically diverse backgrounds are underrepresented in medicine.

#### **Recommendations**

1. Pain medicine physicians should provide culturally competent care to reduce the potential for miscommunication, stigma, and stereotyping. This can be accomplished through a commitment to ongoing continuing education programs that focus on cross-cultural competence.
2. Pain medicine physicians should advocate for cultural competence education and training programs at their professional conferences.
3. Pain medicine physicians should become involved in undergraduate and postgraduate education opportunities to engage and inspire minority students to pursue careers in pain medicine.

## References

- 1 American Medical Association Council on Ethical and Judicial Affairs. Code of Medical Ethics. Chicago, IL: AMA Press; 2002.
- 2 Dubois M, Banja J, Brushwood D, et al. Ethics Charter from American Academy of Pain Medicine. *Pain Med* 2005;6:203–12. AAPM Council on Ethics; 2003.
- 3 Todd K, Samaroo N, Hoffman J. Ethnicity as a risk factor in inadequate emergency department Analgesia. *JAMA* 1993;269:1537–9.
- 4 Bonham VL. Race, ethnicity, and pain treatment: Striving to understand the causes and solutions to the disparities in pain treatment. *J Law Med Ethics* 2001;29:52–68.
- 5 Green CR, Anderson KO, Baker TA, et al. The unequal burden of pain: Confronting racial and ethnic disparities in pain. *Pain Med* 2003;4:277–94.
- 6 Ferrell BR, Novy D, Sullivan MD, et al. Ethical dilemmas in pain management. *J Pain* 2001;2:171–80.
- 7 Lebovits A. The ethical implications of racial disparities in pain: Are some of us more equal? *Pain Med* 2005;6:3–4.
- 8 Cohen DA, Farley TA, Mason K. Why is poverty unhealthy? Society and physical mediators. *Soc Sci Med* 2003;57(9):1631–41.
- 9 Lillie-Blanton M, Rushing O, Ruiz S. Key Facts: Race, Ethnicity, and Medical Care. Washington, DC: Henry J. Kaiser Family Foundation; 2003.
- 10 Stewart AL, Napoles-Springer AM. Advancing health disparities research: Can we afford to ignore measurement issues? *Med Care* 2003;41(11):1209.
- 11 Kaiser Commission on Medicaid and the Uninsured: The Uninsured and Their Access to Health Care. Washington, DC: Henry J. Kaiser Family Foundation; 2003.
- 12 Collins KS, Hughes DL, Doty MM, et al. Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans. New York: Commonwealth Fund; 2002.
- 13 Baicker K, Chandra A, Skinner JS. Geographic variation in health care and the problem of measuring racial disparities. *Perspect Biol Med* 2005;48(1 suppl):S42–53.
- 14 Green CR, Ndao-Brumblay SK, West B, Washington T. Differences in prescription opioid analgesic availability: Comparing minority white pharmacies across Michigan. *J Pain* 2005;6:689–99.
- 15 Morrison RS, Wallenstein S, Natale DK, Senzel RS, Huang LL. “We Don’t Carry That”—Failure of pharmacies in predominantly nonwhite neighborhoods to stock opioid analgesics. *N Engl J Med* 2000;342:1023–6.
- 16 Berwick DM. A user’s manual for the IOM’s “quality chasm” report. *Health Aff* 2002;21:80–90.
- 17 Bernabei R, Gambassi G, Lapane K, et al. Management of pain in elderly patients with Cancer. SAGE Study Group. Systematic assessment of geriatric drug use via epidemiology. *JAMA* 1998;279:1877–82.
- 18 Shaya FT, Blume S. Prescriptions for cyclooxygenase-2 inhibitors and other nonsteroidal anti-inflammatory agents in a Medicaid managed care population: African Americans vs Caucasians. *Pain Med* 2005;6:11–7.
- 19 Emanuel L. Ethics and pain management: An introductory overview. *Pain Med* 2001;2:112–6.
- 20 Mitchell JB, McCormack LA. Time trends in late-stage diagnosis of cervical cancer: Differences by race/ethnicity and income. *Med Care* 1997;35(12):1220–4.
- 21 Sedlis SP, Fisher VJ, Tice D, et al. Racial differences in performance of invasive cardiac procedures in a department of veterans affairs medical center. *J Clin Epidemiol* 1997;50:899–901.
- 22 Blanchard J, Lurie N. R-E-S-P-E-C-T: Patient reports of disrespect in the health care setting and its impact on care. *J Fam Pract* 2004;53(9):721–30.
- 23 Balsa AI, Seiler N, McGuire TG, Bloche MG. Clinical uncertainty and healthcare disparities. *Am J Law Med* 2003;29(2–3):203–19.
- 24 Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O 2nd. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep* 2003;118(4):293–302.