

SCOPE of Pain Podcast Series

Season 3, Episode 1

Addressing Disparities in Pain and Addiction Assessment and Treatment

Daniel Alford, MD: Welcome to SCOPE of Pain Health Disparities Podcast. I'm meeting with my colleague, Dr. Sheila Chapman. Dr. Chapman is board certified in Internal Medicine and is a Primary Care Physician at Boston Medical Center. She's a Clinical Associate Professor at Boston University Chobanian & Avedisian School of Medicine. She also serves as the Associate Chair for Diversity and Inclusion in the Department of Medicine, and practices addiction medicine with the Clinical Addiction Research and Education Unit. She is also a patient experience coach at Boston Medical Center. What is that? She shadows clinicians during clinical encounters to improve their communication skills to better build trust with their patients. So let's start. Welcome, Dr. Chapman.

Sheila Chapman, MD: Hi, Dr. Alford, and for the purposes of this discussion, I'll call you Dan, because we've known each other for a very long time. I really appreciate this opportunity to discuss really one of my favorite topics.

DA: Thanks. Okay, Sheila. Let me highlight some of the alarming racial and ethnic disparities in pain and addiction treatment. There are well-described racial and ethnic disparities in both the assessment and treatment of pain. Research has consistently shown that minoritized populations are systematically undertreated for pain, relative to white Americans. This undertreatment is rooted in false beliefs about biological differences in the experiences of pain between ethnic and racial groups. In an interesting retrospective analysis that was published in 2019 of over 25,000 emergency medical service encounters for patients with traumatic injuries, they examined the role of patient race and ethnicity in both pain assessment and pain medication administration. And the adjusted likelihood of receiving any pain medications for that traumatic injury was 32% less likely in Black patients, 21% less likely in Hispanic patients and 24% less likely in Asian patients, when compared with whites.¹

There are also differences in relation to overdose and addiction as well. While whites had early periods of acceleration in overdose deaths, there has been a decreased rate of change since 2016. However, according to the latest CDC data, since 2019, American Indian/Alaskan Native and non-Hispanic Black persons has experienced the highest

¹ Kennel J, Withers E, Parsons N, Woo H. Racial/Ethnic Disparities in Pain Treatment: Evidence From Oregon Emergency Medical Services Agencies. *Med Care*. 2019 Dec;57(12):924-929. doi: 10.1097/MLR.0000000000001208. PMID: 31730566

increases in drug overdose death rates. Equally troubling are the inequities historically marginalized populations have experienced related to access to life-saving addiction treatment.

So, Sheila, can you now tell us why you believe these disparities continue to exist? I imagine it's multi-factorial, including systems, clinician, and patient factors.

SC: Yes, so we can't begin to talk about disparities we see in any area unless we consider the historical experiences. And for the purpose of our discussion, I'll use the African American experience as an example, with attention to experiences and the relationship with the medical profession and healthcare systems. Historic experiences impact other marginalized communities: Latinx, Native American, and other indigenous populations, LGBTQA colleagues and disabled populations, and those whose primary language is not English, among others. These experiences and history often manifest in multiple subsequent generations. So if we look at the African American experience, we can acknowledge several facts. For centuries, the health of African peoples and their descendants were not considered the center of patient care, the individuals themselves. If we look back all the way to Africa, ship surgeons were hired by the traders, and their role was to ensure Africans were strong enough to make the Middle Passage to America. In America, slaveholders were having Africans evaluated to assure strength, and women for childbearing potential. If slaves got sick, they didn't want to be seen by the master's doctor, as if too weak, they would suffer negative consequences, and others suffered through torturous experimentation.

The US Public Health Services at Tuskegee, the research study of untreated syphilis in the Negro male started in 1932 without informed consent. Participants were told that they were being treated for bad blood. By the mid-1940s, penicillin became the drug of choice for treatment for syphilis, but participants were not informed, and the study was continued until 1972. Please note that this is part of the current living history of many in our patient populations.

