PainWeek®

Bad Breadth: The Role of Bias, Stigma, and Social Determinants in Pain Care

Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP

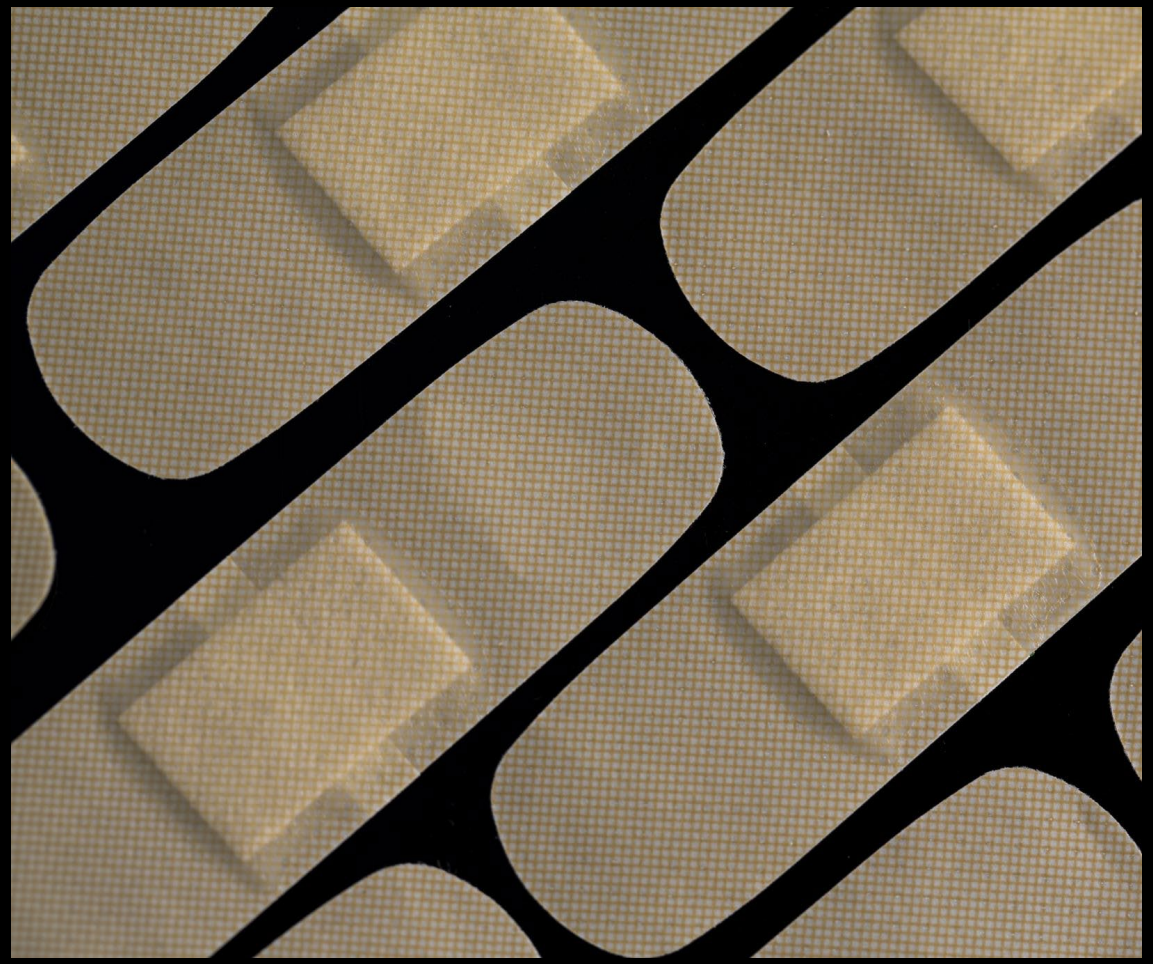
Disclosure

- Nothing to Disclose

Learning Objectives

- Describe the potential negative impact that bias, stigma, and social determinants of health can have in the assessment and treatment of pain
- Identify the difference between equality and equity in the treatment of pain
- Distinguish between implicit and explicit bias
- Describe strategies that can be employed to help mitigate the negative outcomes resulting from bias, stigma, and social determinants of health in pain care

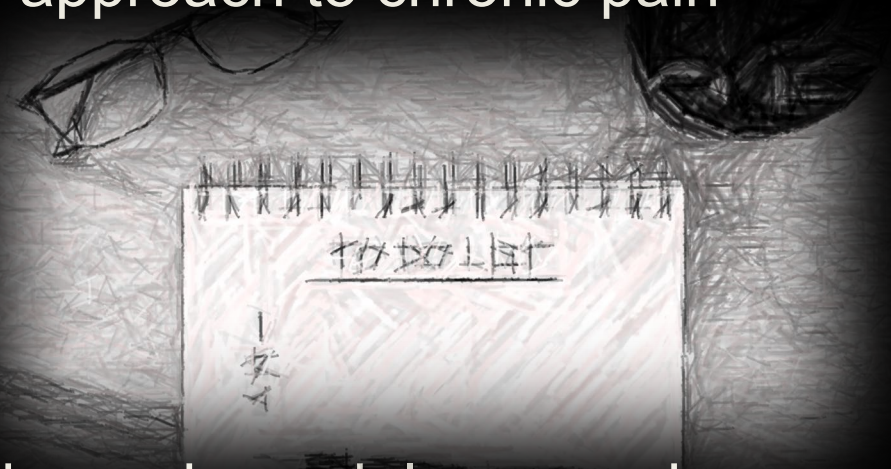
Don’t We Have Enough “*Pain*” in Pain Management?



- Just how many band-aids do we need?
- Educational deficits
- Revision of the CDC Guidelines
- The “Opioid Overdose Epidemic”
- People with pain suffering resulting from clinician apprehension/unwillingness to prescribe opioid analgesics even if considered appropriate
- Regulatory scrutiny or fear of it
- Overall lack of consensus
  - Confusion
- Payers
- Etc.

There are so Many Things on the Pain Management "To Do List"

- Somehow developing consensus on the many controversies that exist in chronic (and acute) pain management today
- Mitigate educational deficits
- Figure out how to integrate a *true* multidisciplinary approach to chronic pain treatment
  - Reimbursed
  - Offered
  - Available
- Practice within reasonable regulatory frameworks
- Find the path to true harmony of biomedical and biopsychosocial approaches to pain treatment



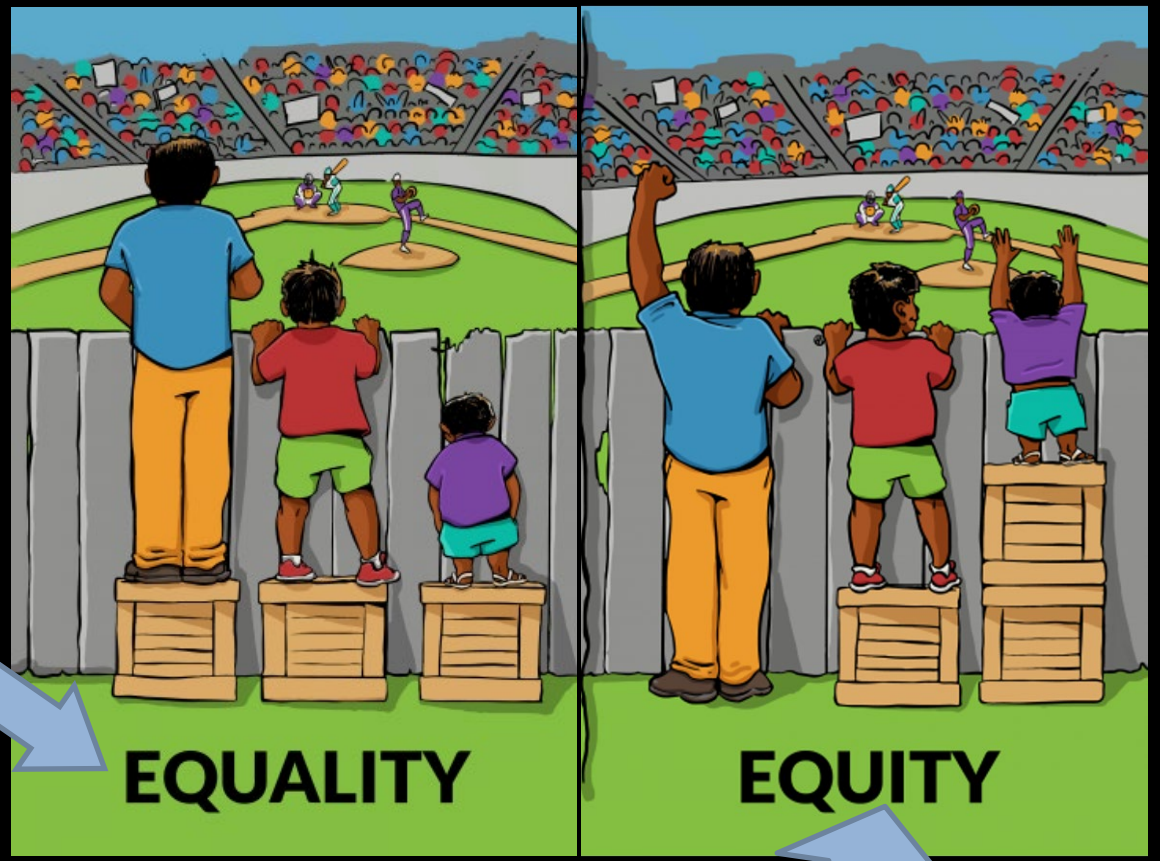
PaiNweek®

What Often Seems to Be Missing From the List?

Bias, Stigma, and Social Determinants of Health Are Often "Under the Radar"

Equality and Equity

- Equality
  - Means each individual or group of people is given the same resources or opportunities
- Equity
  - Recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome



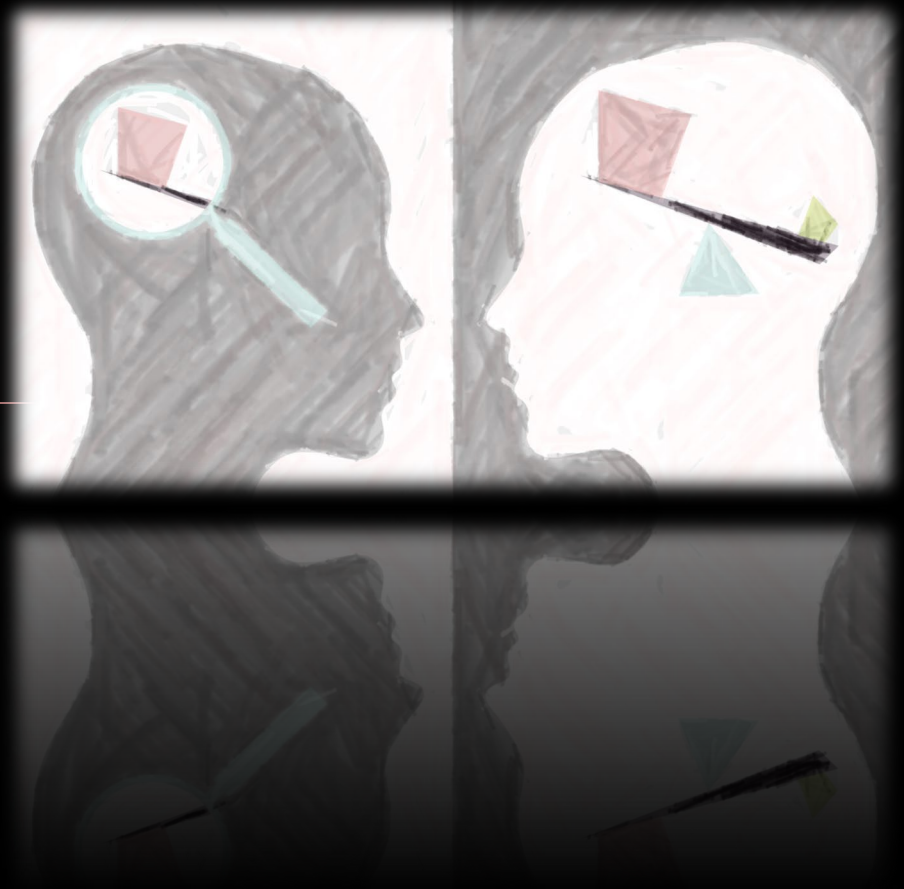
Because Words Matter…

Terminology

PainWeek®

Bias

Prejudice in favor of or against one thing, person, or group compared with another, usually in a way considered to be unfair



Is Bias Common?

