

Race, Ethnicity, Cultural Factors and Chronic Pain in Injured Workers

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Introduction

Race, Ethnicity and cultural factors are explosive issues as they affect the delivery of medical care by the health care provider and acceptance of treatment by the patient. While many people have strong opinions, few discuss this topic openly for fear of being labeled as racially intolerant or even a racist or bigot.

It is just not politically correct to suggest that one or more of these factors (race, ethnicity and culture) might partially explain the type and level of medical care provided and help explain an injured workers' response to chronic pain and the treatment of various neuromuscular and skeletal injuries.

However, I believe that it is very important to determine if any of these factors do play a role in how physicians provide medical care or how injured workers respond to chronic pain and treatment. To ignore this issue would be a disservice to our patients as treatment approaches might differ or be modified depending on the extent of such factors. You cannot fix a problem until you recognize that it exists.

Pain is a complex phenomenon, influenced as much by personal history and values and cultural traditions as by genetic factors, physiological injury and disease. The multiplicity of factors

that influence the perception and expression of pain take on special importance in the health care setting, where pain becomes an interpersonal experience between the patient (sufferer) and the physician (reliever). How pain is viewed and presented by the patient and understood by the provider determines in large measure how it is recognized or valued and, ultimately, how it is treated.

For health care providers, opinions regarding race, ethnicity, culture, gender and socioeconomic status may unduly and inappropriately bias how they relate to and treat the patient. To ignore these facts about the providers and receivers of health care is to promote inefficient and poor medical care and less than optimal outcomes from treatment.

The reality is that people interpret and react differently to health symptoms, including pain, based on their life experiences and their cultural norms. People have different beliefs regarding whether it's good or not good to be experiencing pain. They may use different coping strategies or styles when they encounter painful situations.

Providers are no different and react to patients based on long held biases and preconceptions. Stoic or compliant patients may be viewed as "good patients," therefore they are appreciated. Expressive patients may be viewed as "complainers" or symptom magnifiers who are exaggerating pain. Expressive patients may be "punished" by being described as overall being somatically preoccupied.

For this article, I reviewed the scientific literature and spoke with many healthcare providers and people involved in the California Workers' Compensation system regarding race, ethnic, cultural and socioeconomic issues as they relate to chronic pain evaluation and treatment for injured workers. However, I take full responsibility for the opinions expressed in this article. Your opinions and comments are welcome as well and will be printed in future CWCE issues.

The Under Treatment of Pain

Pain is widely recognized as under treated in the United States, but there are certain groups in which under treatment is a particular problem. All the underlying reasons have not been thoroughly ascertained, race and ethnicity appear to be factors.

Studies have shown that racial and ethnic minorities are at a higher risk of the ineffective treatment of pain. While access to health care and insurance may be responsible for some disparities in treatment, the problem appears to be complex.

Several studies have shown that the use of analgesics in emergency departments is influenced by ethnicity. In one study, Hispanic patients with long bone fractures were twice as likely

to receive no analgesics. This disparity could not be explained on the basis of gender, language, or insurance status, severity of the fracture, or physician characteristics such as gender or their own ethnicity.

One study revealed African-American patients were less likely than Caucasian patients to receive analgesics in the emergency department despite similar reports of pain. Another study identified ethnic and racial disparities in pain treatment for cancer, post operative of low back pain.

The causes of pain under-treatment are varied and this under-treatment afflicts some more than others. What divides some from the others is not limited to one factor, but particularly disturbing factors including race, ethnicity, cultural factors and socioeconomic status.

Pain and Human Biological Diversity

Human responses to pain are highly variable. That variability, however, does not appear to reflect population differences in the anatomy and physiology of pain in terms of race or gender.

Although people may differ in how they respond to pain, it has never been shown that these dissimilar responses reflect differences in biologic mechanisms. Rather, they appear to reflect cultural expectations and psychological predispositions which are powerful predictors of health-related outcomes.

While genetic racial differences exist for certain disease states, it is not race itself, but rather racism, poor education and poverty that accounts for most documented differences in health status and medical care inequalities between minority and majority groups, between the uneducated and the highly educated and between culturally disparate groups.

Many anthropological studies have examined differences in pain perception based on cultural, racial and ethnic differences. Patients describe their pain in affective terms that vary with ethnicity. One study suggested pain responses within ethnic group are shaped by surrounding culture.

In general, racial and ethnic minority populations and particularly the uneducated or those with a language barrier or major cultural differences from the American mainstream, are at higher risk for ineffective treatment of pain. Numerous studies have revealed that these groups often receive different and less optimal management of their healthcare.