We recognize now that the social determinants of health and socioeconomic status are foundational to many of the disparities we see. I encourage you to ponder that economic status – wealth – is power. In relationship to home ownership for African Americans, the issue of redlining is front and center. Mortgage loans, insurance, home improvement and equity credit lines were limited in areas deemed undesirable. And these most often were in the areas where African Americans and immigrants lived. Lack of home ownership limits so many things. Disparate legal enforcement in experience and incarceration are also significant. And after World War II, interest-free home loans were available to veterans. However, the government did not manage these loans, so the rules determined by banks that used redlining to determine risk were enforced. Also for African Americans, the loans were not interest-free. For African American communities, for much of our history, healthcare has not been patient-centered or protective of the rights of the health of African Americans.

So I encourage you to think about the individual communities you serve, to explore the history of their culture, and references to their culture that can identify hesitations and limit the building of trust. The medical profession has not been trustworthy with respect to African Americans and other communities. We must work to gain their trust.

DA: That's a lot to process. So there really have been centuries-old built-in disparities in the experience of different cultures, in this case African Americans. So let's have our discussion with that image in mind. Can we start with disparities in pain care, and how does it all play out?

SC: Again, historically, medical experts in the past had concluded and put forth the notion that Black people were a different species, their skin was thicker and more resistant to pain, and those thoughts carried on, in some ways even today. Pain is a very subjective experience, and nonverbal cues are often misunderstood, with providers thinking patients were either exaggerating their experience with pain, or misinterpreting stoicism for lack of pain. Thus, patients may present assuming the provider won't believe them either way, and this can lead to an undertreatment of pain.

Providers fear more harm than good will be the outcome with opioid prescribing, which indeed can happen. So it's very important for providers to really understand their patients, understand underlying conditions that can cause pain, and use a holistic way to assess pain in their patients. There's often, again, a fear that patients are drug seeking, and to use your term, Dan, the question is, are they drug seeking or are they pain-relief seeking.

DA: Thanks, Sheila. Let's dive into this clinician role. I'm sure we all have biases. Some are conscious, some are unconscious. How do we describe those so that we can start working on them? How can we talk about that?

SC: It really requires a powerful introspection, and you make a very important statement recognizing that we all have biases. And so, often what we found here at our institution over the last several years, having a variety of forums where clinicians can discuss their real world experiences with their patients; where they are in a safe environment to say out loud the things they're afraid to say, that yes, when their patient came in and they were dressed a certain way, or they were speaking in tones that felt threatening, really drilling down on their own reaction, and then really reflecting on this big question, "Did this affect the way that I provided care for this patient?"

And once you start doing that, and you have a community where you can speak freely and get feedback from your colleagues, you're able to start to mitigate that bias. And I often do remind providers that patients have biases as well, and this is where the dialog, even with your patient, needs to be open and nonjudgmental, and sometimes it's fine to share with someone, "You know, until recently, I didn't recognize that this was a blind spot for me." And the more that you can also allow your patients to be your educator, it really does even out the hierarchy that's kind of built into our clinical encounters.

DA: You mention that patients also have biases. Can you talk about that a little bit more?

SC: Oh, sure. Because I am an African American provider with a lot of African American patients, patients might say to me they may have a particular preference for a black provider. This comes up often, and I often tell my majority colleagues, it's not that you can't develop trust with a patient from another culture, but it may take a little bit longer. It may take a little bit more effort, because the patient may be thinking, "Oh, this young white woman is not going to understand my experience." But there are so many experiences we have in common. Parenting is a favorite one that I'll often bring up. Or food choices is also another one that many cultures will share, or say, "Oh my, I've never had that. Is that something that you cook regularly?" "Oh yes, that's a staple in my household." So there are commonalities that can be brought into the encounter that makes us all feel very human.

DA: That's so interesting, because I remember one of my patients, who is African American, at our first visit, she expressed her disappointment that I was an African American. I think she thought that I was going to be, I'm not sure exactly why, and she stayed with me, and we've laughed about it over the past years, about how that first encounter [laughter] was spent talking about her expectations. It was a bonding experience for us.

SC: Yes, yes.

DA: Okay, so you've talked about some potential ways of addressing these disparities, but I wonder if you could talk more about it. What has been your experience in your coaching of clinicians? What are some of the most common issues that you address in terms of how we communicate and build trust with patients who are coming from different cultures. It's obviously impossible to know every culture in and out, and we all come from our own culture, so how does that all work? How should we navigate that?

