

THE RACIAL TENSION BETWEEN UNDERPRESCRIPTION AND OVERPRESCRIPTION OF PAIN MEDICATION AMID THE OPIOID EPIDEMIC

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ABSTRACT

America is in the midst of an opioid crisis. However, unlike prior addiction epidemics, the victims are mostly white. Even in the face of that fact, doctors often discount the pain experienced by African American patients and prescribe patients weaker opioids and lower doses of opioids, leading to prolonged pain. This article attributes at least some of these differences to racial bias, much of it implicit. There are many challenges to combatting racial bias in medicine—particularly pain medicine, including the subjective nature of pain and the lack of a consistent standard of care. This Article explores the problem of pain, the racial bias in treatment, and possible legal avenues for addressing bias. By utilizing the data that have already been gathered and gathering more data in the future, the medical community may be able to develop a better standard of care for pain treatment and institute measures that reduce bias and its impact on African American patients.

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I.

INTRODUCTION

“Among the remedies which it has pleased Almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium.”¹

In the November 8, 2017 episode of *Law & Order: Special Victims Unit*, the lead detective, Olivia Benson, said to a mother whose daughter died after a period of drug addiction, “You don’t have to prove to me that you were a good mother. . . I know that it’s not a comfort, but . . . I’ve seen this a lot. It can happen to anyone.”² *General Hospital* also recently featured a story arc with a veteran hospitalized after a synthetic opioid overdose, following his return from war and many painful surgeries.³ Many other dramas have featured storylines portraying sympathetic victims of the opioid epidemic—victims who are overwhelmingly white, who come from loving families, who originally received valid prescriptions of opioids for pain, and who fell subject to addiction. This is a stark contrast from the media portrayal of past addiction epidemics, which typically did not portray people suffering from addiction in a sympathetic light, and I argue that it is racially motivated.

1. Mark D. Sullivan & Catherine Q. Howe, *Opioid Therapy for Chronic Pain in the United States: Promises and Perils*, 154 *PAIN* S94, S94 (2013) (quoting Thomas Sydenham, who was a 17th century physician).

2. *Law & Order: Special Victims Unit: Unintended Consequences* (NBC television broadcast Nov. 8, 2017).

3. Araceli Aviles, *The Social Justice Stories Daytime Television Shows Are Tackling*, *TV OVER MIND* (Dec. 17, 2017), <http://www.tvovermind.com/days-of-our-lives/the-social-justice-stories-daytime-television-shows-are-tackling> [<https://perma.cc/LQY5-NT74>].

As an added layer, there is copious historical evidence of racial differences in both who prescribes and who is prescribed opioids.

African Americans⁴ are less likely to be prescribed pain medication and service providers often underestimate minority patients' pain.⁵ Beliefs that African American people are physically different from white people go back to times of slavery.⁶ Dr. Samuel Cartright, a prominent physician in the early to mid-1800s, suggested that African American people were "insensible to pain when subjected to punishment";⁷ at the time, the belief that African American patients could tolerate surgery without experiencing pain was widespread amongst Cartright's medical peers.⁸ Whether those assumptions were born of cruelty, true belief, or some mixture of the two remains undetermined.⁹ Today, common-held beliefs include that African American people are better athletes, both naturally and due to their descent from slaves selected for physical fitness and ability.¹⁰ Another myth is that African American people have certain physical abnormalities, like being able to bear "extreme heat from burning coals."¹¹

In part because of these disparities and biases, addiction does not happen to just anyone. Most people prescribed opioids do not become addicted: estimate ranges are less than 12% of patients with chronic non-cancer pain suffer from addiction.¹² But there has been a cultural normalization of this issue, as evidenced by the many television show narratives that make addiction seem common.¹³

In 2017, Narcan, a drug to counteract overdose, was available over-the-counter in 46

4. In this article, I use both "African American" and "Black." My choice to do so often coincides with the choice made by the sources that I cite, in the hopes that their distinction between the two is accurate. Where I was making an independent choice, I chose to use African American because while the problem of racism is not a uniquely American phenomena, it is interwoven in the very fabric of America.

5. NAT'L ACAD. SCI., ENG'G & MED., PAIN MANAGEMENT AND THE OPIOID EPIDEMIC: BALANCING SOCIETAL AND INDIVIDUAL BENEFITS AND RISKS OF PRESCRIPTION OPIOID USE 93 (Richard J. Bonnie, Morgan A. Ford & Jonathan K. Phillips eds., 2017), https://www.ncbi.nlm.nih.gov/books/NBK458660/pdf/Bookshelf_NBK458660.pdf [<https://perma.cc/C67V-DCPL>].

6. Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCI. 4296, 4297 (2016).

7. Samuel Cartright, *Diseases and Peculiarities of the Negro Race*, PBS, <http://www.pbs.org/wgbh/aia/part4/4h3106.html> [<https://perma.cc/C66X-4LFG>] (last visited June 21, 2020).

8. Hoffman, Trawalter, Axt & Oliver, *supra* note 6, at 4297.

9. *Id.*

10. *Id.*

11. *Id.*

12. NAT'L ACAD. SCI., ENG'G & MED., *supra* note 5, at 54. The distinction between cancer and non-cancer pain is made both in clinical treatment and research because part of the problem of treating pain and believing patients with pain is having a defined pain source. Cancer was one of the first diseases for which pain management became a real issue. This is critical when analyzing prescription trends by race for pain subsequent to concrete diagnoses.

13. See *supra* notes 2–3 and accompanying text.

states.¹⁴ The opioid epidemic has been declared a national public health emergency as opposed to criminalized like addictions of the past.¹⁵ Prescription drugs should treat some pain, I argue, but how much and with what are important questions that remain. One may think because Caucasians make up the largest demographic of opioid misusers,¹⁶ they would be the lesser prescribed subpopulation. But that is not so; they are actually prescribed more opioids than African American patients, both by strength and prescription rate.¹⁷ Some suggest that the current opioid epidemic has transpired because society feels that white people should not experience pain if it can be avoided;¹⁸ that is to say, there is an overprescription of drugs that make people feel “good” to those that society has deemed should not feel pain.

This paper will examine the racial discrepancies between prescription trends for African American patients compared to white patients in the context of the opioid epidemic. Further, it will argue that improving medical education about pain, implicit bias, and risk tools in concert can improve prescription techniques. Although the right to live pain-free may not be a fundamental human right or even an achievable goal, pain management should be uniformly accessible for all groups. In order to achieve that goal, we must identify and acknowledge racial disparities and possible methods to combat them. In Part II, this paper describes the medical mismanagement of patients’ pain and the history of opioid treatments leading to the current epidemic. Part III discusses racial disparities in pain treatment that result in African American patients being prescribed less than their white counterparts. In Part IV, this paper discusses rethinking physician education as a potential mechanism to combat these disparities, and Part V discusses possible legal mechanisms for redressing biases, including state law tort claims and the federal Emergency Medical Treatment and Active Labor Act (EMTALA). The ultimate resolution will likely be less adjudicative; but, if necessary, adjudication should be used to push for changes within the medical community.

II.

BRIEF HISTORY OF PAIN

A. *The Problem of Pain*

Pain is “an unpleasant sensory and emotional experience associated with actual or

14. Beth Skwarecki, *Narcan Is Now Available Over the Counter in 46 States*, LIFE HACKER (Oct. 27, 2017, 1:30 PM), <https://vitals.lifehacker.com/narcan-is-now-available-over-the-counter-in-45-states-1819896107> [<https://perma.cc/47VF-JDP8>].

15. Dan Merica, *Trump Declares Opioid Epidemic a National Public Health Emergency*, CNN (Oct. 26, 2017, 5:59 PM), <http://www.cnn.com/2017/10/26/politics/donald-trump-opioid-epidemic/index.html> [<https://perma.cc/645Q-2KDP>].

16. See *infra* Section II.B.

17. See *infra* Section III.A.

18. Tessie Castillo, *White Privilege Helps Explain the Opioid Epidemic*, HUFFINGTON POST (Oct. 25, 2017, 2:36 PM), https://www.huffingtonpost.com/entry/white-privilege-helps-explain-the-opioid-epidemic_us_59f0d806e4b078c594fa14a9?ncid=engmodushpimg00000003 [<https://perma.cc/V8DX-XNW7>].

potential tissue damage, or described in terms of such damage,” though pain does not require tissue damage to be significant.¹⁹ Its pervasiveness led the United States Congress to declare 2001–2010 the “Decade of Pain Control and Research.”²⁰ “Pain is the most common reason for emergency department (ED) visits,” with approximately 44 million visits pertaining to pain each year.²¹ At any given time, approximately 100 million Americans are enduring pain, and pain treatment and management costs over \$500 billion each year.²² The pain varies, and in some cases even develops from acute pain to chronic pain. Chronic pain is defined as pain lasting more than three months beyond normal healing time, and acute pain describes other, shorter bouts of pain.²³

Surgery is a major source of acute pain. Approximately “48 million surgical procedures are performed each year in the inpatient hospital setting,” while “53.3 million surgical and nonsurgical procedures are performed during surgery ambulatory visits.”²⁴ At least 80% of patients who undergo surgical procedures experience postoperative pain, with 75% of that pain being moderate, severe, or extreme.²⁵ If left untreated, this acute pain can impact patients’ quality of life, function, and recovery, and it may increase the risk of chronic pain.²⁶ Acute pain should be effectively managed to optimize patient function, reduce side effects, enhance recovery, and prevent chronic pain onset.²⁷ Unresolved pain activates the pituitary-adrenal axis, which can result in immunosuppression, post-surgical

19. Andrew Tompkins, J. Greg Hobelmann & Peggy Compton, *Providing Chronic Pain Management in the “Fifth Vital Sign” Era: Historical and Treatment Perspectives on a Modern-Day Medical Dilemma*, 173 *DRUG & ALCOHOL DEPENDENCE* S11, S11 (2017).

