**COURSE #97280 — 2 CONTACT HOURS/CREDITS RELEASE DATE: 08/01/20 EXPIRATION DATE: 07/31/23**

# *Pain Management Pearls: Opioids and Culture*

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- Read the enclosed course.
- Complete the questions at the end of the course.
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### *Faculty*

**Mark Rose, BS, MA, LP,** is a licensed psychologist in the State of Minnesota with a private consulting practice and a medical research analyst with a biomedical communications firm. Earlier healthcare technology assessment work led to medical device and pharmaceutical sector experience in new product development involving cancer ablative devices and pain therapeutics. Along with substantial experience in addiction research, Mr. Rose has contributed to the authorship of numerous papers on CNS, oncology, and other medical disorders. He is the lead author of papers published in peer-reviewed addiction, psychiatry, and pain medicine journals and has written books on prescription opioids and alcoholism published by the Hazelden Foundation. He also serves as an Expert Advisor and Expert Witness to law firms that represent disability claimants or criminal defendants on cases related to chronic pain, psychiatric/substance use disorders, and acute pharmacologic/toxicologic effects. Mr. Rose is on the Board of Directors of the Minneapolis-based International Institute of Anti-Aging Medicine and is a member of several professional organizations.

**Alice Yick Flanagan, PhD, MSW**, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

### *Faculty Disclosures*

Contributing faculty, Mark Rose, BS, MA, LP, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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*A complete Works Cited list begins on page 13.*

### Division Planners/Director Disclosure

The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

### Audience

This course is designed for physicians, nurses, and allied health professionals who may intervene to improve the treatment of pain in diverse patient populations.

### Accreditations & Approvals

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### *Disclosure Statement*

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### *Course Objective*

The purpose of this course is to increase clinicians' knowledge and awareness of the appropriate prescription of opioids and the impact of culture on issues of pain and pain management in order to improve the provision of care and patients' quality of life.

### *Learning Objectives*

*Upon completion of this course, you should be able to:*

1. Discuss characteristics of appropriate and inappropriate opioid prescribing and contributory factors to both.
2. Outline the appropriate periodic review and monitoring of patients prescribed opioid analgesics.
3. Describe necessary components of patient/caregiver education for prescribed opioid analgesics, including guidance on the safe use and disposal of medications.
4. Analyze how culture, race and ethnicity influence how pain is defined, expressed, and experienced.

EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

## INTRODUCTION

Pain affects all domains of life, and clinicians have few effective tools at their disposal to help these patients [1]. Opioids remain the strongest group of analgesic drugs available [2]. Millions of patients are safely and effectively maintained on relatively high-dose opioids for chronic, severe pain and require these medications to function. Public pressure and the mischaracterization of patients as "drug addicts" has increasingly deterred prescribers from treating patients with chronic pain successfully managed with opioids for years or decades rather than improving safety practices [3; 4]. However, opioids, like many medications, have serious risks and should not be treated like a cure-all [5]. This dichotomy has resulted in many patients for whom opioid analgesics are appropriate increasingly experiencing barriers to pain relief.

At greatest risk of unrelieved pain from stigma and bias are children, the elderly, racial and ethnic minorities, active duty or military veterans, and those with cancer, HIV, or sickle cell disease. Pain undertreatment in African American patients is especially widespread, from prevalent misperceptions that this group has higher pain tolerance and is more likely to abuse their opioid prescription [6]. As a result, prescribers, dispensers, and administrators would benefit from considering both the tenets of appropriate opioid prescribing and the impact of culture on experiences of pain and effective pain management.

## OPIOID MANAGEMENT OF CHRONIC PAIN

All patients with pain have a level of risk that can only be roughly estimated initially and modified over time as more information is obtained. There are ten essential steps of opioid prescribing for chronic pain to help mitigate any potential problems [7]:

- Diagnosis with an appropriate differential
- Psychologic assessment, including risk of substance use disorders
- Informed consent
- Treatment agreement
- Pre- and post-treatment assessments of pain level and function
- Appropriate trial of opioid therapy with or without adjunctive medication
- Reassessment of patient levels of pain and functioning
- Regular assessment with the 5 A's (i.e., analgesia, activity, adverse effects, aberrant behaviors, and affect)
- Periodically review pain diagnosis and comorbid conditions, including substance use disorders
- Documentation

EVIDENCE-BASED PRACTICE RECOMMENDATION

Despite limited evidence for reliability and accuracy, screening for opioid use is recommended by the American Society of Interventional Pain Physicians, as it will identify opioid abusers and reduce opioid abuse.