SC: Great point. We all know that we're on the computer, right now, during our visits. And sometimes, the simple technique that I've used and I've encouraged providers to use is, at the beginning of the visit, to introduce yourself, have the patient introduce themselves, and also if there are other family members or even maybe the personal care attendant has come in with them, to make sure that those individuals are honored and spoken to and introduced as well. I'll often spend a minute or two greeting the patient, making sure that they're comfortable before I get on the computer. And then I'll often announce that I'm going to be on the computer, I'll be taking some notes, but I will definitely be giving you my full attention.

And I'll often, again, allow the patient, first, to tell me what's on their mind before I go into what's on my list of things to do. Specifically, in talking to folks who have a substance use disorder history, or are in recovery, I'm also very much aware that they may have significant trauma in their background. So this idea of eliciting comfort is very important. So that even with my physical exam, or any activity I'm doing within the visit, I'm usually being very clear about even why I'm asking certain questions, so that it doesn't just feel like a list of just

questions that I'm just asking, even though there really may be a sheet that I'm following to ask these questions. Even if I'm asking about, for instance, last use, I might say, "And when was your last use, because that's important for me to know, because I'd want to be aware if you're going through any withdrawal right now." And I find that patients really appreciate that and are very forthcoming. And I think another key thing that clinicians can do is to believe what their patients are saying. Oftentimes, I think, part of our provider bias may be that maybe we've gotten discouraged by an individual's progress. And we really have to check ourselves on that, so that we still are the ones who are really believing that treatment works and that they can and will recover.

DA: Sheila, you mentioned the term "eliciting comfort" and I've not heard that term before. Could you expand on that a little bit?

SC: Anyone who knows me personally is aware that I like to have fun, and I generally will walk around and greet people with a smile. Even if individuals are at a very low point, I'm usually able to make a comment that still lifts them a little bit. So you know, someone having a tough time, acknowledging, "I get it, this is a tough time." From my faith base, that tends to be one of my favorite comments, is "Winter always turns to spring, spring never turns to winter." I might use a phrase like that. It's the acknowledgement that, "Boy, this is a really tough time and I get that." But it's a way of me also expressing my hope, and hopefully instilling some hope in that individual.

The other thing is, I find touch can also be very comforting, and I may often say to someone, "Is it okay if I just place my hand on your hand?" Again, that human connection can be so very powerful. And another thing sometimes is, it's appropriate to sit in silence with someone. Give them a moment, give yourself a moment to maybe feel some feelings. I think those are all things that can help in the therapeutic process.

DA: Is it helpful to explore with the patient what their prior experiences have been with the healthcare system: how they've been cared for, things that went well, things that went less well, in order to give us kind of an understanding of what their expectations are of our relationship?

SC: I usually won't do that in an exam room with a patient; however, if they bring it up, I will let them explore that and share that with me, and then I will usually try to apologize for the fact that that happened, even if that didn't happen right here, right now, in my institution. And I will also thank them for sharing that with me, and I will encourage them that if I step over any lines or make them uncomfortable, to please, please, please bring that to my attention, or with any experience they're having here with this institution.

DA: Thank you for that. So, when I think about patients who present with chronic pain-related issues, regardless of who they are and where they come from, oftentimes they feel that they're being mistreated or not being treated adequately, and I imagine this plays a bigger role in those individuals who are treated differently because of how they look. Can

you give us some insights, some tips: focusing specifically on the patient who presents with chronic pain. They may be on opioids, they may not be on opioids. How can we better connect with these individuals so that they feel trust? Trust is such an important part of caring for people with pain, because oftentimes, we'll refer them to other types of treatment, and it's important that they trust us in order to then follow through with some of those recommendations. I'm just curious what your thoughts are about building trust in patients who present with chronic pain.

SC: I think that displaying empathy, and how do we display empathy, right? Oftentimes I will share some of the experiences with other patients I've had with chronic pain, for instance. I'll give a clear example: there may be someone who has chronic pain that's been on short-acting opioids for a long period of time, and I would really, really like them to have a long-acting medication onboard, and the moment I mention methadone as a potential medication, the immediate response is, "That's not my problem. I don't have that problem. That's not me." And in fact, get very offended that I even mentioned it.