Do we learn them?

We are Fully Stocked with Cognitive Biases…

Implicit or Explicit Bias?

- **Implicit bias**
  - –***Unconscious*** attitude(s) or stereotype(s) that may affect:
    - Understanding
    - Actions
    - Decisions
  - –We all have them…
  - –May be ***favorable or unfavorable***
  - –Activated ***involuntarily***
    - Usually without awareness or intentional control

Implicit vs. Explicit Bias. Study.com. https://study.com/academy/lesson/implicit-vs-explicit-attitudes-definition-examples-pros-cons.html . Accessed July 20, 2021.

Implicit or Explicit Bias?

- **Explicit bias**
  - Attitude(s) or stereotype(s) we may have about a person or group on a ***conscious*** level
  - ***Deliberate***
  - Generally ***unfavorable***
  - When people perceive their biases to be valid, they may be more likely to justify unfair/unequitable treatment
  - Can have ***significant negative impact*** on patients' physical and mental health

Implicit vs. Explicit Bias. Study.com. https://study.com/academy/lesson/implicit-vs-explicit-attitudes-definition-examples-pros-cons.html . Accessed July 20, 2021.

Cognitive Bias

- *Attribution error*
  - The most common bias
  - Explaining a patient's condition on the basis of their disposition or character rather than seeking a valid medical explanation
  - Why?
    - Because we stereotype
    - Because there are so many things to pick from…
      - Race
      - Gender
      - Age
      - Socioeconomic status
      - Educational level
      - Medical/substance abuse history
      - Diagnosis
      - Etc
    - ***What to do?***
      - Be aware

Commentary

Prejudice in medicine

Our role in creating health care disparities

John Guilfoyle MD FCFP Len Kelly MD MClinSc FCFP Natalie St Pierre-Hansen

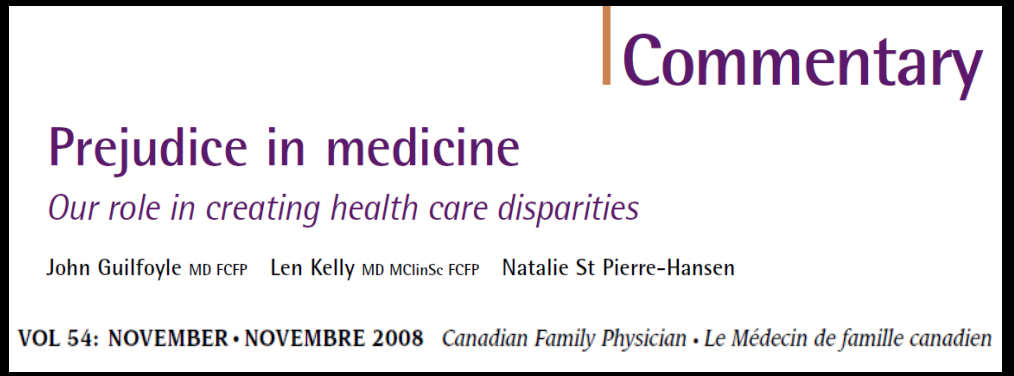
VOL 54: NOVEMBER • NOVEMBRE 2008 *Canadian Family Physician • Le Médecin de famille canadien*

Case Example - Bias

- An intoxicated homeless man presents with a large and painful ulcer on the plantar surface of his right foot
  - As he is unclean, unkempt and without shoes, it is assumed the ulcer is traumatic in origin and there would be little chance of improvement given his lifestyle
  - Social services is contacted for discharge planning to free the bed
  - No pain treatment administered
- Further investigation reveals he is not intoxicated, but diabetic in ketoacidosis
- With appropriate therapy and support the patient is able to manage his diabetes as well as heal the foot ulcer

Bias in Medicine

- Prejudice resulting from bias is *both* an attitude and a cognitive/pre-cognitive process
  - With the measurable outcome being the practice of discrimination
- The Institute of Medicine defined prejudice[1] as:
  - "*Differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention*"
- Resulting in discriminatory health practices at multiple levels:
  - The health care system
  - The practitioner


Commentary

Prejudice in medicine

Our role in creating health care disparities

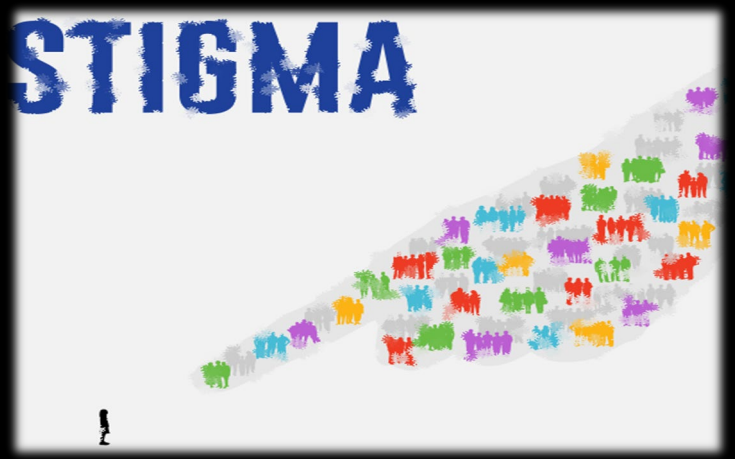
John Guilfoyle MD FCFP Len Kelly MD MClinSc FCFP Natalie St Pierre-Hansen

VOL 54: NOVEMBER • NOVEMBRE 2008 *Canadian Family Physician • Le Médecin de famille canadien*

1. Smedley BD, Stith AY, Nelson AR. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: National Academic Press; 2003.

- A mark of *disgrace* associated with a particular circumstance, quality, or person
- Stigma is a mark of *disgrace* that sets a person apart from others
- When a person is *labeled* by their illness they are no longer seen as an individual but as part of a stereotyped group
- Negative attitudes and beliefs toward this group create prejudice which leads to *negative actions and discrimination*

Stigma



Loss of reputation or respect as the result of a dishonorable action

Or… due to no fault of your own

Disgrace

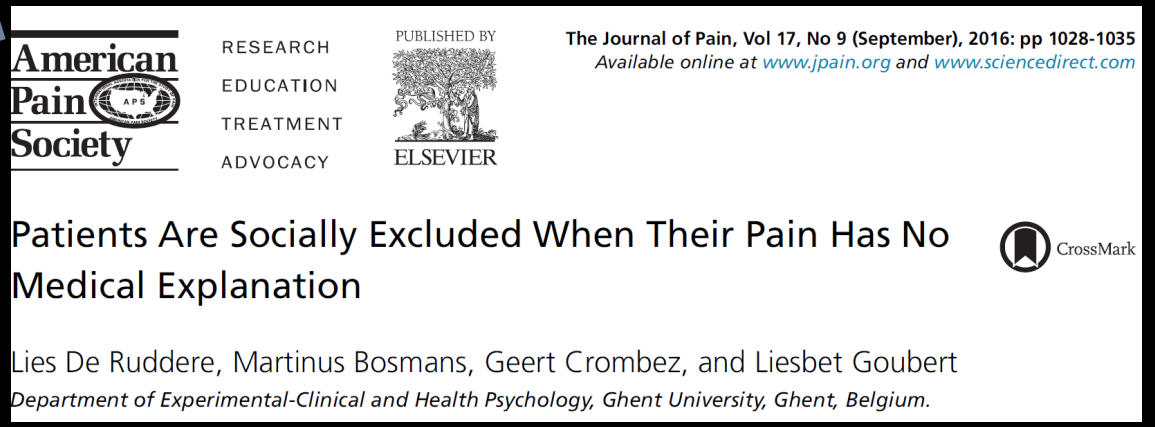
Bias Leads to Stigma

- De Ruddere L, Craig KD: Understanding stigma and chronic pain: A state of the art review. *Pain* 157:1607-1610, 2016
- De Ruddere L, Goubert L, Stevens M, Amanda AC,
- Crombez G: Discounting pain in the absence of medical evidence is explained by negative evaluation of the patient. *Pain* 154:669-676, 2013
- De Ruddere L, Goubert L, Stevens MA, Deveugele M, Craig KD, Crombez G: Health care professionals' reactions to patient pain: Impact of knowledge about medical evidence and psychosocial influences. *J Pain* 15:262-270, 2014
- De Ruddere L, Goubert L, Vervoort T, Prkachin KM, Crombez G: We discount the pain of others when pain has no medical explanation. J Pain 13:1198-1205, 2012
- Holloway I, Sofaer-Bennett B, Walker J: The stigmatization of people with chronic back pain. *Disabil Rehabil* 29: 1456-1464, 2007
- Kool MB, van Middendorp H, Boeije HR, Geenen R: Understanding the lack of understanding: Invalidation from the perspective of the patient with fibromyalgia. *Arthritis Rheum* 61:1650-1656, 2009

De Ruddere L, Bosmans M, Crombez G, Goubert L. Patients Are Socially Excluded When Their Pain Has No Medical Explanation. *J Pain*. 2016 Sep;17(9):1028-35.

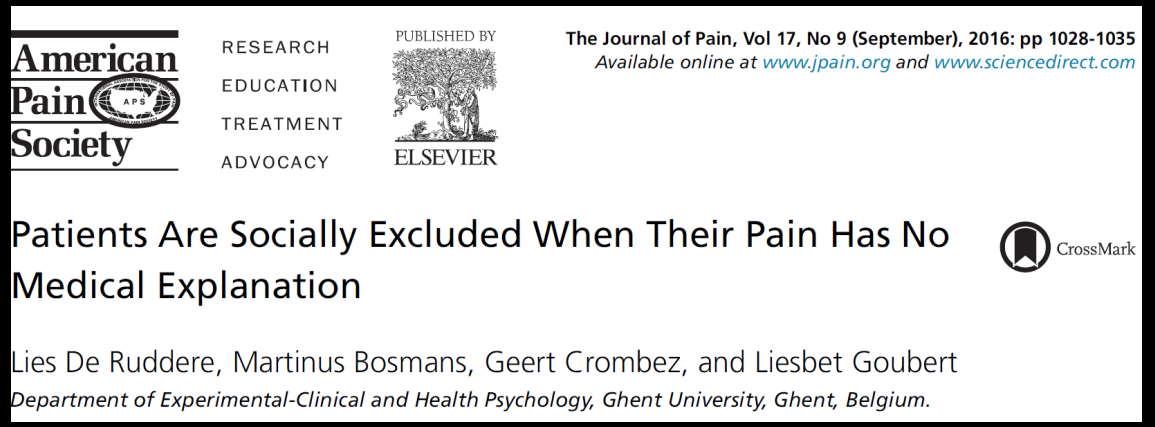
Bias and Stigma in Pain Medicine

- Does this sound realistic?
- Stigmatizing responses in healthcare have been defined as:
  - Devaluing and discrediting responses of observers towards individuals who possess a particular characteristic that deviates from societal norms
- In the context of chronic pain:
  - Pain that is has no identifiable cause
  - This triggers the sense that there is deviation from the traditional biomedical model of pain treatment
    - Leading to lower estimates of pain by observers
    - Higher belief of possible deception
    - Lower level of empathy
    - Less desire to help