(https://painphysicianjournal.com/2012/july/2012;%2015;S67-S116.pdf. Last accessed July 27, 2020.)

**Level of Evidence**: Limited (Evidence is insufficient to assess effects on health outcomes because of limited number or power of studies, large and unexplained inconsistency between higher-quality trials, important flaws in trial design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.)

### INFORMED CONSENT AND TREATMENT AGREEMENTS

The initial opioid prescription is preceded by a written informed consent or "treatment agreement" [8]. This agreement should address potential side effects, tolerance and/or physical dependence, drug interactions, motor skill impairment, limited evidence of long-term benefit, misuse, dependence, addiction, and overdose. Informed consent documents should include information regarding the risk/benefit profile for the drug(s) being prescribed. The prescribing policies should be clearly delineated, including the number/frequency of refills, early refills, and procedures for lost or stolen medications.

The treatment agreement also outlines joint prescriber and patient responsibilities. The patient agrees to using medications safely, refraining from "doctor shopping," and consenting to routine urine drug tests (UDTs). The prescriber's responsibility is to address unforeseen problems and prescribe scheduled refills. Reasons for opioid therapy change or discontinuation should be listed. Agreements can also include sections related to follow-up visits, monitoring, and safe storage and disposal of unused drugs.

It is important to remember that treatment agreements are only one aspect of developing a safe opioid use plan. The evidence to support the use of such agreements to decrease the misuse of opioids is relatively weak, with little or no proof of improvements in adherence or patient care [9].

### INITIATING A TRIAL OF OPIOID THERAPY

Opioid therapy should be presented as a trial for a pre-defined period (e.g., ≤30 days). As noted, the goals of treatment should be reasonable improvements in pain, function, depression, anxiety, and avoidance of unnecessary or excessive medication use [8]. The treatment plan should describe therapy selection, measures of progress, and other diagnostic evaluations, consultations, referrals, and therapies.

In opioid-naïve patients, start at the lowest possible dose and titrate to effect. Dosages for opioid-tolerant patients should always be individualized and titrated by efficacy and tolerability. The need for frequent progress and benefit/risk assessments during the trial should be included in patient education. Patients should also have full knowledge of the warning signs and symptoms of respiratory depression.

Prescribers should be knowledgeable of federal and state opioid prescribing regulations. Issues of equianalgesic dosing, close patient monitoring during all dose changes, and cross-tolerance with opioid conversion should be considered. If necessary, treatment may be augmented, with preference for nonopioid and immediate-release opioids over extended-release/long-acting (ER/LA) opioid formulations. Taper opioid dose when no longer needed [10].

## PERIODIC REVIEW AND MONITORING

When implementing a chronic pain treatment plan that involves the use of opioids, the patient should be frequently reassessed for changes in pain origin, health, and function [8]. This can include input from family members and/or the state prescription drug monitoring program. Prescription drug monitoring programs are one of the most effective measures for reducing opioid analgesic diversion and abuse, but their efficacy is undermined by inconsistent use [9]. During the initiation phase and during any changes to the dosage or agent used, patient contact should be increased. Decisions regarding the continuation, modification, or termination of opioid therapy for pain should be based on evaluation of the patient's progress and the absence of substantial risks or adverse events [8]. At every visit, chronic opioid response may be monitored according to the 5 A's [11]:

- Analgesia
- Activities of daily living
- Adverse effects
- Aberrant drug-related behaviors
- Affect (i.e., patient mood)

### Assessment During Ongoing Opioid Therapy

Signs and symptoms that, if present, may suggest a problematic response to the opioid and interference with the goal of functional improvement include [11]:

- Excessive sleeping or days and nights turned around
- Diminished appetite
- Inability to concentrate or short attention span
- Mood volatility, especially irritability
- Lack of involvement with others
- Impaired functioning due to drug effects
- Use of the opioid to regress instead of re-engaging in life
- Lack of attention to hygiene and appearance
- Escalation of pain and/or pain medication dose
- Increasing number of medications prescribed to treat the side effects of opioids

Patients who display any of these signs or symptoms should be assessed for potential opioid misuse or use disorder/addiction. Persons in active addiction should be referred to an addiction and/or pain specialist.