20. Frank Brennan, Daniel B. Carr & Michael Cousins, *Pain Management: A Fundamental Human Right*, 105 *PAIN MED.* 205, 208 (2007).

21. Victoria J. Ganem, Alejandra G. Mora, Shawn M. Varney & Vikhyat S. Bebarta, *Emergency Department Opioid Prescribing Practices for Chronic Pain: A 3-Year Analysis*, 11 *J. MED. TOXICOLOGY* 288, 288 (2015).

22. *Use of Opioids for the Treatment of Chronic Pain: A Statement from the American Academy of Pain Medicine* 1, *AM. ACAD. PAIN MED.* (Feb. 2013), <https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/pain-management-toolkit/docs/use-of-opioids-for-the-treatment-of-chronic-pain.ashx> [<https://perma.cc/NF39-WZC8>].

23. Tompkins, Hobelmann & Compton, *supra* note 19, at S11.

24. Debra B. Gordon, Oscar A. de Leon-Casasola, Christopher L. Wu, Kathleen A. Sluka, Timothy J. Brennan & Roger Chou, *Research Gaps in Practice Guidelines for Acute Postoperative Pain Management in Adults: Findings from a Review of the Evidence for an American Pain Society Clinical Practice Guideline*, 17 *J. PAIN* 158, 159 (2016).

25. Roger Chou, Debra B. Gordon, Oscar A. de Leon-Casasola, Jack M. Rosenberg, Stephen Bickler, Tim Brennan, Todd Carter, Carla L. Cassidy, Eva Hall Chittenden, Ernest Degenhardt, Scott Griffith, Renee Manworren, Bill McCarberg, Robert Montgomery, Jamie Murphy, Melissa F. Perkal, Samanthanam Suresh, Kathleen Sluka, Scott Strassels, Richard Thirlby, Eugene Viscusi, Gary A. Walco, Lisa Warner, Steven J. Weisman & Christopher L. Wu, *Management of Postoperative Pain: A Clinical Practice Guideline from the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and the American Society of Anesthesiologists’ Committee on Regional Anesthesia, Executive Committee, and Administrative Council*, 17 *J. PAIN* 131, 132 (2016) [hereinafter *Management of Postoperative Pain*].

26. *See id.* at 132; *see also* NAT’L ACAD. SCI., ENG’G & MED., *supra* note 5, at 52.

27. *See, e.g.*, Tompkins, Hobelmann & Compton, *supra* note 19, at S14.

infection, and improper wound healing.²⁸ Importantly, acute pain also affects the psychological state of patients.²⁹

Acute pain usually resolves after healing, but it can progress to chronic pain, through a process known as pain chronification.³⁰ In fact, most chronic pain originates with an episode of acute pain.³¹ Social and psychological factors are the best predictors of chronification, with maladaptive coping and psychiatric illness being two of the strongest predictors, along with history of abuse, anxiety, depression, fear-based avoidance of activity, catastrophizing, self-medication with alcohol or other drugs, patient and family expectations, and worksite factors.³² Importantly, an individual can also experience simultaneous acute and chronic pain.³³

Chronic pain affects approximately 25 to 100 million U.S. patients at a given time.³⁴ Between 15% and 25% of all adults, and around 50% of adults over the age of 65, have chronic pain.³⁵ Chronic pain may be associated with a terminal illness.³⁶ Types of chronic pain include arthritic pain, chronic low back pain, fibromyalgia, sickle cell disease pain, headache, and peripheral neuropathy.³⁷ Around 80% of Americans will experience some back pain in their lives; it subsides within six weeks for almost 90% of patients.³⁸ The other 10% will experience chronic back pain.³⁹ Chronic pain has many effects, including central and peripheral nervous system changes that may result in decreased function due to constant pain signaling.⁴⁰

28. Nancy Wells, Chris Pasero & Margo McCaffery, *Improving the Quality of Care Through Pain Assessment and Management*, in AGENCY FOR HEALTHCARE RSCH. AND QUALITY, PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES 1 (Ronda G. Hughes ed., 2008), <https://archive.ahrq.gov/professionals/clinicians-providers/resources/nursing/resources/nurseshdbk/nurseshdbk.pdf> [<https://perma.cc/3E8J-BSMQ>].

29. *See id.*

30. *See* Tompkins, Hobelmann & Compton, *supra* note 19, at S12.

31. *See* WORK LOSS DATA INST., MEDICAL TREATMENT UTILIZATION SCHEDULE CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 1–2 (July 28, 2016), <https://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Opioids-ChronicPain/Final-Regulations/CleanCopy/Chronic-Pain-Guidelines.pdf> [<https://perma.cc/FUN4-DPWB>].

32. *See* Tompkins, Hobelmann & Compton, *supra* note 19, at S12; WORK LOSS DATA INST., *supra* note 31, at 9.

33. WORK LOSS DATA INST., *supra* note 31, at 1.

34. Kelly S. Barth, Constance Guille, Jenna McCauley & Kathleen T. Brady, *Targeting Practitioners: A Review of Guidelines, Training, and Policy in Pain Management*, 173 DRUG & ALCOHOL DEPENDENCE S22, S22 (2017); Tompkins, Hobelmann & Compton, *supra* note 19, at S12; NAT'L ACAD. SCI., ENG'G & MED., *supra* note 5, at 50.

35. Brennan, Carr & Cousins, *supra* note 20, at 207.

36. NAT'L ACAD. SCI., ENG'G & MED., *supra* note 5, at 49.

37. NAT'L PHARM. COUNCIL & JT. COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., PAIN: CURRENT UNDERSTANDING OF ASSESSMENT, MANAGEMENT, AND TREATMENTS 68–71 (Patricia H. Berry, C. Richard Chapman, Edward C. Covington, June L. Dahl, Jeffrey A. Katz, Christine Misaskowski & Michael J. McLean eds., 2001), <http://www.npcnow.org/system/files/research/download/Pain-Current-Understanding-of-Assessment-Management-and-Treatments.pdf> [<https://perma.cc/537Q-UNXX>].

38. *See id.* at 69.

39. *See id.*

40. *See* NAT'L ACAD. SCI., ENG'G & MED., *supra* note 5, at 52.

Some religions add meaning and importance to pain, which can be reflected in societal constructions of childbirth that give pain meaning.⁴¹ These religious interpretations could lead to a perception that pain or the endurance of pain is beneficial. After all, from childbirth, you get a “bundle of joy.” However, inadequate pain treatment has many negative effects.⁴² With respect to patient health, unresolved pain can increase risk of myocardial ischemia, stroke, and bleeding; neural changes that may evolve into chronic pain; and reduced mobility, among other things.⁴³ Sociologically, chronic pain has been associated with lower socioeconomic status and reduced workforce participation.⁴⁴ Acute pain has become a large problem due to the amount of “emergency and elective surgery, severe medical illness, trauma, childbirth, burns, natural calamities, war, and torture.”⁴⁵ These factors are simply those that have been studied, and they underscore pain as a multifaceted problem that is difficult to address.

B. The History of Opioid Use and the Opioid Epidemic

Many opioids have subsequently been discovered and developed since morphine, an opioid, was first isolated for formal use in pain treatment in 1803.⁴⁶ Addiction has since accompanied a rise in recreational and medicinal uses of the drug. In the 1960s, Dr. Warren Cole, a preeminent oncologist, spoke of the delicate balance between administering pain medication and addiction.⁴⁷ In the 1970s, health providers were trained to administer the lowest possible amount of opioids, in spite of the dosage prescribed.⁴⁸ Despite this caution, in 1981 and 1986, Dr. Kathleen Foley published two studies that reported opioids had a low risk of addiction and claimed the lack of long-term data concerning opioids’ addictive qualities. These articles fundamentally changed the way opioids were prescribed in the United States.⁴⁹

Foley and Dr. Russell Portenoy, emphasized that, “the intensive involvement of a single physician’ was essential to successful treatment.”⁵⁰ Their two small retrospective studies suggested that patients rarely became addicted to opioids, with one reporting a 0.03% addiction rate in hospitalized patients with acute pain and the other reporting a 5.3% addiction rate for patients with chronic non-cancer pain.⁵¹ Notably, the two patients in the later study who became addicted had histories of substance use disorder.⁵² Although many physicians were aware there was no long-term data suggesting long-term opioid use was

41. See Brennan, Carr & Cousins, *supra* note 20, at 207–08.

42. *Id.* at 206.

43. *See id.*

44. *See id.*

45. *Id.*

46. See NAT’L ACAD. SCI., ENG’G & MED., *supra* note 5, at 53.

47. Marcia L. Meldrum, *The Ongoing Opioid Prescription Epidemic: Historical Context*, 106 AM. J. PUB. HEALTH 1365, 1365 (2016).

48. *See id.*

49. *See id.*

50. *Id.* at 1365.