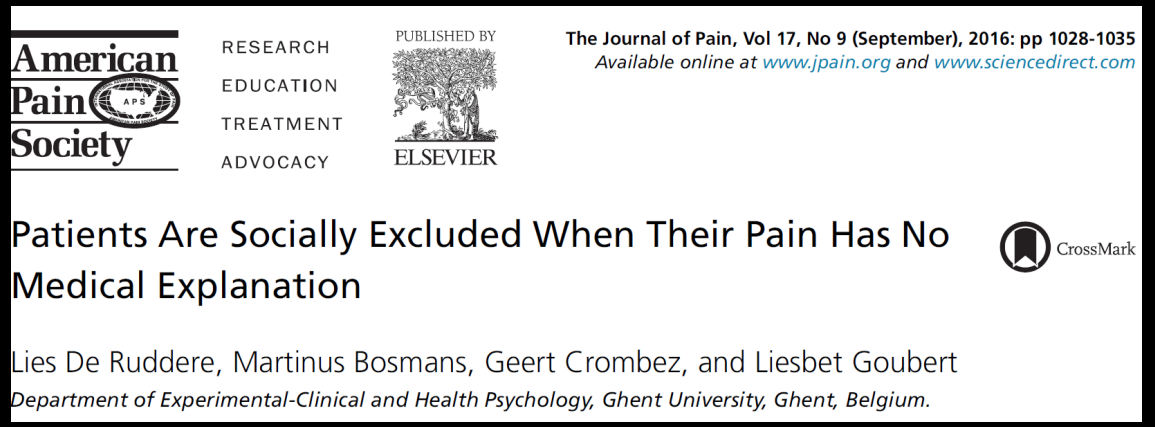
Study Results

- The primary aim of this study was to investigate the effects of presence versus absence of medical evidence for pain on social exclusion by observers
- The results indicated:
  - That observers were less willing to interact with patients whose pain is not medically explained
  - Observers selected to see patients with unexplained pain less often
  - Healthcare professionals attribute lower severity of pain to patients with "unexplained pain"
- "*There is abundant research suggesting that individuals with 'medically unexplained pain' are more prone to stigmatization*"



Bias and Stigma Can Lead to "Social Pain"

- Social Pain
  - A distressing experience arising from the perception of actual or potential psychological distancing
  - Feeling rejected
  - Feeling excluded
  - Leads to:
    - Lower level of psychological well-being
    - Lower level of self esteem
    - Depression
    - Negative affect



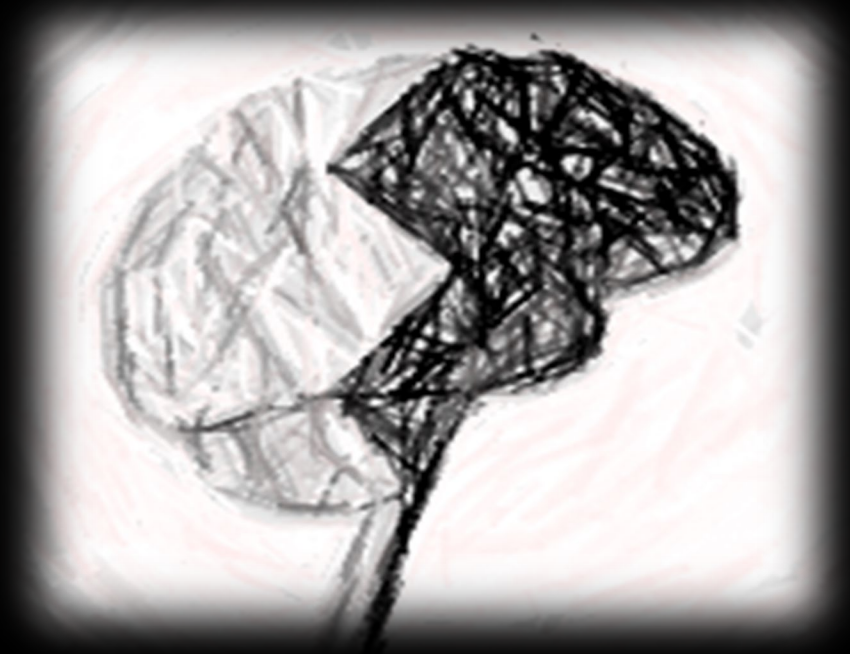
Stigma and Back Pain

- Nonspecific low back pain is a significant problem in industrialized societies
  - Can account for up to 80% of total cost of back pain care
  - It is a significant source of:
    - Disability
    - Work absenteeism
    - Social burden
    - Personal burden
- Can be a source of subtle and overt stigmatization from :
  - Healthcare professionals – more about this in a few moments
  - Family and friends
  - The larger community
  - The workplace
  - Other back pain sufferers

Slade SC, Molloy E, Keating JL. Stigma experienced by people with nonspecific chronic low back pain: a qualitative study. Pain Med. 2009 Jan;10(1):143-54.

Internalized Stigma

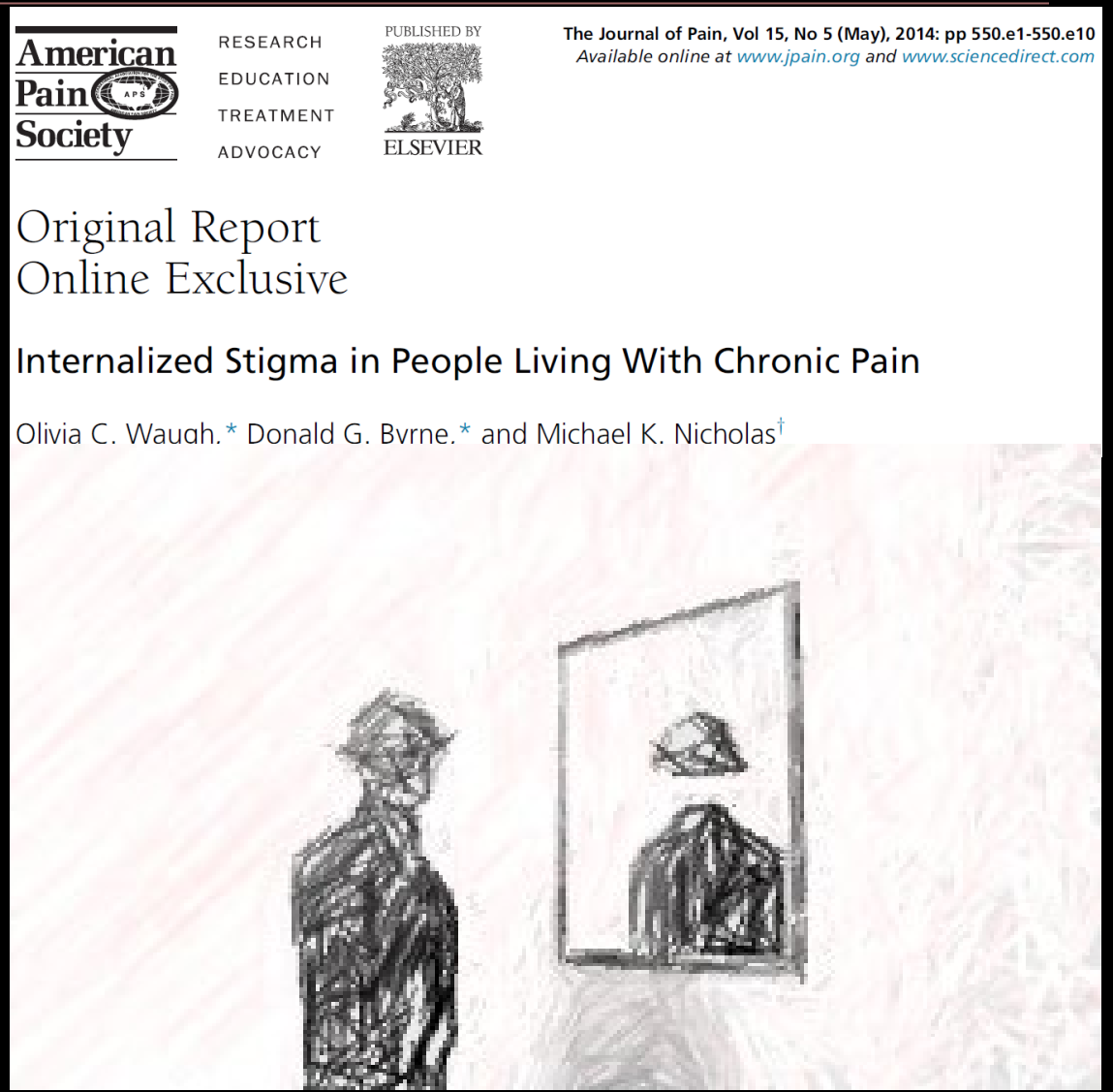
- Refers to the process in which a person with an illness cognitively or emotionally absorbs negative messages or stereotypes about that illness and comes to:
  - Believe them
  - Apply them to themselves or other people with the same condition
- Occurs when subgroup members adopt prejudicial attitudes either to themselves or members of a subgroup leading to feelings of:
  - Guilt
  - Shame
  - Disgrace
- Five phases of "dealing with it":
    - Learn what it is to be normal
    - Learn that one is "not normal"
    - Learn to control disclosure of information to avoid stigmatization
    - Learn to present oneself as someone without stigma
    - Learn to "take it"



Slade SC, Molloy E, Keating JL. Stigma experienced by people with nonspecific chronic low back pain: a qualitative study. Pain Med. 2009 Jan;10(1):143-54.