Definitions

It is difficult to isolate racial, ethnic and cultural differences from socioeconomic disparities as they are intertwined in this country.

Race is not a scientific category but a social construct that is used to define populations that have distinct physical characteristics and different ancestral roots. Most scientists now view skin color, eye color, hair type, and other outward signs associated with race as variations insignificant at the level of the genes. Human migration, intermarriage, and genetic variation mean that groups of people are rarely homogeneous. Africans, Hispanics, Caucasians, and Asians (to name the most common racial designations) show wider genetic differences within groups than across groups.

Ethnicity, sometimes employed as a soft synonym for race, inspires similar confusions. Some ethnic groups show physiological and morphological distinctness, such as variations in drug metabolism and in muscle enzyme levels after exercise. Such genetic variations, however, do not tell us what we mean by ethnicity.

Ethnicity remains a concept in dispute. Labels such as white, Asian, Latino, Afro-Caribbean, and black constitute a loose and inaccurate "shorthand" developed for non-scientific purposes.

Ethnic identity contains an irreducible element of personal choice. Individuals can, and do change their ethnic identification.

It is no longer possible (if it ever was) to discuss ethnicity as the changeless, solid attribute of fixed and solitary groups. Like race, ethnicity is a social construct; dynamic rather than static.

Ethnicity implies a common language or religious tradition, shared origins or social background, and shared culture and traditions that are distinctive, maintained between generations, and conducive to a sense of identity and group. This suggests that ethnicity is inseparable from shared social experience or culture.

Ethnicity combines race and culture in that ethnic groups are groups that include people because of their culture and customs (language, dietary, marital, religious), and are related to ancestry.

Culture refers to thoughts, communications, actions, beliefs, and customs of specific social groups (infers social and behavioral influences) and is defined as the totality of socially transmitted behavior patterns, arts, beliefs, institutions, and all other products of human work and thought. Culture, not race, ethnicity or genes, shape patterns of behavior to determine perceived sensitivity to pain and how individuals seek, obtain and receive medical care.

Socioeconomic status refers to an individual's or group's position within a hierarchical social structure. Socioeconomic status depends on a combination of variables, including occupation, education, income, wealth, and place of residence.

The Impact of Race & Ethnicity on Medical Providers

Medical encounters are not immune from the dangerous consequences that sometimes flow from racial and ethnic differences and stereotypes. The race, ethnicity, cultural or socioeconomic aspects of patients may have significant impact on how clinicians assess and treat their pain.

There is a tendency for most people to see their own culture as the "center of the world." There is an inherent assumption that what we know is the "truth" and every other viewpoint is a deviation from the truth.

When the goals of the physician and that of the patient are similar, the treatment course is smooth. But when the physician has a certain treatment path in mind and if the patient is viewed as not entirely cooperative or enthusiastic, the physician may start to feel that the patient is an impediment to successful treatment or "non-compliant." This perceived lack of cooperation or enthusiasm may be related more to misunderstanding due to language barriers and/or cultural factors as well as to different belief systems.

Physicians and nurses also belong to ethnic groups. They belong to subcultures, including the subculture of medicine, where ingrained attitudes toward particular ethnic groups may have a powerful impact on how those individuals are treated. More importantly, each healthcare provider brings to each encounter long established biases towards patients that affect how they interpret the clinical presentation and how they then provide care for those individuals.

The doctor arrives at the patient's bedside with pre-conceived notions about the patient's needs for pain treatment that are tied to race, ethnicity and cultural factors and not to the illness per se. What is worse is that there are no data to suggest that such perceptions are accurate, nor are physicians even aware of their behavior.

It is not surprising that sometimes interactions between health care providers and patients results in intercultural conflicts where both doctor and patient have difficulty understanding the other's point of view.

Although it is not talked about openly, some physicians are avoided for consultations because they have a reputation for being biased against certain personality types, patients who are markedly overweight, certain sexual orientations or certain ethnic group(s), etc.

If in a clinical encounter, the physician focuses exclusively on medical and laboratory information and lays out an assessment and plan that does not take into account the cultural and socioeconomic aspects, the physician's ability to predict the patient's response to treatment will be poor. So in essence the physician may be creating a "non-compliant" patient.

The physician needs to inquire about the patient's perspective on their illness experience and what it means to them physically, psychosocially, cognitively, functionally and spiritually. The patient's long-term goals, hopes and dreams need to be identified along with how their beliefs help them cope with their illness.