51. Tompkins, Hobelmann & Compton, *supra* note 19, at S14.

52. *Id.*

safe, many increasingly prescribed opioids.⁵³

But before the risks of opioid addiction became common knowledge, other bodies encouraged its use for pain management as well. “In 1996, the American Academy of Pain Medicine and the American Pain Society issued a consensus statement on ‘The Use of Opioids for the Treatment of Chronic Pain’ which argued that opioids should have a role in the treatment of patients with chronic non-cancer pain.”⁵⁴ Many states subsequently passed “Intractable Pain Acts” that removed sanctions surrounding opioid prescriptions.⁵⁵ The average dose of morphine prescribed per patient increased more than 600% between 1997 and 2007.⁵⁶ While the overall percentage of people who used opioids was the same from 2003–2006 and 2011–2012, the percentage of users who were prescribed an opioid stronger than morphine more than doubled between the years 1999–2002 and 2011–2012.⁵⁷

Between 2001 and 2010, the number of emergency room visits for pain that resulted in opioid prescription increased between 7% and 10%, including prescriptions for hydro-morphone, morphine, oxycodone, and hydrocodone.⁵⁸ Approximately 20% of people who present with non-cancer pain receive an opioid prescription.⁵⁹ Additionally, around two million people reported using opioids for nonmedical reasons in 2010.⁶⁰ Over half of those people obtained the drug from a friend or relative, with almost 80% of those relatives or friends having a valid prescription.⁶¹ Only 17% had a prescription from a physician.⁶² For patients hospitalized with opioid dependence, 51% reported that they first used the drug for pain relief.⁶³

Drug abuse is commonly defined as the “deliberate overuse of controlled or illegal substances,” while addiction is defined as “the pursuit of such substances for no medical purpose despite resulting physical or psychological harm.”⁶⁴ More recent studies have found opioid abuse rates of up to 3.27% of opioid users, with aberrant drug-related

53. Meldrum, *supra* note 47, at 1365–66.

54. Sullivan & Howe, *supra* note 1, at S95.

55. *Id.*

56. Susan Calcaterra, Jason Glanz & Ingrid A. Binswanger, *National Trends in Pharmaceutical Opioid Related Overdose Deaths Compared to Other Substance Related Overdose Deaths: 1999–2009*, 131 *DRUG & ALCOHOL DEPENDENCE* 263, 267 (2013).

57. See NAT’L ACAD. SCI., ENG’G & MED., *supra* note 5, at 57.

58. Ganem, Mora, Varney & Bebartha, *supra* note 21, at 288; Deborah Dowell, Tamara Haegerich & Roger Chou, *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*, 65 *MORBIDITY & MORTALITY WKLY. REP.* 1, 1 (2016), <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm> [<https://perma.cc/HCX5-GGF7>].

59. Dowell, Haegerich & Chou, *supra* note 58 at 1.

60. Richard D. Blondell, Mohammadreza Azadfar & Angela M. Wisniewski, *Pharmacologic Therapy for Acute Pain*, 87 *AM. FAM. PHYSICIAN* 766, 771 (2013).

61. *Id.*

62. *Id.*

63. *Id.*

64. Lynn R. Webster & Rebecca M. Webster, *Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Tool*, 6 *PAIN MED.* 432, 433 (2005).

behavior ranging between 15% and 20% of opioid users.⁶⁵ Studies that do not control for mental health or substance abuse issues have reported opioid misuse rates of up to 32%, with a lifetime aberrant behavior rate of 80% for patients with chronic pain.⁶⁶ Patients who take opioids for more than ninety days are at an increased risk for developing a use disorder.⁶⁷ A 2015 review of studies estimated 21.7% to 29.3% of patients with chronic pain misused opioids, while 7.8% to 11.7% of patients became addicted.⁶⁸

Opioid use can cause hyperalgesia (increased sensitivity to and intensity of pain)⁶⁹ and lead to the development of an increased tolerance to the opioids; both of which have been suggested as contributors to opioid misuse and addiction.⁷⁰ The opioid system is normally associated with regulating social affiliative behaviors. This association may explain the abuse of opioids by patients experiencing emotional distress, who may substitute opioid use for social connection.⁷¹ While Portenoy and Foley have acknowledged opioid misuse and addiction since publishing their studies, they maintain that opioids are useful for treatment of some pain and oppose specific dose guidelines.⁷² Notably, Portenoy later acknowledged that his initial stance that long-term opioid use was safe actually led to its abuse and the consequent epidemic.⁷³ However, I would argue it is possible that the increased physician interactions with patients during these initial studies lessened the extent of the opioid epidemic, as physicians identified indicators of misuse sooner due to the inpatient setting for non-cancer patients, and repeated physician interactions for cancer patients.

Between 1999 and 2014, more than 165,000 people died from opioid-related overdoses in the United States, with more than 420,000 emergency room visits for misuse or abuse of pain relievers in 2011.⁷⁴ More than 16,000 deaths per year are attributable to opioids.⁷⁵ Between 2000 and 2014, deaths from drug overdose increased by 137%, and the deaths from opioids and heroin increased by 200%.⁷⁶ By 2002, opioids had become a more common source of death than heroin or cocaine, and by 2006, opioid-related deaths were more common than those attributed to cocaine, heroin, and psychostimulants combined.⁷⁷ Deaths from accidental opioid overdose now exceed motor vehicle deaths in thirty

65. Sullivan & Howe, *supra* note 1, at S96. There are no clear definitions for aberrant behavior or misuse, which are similar terms. The criteria used for each term can differ between researchers but usually is detailed in each individual study. These numbers come from a conglomeration of sixty-seven other studies so the definitions may vary slightly and may contribute to the numerical ranges.

66. *Id.* at S96.

67. NAT'L ACAD. SCI., ENG'G & MED., *supra* note 5, at 54.

68. *Id.*

69. *Hyperalgesia*, NAT'L CANCER INST., <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/hyperalgesia> [<https://perma.cc/56JR-9MBQ>] (last visited Feb. 18, 2021).

70. NAT'L ACAD. SCI., ENG'G & MED., *supra* note 5, at 55.

71. Sullivan & Howe, *supra* note 1, at S98.

72. *Id.* at S94–S95.

73. *See* Meldrum, *supra* note 47, at 1366.

74. Dowell, Haegerich & Chou, *supra* note 58, at 2.

75. Barth, Guille, McCauley & Brady, *supra* note 34, at S22.

76. Meldrum, *supra* note 47, at 1366.

77. Calcaterra, Glanz & Binswanger, *supra* note 56, at 263–64.

states.⁷⁸ This highlights the importance of dealing with the opioid crisis.

Racial disparities in opioid prescriptions are likely attributable to an interest in eliminating drug abuse, despite the demographics. Doctors likely do not want to prescribe more than they feel is necessary, but systemic devaluation of Black pain lowers what doctors feel is necessary for Black patients. One 2013 study examined demographics for heroin and prescription opioid overdoses between 1993 and 2009 using insurance codes.⁷⁹ During this time, prescription opioid overdose increased 7.5 times for whites, but only 3.3 and 3.2 times for Blacks and Hispanics, respectively.⁸⁰ The peak rate for heroin overdose occurred in 1995 for African Americans and Hispanics, while heroin overdose for whites peaked in 2009,⁸¹ and heroin overdose rates for whites have exceeded those for African Americans only as of 2008.⁸² The drop in African American heroin overdose may be due to generational resilience,⁸³ meaning that having seen addiction firsthand discouraged the next generation from heroin use. Therefore, any racial disparities that exist in prescribing should not be attributed to a response to the current crisis because African American opioid use had decreased prior to this current epidemic.

III.

RACIAL DISPARITIES⁸⁴

A. Prescription Differences by Race of Patient

Clinicians often underestimate or misinterpret pain in African American patients.⁸⁵ This may be due to (1) differing modes of expression by African American patients and white patients, (2) flawed communication and lack of trust between doctors and African American patients, or (3) implicit biases on the part of the doctor. Race itself may be a predictor of disease risks and outcomes, but the use of race can also lead to entrenching biases.⁸⁶ On the whole, opioids are prescribed less often to African American patients at

78. Sullivan & Howe, *supra* note 1, at S95.

79. George Jay Unick, Daniel Rosenblum, Sarah Mars & Daniel Ciccarone, *Intertwined Epidemics: National Demographic Trends in Hospitalizations for Heroin – and Opioid-related Overdoses, 1993–2009*, 8 PLOS ONE 1, 2 (2013), <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0054496&type=printable> [<https://perma.cc/MFK3-MWHK>].

80. *Id.* at 3.

81. *Id.*

82. *Id.*

83. *Id.* at 5.

84. The decision to use the term “Black” or “African American” throughout this section depends completely upon the identifier used in the underlying study in discussion.

85. Staja Q. Booker, *African Americans’ Perceptions of Pain and Pain Management: A Systematic Review*, 27 TRANSCULTURAL NURSING 73, 73 (2016).

86. Shedra Amy Snipes, Sherrill L. Sellers, Adebola Odunlami Tafawa, Lisa A. Cooper, Julie C. Fields & Vence L. Bonham, *Is Race Medically Relevant? A Qualitative Study of Physicians’ Attitudes about the Role of Race in Treatment Decision-Making*, 11 BMC HEALTH SERVS. RES. 1, 2 (2011), <https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-11-183> [<https://perma.cc/G93T-YU33>].

each socioeconomic level.⁸⁷ The disparities in treatment between white patients and African American patients could be a result of the underprescription of medicine to Black patients, the overprescription of medicine to white patients, or a combination of the two.⁸⁸ With respect to prescriptions, a better categorization tool is ethnicity, since race distinguishes groups based on physical characteristics, and ethnicity focuses on social background, culture, beliefs, and conventions and traditions.⁸⁹

The racial and ethnic differences observed in various diseases could also be due to cultural differences. Culture dictates behavioral and attitudinal norms to some degree, and therefore shapes pain expression, expectations of treatment, and perceptions of the healthcare system.⁹⁰ For instance, African Americans often report greater pain sensitivity and intensity of pain using pain scales.⁹¹ There are also ethnic differences in response to multidisciplinary pain treatment, perhaps due to differences in metabolism, clinical effectiveness, or side effects of drugs.⁹² There have been genetic polymorphisms⁹³ that underlie analgesic differences in the Chinese population, and other such polymorphisms may be present.⁹⁴ Lastly, stress-induced pain regulatory systems have been found to be more effective in whites than African Americans, which means there could be similar undetected polymorphisms in those pathways.⁹⁵

One systematic review by Staja Booker examined African Americans' general perceptions of pain and their perceptions of coping, living with, and treating pain.⁹⁶ Cancer pain for African Americans was attributed to physical limitations or worsening of the disease.⁹⁷ However, there was also an association between pain and survivorship, pain and meaning, and pain and evolving life perspectives, which harkens back to earlier religious glorification of pain.⁹⁸ Linguistically, the review found that African American patients describe pain quality and intensity using a larger variety of words than their white

87. Michael Joynt, Meghan K. Train, Brett W. Robbins, Jill S. Halterman, Enrico Caiola & Robert J. Fortuna, *The Impact of Neighborhood Socioeconomic Status and Race on the Prescribing of Opioids in Emergency Departments Throughout the United States*, 28 J. GEN. INTERNAL MED. 1604, 1606 (2013).