The decision to continue, change, or terminate opioid therapy is based on progress toward treatment objectives and absence of adverse effects and risks of overdose or diversion [8]. Satisfactory therapy is indicated by improvements in pain, function, and quality of life. Brief assessment tools to assess pain and function may be useful, as may UDTs. Treatment plans may include periodic pill counts to confirm adherence and minimize diversion.

Information obtained by patient history, physical examination, and interview, from family members, a spouse, or state prescription drug monitoring database, and from the use of screening and assessment tools can help the clinician to stratify the patient according to level of risk for developing problematic opioid behavioral responses. A urine drug test should be performed prior to initiating opioid treatment.

Low-risk patients receive the standard level of monitoring, vigilance, and care. Moderate-risk patients should be considered for an additional level of monitoring and provider contact, and high-risk patients are likely to require intensive and structured monitoring and follow-up contact, additional consultation with psychiatric and addiction medicine specialists, and limited supplies of short-acting opioid formulations.

If substance abuse is active, in remission, or in the patient's history, one should consult an addiction specialist before starting opioids. In the setting of active substance abuse, opioids should not be prescribed until the patient is engaged in a treatment/recovery program or other arrangement are made, such as addiction professional co-management and additional monitoring. When considering an opioid analgesic (particularly those that are extended-release or long-acting), one must always weigh the benefits against the risks of overdose, abuse, addiction, physical dependence and tolerance, adverse drug interactions, and accidental exposure by children.

## PATIENT AND CAREGIVER EDUCATION

### Safe Use of Opioids

Patients and caregivers should be counseled regarding the safe use and disposal of opioids. As part of its mandatory Risk Evaluation and Mitigation Strategy (REMS) for ER/LA opioids, the U.S. Food and Drug Administration (FDA) has developed a patient counseling document with information on the patient's specific medications, instructions for emergency situations and incomplete pain control, and warnings not to share medications or take them unless prescribed [10]. A copy of this form may be accessed online at https://www.fda.gov/media/86281/download.

When prescribing opioids, clinicians should provide patients with the following information and instructions [10]:

- Product-specific information
- Taking the opioid as prescribed
- Importance of dosing regimen adherence, managing missed doses, and prescriber contact if pain is not controlled
- Warning and rationale to never break or chew/crush tablets or cut or tear patches prior to use
- Warning and rationale to avoid other central nervous system depressants, such as sedative-hypnotics, anxiolytics, alcohol, or illicit drugs
- Warning not to abruptly halt or reduce the opioid without physician oversight of safe tapering when discontinuing
- The potential of serious side effects or death
- Risk factors, signs, and symptoms of overdose and opioid-induced respiratory depression, gastrointestinal obstruction, and allergic reactions
- The risks of falls, using heavy machinery, and driving
- Warning and rationale to never share an opioid analgesic
- Rationale for secure opioid storage
- Warning to protect opioids from theft
- Instructions for disposal of unneeded opioids, based on product-specific disposal information

### Disposal of Opioids

There are no universal recommendations for the proper disposal of unused opioids, and patients are rarely advised of what to do with unused or expired medications. According to the Office of National Drug Control Policy, most medications that are no longer necessary or have expired should be removed from their containers, mixed with undesirable substances (e.g., cat litter, used coffee grounds), and put into an impermeable, nondescript container (e.g., disposable container with a lid or a sealed bag) before throwing in the trash [12]. The FDA recommends that most opioid medications, including oxycodone/acetaminophen (Percocet), oxycodone (OxyContin tablets), and transdermal fentanyl (Duragesic Transdermal System), be flushed down the toilet instead of thrown in the trash [12]. Disposal by flushing down the toilet provides immediate and definitive elimination of safety hazards from intentional use or accidental exposure involving opioid products. All transdermal patch opioid products should be flushed down the toilet after folding in half by adhesive side against adhesive side [13]. Patients should be advised to flush prescription drugs down the toilet only if the label or accompanying patient information specifically instructs doing so. Flushing unused medications has been the subject of controversy, with some state governments and boards recommending against the practice due to pollution concerns and effects on waterways and wildlife [14].

The American Medical Association recommends the following three steps to promote the safe storage and disposal of opioids [15]:

- Educate patients about the safe use of opioids, including not sharing prescriptions with others.
- Remind patients that medications should be stored out reach of children and in a safe place—preferably locked—to prevent other family members and visitors from taking them.
- Talk to patients about the most appropriate way to dispose of expired, unwanted, and unused medications. The preferred option is that unwanted or unused pills, liquids or other medications should be disposed of in a local "take-back" or mail-back program or medication drop box at a police station, pharmacy, or authorized collection site. Contact your state law enforcement agency or visit https://takebackday.dea.gov to determine if a program is available in your area.