As a pain specialist for over thirty years, I have come to understand the disconnection between pathology and a patient's perception of dysfunction and disability. We see some individuals who insist on working despite the most significant pathology and others with little or no pathology who present as incapacitated.

Cultural Factors Affecting Pain Treatment

There is fairly clear evidence that minority patients are likely to receive less adequate pain relief (acute or chronic). African-American and Latin-Americans are three times more likely to have inadequate analgesia than non-minority patients.

Because of their beliefs, attitudes & behavior, minority pain patients may be perceived as needing less pain medications. There are also language barriers. As noted previously, pain practitioners' beliefs and attitudes also affect pain assessment.

Healthcare providers may be more concerned about addiction of minority patients. Research also suggest less frequent follow-up of minority patients.

Minority patients are more often economically disadvantaged, and may face the dilemma of choosing between paying for medications or other necessities. They may have no health coverage at all or coverage with inadequate reimbursement for the care prescribed. Because of concerns about theft and violence, pharmacies located in minority neighborhoods may not stock opioid analgesics.

The disparity in treatment could also be due to greater difficulty by the physician in assessing pain because of language and cultural barriers along with lack of health literacy and poor education as well as the inability or failure to advocate for one's health. Inadequate medical care may result from the patient's fear of aggressive treatment or the lack of expertise at the sites that treat patients belonging to ethnic minority groups.

Pain & the Injured Worker

Pain is difficult enough to treat without adding the complexities of the workers' compensation system. In this system we have gone beyond a simple doctor-patient relationship and added claims examiners, employers, attorneys, nurses and medical legal evaluators. We have added issues of causation and apportionment, temporary disability and permanent and stationary status and awards for loss of ability to compete in the open labor market.

We have vendors hawking various costly wares and services such as drugs, implanted spinal stimulators and pumps, electrical type devices and of course, injections, various procedures and surgeries at hospitals and surgicenters, and pain clinics.

Injured workers often get caught up in a maelstrom of emotions including entitlement, anger, and fear along with a sense of various losses (job, financial security, recreational activities, normal family life, etc).

Thrown into this mix are issues of race, ethnicity, culture and socioeconomic status.

I remain highly discouraged by the often provided passive, palliative and prolonged treatment approaches provided to many injured workers that seem to result in everlasting disability and dysfunction.

When we consider the goal of the workers' compensation system to be one of returning people to optimum health and back to gainful employment, we clearly fall short for many injured workers.

Physiatrist Dr. Allen Kaisler-Meza of San Jose provided the following excerpted comments.

The barriers with communication between non-English speaking injured workers and their primary English speaking doctors has a significant impact on their care. Immigrants learn pretty quickly that the one word that gets attention from doctors is "pain." But they don't have the skill to explain the specifics of their pain. In other words, they use the word pain to signify any complaint they may have and generalize every body movement as "painful." Educated English speakers can describe their pain as related to a particular activity or body position or body part. They can add adjectives such as soreness, fatigue that often get lost in translation.

The Hispanic (Latino) culture and even the language itself promotes the "emotional." We use our hands a lot, we touch a lot, we speak loudly, our facial expressions change with each passing sentence. Many Anglo (or non Romantic) doctors seem to think this is exaggeration or some other character flaw.

There is a rich tradition in Asian and Latino societies of "passive" treatment. Passive treatment is an abhorrence to American doctors and society. We demand activity and since we admire the individual, we push the patient to treat himself! This is not how illness is treated in other cultures. It focuses on treatment such as massage, herbs, acupuncture, praying and community.

Applicant attorney Mr. Jim Gonzalez of Salinas provides the following excerpted comments.

Pain and the reaction people have coping with pain is influenced by culture and language - especially when a doctor has to treat someone of a different language and culture.

Language is not just literal. It is also mannerisms, beliefs, body language, respect, etc. When a patient is asked by a doctor, through an interpreter, what do you feel, describe the pain, how does it affect you - there is that one degree of separation having to work through an interpreter which has to make the communication of the feeling and affect of pain that much more difficult to communicate to and understand by the doctor asking the questions.

Racism or preconceived notions by the person treating and the person being treated, based on stereotypes in the mind of the doctor, nurses, therapist and the patient, is the most delicate issue to deal with and acknowledge. People seemed to pussyfoot around the subject of racism and are afraid to come face to face with the fact that people are racist and do have stereotypes and do feel more comfortable with their "own kind," their own click, their own social and educational equals.