88. Hoffman, Trawalter, Axt & Oliver, *supra* note 6, at 4296.

89. See Claudia M. Campbell & Robert R. Edwards, *Ethnic Differences in Pain and Pain Management*, 2 PAIN MGMT. 219, 220 (2012).

90. *Id.*

91. *Id.* at 221; Booker, *supra* note 85, at 73.

92. Campbell & Edwards, *supra* note 89, at 223.

93. Genetic polymorphisms are minor differences in gene coding. For example, everyone has genes for various proteins in the body. However, if you have a slightly different genetic makeup for the same protein, that could affect its function. If a polymorphism affects an enzyme, it could lead to enhanced or decreased ability to process certain materials. This explains why some people are lactose-intolerant, and others are not. For more information, see *Polymorphism*, NAT'L HUMAN GENOME RESEARCH INST., <https://www.genome.gov/genetics-glossary/Polymorphism> [<https://perma.cc/NP7H-PBPA>] (last visited Aug. 23, 2020).

94. Campbell & Edwards, *supra* note 89, at 223.

95. *Id.* at 224.

96. Booker, *supra* note 85, at 74.

97. *Id.*

98. *Id.* at 74–75.

counterparts.⁹⁹ It is possible that the lack of comprehension by physicians of the words used by African American patients contributes to underestimating or undervaluing their pain and, therefore, a subsequent lower prescription.

Confoundingly, talk about pain is often avoided in the African American community, due to the belief that “good patients should not talk or complain about pain.”¹⁰⁰ The lack of pain discussion is also attributed to individual efforts to minimize the concerns of others and to maintain a sense of personal privacy.¹⁰¹ Additionally, African Americans may rely on spiritual mechanisms to deal with pain amongst other mechanisms, including passive coping strategies like prayer.¹⁰² African Americans were less likely to consider surgical interventions when they perceived prayer as helpful.¹⁰³ African Americans are hesitant to use drugs to treat their pain, in part due to fears of addiction, dependence, and side effects, which supports a theory of generational resilience.¹⁰⁴ Even when drugs are taken, they are often used at a lower dose than recommended.¹⁰⁵ Thus the prescribed treatments for pain may be less adequate for African American patients than for white patients.

Another racially-influenced aspect of pain treatment is trust and communication between Black patients and their doctors.¹⁰⁶ Black patients rate their doctor visits as less participatory than white patients,¹⁰⁷ and African Americans found more than white patients that ethnicity affects access to health care and, more specifically, pain care.¹⁰⁸ Because of this, some older African Americans use family and friends as sources of medical information, rather than doctors.¹⁰⁹ It is important that when doctors are formulating a treatment plan, they consider this information. Doctors can preemptively emphasize the need to take medication and work to alleviate the fears associated with doing so in order to effectively treat their patients.

Though the aforementioned may contribute to disparities in pain management, implicit bias is arguably the largest factor. Most of the focus on opioid prescription has to do with non-cancer pain, but the presence of disparities in cancer pain may be even more telling, as there is a diagnosis from which doctors should likely follow similar prescription patterns. For example, in patients with renal cancer, those with reduced kidney function who receive weaker opioids, like morphine, may be subjected to higher levels of toxic

99. *Id.* at 75.

100. *Id.*

101. *Id.*

102. *Id.*; Campbell & Edwards, *supra* note 89, at 225.

103. Booker, *supra* note 85, at 76–77.

104. *Id.* at 76.

105. *Id.*

106. *Id.*

107. Lisa Cooper-Patrick, Joseph J. Gallo, Junius J. Gonzales, Hong Thi Vu, Neil R. Powe, Christine Nelson & Daniel E. Ford, *Race, Gender, and Partnership in the Patient-Physician Relationship*, 202 J. AM. MED. ASS'N 583, 586 (1999).

108. Booker, *supra* note 85, at 76.

109. *See id.* (finding that “many older African Americans with arthritis pain look to family and friends as sources of information,” but that only 36% of surveyed African Americans with cancer pain look to family for information, while 86% of African Americans with cancer pain trust their doctor for information).

metabolites.¹¹⁰ African Americans are often at greater risk of such reduced function.¹¹¹ Therefore, doctors should be more willing to prescribe stronger opioids, given the verifiable diagnosis underlying the pain. Yet, African American patients with kidney cancer are less likely to be prescribed oxycodone and more likely to be prescribed morphine than their white counterparts.¹¹² They also tend to belong to a lower socioeconomic bracket and are less likely to have private health insurance, which can influence prescription trends.¹¹³

Even accounting for differences in insurance, the difference by race in prescribing for patients with chronically reduced function persist.¹¹⁴ Furthermore, the average severity of adverse effects for African American patients with chronically reduced renal function is significantly greater than that for white patients with a similar disease.¹¹⁵ In addition to biases, these differences might result from educational lapses in pain on the part of physicians, especially related to knowledge of the toxic metabolites that these drugs produce. This is an area in which clear continuing education related to pain management should be required.

Patients' educational attainment is also associated with pain response, with higher educated individuals experiencing better responses.¹¹⁶ Since African Americans experience lower levels of education on the whole compared to whites,¹¹⁷ this difference may explain some of the racial disparities in pain treatment. Education is also tied to socioeconomic status, which could be responsible for racial differences in pain treatment as well, influencing differences in hospital and physician settings and insurance coverage. To address this hypothesis, a study using cross-sectional data from the National Hospital Ambulatory Care Survey examined the prescription of opioids based on neighborhood-level socioeconomic status.¹¹⁸ Opioids were prescribed less in poorer neighborhoods, and less in neighborhoods with lower education levels.¹¹⁹ This may be because pharmacies in minority-serving neighborhoods are less likely to stock opioids than those in majority

110. Salimah H. Meghani, Youjeong Kang, Jesse Chittams, Erin McMenemy, Jun J. Mao & Jeffrey Fudin, *African Americans with Cancer Pain Are More Likely to Receive an Analgesic with Toxic Metabolite Despite Clinical Risks: A Mediation Analysis Study*, 22 J. CLINICAL ONCOLOGY 2773, 2773 (2014). Metabolites are byproducts of the breakdown of drugs in the system.

111. *Id.*

112. *Id.* at 2775.

113. *Id.*

114. *Id.* at 2776.

115. *Id.*

116. Campbell & Edwards, *supra* note 89, at 224.

117. See *Educational Attainment, by Race and Ethnicity*, AM. COUNCIL ON EDUC., <https://www.equityinhighered.org/indicators/u-s-population-trends-and-educational-attainment/educational-attainment-by-race-and-ethnicity/> [<https://perma.cc/R99J-MLDH>] (last visited Aug. 23, 2020).

118. See Joynt, Train, Robbins, Halterman, Caiola & Fortuna, *supra* note 87, at 1605.

119. *Id.* at 1606.

communities, leading to difficulty filling prescriptions.¹²⁰ Differences in prescribing persist even when “accounting for pain level, type of visit, age, gender, frequency of ED prior visits, and hospital location.”¹²¹ Overall, African American patients in poorer neighborhoods were about 6% less likely to receive opioids than both white patients in similar neighborhoods and African American patients in more affluent neighborhoods.¹²² Furthermore, there was an overall difference in prescriptions of about 14% between African Americans from poorer neighborhoods and whites from affluent neighborhoods.¹²³ It would also be informative to see the quantity and strength of the opioids prescribed, which was unavailable in this study.¹²⁴

Another study examined prescription trends for African American and white Medicaid beneficiaries using insurance codes.¹²⁵ For each specialty examined, with the exception of ear, nose, and throat specialists, doctors prescribed opioids to white patients more often than Black patients, with obstetricians and gynecologists, internal medicine doctors, and general and family practitioners showing the worst disparities.¹²⁶ For all specialties in the aggregate, African Americans were prescribed approximately 10% fewer opioids than white patients.¹²⁷ Nevertheless, this study had several limitations, including the fact that Medicaid beneficiaries “are twice as likely as those in the general population to fill an opioid prescription.”¹²⁸

Another study examined emergency room prescribing trends both department-wide and at the physician level at an academic institution using insurance codes for back pain, migraine, or long bone fracture.¹²⁹ While the study reported no significant differences for patients who received some form of pain medication for the diagnoses, African American patients with back pain were significantly less likely to be prescribed opioids.¹³⁰ Even with data that white patients are more likely to experience lethal overdose, African Americans are prescribed fewer opioids. In some cases, even when physicians assess African American pain appropriately, they still prescribe fewer opioids to African Americans.¹³¹ This could be evidence of implicit bias.

120. See Chris Ringwalt, Andrew W. Roberts, Hallam Gugelmann & Asheley Cockrell Skinner, *Racial Disparities Across Provider Specialties in Opioid Prescriptions Dispensed to Medicaid Beneficiaries with Chronic Noncancer Pain*, 16 PAIN MED. 633, 634 (2015).

121. Joynt, Train, Robbins, Halterman, Caiola & Fortuna, *supra* note 86, at 1607.

122. *Id.*

123. *Id.*

124. *Id.* at 1608.

125. Ringwalt, Roberts, Gugelmann & Cockrell Skinner, *supra* note 120, at 634.

126. *Id.* at 636.

127. *Id.* at 638.

128. *Id.*

129. See Myles Dickason, Vijai Chauhan, Astha Mor, Erin Ibler, Sarah Kuehnle, Daren Mahoney, Eric Ambrecht & Preeti Dalwari, *Racial Differences in Opiate Administration for Pain Relief at an Academic Emergency Department*, 16 W. J. EMERGENCY MED. 372, 373 (2015).

130. *Id.* at 374.