There's that moment again where the discussion becomes very important about why I'm bringing this up, the education about how we can treat chronic pain, the rationale behind this thinking. Just recently, I had a patient who, even changing her to a long-acting oxycontin (oxycodone) took about 2½, almost 3 years, and I finally had to say, No, I'm putting my foot down, I'm not prescribing an increased dose of the short-acting." And she finally tried it and literally the next visit, she was like, "I feel so much better." [Laughter] And she apologized for all the times she left angry at me. But she always came back. But she would leave angry and we would have this same discussion over and over again. So I think having patience with your patients [laughter] is critically important.

DA: That response is the experience that I've had with asking someone to sign a patient/provider agreement or leave a urine for a urine drug test, and sometimes there is that response like, "I'm not addicted. Why are you treating me this way?" And I'm just wondering, what are your thoughts about some of those monitoring strategies that we do to keep people safe, how best to present that so people don't feel like we are discriminating against them because of who they are.

SC: Exactly. So that's when I generally will remind folks about my role to keep them safe. We often forget that there are side effects and harms that can come from these powerful medications, and that this is part of the way that I'm able to also let them know, it's not just the agreement they're making with me but it's the agreement I'm making with them.

And this often comes up a lot in my practice where my patients and myself are aging, right? So what they might have tolerated without a lot of negative consequence in terms of their medication management, now that they are older, they may be on an increased number of sedating medications, that I'm thinking about fall risk, I'm thinking about having a state of confusion, I may be thinking about respiratory depression. So these are things that I will share with the patient openly.

DA: I want to go back for a moment. This is probably a complicated question, but we talked a little bit about the biases that we as caregivers have towards our patients that oftentimes are unconscious. If we're not aware of them, if they're unconscious, how do we acknowledge that they're happening, and then address them? So how do I even do kind of a self-assessment of my own practice and my own unconscious false beliefs and implicit bias?

SC: Right. So this is where your trusted colleagues become very important. Say for instance, within our faculty, we talk about underrepresented-in-medicine faculty members, and we also have allies who are our majority colleagues. And over the years, we've been able to have a comfort with each other, where you can go to a colleague or a friend and check in. Sometimes you'll see it more as a reaction from a patient, like you didn't get it, right? It went over your head. Maybe it was a microaggression, right? It went over your head. So you may simply be wondering what went wrong in that interaction. And so you can talk to a colleague.

I have another African American colleague that I've known for years, and one of our favorite experiences over the years has been, you know, a resident trainee goes in to see a patient, African American patient, and the resident comes out and says, "You know, this was a really difficult encounter. I'm really not sure what to do." And then she or I walk in with the trainee, and then we have this kind of non-argumentative discussion. There's kind of the teachable moment, and you say to someone, "What do you think was different?" "Well yeah, they liked you as soon as you walked in the room." And then you kind of delve a little deeper. "What else did you see? What else was different?" "Well, you know what? You kind of stood closer to the patient. You put your hand on the patient's shoulder. You sat down to talk. You listened in a way." I've even had a resident say to me, "You weren't scared."
[Laughter]

So sometimes, it is the small things. And to go further, many times, after an incident like that, the patient goes on to follow up with that same resident for the next three years. You have to be willing sometimes to recognize: okay in this moment, I might not be the right person, but let me take a moment and just, you know, let my shoulders relax, let me breathe, let me sit down, let me hear this person out, and then move on from there. And again, because I'm a provider, I'm very cognizant of the limited time we have with patients. And so, being able to develop some kind of longitudinal relationship really does help. So you know, on that first visit, you may not get through all the routine questions you want to ask, right? But you know what, the more important thing in that visit might be to have a trust-building moment.

DA: Yeah, I'm glad you brought up that first visit, or visits, because I think, in particular with patients presenting with chronic pain-related issues, those first visits can be trust-building. And for instance, the patient is thinking, is this clinician going to believe me or believe the severity of my pain and how much I'm suffering. And maybe if they're on opioids, the clinician is thinking, is this person scamming me, are they trying to get more opioids, are

they, as you mentioned, drug seeking, and how do I figure that all out? So there's this kind of, this feeling each other out. And I agree, during those visits, oftentimes you are not going to be able to do all of your routine healthcare maintenance. And that's okay in Primary Care because we've got time. We've got a longitudinal relationship, there's lots of time to get all this stuff done. So I appreciate – I appreciate that. You mentioned microaggressions. Can you define microaggressions, and can you give an example of how that might play out in someone with chronic pain on opioids. How does microaggression play out?

