Despite efforts targeted at physicians for improving the way in which they manage pain, discrepancies still abound in how they treat certain patients for this condition. Special populations of patients such as racial minorities, women, and substance abusers are victims of deficiencies in pain management and suffer needlessly. Healthcare providers need to be aware of disparities that may not be readily apparent. To provide appropriate care, physicians need to follow pain management guidelines; however, they receive contradictory information on how to treat patients in pain, and they may be apprehensive about prescribing opioids. Recognizing that pain is one of the most frequent reasons a patient may see a physician, it is important to recognize the healthcare disparities in managing pain as well as the barriers to providing appropriate treatment for pain. Only when physicians acknowledge disparities and barriers can they begin to evaluate and improve on their own practices of pain management.

The following case scenarios illustrate the disparities in how some patients are treated for their pain.

Case Presentations

Case 1—African American Woman

Rosanna is a 32-year-old African American woman who is referred from the emergency department to follow-up at a primary care physician’s office. She recently relocated to the area, and during the move, she slipped and fell, injuring her left ankle. Rosanna complains of severe pain in her left ankle that impairs her gait and caused her absence from work for 2 days. She had undergone an open reduction and internal fixation 6 months earlier secondary to a trimalleolar fracture. X-ray films did not reveal any new injury or osseous abnormalities other than the internal fixation device.

Her past medical history revealed no medical problems, and her medications before the recent fall included ibuprofen and oral contraceptives. Rosanna is not a smoker, she drinks fewer than two standard servings of alcohol per week (ie, one standard serving is 14 g of ethanol, the equivalent of 1.5 ounces of distilled spirits at 80 proof), and she does not use or abuse any illegal drugs. The physician evaluates Rosanna and gives her a prescription for a refill of ibuprofen, 600 mg, to be taken three times a day. She has a follow-up visit scheduled for 4 weeks later.

Case 2—Native American Woman

Lenor is a 56-year-old Native American woman who presented with a chief complaint of chronic low back pain. She abused heroin 20 years ago and did not abuse again until recently. Lenor was seen by a primary care physician and was denied opioids for her back pain because the physician thought that they would be inappropriate because of her history of drug abuse. Frustrated and in pain, Lenor sought medical care from a different physician.

During a follow-up visit, Lenor was found to have a positive urine drug screen but maintained that she was not using any illegal drugs. Because of violation of her pain contract (Figure 1) with the pain specialist, she was referred for evaluation and treatment for back pain. When interviewed, Lenor admitted that besides the back pain, she also had some vaginal bleeding. On gynecologic evaluation, she was found to have 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 she tearfully admitted that she had been unable to cope with her back pain after being denied analgesic medications and began self-injecting heroin subcutaneously.

Lenor was remorseful of her actions and wanted to receive help; however, she was hesitant to speak openly about her drug problem because of fear of legal consequences. After a complete medical and behavioral evaluation, the patient gave consent to begin a combination of buprenorphine and naloxone. This regimen would be effective at treating the heroin dependence and cravings and because buprenorphine has partial mu agonist capacity, it would also reduce her low back pain. Since beginning this
regimen, Lenor has managed to stay drug-free and her ratings of back pain on the 11-point scale of 0 to 10 have decreased.

**Discussion**

Rosanna admitted to having clinically significant pain and inability to go to work for 2 days. Her physician thought that opioids were inappropriate for her acute pain. The first physician for Lenor was concerned that the use of opioid narcotics in a patient with a history of substance abuse was illegal based on a recent publication from the Drug Enforcement Administration (DEA)\(^1\) and the DEA interim policy statement. Rosanna and Lenor had several factors working against them. They were people of color, women, and were seen by providers who were uncomfortable giving narcotic medications to them. They were suffering from pain in a time when physicians are receiving contradictory information on how to treat pain, and they 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 this medical condition. Special populations of patients such as racial minorities, women, and substance abusers are victims of deficiencies in pain management and consequently suffer needlessly. The Institute of Medicine recommends that one of the first steps to take in fighting inequalities in healthcare, including pain management, is to acknowledge the inconsistencies\(^2\):

> Healthcare 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.

Only when providers are conscious of the deficits in pain management of patients in certain populations can they take the next step to correct these inequalities and provide the best appropriate care.

Ethnic minorities suffer from undertreatment of their pain in the emergency department as compared with their white counterparts. In a recent study, physicians were found guilty of inadequately managing pain in racial and ethnic minorities no matter the type of pain, eg, acute, chronic, cancerous, end-of-life, and in all type of healthcare settings, ie, surgical, emergency, postoperative, outpatient. Even when income, insurance, and access to care are controlled for, minority persons are not as likely as white persons to receive the care that is needed; this includes medically necessary procedures.\(^3\)

Todd et al\(^4\) reviewed University of California at Los Angeles emergency department records for analgesia rates in patients with isolated extremity fractures. 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 than the non-Hispanic white patients to not receive any pain medication.\(^5,7\) African Americans were no exception, either. Bernabei et al\(^8\) illustrated how African Americans residing in nursing homes were assessed and treated less often than white persons. Asian and Hispanic women were less likely to receive epidural analgesia than white women in a study done in Georgia among patients with identical insurance coverage with Medicaid.\(^9\)

Gender disparities have also been reported in pain management. Differences exist between men and women in how often pain is reported, the severity of pain perceived, and treatment of pain.\(^10\) Women complain of pain to their healthcare provider more frequently than men do and also report greater sensitivities to pain than men. However, the way in which physicians respond to pain reported by women differs from how they respond to men. Green and Wheeler\(^11\) surveyed Michigan physicians to find out how they manage cancer pain and postoperative pain. The survey consisted of cases 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 the better option more frequently for men with metastatic prostate cancer than for women with metastatic breast cancer.\(^11\)

One other subset of patients who often receive inadequate treatment of pain is patients with a history of substance abuse. Feelings of frustration by both the patient and physician often preclude the patient-physician encounter. The patient may have already had a bad experience with a physician and be distrustful of the healthcare system.