131. Campbell & Edwards, *supra* note 89, at 224.

B. *Measuring Implicit Biases*

It was previously unclear the extent to which medical myths about Black people pervaded the more medically educated populations and how those myths impact prescribing.¹³² A 2016 study, therefore, examined myths about African Americans that were held by either laypeople or medical students and residents, with a majority of the sample size being white.¹³³ Amongst laypeople, 73% of the sampled population endorsed at least one false belief about African American people, such as statements like “Blacks have thicker skin than do white people” or “Black people’s blood coagulates more quickly than white people’s blood.”¹³⁴ When people who held more false beliefs were asked to rate pain of African American and white participants, there were greater disparities in rating pain for the same symptoms based on race.¹³⁵ About half of the medical students and residents surveyed stated that at least one false belief was “probably, possibly, or definitely true.”¹³⁶ Again, those who endorsed more false beliefs had greater disparities in their treatment recommendations.¹³⁷

Implicit biases are the “thoughts and feelings that often exist outside of conscious awareness, and thus are difficult to consciously acknowledge and control.”¹³⁸ Perhaps more dangerously, manifestations of implicit biases can occur that run counter to a person’s professed beliefs.¹³⁹ A study on implicit biases of physicians showed that doctors who “explicitly endors[ed] prejudiced beliefs”—meaning they believed them—and those who did not were both able to list many cultural stereotypes about African American people.¹⁴⁰ More importantly, after exposure to “stereotype-activating words,” both groups subsequently rated ambiguous behavior by African American people as hostile.¹⁴¹ This underlies how implicit bias works. People are still influenced by the prejudices to which they have been exposed even if they do not accept them. Many studies show that simply knowing a stereotype distorts information processing.¹⁴² One study showed that while physicians of advanced age tended to believe more in racial equality explicitly, implicit biases did not follow that same trend.¹⁴³

132. Hoffman, Trawalter, Axt & Oliver, *supra* note 6, at 4297.

133. *See id.*

134. *Id.*

135. *Id.* at 4297–98.

136. *Id.* at 4298.

137. *Id.* at 4299.

138. William J. Hall, Mimi V. Chapman, Kent M. Lee, Yesenia M. Merino, Tainayah W. Thomas, Keith Payne, Eugenia Eng, Steven H. Day & Tamara Coyne-Beasley, *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, 105 AM. J. PUB. HEALTH e60, e60 (2015).

139. *See* Elizabeth N. Chapman, Anna Kaatz & Molly Carnes, *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504, 1504 (2013).

140. *Id.*

141. *Id.*

142. *See id.* at 1505.

143. *See id.*

This disparity between expressed racial beliefs and internalized racial biases must be emphasized, though it runs counter to principles of medical education. Medical education is often focused on diagnosing patients based on explicit generalizations, be they about groups of people, symptoms, or medications, rather than based on interrogating subconscious biases that also impact diagnoses. The training to become a physician uses group-level information, such as demographic data or presenting symptoms, which may lead to reinforcing stereotypes.¹⁴⁴ While doctors' use, or at least knowledge, of scientific data often encourages a personal belief that they are objective, this discounts the pervasive implicit biases in the medical field.¹⁴⁵ Using data from people who self-reported as physicians and took an implicit bias assessment online, a study found that medical doctors showed a significant pro-white bias, which is generally reflected when people have lower response times for associating white with good and Black with bad as compared to associating white with bad and Black with good.¹⁴⁶ Physicians with high implicit bias ratings were also more likely to disagree with a standard of care that included providing opioid analgesics to Black patients than those who had a lower bias score.¹⁴⁷

African American patients internalize these biases. Research shows that they are less satisfied with physicians who have low explicit and high implicit race bias, as compared with physicians with equal implicit and explicit bias rates.¹⁴⁸ They likely still feel or recognize a disconnect between themselves and their doctors, and thus wonder if their treatment is inadequate. Many are certain that it is, but they do not have much recourse to do anything about it.

C. Prescription Differences by Race of Doctor

Differences in treatment are impacted not only by patients' race, but also by doctors' race. One study conducted ten focus groups with either African American or white general internists and provided them with a patient vignette. Afterwards, the doctors described how race and ethnicity affected their plans for treatment.¹⁴⁹ Both African American and white physicians said that a specific patient's medical information, such as their own medical history and family history, was the most important factor in their decision-making.¹⁵⁰ Nevertheless, all of the focus groups with African American physicians had intensive discussions about race of the patient, while focus groups with white physicians did not.¹⁵¹ The African American physicians said race is important for decision-making because it affects which medication they may choose, the disease risk, and social determinants that may ultimately influence health.¹⁵² The African American physicians also suggested a

144. *Id.*

145. *Id.*

146. *See id.*

147. *Id.* at 1507.

148. *Id.*

149. Snipes, Sellers, Tafawa, Cooper, Fields & Bonham, *supra* note 86, at 2–3.

150. *Id.* at 4.

151. *Id.* at 5.

152. *See id.* at 4.

need to treat African American patients more aggressively due to comorbidities as well as other sociocultural effects.¹⁵³ African American physicians wanted to know more about patients' home life, insurance status, and other non-medical variables that may affect their actual treatment outcomes.¹⁵⁴ Perhaps this seemingly more empathetic style of care was due to their own experiences as racial minorities.¹⁵⁵ At some point, they too have likely been patients that may have felt unheard by their doctors. If not, they certainly have had other societal interactions that were colored by bias. It is also possible that they were able to more quickly build rapport due to racial similarities.

Only four out of 50 white physicians discussed the importance of race, and those who did stated that it might contribute to a patient's diet or the severity of their disease, namely for hypertension.¹⁵⁶ Some white physicians also warned that talking to patients too much about their race's comorbidities may be ill-received.¹⁵⁷ It is possible that white doctors' avoidance of racial considerations in decision-making meant that their implicit biases ultimately played a greater role; instead of asking worthwhile questions about family history, access to care, and other cultural differences, the doctors relied on assumptions. This suggests doctors cannot give the best personalized care because they do not have a full complement of useful information.

Race, ethnicity, and culture can be useful tools in medicine. They can highlight everything genetic, dietary, linguistic, and philosophical that could influence patient treatment. However, these tools must always be used as a complement to actual data and not to replace data with stereotypes. This is why if race is to be used, it should be used more explicitly so that when individual patients do not fit into group norms, that information is also appropriately considered for treatment. It should not be used in a stereotypical way to infer past or future behavior of a patient beyond any independent information given during a patient history recall.

IV.

EDUCATION FOR PAIN MANAGEMENT

A. Inadequacy of Pain Training for Physicians

Pain is under-addressed at all stages of medical education.¹⁵⁸ The First National Pain Medicine Summit was convened in 2009 to help address shortcomings in medical education.¹⁵⁹ Overall, training programs in pain at the undergraduate and residency levels were graded as poor, and the consensus was that the top three barriers to pain care were a

153. *See id.* at 6.

154. *Id.*

155. *Id.* at 8.

156. *Id.* at 5.

157. *Id.*

158. COMM. ON ADVANCING PAIN RES., CARE & EDUC., INST. OF MED., NAT'L ACAD. SCI., ENG'G & MED., RELIEVING PAIN IN AMERICA: A BLUEPRINT FOR TRANSFORMING PREVENTION, CARE, EDUCATION, AND RESEARCH 191 (2011).

159. *Id.*

shortage of providers, a lack of knowledge among physicians about pain care, and a lack of public knowledge about pain.¹⁶⁰ In 2011, only four U.S. medical schools had a required course on pain out of 117 U.S. and Canadian schools.¹⁶¹ While most schools did somehow address pain in other courses, only an average of nine sessions totaling eleven hours were given in U.S. medical schools.¹⁶² At the Summit, it was clear that most medical school education still treated pain as a symptom of a larger illness, and not an illness in itself.¹⁶³ While some pain, mostly acute, is often a symptom associated with illness, sometimes there is no corresponding condition associated with pain.¹⁶⁴ Additionally, measurement of competency in licensure and certification was lacking.¹⁶⁵ It also became evident that many physicians have inadequate or ignorant attitudes about pain and are poor listeners, which prevents patients from conveying facts necessary to treat their pain.¹⁶⁶

Physicians report “feeling ill-prepared to manage chronic non-cancer pain due to inadequate training.”¹⁶⁷ A 2007 survey of 500 primary care physicians indicated that only 34% felt comfortable treating patients for chronic non-cancer pain.¹⁶⁸ Another 2006 survey emphasized the lack of preparedness in treating pain, although almost 40% of appointments involved chronic pain.¹⁶⁹ A majority of patients with substance use disorders reported that their physicians failed to address their disorder, and only around 20% of physicians considered themselves able to identify drug or alcohol dependence.¹⁷⁰

B. Recent Changes to Education and Assessment

There have been some recent changes in medical education to help address the inadequacy of the profession’s approach to pain. In 2010, Johns Hopkins introduced a four-day program in pain medicine for its first-year students.¹⁷¹ In 2001, California began requiring all physicians who were not radiologists and pathologists to take twelve continued medical education (CME) credits in pain management or end-of-life care.¹⁷² This, however, is only a one-time commitment.¹⁷³ Interdisciplinary education targeting primary care physicians, nurses, pain specialists, and medical assistants, among others, has been suggested as a mechanism to improve patient care with respect to pain.¹⁷⁴

There are tools available to assess patient risk for misuse and abuse, including the

160. *Id.* at 191–92.

161. *Id.* at 194.

162. *See id.*

163. *Id.* at 192; Barth, Guille, McCauley & Brady, *supra* note 34, at S26.

164. *See supra* Section II.A.

165. *See* Barth, Guille, McCauley & Brady, *supra* note 34, at S26.

166. *See* COMM. ON ADVANCING PAIN RES., CARE & EDUC., *supra* note 158, at 194.