Internalized Stigma and Chronic Pain

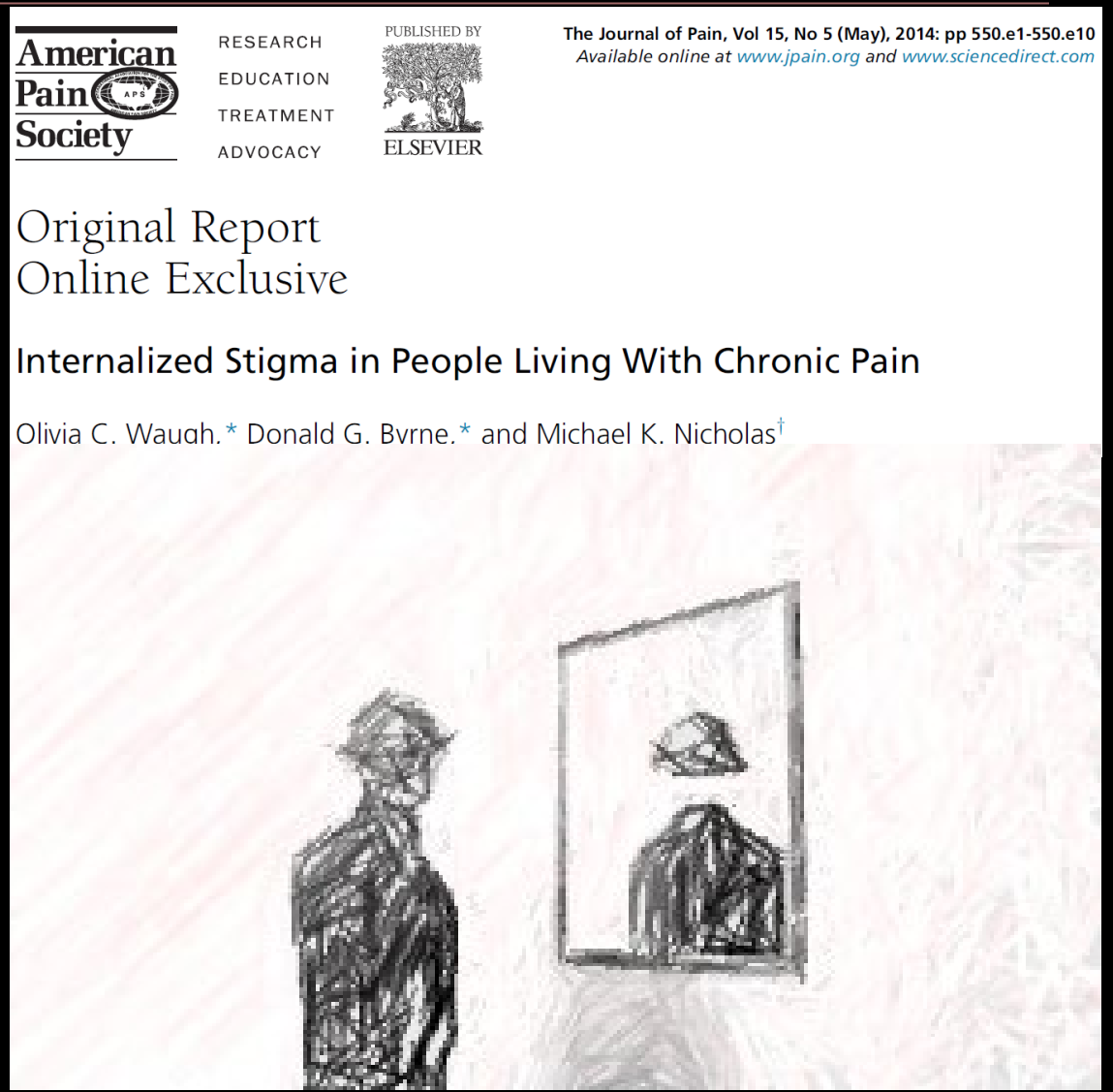
- A large percentage of people living with chronic pain endorse the experience of internalized stigma (in this study 38%)
- "Stereotypical Endorsement"
  - When patients start to feel negative feelings about themselves resulting in:
    - Maladaptive behavior
    - Identity transformation
      - Low self-esteem
    - Acceptance of negative social reactions
    - Alienation
    - Social withdrawal
    - Discrimination
    - Questioning of legitimacy
    - Psychological distress



PAINWEEK

Internalized Stigma and Chronic Pain

- Clinical Implications
  - –Diminished self-efficacy
    - *"Why try?"*
  - –Diminished perceptions of personal control
  - –Increased likelihood of catastrophizing about pain
  - –Lack of focus of goals and expectations
  - –Decreased likelihood of perceiving a "successful" treatment
    - Remember – The patient in pain gets to weigh in on whether treatment is a success or not



PainWeek

Stigma Can Come From Us in a Variety of "Flavors"…

- Australia, United Kingdom, United States, Canada, and Ireland
- Health professionals were found to express negative attitudes towards patients with substance use disorders leading to:
  - Shorter visits
  - Decreased empathy
  - Lower level of provider personal engagement
  - May reduce collaboration
  - Decrease sense of empowerment
  - Diminish patients' self-esteem

Drug and Alcohol Dependence 131 (2013) 23–35

Contents lists available at SciVerse ScienceDirect

Drug and Alcohol Dependence

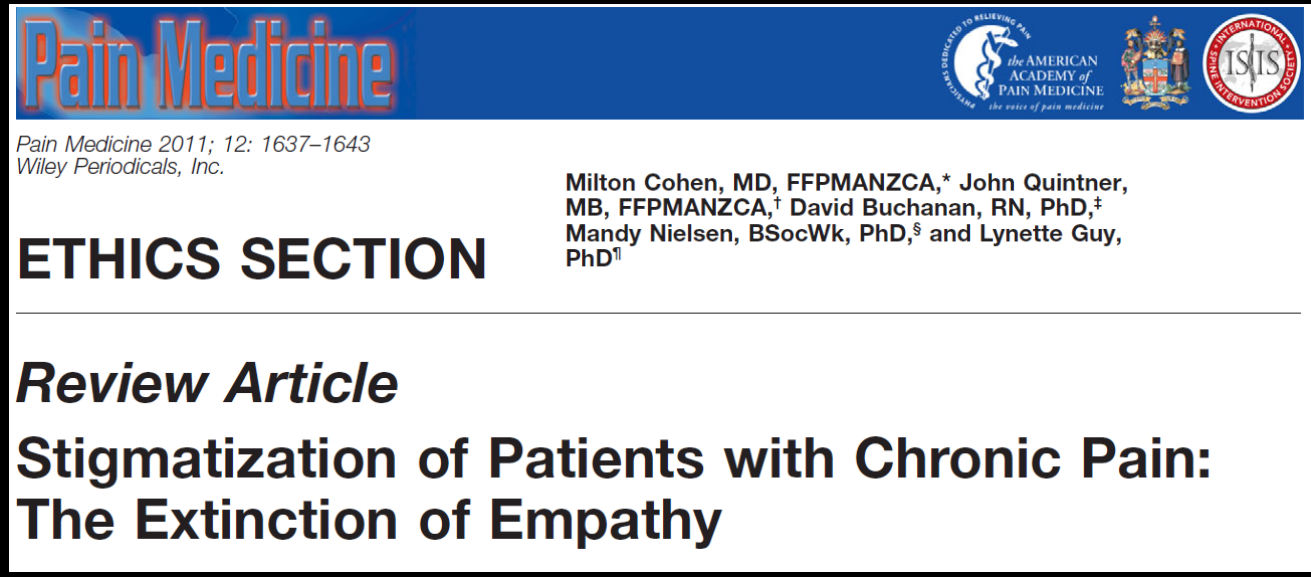
journal homepage: www.elsevier.com/locate/drugalcdep

Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review

Leonieke C. van Boekel[a,*], Evelien P.M. Brouwers[a], Jaap van Weeghel[a,b,c], Henk F.L. Garretsen[a]

Stigma and the Extinction of Empathy

- *"Why is pain, something invisible and experienced by everyone—and therefore unlike the kinds of characteristics that usually lead to stigmatization— so often stigmatizing in its chronic form?"*
- People with chronic pain are particularly at risk of being placed in "moral jeopardy" by their clinicians
  - Especially if they don't respond to treatment as expected
  - Possibly because of regulatory stressors?
    - Opioids as a case in point



The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of life including:

- Health
- Functional level
- Quality-of-life
- Outcomes of pain treatment
- Risks of nonadherence and/or aberrant drug-related behaviors

Social Determinants of Health

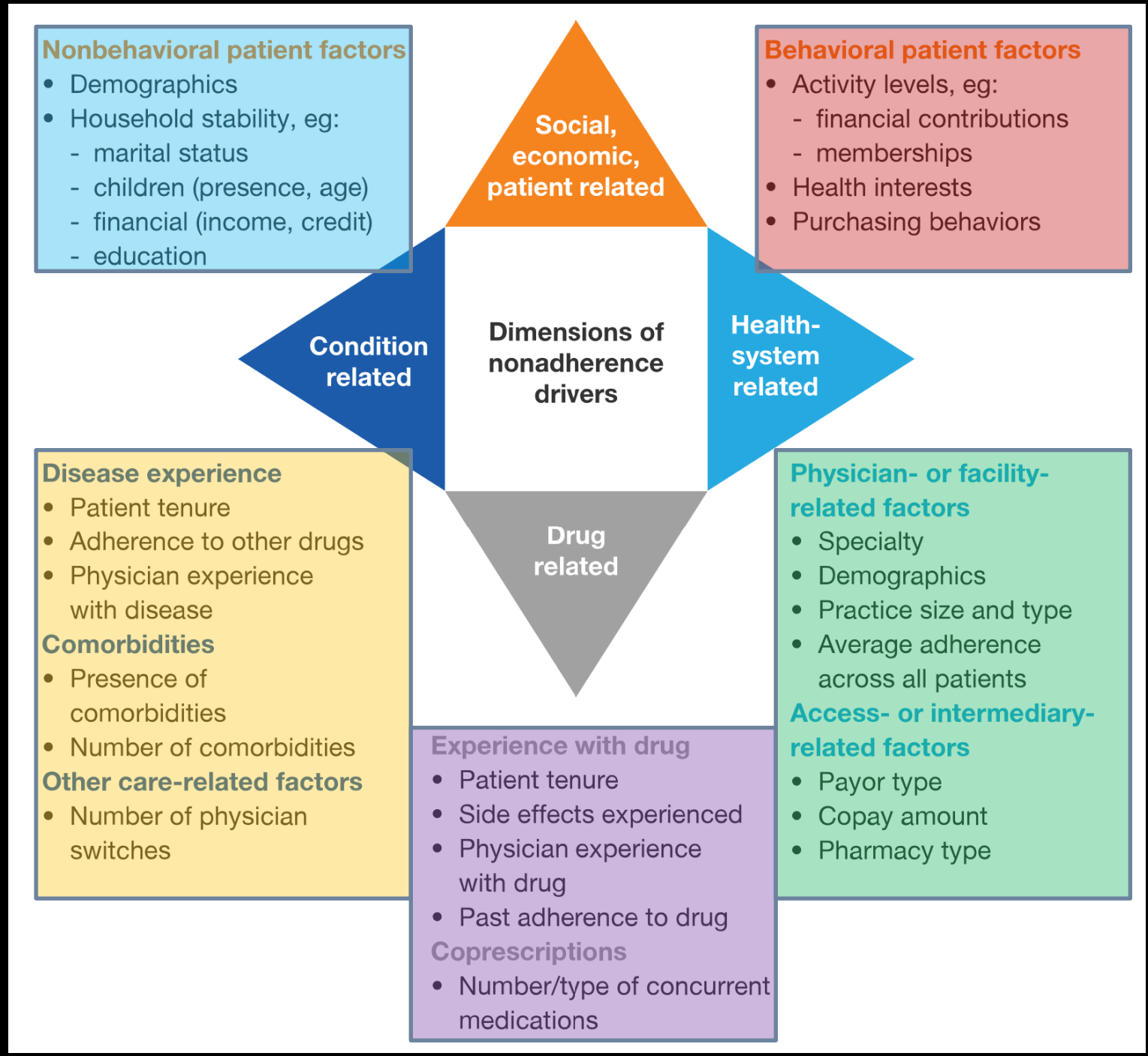
https://health.gov/healthypeople/objectives-and-data/social-determinants-health . Accessed July 20, 2021.