Physicians may have legitimate concerns about the scientific evidence of opioid addiction that are intermingled with moral judgments about patients who have used illicit drugs. Patients who admit to using drugs may be seen as drug-seeking. This perception exists despite the fact that about a third of people living in the United States have at some time used illegal drugs.\(^13\) It is important for physicians to remember that even though patients may abuse drugs, they may still be in much pain.
that needs to be treated.

Individual differences exist in how people perceive pain. Healthcare providers may not be aware that there are even differences between how opioid-dependent patients as a group feel pain compared with those who are not so dependent. Long-standing use of opioids creates neurophysiologic changes that result in a decreased tolerance to pain. In essence, patients in opioid withdrawal have a greater response to pain and lower pain tolerance than other patients. Physicians need to recognize patients with a history of substance abuse, acknowledge the pain that they may have, and provide appropriate treatment.

With the discrepancies in how pain treatment is provided, careful patient assessment becomes even more important. The American Pain Society (APS) feels strongly about this medical condition and consequently coined and trademarked the phrase, “Pain: The 5th Vital Sign.” In his presidential address to the APS, James Campbell, MD, 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.

Measuring and assessing pain in a patient requires looking at the entire person. Osteopathic physicians, trained to think about a patient as a whole, have an advantage over other healthcare providers in measuring and assessing pain. Because pain affects so many aspects of life, assessment requires a multidisciplinary approach that examines the physiologic, psychological, social, and economic impact of pain on the patient. Pain is often accompanied by depression, sleep disturbances, job loss, and disability, all of which may then only add to the pain. Early evaluation and effective treatment of pain could break this cycle. This concept is especially important in minorities and drug abusers who may already be facing socioeconomic difficulties.

Physicians face several barriers when it comes to treating pain effectively. Vilensky recognized several obstacles that challenge physicians’ capabilities to properly prescribe opioids: inadequate formal education in medical school about managing pain, fear of opioids causing addiction, physical dependence and respiratory depression, poor history taking, lack of patient education, and low understanding that pain management is a vital portion of patient care.

Educat ing 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 al, 30% of physicians studied in Michigan received no formal education in pain management during medical school, residency training, or continuing medical education (CME) programs. Without formal training, physicians may believe that they lack the experience in treating pain effectively, especially in patients who have abused drugs or are currently doing so. Poor pain management skills and uncomfortable feelings about treating patients with all types of pain are problematic issues for physicians, especially because this medical condition is one of the most common reasons people see a healthcare provider.

Physicians are receiving mixed signals on how to manage pain. Recent new changes in the way in which schedule II drugs are prescribed has made it more difficult—and even confusing—for both physicians and patients. On November 16, 2004, the DEA issued an Interim Policy Statement (IPS) via the Federal Register. The IPS states that healthcare providers do not have the privilege they once had to write multiple prescriptions on the date of a face-to-face examination with the actual date the prescriptions are to be issued. Physicians are not allowed to write directions for dispensing medication on a specified future date.

The IPS is contradictory to the standard of care endorsed by such professional organizations as the American Pain Society, American Academy of Pain Medicine, and the American Society of Addiction Medicine. The American Osteopathic Academy of Addiction Medicine (AOAAM) has provided educational programs with the American Osteopathic Association encouraging comprehensive evaluation and treatment of patients in pain. The special considerations of pain evaluation and treatment of patients with a history of substance abuse are reviewed annually in the AOAAM continuing education programs.

The AOAAM supports the careful but comprehensive approach in the effective treatment of chronic pain in all populations in a culturally appropriate manner. This approach emphasizes the return to function and use of nonpharmacologic approaches in addition to modes of pharmacotherapy that may include narcotic analgesics. Through journals, newsletters, and CME programs provided by these groups, healthcare providers are instructed that it is suitable to write multiple prescriptions on the date of a face-to-face examination with the actual date the prescriptions were issued and to write directions for dispensing medications on future specified dates.

Physicians are receiving conflicting information regarding how they are to appropriately dispense schedule II pain medications such as opioids. Without clear, national guidelines for managing pain and dispensing opioid medications, appropriate care for patients who suffer pain becomes extremely difficult.
**Comment**

Disparities clearly exist in the way in which certain patients receive treatment for their pain. Physicians need to be aware of these problems so they can provide proper care to all their patients, with special attention to racial and ethnic minorities, women, and substance abusers. Only when physicians acknowledge and understand such disparities and barriers can they begin to evaluate and improve on their own practices of pain management. There are many simple steps that physicians can take to move toward a more equitable delivery of healthcare (Figure 2).

In addition, clear national guidelines in pain management need to be established to provide physicians with information on how to appropriately care for their patients in need of such treatment. Physicians need to feel comfortable prescribing opioids if indicated without fear of professional retribution. All patients have the right to be treated for their pain and healthcare providers need to work with them to render the best possible care. Having significant knowledge in recognizing, assessing, and treating pain appropriately is fundamental to diminishing inconsistencies in healthcare management among various social groups.

**References**