## CONSULTATION AND REFERRAL

It is important to seek consultation or patient referral when input or care from a pain, psychiatry, addiction, or mental health specialist is necessary. Clinicians who prescribe opioids should become familiar with opioid addiction treatment options (including licensed opioid treatment programs for methadone and office-based opioid treatment for buprenorphine) if referral is needed [8].

Ideally, providers should be able to refer patients with active substance abuse who require pain treatment to an addiction professional or specialized program. In reality, these specialized resources are scarce or non-existent in many areas [8]. Therefore, each provider will need to decide whether the risks of continuing opioid treatment while a patient is using illicit drugs outweigh the benefits to the patient in terms of pain control and improved function [16].

## MEDICAL RECORDS

Documentation is a necessary aspect of all patient care, but it is of particular importance when opioid prescribing is involved. All clinicians should maintain accurate, complete, and up-to-date medical records, including all written or telephoned prescription orders for opioid analgesics and other controlled substances, all written instructions to the patient for medication use, and the name, telephone number, and address of the patient's pharmacy [8].

Good medical records demonstrate that a service was provided to the patient and that the service was medically necessary. Regardless of the treatment outcome, thorough medical records protect the prescriber.

### DISCONTINUING OPIOID THERAPY

The decision to continue or end opioid prescribing should be based on a joint discussion of the anticipated benefits and risks. An opioid should be discontinued with resolution of the pain condition, intolerable side effects, inadequate analgesia, lack of improvement in quality of life despite dose titration, deteriorating function, or significant aberrant medication use [8].

Clinicians should provide physically dependent patients with a safely structured tapering protocol. Withdrawal is managed by the prescribing physician or referral to an addiction specialist. Patients should be reassured that opioid discontinuation is not the end of treatment; continuation of pain management will be undertaken with other modalities through direct care or referral.

## THE IMPACT OF CULTURE ON PAIN AND PAIN MANAGEMENT

Patients' experiences of pain may be frustrating if they defy biomedical explanation, and the treatment of pain tends to be stigmatized [17]. When culture, race, and ethnicity are taken into consideration, the treatment of pain becomes even more complex. Practitioners should address how patients construct the meaning and experiences of pain rather than simply dealing with a set of medical procedures and routines [17].

Practitioners working with patients experiencing pain should be aware of the patient's cultural value and belief systems and how they impact their pain experience and also how their own cultural background and professional culture/system affects how they view pain. Furthermore, culture can influence access to and utilization of pain management services and medications and provider communication [22]. For the most part, practitioners are trained and socialized from a biomedical tradition [23]. Practitioners should reflect on their own experiences and the values and beliefs they attribute to pain [24]. Take a moment to consider the following self-reflective questions [24].

#### Pain Experiences in Childhood

- When you were a child, how did those who cared for you react when you were in pain?
- How did they expect you to behave when you had a minor injury?
- How did they encourage you to cope when you had severe pain?
- How did they encourage you to behave during an injection or procedure?
- When those who cared for you as a child were in pain, how did they react?
- What words did they use to describe the pain?
- How did they cope with their pain?
- Do you tend to follow their example?

#### Pain Experiences in Adulthood

- What painful experiences have you had as an adult (e.g., childbirth, fracture)?
- How did you express (or not express) your pain?
- Did the pain cause you fear? What were you afraid of?
- How did you cope with the pain?
- How did you want others to react while you were in pain?

**Pain Experiences by Patients**

- Have you ever felt uncomfortable with the way a patient was reacting (or not reacting) to pain?
- What did the patient do that concerned you?
- Why did you feel that way?
- Do you make value judgments about patients in pain who:
  - Behave more stoically or expressively than you would in a similar situation?
  - Ask for pain medication frequently or not often enough?
  - Choose treatments you do not believe are effective or with which you are unfamiliar?
  - Belong to a cultural group (e.g., ethnic, linguistic, religious, socioeconomic) different from your own?
- Do you tend to feel certain reactions to, descriptions of, or treatments for pain are "right" or "wrong?" What about these reactions makes them seem right or wrong?