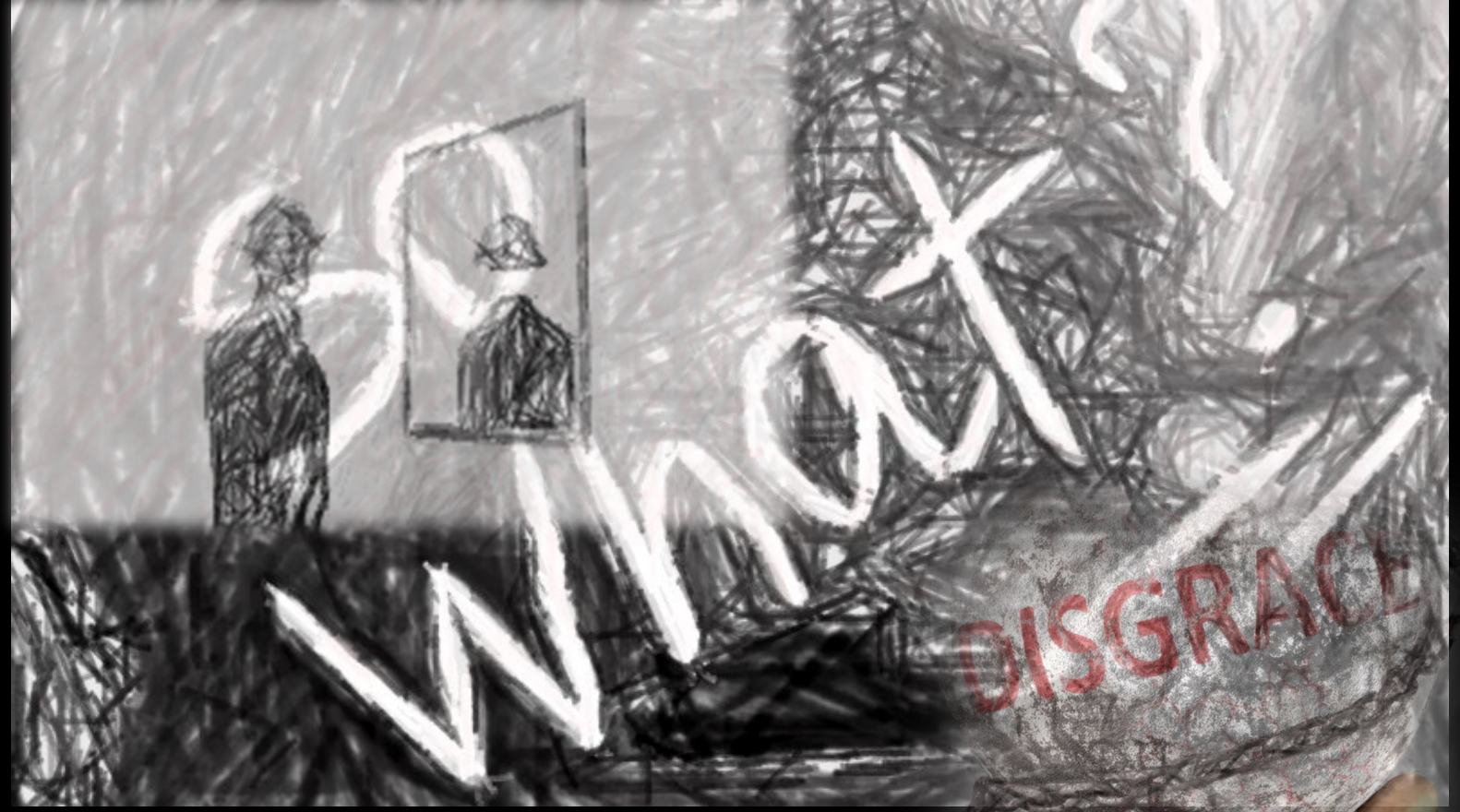
No Secrets…

- Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life
- Examples of SDOH include:
  - Safe housing, transportation, and neighborhoods
  - Racism, discrimination, and violence
  - Education, job opportunities, and income
  - Access to nutritious foods and physical activity opportunities
  - Polluted air and water
  - Language and literacy skills

https://health.gov/healthypeople/objectives-and-data/social-determinants-health . Accessed July 20, 2021.

The Relationship Between Social Determinants of Health and Nonadherence



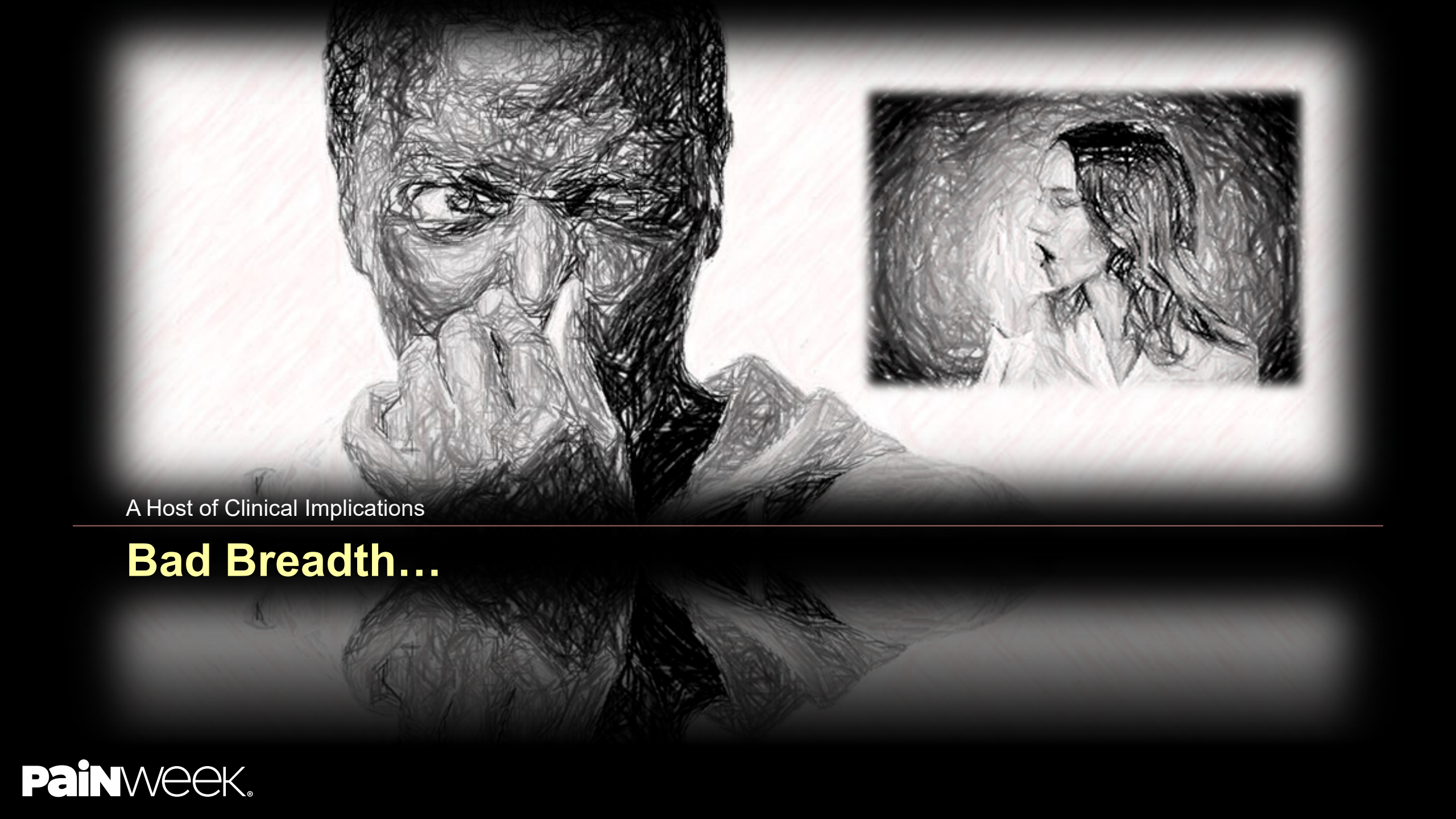

STIGMA
DISGRACE


BIAS


STIGMA


Social Determinants
of Health

PAINWEEK®



A Host of Clinical Implications

Bad Breadth…

PainWeek®

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

Kelly M. Hoffman[a,1], Sophie Trawalter[a], Jordan R. Axt[a], and M. Norman Oliver[b,c]

[a]Department of Psychology, University of Virginia, Charlottesville, VA 22904; [b]Department of Family Medicine, University of Virginia, Charlottesville, VA 22908; and [c]Department of Public Health Sciences, University of Virginia, Charlottesville, VA 22908

Edited by Susan T. Fiske, Princeton University, Princeton, NJ, and approved March 1, 2016 (received for review August 18, 2015)

- Examines risks associated with racial bias in pain management
- Specifically, evidence is provided that white laypeople and medical students and residents believe that the "black body" is biologically different—and in many cases stronger—than the "white body"
- These beliefs predict racial bias in belief of pain perception and treatment plan formulation
- *"False beliefs about biological differences between blacks and whites continue to shape the way we perceive and treat black people—they are associated with racial disparities in pain assessment and treatment recommendations"*

Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proc Natl Acad Sci U S A*. 2016 Apr 19;113(16):4296-301.

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

Kelly M. Hoffman[a,1], Sophie Trawalter[a], Jordan R. Axt[a], and M. Norman Oliver[b,c]

[a]Department of Psychology, University of Virginia, Charlottesville, VA 22904; [b]Department of Family Medicine, University of Virginia, Charlottesville, VA 22908; and [c]Department of Public Health Sciences, University of Virginia, Charlottesville, VA 22908

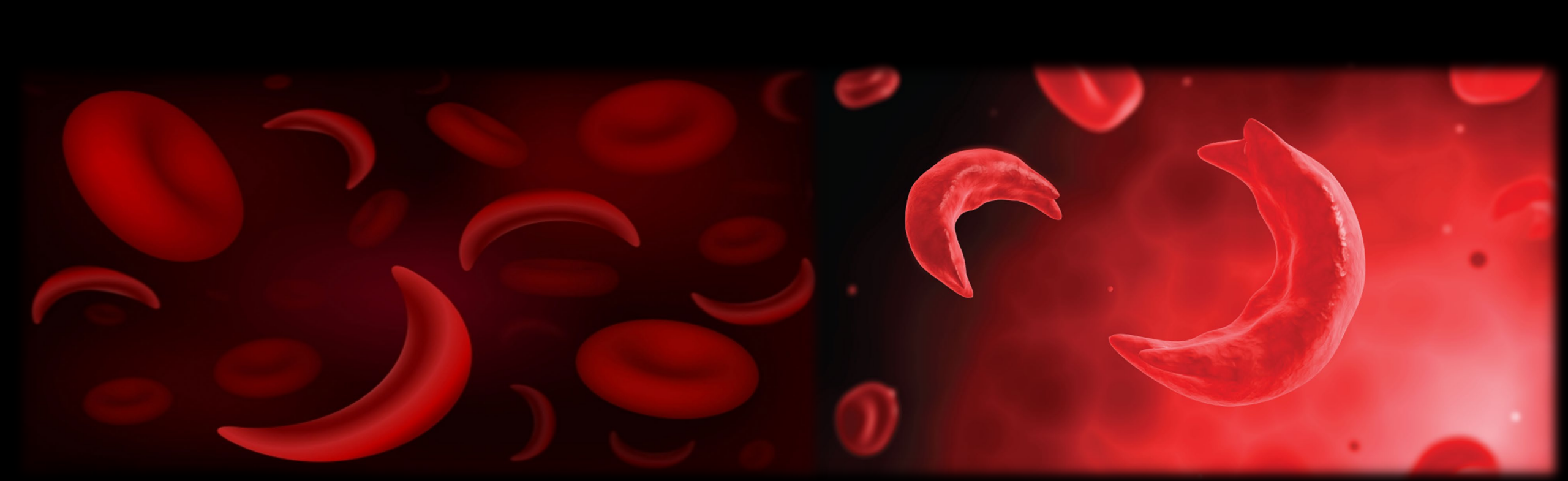
Edited by Susan T. Fiske, Princeton University, Princeton, NJ, and approved March 1, 2016 (received for review August 18, 2015)

Item	dy 1: Online sample (n = 92)	Study 2			
		First years (n = 63)	Second years (n = 72)	Third years (n = 59)	Residents (n = 28)
Blacks age more slowly than whites	23	21	28	12	14
Blacks' nerve endings are less sensitive than whites'	20	8	14	0	4
Black people's blood coagulates more quickly than whites'	39	29	17	3	4
Whites have larger brains than blacks	12	2	1	0	0
Whites are less susceptible to heart disease than blacks*	43	63	83	66	50
Blacks are less likely to contract spinal cord diseases*	42	46	67	56	57
Whites have a better sense of hearing compared with blacks	10	3	7	0	0
Blacks' skin is thicker than whites'	58	40	42	22	25
Blacks have denser, stronger bones than whites*	39	25	78	41	29
Blacks have a more sensitive sense of smell than whites	20	10	18	3	7
Whites have a more efficient respiratory system than blacks	16	8	3	2	4
Black couples are significantly more fertile than white couples	17	10	15	2	7
Whites are less likely to have a stroke than blacks*	29	49	63	44	46
Blacks are better at detecting movement than whites	18	14	15	5	11
Blacks have stronger immune systems than whites	14	21	15	3	4
False beliefs composite (11 items), mean (SD)	22.43 (22.93)	14.86 (19.48)	15.91 (19.34)	4.78 (9.89)	7.14 (14.50)
Range	0–100	0–81.82	0–90.91	0–54.55	0–63.64
Combined mean (SD) (medical sample only)			11.55 (17.38)		

Racial and Ethnic Differences in Emergency Department Pain Management of Children With Fractures

- Children with long-bone fractures in the Emergency Department (ED)
- 21,069 visits to 7 Pediatric EDs
- Racial and ethnic disparities in both process measures and clinical outcomes of pain management
- Minority children (Hispanic and Black) were:
  - More likely to receive non-opioid analgesics (ibuprofen or acetaminophen) than white children
  - Less likely to receive opioid analgesics than white children
  - Less likely to achieve optimal pain control than white children
  - More likely to have persistent pain than white children

Goyal MK, Johnson TJ, Chamberlain JM, Cook L, Webb M, Drendel AL, Alessandrini E, Bajaj L, Lorch S, Grundmeier RW, Alpern ER; PEDIATRIC EMERGENCY CARE APPLIED RESEARCH NETWORK (PECARN). Racial and Ethnic Differences in Emergency Department Pain Management of Children With Fractures. *Pediatrics*. 2020 May;145(5):e20193370.