167. Calcaterra, Glanz, & Binswanger, *supra* note 56, at 264.

168. *See* COMM. ON ADVANCING PAIN RES., CARE & EDUC., *supra* note 158, at 196.

169. *See id.*

170. Barth, Guille, McCauley & Brady, *supra* note 34, at S26.

171. COMM. ON ADVANCING PAIN RES., CARE & EDUC., *supra* note 158, at 195.

172. *Id.* at 195–96.

173. *Id.* at 196.

174. *Id.* at 197–98.

Screening and Opioid Assessment for Patients with Pain (SOAPP), Diagnosis, Intractability, Risk, and Efficacy (DIRE), and Opioid Risk Tool (ORT).¹⁷⁵ There are also possible opioid treatment agreements that are used in chronic pain treatment that exist as a contract between service providers and patients.¹⁷⁶ While useful in theory, providers are often unable to recognize breach, and it is questionable if the treatment plans are ethical, enforceable instruments anyways, as they are not binding contracts.¹⁷⁷ Patients may have decreased health literacy,¹⁷⁸ and such a contract increases the stigma associated with pain patients because patients see the contract as presupposing their addiction, much in the way that a prenuptial agreement can be seen as presupposing an eventual divorce.¹⁷⁹

The Opioid Risk Tool (ORT) assesses patients for family and personal history of alcohol, drug and prescription abuse, age, sexual abuse, and mental disorder.¹⁸⁰ Using the tool, 94.4% of the patients that scored as “low-risk” displayed no aberrant behaviors, while 90.9% of those rated “high-risk” did.¹⁸¹ Males were at greater risk for at least one aberrant behavior.¹⁸² In the ORT, various criteria—history of drug misuse, history of sexual abuse, age, and psychological history—are differentially weighted to calculate a predictive value. Moreover, for both men and women, the weighted ORT was a better identifier of people who would exhibit behaviors associated with opioid misuse than the unweighted ORT.¹⁸³ One may wonder if the patient history must be genetic or psychological, but studies show that biological children of alcohol-dependent parents raised elsewhere are at increased risk for developing alcohol abuse or dependency themselves.¹⁸⁴ This suggests that such a tool could be useful for predicting opioid misuse, and should be implemented as a more objective measure of prescribing. However, that will undoubtedly require further development of such tools to refine their performance.

C. Need for Further Educational Improvements

Prescription often differs based on practice area. From 2007 to 2012, physical medicine and rehabilitation specialists increased their opioid prescribing, while those in emergency medicine and dentistry decreased prescribing.¹⁸⁵ Specialists can be trained in

175. NAT’L ACAD. SCI., ENG’G & MED., *supra* note 5, at 65–66.

176. *Id.* at 67–68.

177. *See id.* at 68.

178. Health literacy refers to the ability to process and understand health information to make informed decisions that affect health outcomes, including undertaking or abstaining from particular activities or treatments. For more information, see *Health Literacy*, HEALTH RES. & SERVS. ADMIN., <https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/index.html#:~:text=Health%20literacy%20is%20the%20degree,Older%20adults> [<https://perma.cc/LGE5-CVHM>] (last visited Aug. 23, 2020).

179. *See id.*

180. *See Webster & Webster, supra* note 64, at 433.

181. *Id.* at 436.

182. *Id.*

183. *Id.* at 437.

184. *Id.* at 437–38.

185. NAT’L ACAD. SCI., ENG’G & MED., *supra* note 5, at 57.

psychiatry and addiction, which may help them evaluate each patient and create individualized treatment plans, especially for those with psychiatric and mental health issues.¹⁸⁶

1. *Prescriptions in Dentistry*

Dentists have been estimated to prescribe around 12% of all instant-release opioids, like hydrocodone and oxycodone.¹⁸⁷ For dental pain, nonsteroidal anti-inflammatory drugs (NSAIDs), like aspirin and ibuprofen, and non-opioid analgesics are recommended for first-line treatment, although third molar extractions alone are responsible for 3.5 million dental patients per year receiving opioid prescriptions.¹⁸⁸ The advantage of dentists being involved in prescribing is that there is usually a longer relationship with a dentist, compared to a surgeon or specialist,¹⁸⁹ resulting in better rapport with the patient and perhaps a better ability to notice and combat potentially addictive behaviors. However, due to the nature of emergency room and some primary care visits, it can be difficult for a doctor or nurse in those spaces to limit the risks of addiction.¹⁹⁰ Therefore, practitioners without prolonged relationships must be better instructed on how to quickly assess their patients.

2. *Prescriptions on Military Bases*

One 2015 study examined prescription rates at a hospital on a military base that saw 80% civilian patients.¹⁹¹ Researchers found that civilian providers were more likely to prescribe opioids than active duty providers, and physician assistants (PAs) were more likely to prescribe opioids than doctors, which the authors attributed to their status as the primary contact with patients more likely to have ongoing pain prescriptions.¹⁹² The overall prescribing rate was 14%, which the authors attribute to a combination of concern for opioid misuse and the fact that active duty providers are provided with annual education regarding chronic pain and pain medication.¹⁹³ The annual education requirement for active duty physicians may be responsible for the lower prescription rate. However, it is unclear whether or not that lower prescription rate also adequately dealt with patient pain, or whether the fear of addiction was so great that everyone was underprescribed.

3. *Pain Specialists*

In total, there are between 3,000 to 4,000 practicing pain specialists currently.¹⁹⁴

186. *See id.* at 69.

187. *Id.* at 63.

188. *See* Barth, Guille, McCauley & Brady, *supra* note 34, at S25.

189. *See* NAT'L ACAD. SCI., ENG'G & MED., *supra* note 5, at 64.

190. *See* Ganem, Mora, Varney & Bebart, *supra* note 21, at 289.

191. *See id.*

192. *Id.* at 291–92.

193. *Id.* at 291.

194. *See* COMM. ON ADVANCING PAIN RES., CARE & EDUC., *supra* note 158, at 198.

Considering the existence of over 100 million patients with pain,¹⁹⁵ that would result in, at best, 25,000 patients per physician. The Institute of Medicine Committee on Advancing Pain Research, Care, and Education suggests that there is a need to “[e]xpand and redesign education programs to transform the understanding of pain,” “[i]mprove curriculum and education for healthcare professionals,” and “[i]ncrease the number of health professionals with advanced expertise in pain care.”¹⁹⁶

4. Federal and State Regulation

The federal government has created rules for opioid-prescribing physicians to deal with the fact that most prescribers are not pain specialists. On the federal level, the Food and Drug Administration (FDA) requires that manufacturers complete the Risk Evaluation and Mitigation Strategies (REMS) program for extended-release opioids, which consists of the FDA training and educating prescribing physicians.¹⁹⁷ The FDA cannot mandate that the physicians complete these education and training programs, but there have been some efforts to offer them as formal continuing education in hopes of increasing physician participation.¹⁹⁸

Since many states require physicians to complete continuing medical education credits, it would make sense to require pain-specific credits, especially for high-prescribing practice areas or high-prescribing physicians. These REMS program courses could provide a starting point for the type of pain-specific education course that doctors need. The registries through which prescription monitoring is performed could be used to see who should qualify. This should not discourage doctors from appropriately prescribing. To the contrary, the education should make them feel more comfortable with what they are prescribing.

V.

THE RIGHT TO PAIN MANAGEMENT

As a society, we have not declared healthcare a fundamental human right, but there is some legal recourse for healthcare claims. For Due Process constitutional claims to arise, there must generally be some state action that impinges on a fundamental right.¹⁹⁹ The Supreme Court has generally refused to find a fundamental right to medical care.²⁰⁰ As such, disparities in medical care alone do not give rise to constitutional claims, such as equal protection under the Fourteenth Amendment. Although public hospitals are public

195. See Ganem, Mora, Varney & Bebart, *supra* note 21, at 289.

196. COMM. ON ADVANCING PAIN RES., CARE & EDUC., *supra* note 158, at 209–10.

197. Barth, Guille, McCauley & Brady, *supra* note 34, at S27.

198. See *id.*

199. See *Washington v. Glucksberg*, 521 U.S. 702, 722 (1997).

200. See Emily S. Stopa, *Harnessing Comparative Effectiveness Research to Bend the Cost Curve and Achieve Successful Health Reform: An Assessment of Constitutional Barriers to Limiting Health Care Treatment Options*, 13 U. PA. J. CONST. L. 815, 853 (2011); see also *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 507 (1989) (evaluating the need for services under rational-basis review because it is not a fundamental right).

institutions and possibly therefore state actors, the Fifth Circuit has stated that the mere acceptance of government funding does not make a hospital a state actor.²⁰¹ Additionally, the Department of Health, Education, and Welfare has stated that physicians who receive Medicare funding are not recipients of federal financial assistance with respect to Title VI and therefore do not qualify as state actors.²⁰² This creates a barrier to federal legal action due to disparate medical treatment. Without a fundamental right to health or qualified state action, there is no ground for a constitutional claim. This does not mean that there should not be a fundamental right to pain management or that there is no legal recourse; it simply remains less clear what that legal recourse should be.

In 2007, Drs. Frank Brennan, Daniel Carr, and Michael Cousins suggested that there was a fundamental human right to reasonable treatment of pain.²⁰³ The Hippocratic Oath says, “I will keep them from harm,” and the American Medical Association, similarly, says that “physicians have an obligation to relieve pain and suffering.”²⁰⁴ The clear ethical duties that doctors have to relieve pain suggest there is a right to be free from pain.²⁰⁵

However, it may not even be possible for some people to be free of pain, outside of a complete anesthetic state. Given the dangers of such drugs, freedom from pain should not be the goal. Often, patients expect to no longer experience pain after they tell a doctor, and because medicine works faster than other methods, medicine is requested and prescribed.²⁰⁶ Better education of both the individual and the public could help people to understand the ideal level of pain that should be tolerated and what pain should be treated.