SC: Really interesting. So we think of microaggressions are those acts that are harmful that occur over and over and over again, right? The thousand little pinpricks that through a lifetime add up. And a microaggression can be something as simple as, you know, a Black resident presents a very well thought out comment and someone says, "Boy, that was really a very intelligent response." Right? And so by saying that, you're implying that you didn't expect an intelligent response. And even a question to someone who has an accent – and again, this was one I had to moderate myself, because I might say, "Oh, where are you from?" And you may think that's a very benign kind of question, and in my instance, my intent was to get to know the person better, right?

But intent versus impact is different, and that's one of the hallmarks of microaggressions, that often we aren't trying to harm but our statement causes harm. And that person who is experiencing microaggressions, that's happening over and over and over again. And what we really want to focus on, when we actually do trainings about microaggression is, how to bring someone into a conversation versus shaming them and pushing them out of the conversation.

So this is where team-based care can be very instrumental in breaking up a micro-aggression, because a colleague might interrupt it and say, "Oh, did you mean to say that?" And then the person can have a moment to reflect and say, "Oh, no, no, what I really meant was this." Honestly, a lot of microaggressions happen and either the team or the person themselves doesn't actually – isn't able to really reflect on it. It's like you have a deer in the headlights moment. That happens quite frequently. But again, when you're out of the headlights and you're thinking about it, please don't – don't be afraid to approach someone and ask if they were okay or go back to a colleague and say, "You might not have realized this, but what you said could be really hurtful." And we also recognize the hierarchy that's in medicine. So it does mean that oftentimes, someone is in a very vulnerable state when this happens. And so, it may not be the medical student who might be free enough to say something, but if they say it to their resident, then their resident is able to take action, or the resident might talk to their attending, and the attending can take action.

And oftentimes, you don't know if you're doing the right thing or not, but you have to try. [Laughter] You have to try, yeah.

DA: Thanks, Sheila. Can you give us an example of what a microaggression might look like for a patient presenting with chronic pain?

SC: Let's say we have a patient who has had long-standing back pain from severe disc disease, and they are not a surgical candidate. And when a provider looks at their MRI, they say, "You shouldn't have that much pain from this," right? You know, that's completely off base, and it's the same with many types of arthritis pain, right? "The x-rays don't look that bad, so you shouldn't have" – so where does that leave the patient? They're having pain, and they're having, you know, life-altering pain, so that's where I get back to this point about believing someone's subjective pain.

DA: And to bring it back to race, would that comment be even more hurtful in someone who's already feeling that they may be treated differently because of how they look?

SC: Very much so. Very much so, and this is where, you know, not only the historical perspective but perspective of treatment that people have seen with their family members in other situations. Frankly, we can't forget social media in 2024, when you're seeing social media from Black physicians who have been inadequately treated for pain during their hospitalizations. So this is a real issue. It is a real phenomenon, and I think there's also a role for us to think about encouraging patients about their own self-advocacy. And that one, I don't have all the answers for yet, but it's one that I – I'm thinking a lot about.

DA: Well, this has been a very eye-opening discussion, and I just wonder if you have any parting words before we conclude, because you know, I want people to feel comfortable, you know, trying things, and sometimes we're going to make mistakes. While it's not the end of the world, we need to be able to self-assess how we are communicating, and anyway – so do you have any parting to kind of share with us?

SC: Yes. So, the things that I would offer as suggestions would be to have courageous introspection, to stay curious, to recognize the things that you don't know that you don't know, to use your friends and colleagues as support, to be able to be vulnerable, open, and honest, and being able to have someone to talk about these things in a way that you won't be judged and your intention will be clear that you're really just trying to do better.

I would, especially in the realm of treatment for substance use disorders, maintain your hope for your patient's wellness. I think it's important for us to follow through with our commitments, and it's also important not to over-promise what you can and can't do. So I've thoroughly appreciated and enjoyed this conversation. I think the burden is on us as healthcare professionals to demonstrate patient-centered care with our populations, to create systems and programming that incorporates the experience and desires of our patients, families, and the communities that we serve. So thank you so much, Dan.

DA: Thank you, Sheila.