It really starts to smell bad right about here…

Pain Management in Patients with Sickle Cell Disease

PAINWEEK®

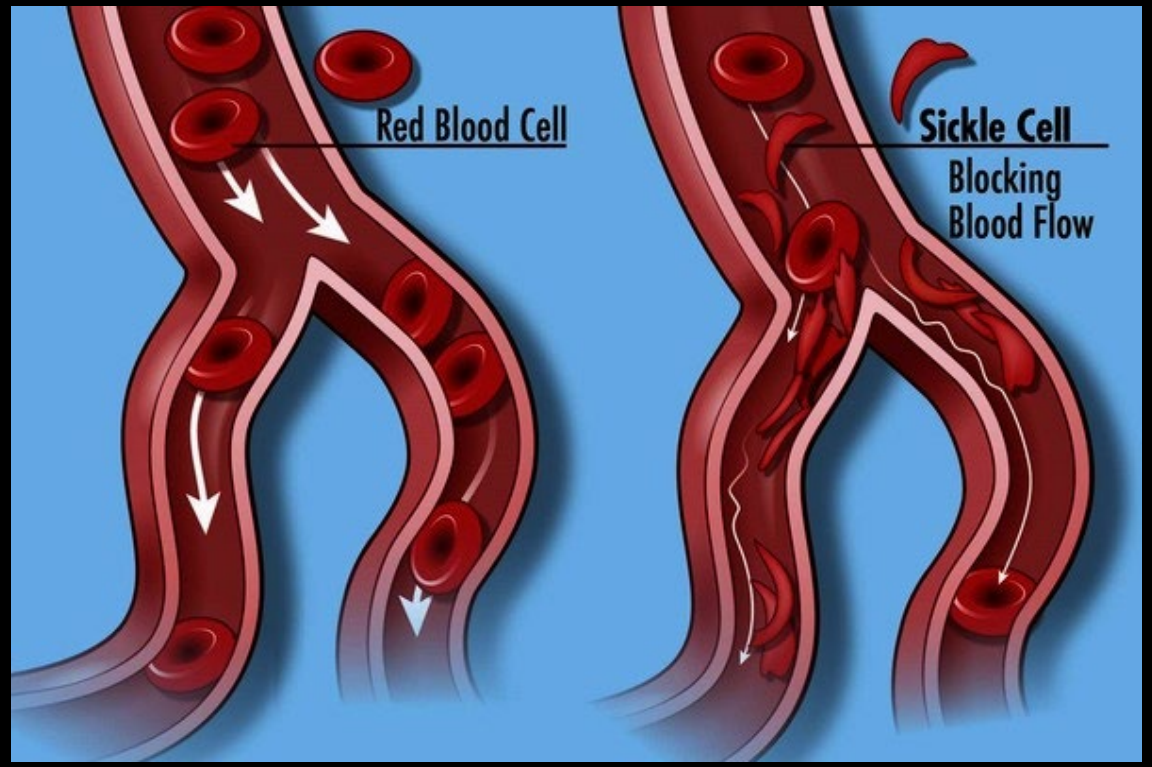
Sickle Cell Disease

- Sickle cell disease (SCD) encompasses a group of related genetic disorders of hemoglobin structure and is the ***most common genetic blood disease*** **among individuals in North America**
- Affects approximately 100,000 people in the U.S., millions worldwide
- SCD most commonly occurs in individuals whose ethnic origin is from Africa, Middle East, Indian Subcontinent, Southern Europe, South or Central America, or the Caribbean

Williams AF. Inconsistent Emergency Department Care: The Hidden Cost for Patients With Sickle Cell Disease. *Ann Emerg Med*. 2020 Sep;76(3S):S4-S5.

SCD and Pain

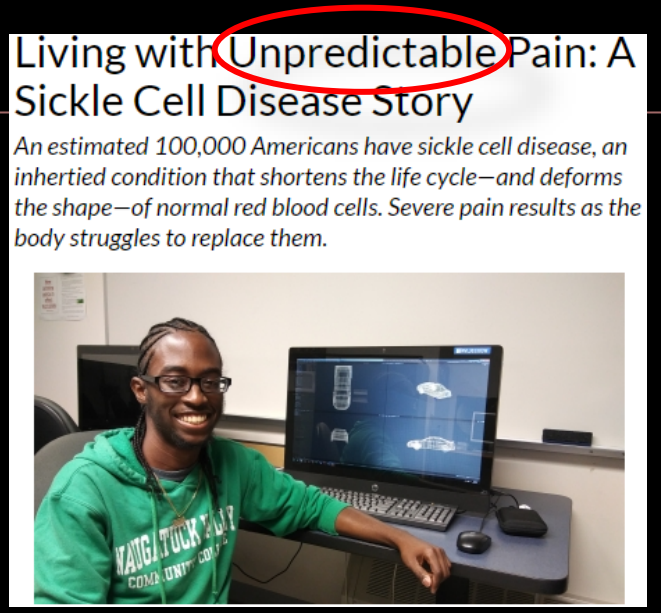
- The hallmark feature of SCD is recurrent episodes of *acute pain*, presumably ischemic in origin, caused by a remarkably complex process leading to obstruction of blood flow in vulnerable tissue beds by sickled erythrocytes, typically referred to as a “vaso-occlusive crisis”
- SCD pain is often debilitating and reported to be more severe than post-op or cancer-related pain diminished quality of life



Williams AF. Inconsistent Emergency Department Care: The Hidden Cost for Patients With Sickle Cell Disease. *Ann Emerg Med*. 2020 Sep;76(3S):S4-S5.

SCD and Pain

- Pain manifests as:
  - –Acute pain
  - –Intermittent pain
  - –Chronic pain
  - –Acute-on-chronic pain
- Pain spans the life course and begins as early as year one
- 30-40% of adolescents and adults have chronic pain
- Resulting in:
  - –Diminished quality of life
  - –…



Williams AF. Inconsistent Emergency Department Care: The Hidden Cost for Patients With Sickle Cell Disease. *Ann Emerg Med*. 2020 Sep;76(3S):S4-S5.

SCD and Stigma

- Many people report experiences of discrimination in health care encounters – even those related to SCD crisis and pain
- Even though The Health and Medicine Division of the National Academies described pain management as a “moral imperative,” stating that pain is undertreated, especially in disadvantaged populations
- Evidence-based guidelines for the treatment of crises recommend the first dose of pain medication (opioid analgesics) be administered within 30 minutes of ED triage or 60 minutes of presentation


REVIEW ARTICLE

blood advances

10 DECEMBER 2019 • VOLUME 3, NUMBER 23

2019 sickle cell disease guidelines by the American Society of Hematology: methodology, challenges, and innovations

M. Hassan Murad,[1] Robert I. Liem,[2] Eddy S. Lang,[3] Elie A. Akl,[4] Joerg J. Meerpohl,[5] Michael R. DeBaun,[6] John F. Tisdale,[7] Amanda M. Brandow,[8] Sophie M. Lanzkron,[9] Stella T. Chou,[10] Starr Webb,[11] and Reem A. Mustafa[12]

[1]Evidence-Based Practice Center, Mayo Clinic, Rochester, MN; [2]Division of Hematology, Oncology & Stem Cell Transplant, Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago, IL; [3]Department of Emergency Medicine, University of Calgary Alberta Health Services, Calgary, Canada; [4]Department of Internal Medicine, American University of Beirut, Beirut, Lebanon; [5]Institute for Evidence in Medicine, Medical Center, University of Freiburg, Freiburg, Germany; [6]Department of Pediatrics, Vanderbilt-Meharry Center of Excellence in Sickle Cell Disease, Vanderbilt University Medical Center, Nashville, TN; [7]National Heart, Lung, and Blood Institute, National Institutes of Health, Bethesda, MD; [8]Section of Pediatric Hematology/Oncology, Medical College of Wisconsin, Milwaukee, WI; [9]Division of Hematology, Johns Hopkins University School of Medicine, Baltimore, MD; [10]Children's Hospital of Philadelphia, Philadelphia, PA; [11]American Society of Hematology, Washington, DC; and [12]Department of Medicine, University of Kansas Medical Center, Kansas City, KS

Williams AF. Inconsistent Emergency Department Care: The Hidden Cost for Patients With Sickle Cell Disease. *Ann Emerg Med*. 2020 Sep;76(3S):S4-S5.

Numerous Guidelines Exist

CLINICAL G 23 JUNE 2020 • VOLUME 4, NUMBER 12

blood advances

American Society of Hematology 2020 guidelines for sickle cell disease: management of acute and chronic pain

Amanda M. Brandow,[1] C. Patrick Carroll,[2] Susan Creary,[3] Ronisha Edwards-Elliott,[4] Jeffrey Glassberg,[5] Robert W. Hurley,[6,7] Abdullah Kutlar,[8] Mohamed Seisa,[9] Jennifer Stinson,[10] John J. Strouse,[11,12] Fouza Yusuf,[13] William Zempsky,[14] and Eddy Lang[15]

American Pain Society — RESEARCH EDUCATION TREATMENT ADVOCACY

PUBLISHED BY ELSEVIER

The Journal of Pain, Vol 18, No 5 (May), 2017: pp 490-498
Available online at www.jpain.org and www.sciencedirect.com

Focus Article

AAPT Diagnostic Criteria for Chronic Sickle Cell Disease Pain

CrossMark

Carlton Dampier,* Tonya M. Palermo,† Deepika S. Darbari,‡ Kathryn Hassell,§ Wally Smith,¶ and William Zempsky‖