Diseases don't happen in isolation. Diseases happen to people. Just as the disease changes the patient, so too does the patient's personality and culture affect the disease process and the way it manifests in that patient.

Culture is much more than just race, ethnicity or country of origin. In fact, race and ethnicity are just some of the facets that help understand the meaning of culture. Culture is a dynamic frame of reference that develops as a group of individuals grow and evolve together over time. Culture is like an arrangement of lenses through which people view the world and try to understand it.

The data gathered during any communication are processed at multiple levels through these cultural filters, which are very specific for each individual. The final end product of this processing is the "meaning" that is ascribed to the communication. That is to say, the meaning is not only influenced by what was said but also to whom it was said and by whom it was said. The meaning for the most part rests in the person and not in the utterances. This then implies that people can have similar meanings only to the extent that they have had, or can anticipate having, similar experiences. So, most physicians can only guess at what it means to a patient to have to live with a chronic illness and how this may alter the cultural filters of the patient and thereby the process of finding meaning in the illness process.

Physiatrist Dr. Vanessa Ortiz of San Mateo provided the following excerpted comments.

In regards to the very important yet daunting topic of racial, ethnic, and cultural differences in the pain experience, being aware of how these differences impact both the experience and expression of pain is a very important aspect of providing good medical care and is unfortunately an area which is all too often neglected in both the education and practice of most physicians.

I am a Latin-American of Puerto Rican heritage; I am also a physician. My personal experience has been that Latin-Americans as a whole deeply admire, trust and respect physicians, and look to physicians in an almost "paternal" way with regards to making vital medical decisions.

Of course, it is very difficult to make broad generalizations with regards to Latin-Americans because the Latin-American community is made up of many diverse segments, with people coming from such regions as Mexico, Cuba, Puerto

Rico, Central America and South America. In addition, socioeconomic factors often affect patient beliefs and attitudes towards physicians as well.

Summary & Conclusions

For all of us in the workers' compensation arena, our mandate is clear; to provide the best and most cost-effective care possible to cure or relieve from the effects of the industrial injury. The goal is to assist the injured worker in stabilizing medically while returning to gainful employment with the least residual disability that is possible.

In many case, unfortunately, race, ethnicity, culture and socioeconomic status play a major negative role in the medical care provided to injured workers. These issues not only affect how the physician provides care but how the injured worker accepts treatment.

Health care providers need to be educated to avoid biases and stereotyping while learning how to provide beneficial treatment in the context of the injured workers lifestyle and cultural background.

A number of reasons have been suggested to account for ethnic and racial disparities in pain management, including healthcare provider concern about potential drug abuse in minority patients, fewer resources with which to pay for analgesics, greater difficulty accessing care and in filling analgesic prescriptions, and greater difficulty for physicians and other healthcare professionals in assessing pain in minority patients because of differences in language and cultural background. Inadequate pain management in minority patients may also result from the patient's fear of aggressive treatment, the patient's lack of assertiveness in seeking care, or lack of expertise in the clinical setting where ethnic minority receive treatment.

There are a number of reasons for pain management disparities ethnic/racial minority patients which include:

The physician may have a perception of the patient's race and ethnicity, independent of any communication with the patient, that can influence the clinical decisions made by the health care team. This may particularly occur in the emergency department where physicians and patients have no established relationship, the physicians' and stereotypes maybe more influential, and consequently, pain may not be treated adequately.

The Healthcare providers level of fluency in the patient's primary language can be a significant factor in effect of physician-patient communication, but there may be other aspects besides language fluency that are important, since studies show disparities in analgesic use even when language fluency is accounted for.

Race and ethnicity can be important cultural barriers in patients-physician communication. One study of African-American patients found that these patients reported less participatory visits with their physicians than Caucasian patients.

A number of factors may account for these problems. Healthcare professionals may unintentionally incorporate biases, such as racial and ethnic stereotypes, in their interpretation of patients' symptoms, predictions of patients' behaviors, and medical decision making, or may lack of understanding of patients' ethnic and cultural disease models or attributions of symptoms. Another possibility is that physicians are often not aware or have expectations of the visit that differ from those of their patients. Patient factors such as language barriers, low health literacy, educational status or lack of self efficacy regarding managing one's health maybe more prevalent among ethnic minorities, and also contribute less participatory visits.

Healthcare professionals should be sensitive to patients' specific needs as well as their own biases, recognizing that they may be influenced by race, ethnicity or culture. The United States is a multicultural society. Healthcare professionals must communicate effectively to persons who differ markedly in their cultural beliefs and attitudes to provide effective medical care.

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