Unlike normal pain treatment, pain treatment in the course of palliative care has generally found favor.²⁰⁷ Brennan, Carr, and Cousins point to *Washington v. Glucksberg* and *Vacco v. Quill* as highlighting a constitutional right to adequate palliative care.²⁰⁸ They state that the Court in these cases placed pressure on the states to reform laws for pain management, provided arguments for medical boards that are more hesitant to allow the use of high-dosage medications for terminally ill patients, and compelled states to remove any blocks to end-of-life care.²⁰⁹ The *Glucksberg* Court noted that those who attempt

201. *Wheat v. Mass*, 994 F.2d 273, 275–76 (5th Cir. 1993) (“[The hospital] Ochsner is not a state actor and cannot be considered as such solely because it receives medicare and medicaid funds and is subject to state regulation.”).

202. See Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195, 265–66 (2003).

203. See Brennan, Carr & Cousins, *supra* note 20, at 206.

204. See *id.* at 210.

205. *Id.*

206. NAT’L ACAD. SCI., ENG’G & MED., *supra* note 5, at 64.

207. Palliative care describes the care given to patients with serious illness in order to improve their quality of life. This includes everything from pain management to end-of-life planning. Palliative care is often thought of in the context of hospice treatment, in which it would be used to reduce pain prior to death, but can be given at any and all stages of a serious illness. For more information, see *WHO Definition of Palliative Care*, WORLD HEALTH ORG., <https://www.who.int/cancer/palliative/definition/en> [<https://perma.cc/3TRP-HJ9A>] (last visited Aug. 23, 2020).

208. Brennan, Carr & Cousins, *supra* note 20, at 211.

209. *Id.*

suicide irrespective of illness are usually depressed,²¹⁰ and pain can contribute to that depression. The Court cited a study stating that once patients are treated for pain and depression, they are more likely to want to live.²¹¹

In *Glucksberg*, terminally ill patients and the doctors treating them sued the state of Washington and argued that a statute outlawing physician-assisted suicide was unconstitutional.²¹² In their decision, the Court distinguished a right to refuse medical care, which does exist, from a right to assistance in committing suicide.²¹³ The Court did not declare assisted suicide a fundamental right; instead, the statute was upheld on the basis of the state's compelling interest in the preservation of life.²¹⁴ In *Vacco v. Quill*, doctors and patients sued over a similar assisted suicide statute in New York.²¹⁵ The Court distinguished cases where doctors prescribed painkillers to ease pain that inadvertently hastened death from those cases where doctors prescribed painkillers to assist suicide.²¹⁶ However, because the cases both involved end-of-life decisions, it is not immediately evident how their facts inform the management of all levels of pain. If there existed a fundamental right to die when one chose, one could more easily advocate for a fundamental right to do some harm less than death. However, because end-of-life palliative *care* was only mentioned, and it was not part of the Court's holding, the decision offers little guidance on how other palliative care or regular pain management should be analyzed legally moving forward.²¹⁷

The World Health Organization has declared appropriate palliative care as fundamental to the human right of health.²¹⁸ Because the needs for dignity and control in end-of-life care are generally recognized, hospice and palliative care successfully set forth an ethical argument for pain treatment.²¹⁹ This has led to expansions in the push for pain management—from end-of-life cancer-related pain to all cancer-related pain, and from cancer-related pain to chronic non-cancer pain.²²⁰ As each preceding population has been treated for their pain, doctors have increasingly treated more similarly situated patients.

210. *See* 521 U.S. at 730.

211. *See id.*

212. *See id.* at 707–08.

213. *Id.* at 725 (“The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection.”).

214. *See id.* at 728.

215. *See Vacco v. Quill*, 521 U.S. 793, 797 (1997).

216. *Id.* at 802.

217. *See Glucksberg*, 521 U.S. at 792 (J. Breyer concurring) (“Were the legal circumstances different—for example, were state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life—then the law’s impact upon serious and otherwise unavoidable physical pain (accompanying death) would be more directly at issue.”)

218. *See Ringwalt, Roberts, Gugelmann & Cockrell Skinner, supra* note 120, at 634; *see also* WORLD HEALTH ORG., INTEGRATING PALLIATIVE CARE AND SYMPTOM RELIEF INTO PRIMARY HEALTH CARE: A WHO GUIDE FOR PLANNERS, IMPLEMENTERS AND MANAGERS 13–14 (2018) (noting that palliative care, like primary healthcare, involves principles of “equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation as the basis for strengthening health systems”).

219. Sullivan & Howe, *supra* note 1, at S94.

220. *Id.* at S95.

But even if society accepts a need for pain management, that does not constitute a need or right to opioid therapy, as that is not the only pain relief available.²²¹ Brennan, Carr, and Cousins point to three statutory measures to argue that pain management should be a fundamental human right: the Australian Capital Territory Medical Treatment Act of 1994, the South Australian Consent to Medical Treatment and Palliative Care Act of 1995, and California Statute 103.²²²

The Australian Capital Territory Medical Treatment Act of 1994 provides a statutory right to pain relief.²²³ It provides that “a patient under the care of a health professional has a right to receive relief from pain and suffering to the maximum extent that is reasonable in the circumstances.”²²⁴ Additionally, the statute directs healthcare professionals to pay attention to the “*patient’s* account of his or her level of pain and suffering.”²²⁵ This is important because objective measurements of pain are not readily available.²²⁶ Notwithstanding that, the statute advises healthcare professionals that patients are entitled to pain relief in accordance with their stated pain level, presumably allowing for some level of interrogation. Because of the lack of clear pain treatment standards in the United States, there is also no consensus on what “reasonable” means in this context. At best, it likely resembles a standard of care, but no standard of care has been agreed upon.²²⁷

The Consent to Medical Treatment and Palliative Care Act of 1995 was passed by the state of South Australia and provides statutory protection for doctors.²²⁸ The statute absolves medical practitioners from criminal and civil liability as long as their treatments of terminally ill patients were performed in “good faith” and in “proper professional standards of palliative care.”²²⁹ This requires developing professional standards of care, which we do not have for pain management in the United States. Creating a safe harbor of activity for doctors is not antithetical to the scope of this argument, as long as the standard of care created is evidence-based. This should likely result in more uniform treatment, but it should also provide more obvious evidence of treatment errors.

California Statute 103 focuses on doctors, imposing three requirements.²³⁰ First, doctors who refuse to prescribe opioids must tell patients that there are doctors who specialize in pain management that can treat them.²³¹ Second, doctors must complete continuing education focusing on pain management and the treatment of terminally ill patients.²³²

221. *Id.*

222. Brennan, Carr & Cousins, *supra* note 20, at 211–12.

223. *See id.* at 211.

224. *Id.*

225. *Id.* (emphasis added).

226. *See Management of Postoperative Pain*, *supra* note 25, at 135 (noting that while patients may exhibit “pain-related behaviors” or vital signs, pain behaviors can be different between individuals with similar pain levels).

227. *See id.*

228. *See* Brennan, Carr & Cousins, *supra* note 20, at 211.

229. *Id.*

230. *See id.*

231. *See id.*

232. *See id.*

Continuing education will be critical to improving treatment practices as long as those educational programs are modified to include best practices based on data, as it develops. Thus, it is imperative that more research on pain management be done so that new guidelines can be created and relayed to practicing professionals through the continuing education requirement. Finally, the California Medical Board must develop a framework to investigate complaints of under-treatment of pain and report actions relating to under-treatment to the state legislature.²³³ It is unclear how much a patient will know about his or her own under-treatment, but collecting those reports is important because they can then be used as grounds for further investigation, and as they will be in the hands of the legislature, they may provide a push for further legal interventions.

Additionally, the International Covenant on Economic, Social and Cultural Rights acknowledges an express right to different types of health,²³⁴ from which a right of pain management could flow.²³⁵ The definition of “health” is “a state of complete physical, mental, and social well-being.”²³⁶ This ought to include effective pain management. However, even if that right exists, it is unclear what recourse would be available to individuals who wish to make a complaint under the Covenant.²³⁷ The DEA has prosecuted physicians for overprescribing pain medicine;²³⁸ accordingly, doctors walk a fine line between properly treating pain and overtreating it. However, the DEA has permitted multiple prescriptions to be filled sequentially,²³⁹ and it is unclear if patients not subject to that level of overprescription have other accessible remedies.

If pain management were to be a fundamental right, then there should be no disparities in pain management because everyone should be treated to the same standard. This does not mean there would not be disparities in pain, especially if there are underlying genetic reasons why persons of different races experience different levels of pain. Rather, whatever right to pain management exists, the treatment should not be disparate based on race. While it would be hard to prove any discriminatory intent in pain treatment, evidence of disparate impact exists.

Although affirmative actions have been undertaken to correct other disparate impacts in medical care, there is no clear fix for the racial disparities in pain management. More minority physicians could be trained to participate in pain management, so that there would be more of them to interact with minority patients in a less biased way; however, that would not deal with the underlying complexities of pain. It would also further burden minority physicians and relieve white doctors of their duty to confront their biases in order to do their jobs correctly. That solution also necessitates training a pool of physicians to specialize in pain management and primarily work in areas with minority patients. Due to

233. *See id.* at 211–12.

234. *See* International Covenant on Economic, Social and Cultural Rights art. 12, *adopted and opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976).

235. *See* Brennan, Carr & Cousins, *supra* note 20, at 211.

236. *See id.*

237. *See id.*

238. *See id.* at 209.

239. *See id.*

the lack of definitive research on what proper prescribing levels are, it remains unclear who is being prescribed opioids at the proper level. Therefore, there should be further studies and data collection to improve pain treatment guidelines, such that a proper set of rules around opioid prescription is created.