Check for updates

REVIEW ARTICLE

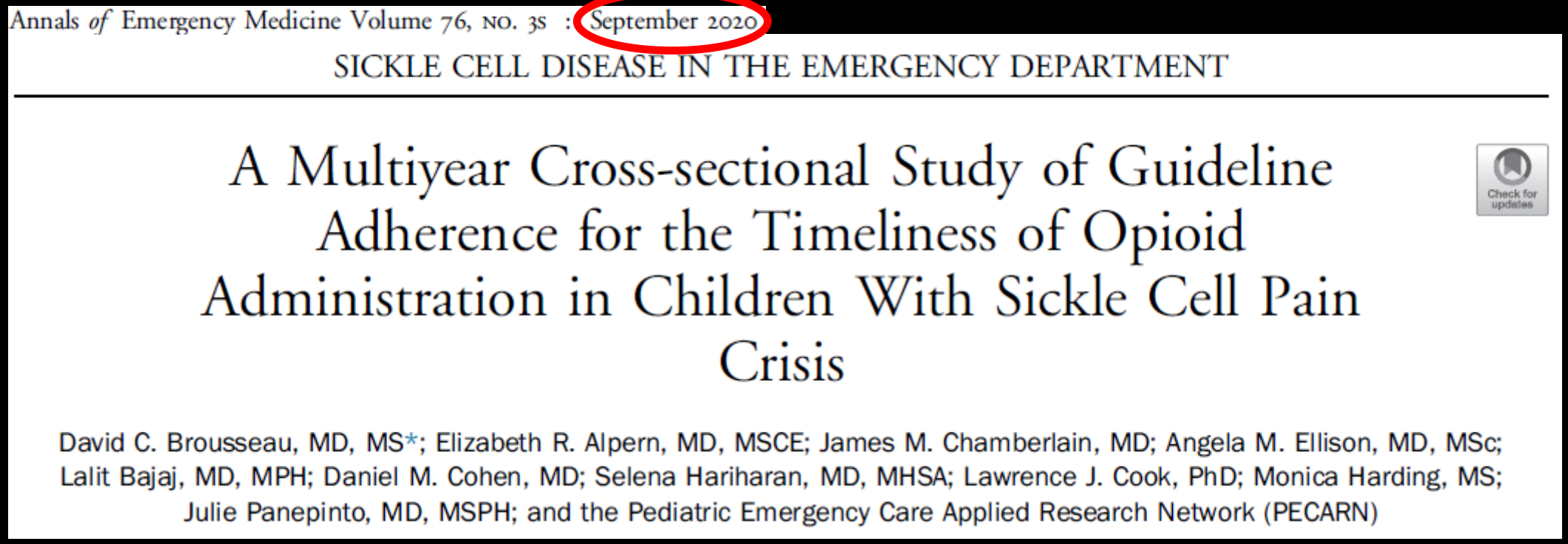
blood advances

10 DECEMBER 2019 • VOLUME 3, NUMBER 23

2019 sickle cell disease guidelines by the American Society of Hematology: methodology, challenges, and innovations

M. Hassan Murad,[1] Robert I. Liem,[2] Eddy S. Lang,[3] Elie A. Akl,[4] Joerg J. Meerpohl,[5] Michael R. DeBaun,[6] John F. Tisdale,[7] Amanda M. Brandow,[8] Sophie M. Lanzkron,[9] Stella T. Chou,[10] Starr Webb,[11] and Reem A. Mustafa[12]

How Are We Doing Regarding Adherence to Guidelines?



Annals *of* Emergency Medicine Volume 76, NO. 3S : September 2020

SICKLE CELL DISEASE IN THE EMERGENCY DEPARTMENT

A Multiyear Cross-sectional Study of Guideline Adherence for the Timeliness of Opioid Administration in Children With Sickle Cell Pain Crisis

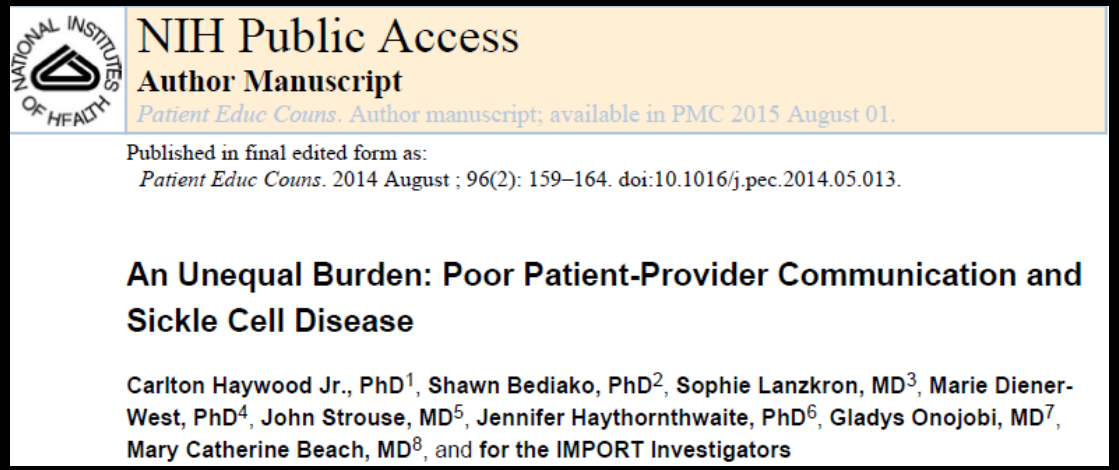
David C. Brousseau, MD, MS*; Elizabeth R. Alpern, MD, MSCE; James M. Chamberlain, MD; Angela M. Ellison, MD, MSc; Lalit Bajaj, MD, MPH; Daniel M. Cohen, MD; Selena Hariharan, MD, MHSA; Lawrence J. Cook, PhD; Monica Harding, MS; Julie Panepinto, MD, MSPH; and the Pediatric Emergency Care Applied Research Network (PECARN)

Conclusion: "*Guideline adherence for **timeliness of SCD pain treatment is poor**, with only half of visits adherent for time to first opioid and one seventh adherent for second dose of opioid. Dissemination and implementation research/quality improvement efforts are critical to improve care across Emergency Departments. It is unclear why the expected improvement has not occurred, but **simply developing guidelines is obviously not sufficient**."*

Not Good…

Ethical Principles and Opioid Prescribing in SCD

- Do not under-prescribe
- Vigilance for and management of adverse effects
- Vigilance for aberrant drug-related behaviors
- Trust, context, communication, reflection about:
  - Bias and stigma

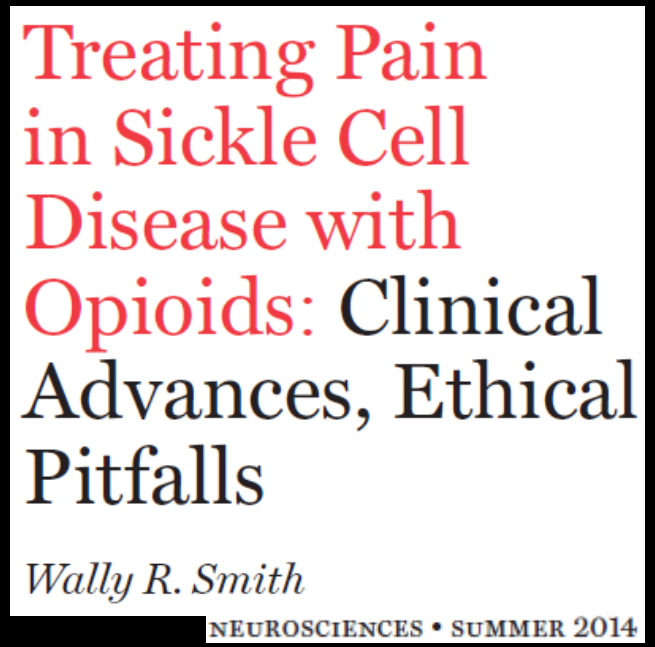


NIH Public Access
Author Manuscript
Patient Educ Couns. Author manuscript; available in PMC 2015 August 01.

Published in final edited form as:
Patient Educ Couns. 2014 August ; 96(2): 159–164. doi:10.1016/j.pec.2014.05.013.

An Unequal Burden: Poor Patient-Provider Communication and Sickle Cell Disease

Carlton Haywood Jr., PhD[1], Shawn Bediako, PhD[2], Sophie Lanzkron, MD[3], Marie Diener-West, PhD[4], John Strouse, MD[5], Jennifer Haythornthwaite, PhD[6], Gladys Onojobi, MD[7], Mary Catherine Beach, MD[8], and for the IMPORT Investigators

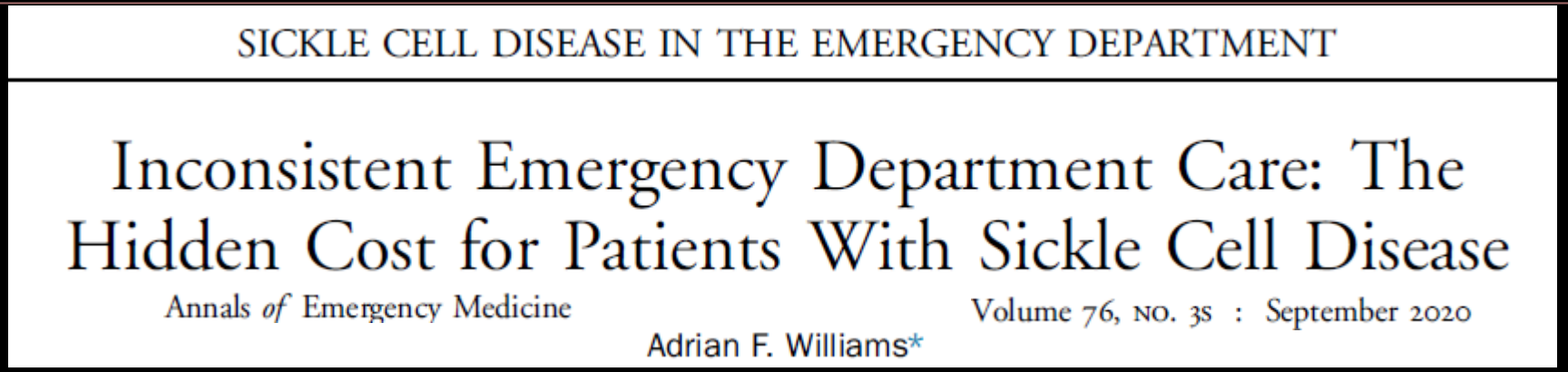


Treating Pain in Sickle Cell Disease with Opioids: Clinical Advances, Ethical Pitfalls

Wally R. Smith

NEUROSCIENCES • SUMMER 2014

September 2020…



SICKLE CELL DISEASE IN THE EMERGENCY DEPARTMENT

Inconsistent Emergency Department Care: The Hidden Cost for Patients With Sickle Cell Disease

Annals *of* Emergency Medicine Volume 76, NO. 3S : September 2020

Adrian F. Williams*

- Stigmatization
- Psychological damage
- Neurologic events leading to cognitive decline
- Adverse social determinants of health

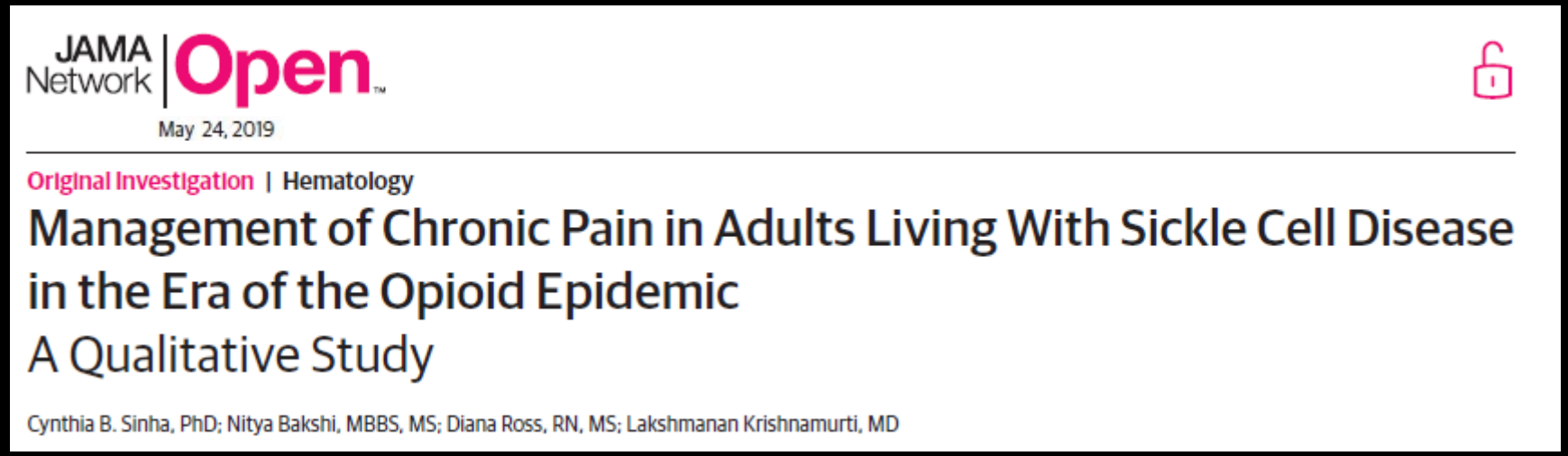
"All adult SCD patients experience the unwanted burden and unwelcomed responsibility of managing their ED treatment and care through a maze of implicit biases that further complicate their interactions with emergency clinicians when they are sick. It is not surprising to see how difficult some individuals with SCD have become 'difficult' to deal with as a result of these conditions."

Internalized Stigmatization

- *"Many patients are often faced with the responsibility of presenting themselves in a visual, cultural, and intellectual manner that best translates to being worthy of prompt, kind, and courteous professional care*
- *In other words, we feel a responsibility to assuage the racial, social, and cultural biases of physicians and nurses to receive optimal ED care*
- *SCD patients have been known to shower, shave, visit a hair salon, apply fragrances, and wear designer clothes in an attempt to persuade emergency clinicians that they are worthy of equal and fair treatment in Emergency Departments."*

Williams AF. Inconsistent Emergency Department Care: The Hidden Cost for Patients With Sickle Cell Disease. *Ann Emerg Med*. 2020 Sep;76(3S):S4-S5.

Other Barriers We All Face and More



JAMA Network | Open™

May 24, 2019

Original Investigation | Hematology

Management of Chronic Pain in Adults Living With Sickle Cell Disease in the Era of the Opioid Epidemic

A Qualitative Study

Cynthia B. Sinha, PhD; Nitya Bakshi, MBBS, MS; Diana Ross, RN, MS; Lakshmanan Krishnamurti, MD

- Participants reported that recently their opioid prescriptions had become more restrictive, were more closely monitored, and were increasingly difficult to fill in pharmacies
- Participants also described increased stigmatization about opioid use and that their medical care was being affected by the clinician's exclusive focus on reducing pain medication use

Social Determinants of Health – The Story of Mr. O

- Mr. O is a 43-year-old Hispanic man with severe, destructive rheumatoid arthritis and chronic pain
- Works at an auto-parts factory in Michigan
- Maintained on stable low doses of acetaminophen-hydrocodone for 15 years by his Primary Care Clinician (PCP)
  - No evidence of opioid use disorder (OUD)
  - In 2011, patient-provider agreements were implemented, along with interval urine drug testing (UDT)
    - Mr. O participated willingly and his UDTs were consistently negative for unprescribed substances

Social Determinants of Health – The Story of Mr. O

- In 2014, his insurance company began to require prior authorizations for all controlled substances refills
  - Although there were occasional small delays related to this annual task, Mr. O was able to keep his pain level stable on his prescribed regimen
- In 2016, his PCP retired, and his care was transferred to another younger clinician in the same office who was "well educated" about safe opioid prescribing
- That same year, the insurer required more frequent authorizations and that prescriptions be sent to the pharmacy every 15 days

Social Determinants of Health – The Story of Mr. O

- The new PCP was occasionally late providing the prescriptions and getting the prior authorizations approved because of “resource availability”
- Additionally, Mr. O did not own a car and sometimes could not get to the pharmacy before they closed after work – he had to take 2 buses
- He began to have several-day gaps in his pain medication
  - Increased pain
  - Mild withdrawal symptoms

Social Determinants of Health – The Story of Mr. O

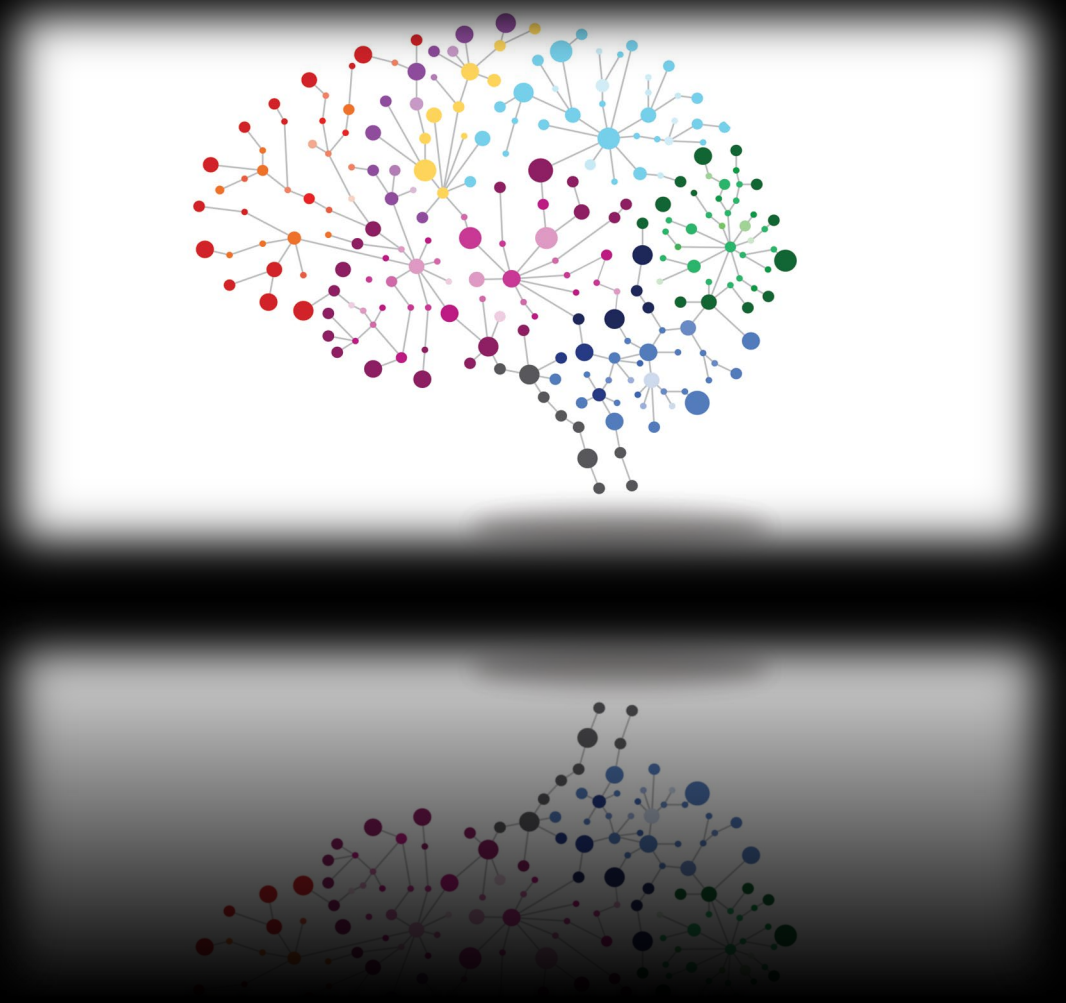
- Mr. O made an appointment and requested that extra pills be prescribed to help cover the gaps – he was agitated
- The "new" PCP notes in the medical record and that she considered this a "red-flag" for aberrant behavior
  - She said no
- 3 months later, Mr. O's UDT was positive for unprescribed oxycodone
  - He reported that he obtained it from a friend to help him through the gaps
- The PCP reported that he violated his "contract" and that he now needed to be referred to a local pain clinic – 4 month wait…

Social Determinants of Health – The Story of Mr. O

- Mr. O began purchasing his full narcotic regimen from a friend
  - –What to you think happened to him?
- Structural Iatrogenesis:
  - –The causing of clinical harm to patients by bureaucratic systems within medicine
  - –Including those intended to benefit them
  - –A type of “violence” defined as the systematic infliction of disproportionate harm on certain people based on race, gender, language, or other characteristics

Connecting the Dots – What to Do on Monday

- Think about the breadth of the steps and guidelines don't necessarily end up being equal or equitable
- Reflect:
  - Bias check
  - Stigma check
  - Social determinants of health check
- Think about what you would have done for Mr. O
- Think about what you might have done if you *were* Mr. O

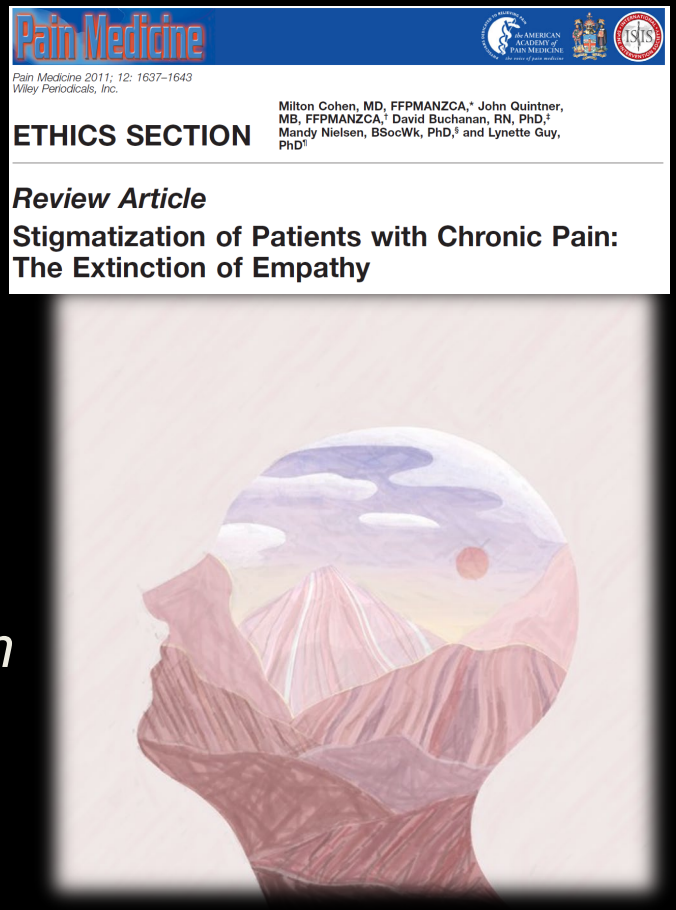


Important Terms to Remember

- Implicit bias
- Explicit bias
- Internal(ized) stigma(tization)
- Moral imperative(s)
- Moral jeopardy
- Social pain
- Stereotypical endorsement
- Structural iatrogenesis

Strategies to Destigmatize Pain

- Comprehensive education
  - Ensuring that education doesn't default to the imposition of beliefs and attitudes from the clinician to the person with pain
- Awareness of what is happening in the "intersubjective space" which might occur upon the first patient encounter
- Use Ethics as a guide:
  - Autonomy
  - Beneficence
  - Nonmaleficience
  - Justice
- *"If clinicians and researchers reframe their conceptual models to incorporate neurobiological insights into the nature of empathy in the clinical encounter, they may be better placed to recognize stigmatization of their patients and to assist them toward achieving societal validation and inclusion"*



van Boekel LC, Brouwers EP, van Weeghel J, Garretsen HF. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug Alcohol Depend*. 2013 Jul 1;131(1-2):23-35.

PainWeek®

“Cure sometimes, treat often, comfort always.”
— Hippocrates

Questions?

Thank You!

PAINWEEK®