The Emergency Medical Treatment and Active Labor Act (EMTALA) could provide a mechanism for addressing claims that doctors treat patients in a discriminatory manner.²⁴⁰ Under EMTALA, hospitals are required to screen and stabilize individuals seeking emergency care.²⁴¹ The statute defines an “emergency medical condition” as “a medical condition manifesting itself by acute symptoms of sufficient severity (*including severe pain*) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.”²⁴² It is clear, for example, that a headache would not be an emergency. However, the word “severe” is vague, and the details underlying serious jeopardy, impairment, or dysfunction are equally unclear. Assuming that one could argue that pain is emergent and thus requires emergency care, EMTALA requires screening and stabilization that is applied uniformly to patients with similar symptoms.²⁴³ Because this only applies to patients seeking emergency care, it would not apply to all patients with pain management needs. However, because pain is the primary reason for emergency room visits in the United States,²⁴⁴ it may be a good first place to start.

“Stabilize” is defined in the statute as “to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer [or discharge] of the individual from a facility”²⁴⁵ This suggests that EMTALA may only be applicable to in-hospital administration of opioids and not all prescriptions. While we have evidence that overall treatment with opioids has been disparate, the EMTALA requires specific analyses of “severe” pain in emergency care. EMTALA also cannot be used when patients simply received “substandard” treatment, rather, the treatment must be “non-uniform.”²⁴⁶ “Substandard” care refers to care that is below a treatment standard, while “non-uniform” care refers to treatment that is abnormal for that physician given a

240. See Beverly Cohen, *Disentangling EMTALA from Medical Malpractice: Revising EMTALA's Screening Standard to Differentiate Between Ordinary Negligence and Discriminatory Denials of Care*, 82 TUL. L. REV. 645, 655 (2007). Professor Cohen has produced a substantial body of scholarship in the regulatory space, including the above analysis of ways in which the law may be used to combat healthcare discrimination.

241. *Id.* at 646.

242. 42 U.S.C. § 1395dd(e)(1) (2012) (emphasis added).

243. Cohen, *supra* note 240, at 663–64; see also *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994) (citing *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879–80 (4th Cir. 1992) (“The plain language of [EMTALA] requires a hospital to develop a screening procedure designed to identify such critical conditions that exist in symptomatic patients and to apply that screening procedure uniformly to all patients with similar complaints.” (emphasis added))).

244. Ganem, Mora, Varney & Bebart, *supra* note 21, at 288.

245. 42 U.S.C. § 1395dd(e)(3)(A) (2012).

246. Cohen, *supra* note 240, at 663–64.

similar set of circumstances. For example, if the standard of care is to give opioid A for a bone break, but a doctor consistently prescribes opioid B, that claim would not be subject to EMTALA. However, if the doctor normally prescribes opioid A, but in an instance where all other circumstances are similar, the doctor prescribes dissimilar opioid B, that would be non-uniform care. A properly stated claim allows for discovery of hospital procedures and records in order to rebut a defense of the treatment being merely negligent.²⁴⁷ That is important because negligence may provide standing for a state malpractice claim, and thus mere negligence does not constitute a claim under EMTALA.²⁴⁸

State tort law claims for medical malpractice are difficult in pain management because there is no agreed upon standard of care.²⁴⁹ Additionally, to prove negligence, a plaintiff must show that the action a doctor took caused harm due to the doctor's action being the cause-in-fact and not just a contributing factor.²⁵⁰ For pain management, it is unclear what the alternative action would or should be. Would it be more treatment, similar treatment with a different drug, or no treatment at all? How would each of those options affect the outcome of a specific plaintiff for whom there is both no objective measure of pain and no way to show that alternative treatments would lead to different results? Without drastically different treatment regimens for extremely similar people, it would be hard to escape the reasonableness of any choice of a physician in a particular instance. The barrier to litigation would not be that the doctor had not caused harm, but rather that every reasonable doctor likely would have caused that same harm, which is hard to prove, making malpractice usually an inviable claim. This underscores the need for clearer guidelines, because showing a deviation from the "norm" is that much more difficult in the absence of a clearly defined practice.

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act was recently passed in response to the opioid crisis²⁵¹ and has a focus on treatment of addicted individuals and follow-up care.²⁵² The law also expands the types of facilities covered for Medicare beneficiaries and authorizes some nurse practitioners and physician assistants to administer treatment.²⁵³ Importantly, it does not extend to incarcerated individuals, as services in jails are not provided.²⁵⁴ The law also requires the FDA to develop specific guidelines for the

247. *See id.* at 667.

248. *Id.* at 667–68.

249. *See Management of Postoperative Pain, supra* note 25. This article is cited to show the lack of consensus on a standard of care. The physicians are only able to make "recommendations" based on a systematic review of pain treatment without making any definitive statements. That lack of standard of care makes it more difficult to show a deviation from any defined practice procedure.

250. *See Crossley, supra* note 202, at 261.

251. Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018) (addressing the opioid crisis in Titles I and II explicitly).

252. *See* Corey S. Davis, *The SUPPORT for Patients and Communities Act—What Will it Mean for the Opioid Overdose Crisis?*, 380 NEW ENG. J. MED. 1, 3 (2019).

253. *See id.* at 4.

254. *See id.*

treatment of conditions of acute pain, though the guidelines “are not intended to restrict, limit, delay, or deny coverage or access by individual health professionals.”²⁵⁵ However, none of the guidelines created thus far by specialists have been “specific,” and if they are not in place to influence actual behavior by health professionals, it is hard to foresee any impact of the use of such standards. There needs to be a more concrete mandate for protocol creation *and* following those protocols. This may mean putting more time and effort into their creation, but it would also be a more adequate response to the weight of the issue. Doctors would ultimately be responsible for doing this, though as government involvement in prescription monitoring and research increases, there could be some governmental oversight.

Currently, there are two potential legal avenues for claims that African American patients were harmed due to improper pain treatment: state malpractice claims and federal EMTALA claims. Both have barriers to entry. Because pain treatment does not have a clear standard of care, for malpractice claims it will be difficult to show that any doctor deviated from the standard in a way that was unreasonable. EMTALA does not require this, and there only needs to be a showing that the doctor did something aberrant according to the rest of their practice. However, EMTALA only applies to treatment in the emergency room, and perhaps only to severe pain, which limits who can bring a claim under this statute, while malpractice claims can be brought in all treatment contexts. There is no perfect solution for this problem, but these are two good places to start.

VI.

CONCLUSION

Overall, the current information surrounding opioid use makes it clear that more research needs to be done on proper treatment levels and prescription guidelines. There are no long-term studies of opioid therapies compared to placebo therapy, no opioid therapy, or non-opioid therapy for chronic pain, but there is difficulty in doing such studies given the harms of inadequate pain treatment.²⁵⁶ Therefore, prescribing opioids for pain appears more as a pattern of habit, and not as evidence-based as it is for other medical conditions. However, there is evidence that prescribing higher doses leads to more opioid abuse.²⁵⁷ It is unclear exactly what therapy should be prescribed, and the problem is made more complicated because pain is subjective, meaning objective measures are not always accurate. In spite of that, racial disparities in treatment for the same symptoms should not exist.

Physicians need to be better educated, both about the opioids they are prescribing and their own implicit biases that have influenced prescribing thus far. There also needs to be *continued* education at both levels as new research reveals new information. Additionally, physicians need to undergo implicit bias evaluations and training. Ideally, this training

255. Kevin B. O'Reilly, *10 Ways the New Opioids Law Could Help Address the Epidemic*, AM. MED. ASS'N (Oct. 24, 2018), <https://www.ama-assn.org/delivering-care/opioids/10-ways-new-opioids-law-could-help-address-epidemic> [<https://perma.cc/A6V4-XU2T>].

256. See Dowell, Haegerich & Chou, *supra* note 58, at 10–11.

257. See *id.* at 6.

would be another part of the medical school curriculum, and further training and evaluation would happen at hospitals through a self-evaluation process at the organizational level, at least initially. Greater education should be developed around using group-level data to identify diseases and disease potentials among patients without importing biases into patient treatment. Because implicit biases are not necessarily professed beliefs, such biases could be harder to train away. Nevertheless, while it may be easier to change patterns for younger physicians, it is unavoidably necessary to address implicit and explicit biases for *all* physicians.

After we develop clearer, evidence-based standards for treatment and training for physicians, we can continue to evaluate disparities with a better set of marks to use. It will be easier to tell who is properly or negligently prescribing and thus regulate those who are not proper prescribers. This will allow tort law claims for pain-associated treatment. However, without a clear standard of care, there is no way to determine deviations. Since EMTALA only covers “severe” pain in an emergency room setting, strengthening the defined standard of care should both lead to better treatment *and* better deterrence of poor treatment. However, EMTALA claims should still be investigated in emergency scenarios where applicable.

The actual demographics of both the epidemic and normal pain prescribing trends should additionally inform whatever education and management tools are developed in the future, such that changes can be tracked. Is it possible that African Americans are being prescribed at the right level when weighing the benefits of freedom from pain and reduction of addiction, and white patients should be prescribed less, in which case the harm is done exclusively to white patients? Is it possible that African Americans are truly being underprescribed, and even if they should not be prescribed to a level of no pain due to abuse and misuse concerns, they are still experiencing harm? The truth likely lies somewhere in the middle, with underprescription and overprescription occurring simultaneously. However, no matter who is currently being prescribed properly, if anyone at all, any reductions in prescriptions to combat the opioid crisis could cause further harm to African American patients if these implicit biases are not corrected, because they enshrine a difference in prescribing level between African American and white patients.

By lessening biases, providing more medical education, and doing more research into treatment and risks, the medical community can move closer to a world in which more patients are prescribed medication in a more evidence-based, equitable manner. Proper guidelines can, at the very least, begin to form a basis for these claims in tort law that more adequately ensures equitable treatment. There may still be a class of victims who can make claims under EMTALA for non-uniform treatment of their severe pain in emergency room settings. However, their individual claims may not be as common. Here, the onus falls heaviest on the medical community. Its members took an oath to not harm patients, and eradication of harm—not adjudication—is the ultimate goal. The treatment of pain, especially with opioids, is a delicate balance, but one the medical community should be prepared to fully take on.