## FACTORS THAT CONTRIBUTE TO RACIAL AND ETHNIC DISPARITIES IN PAIN MANAGEMENT

It is clear that health disparities exist among racial and ethnic minority groups, and this is true for pain management services and medications. A large-scale national study in the United States found racial differences in the prescription of analgesics for patients with migraine, low back pain, and bone fractures [25]. Specifically, African Americans were less likely to be prescribed analgesics for their pain compared with their white counterparts. Racial minority patients are also more likely to experience longer wait times for medication compared with white patients [20].

Analysis of a national dataset found that African Americans were less likely to be prescribed opioids for back pain and abdominal pain compared with non-Hispanic white Americans [26]. The authors speculate that racial biases may influence prescribing behaviors. An examination of Medicaid patients who received epidural analgesia during vaginal childbirth also found statistically significant racial/ethnic differences [27]. In this study, 59.6% of the white patients received epidural analgesia, compared with 49.5% of African Americans, 48.2% of Asians, and 35.2% of Hispanics. Even after the researchers controlled for age, urban/rural residence, and the availability of anesthesiologists, race and ethnicity still predicted epidural analgesia prescribing trends [27].

In a meta-analysis of ethnicity and pain management researchers found that professionals under-rated ethnic minority patients' levels of pain and were less likely to indicate their pain scores on their charts compared with their white counterparts [28]. In addition, African American and Hispanic patients were less likely to have been given analgesics than white patients.

Studies have not definitively isolated the factors that contribute to these disparities. One of the challenges in understanding health disparities, and particularly pain management disparities, is the fact that racial and ethnic minority groups are heterogeneous [29; 30]. Recent immigrants from Japan, for example, are going to be very different from native-born Japanese who have resided in the United States for generations [29]. However, researchers have often combined these groups, as challenges in recruitment yield small sample sizes that make it difficult for statistical analyses to be meaningful. The literature has identified a variety of reasons for these disparities stemming from several factors [31].

### Barriers Related to Western Biomedical Culture

Western biomedical culture emphasizes a clear dichotomy between the mind and the body as well as what is observable (objective) and what is not (subjective) [32]. Pain is not easily measured, making its assessment and treatment a challenge in Western medicine [32]. In addition, many healthcare professionals may not be adequately trained to incorporate spirituality in the management and treatment of pain for patients who desire to incorporate a more holistic approach [33]. The Western American medical paradigm also leans toward cure rather than care [32]. Patients who present with symptoms that lead to a diagnosis for which there is a clear pathway of interventions and treatment are "favored." Because of the subjective nature of pain, healthcare professionals must often make clinical decisions in the face of a lack of absolute, clear physical evidence [34].

### Societal and Institutional Barriers

Societal and institutional barriers include racism, discrimination, poverty, lack of health insurance, and deleterious environmental factors in communities [35]. For example, groups that have historically (or currently) been victims of institutional racism and discrimination are more likely to delay seeking help for pain [28]. Some studies indicate that African American men may experience higher levels of pain intensity in part due to their experiences with different forms of racial discrimination [20]. Even today, racial and ethnic minority patients are more likely to be placed in a negative valenced relationship [34]. In the context of pain management, healthcare providers are more likely to discount the pain due to the negative valenced relationship triggered by racism and discrimination [34].

It has been shown that physicians tend to have less involved communication and less participatory interactions with racial minority patients and low-income patients [32]. In addition, the stereotype that certain racial minority groups come from chaotic and disorganized families and environments increases the likelihood of healthcare professionals labeling them as "difficult." Just as healthcare professionals may have preconceived notions about patients, patients may have pre-existing assumptions about the provider. For example, one study of Native American patients found that the participants tended to feel that healthcare professionals were not interested in hearing about their pain experience and did not have confidence that they would be helped [36]. Thus, a cycle of myths and stereotypes continues.

One oft-cited study found that three-quarters of pharmacies located in areas of New York City with a high proportion of racial and ethnic minority residents did not stock adequate supplies of opioid analgesics [37]. Some pharmacists attributed the low supply to lower demand, but others cited factors related to racism and discrimination. In addition, pharmacies in areas with high concentrations of racial minorities are more concerned with burglaries, additional regulations, and penalties imposed by state and federal drug-enforcement agencies than pharmacies in predominantly white neighborhoods [37].

### Healthcare Professional-Related Barriers

Healthcare professional barriers may include professionals' beliefs about appropriate pain management; lack of training and knowledge about the intersection of pain and culture, race, and ethnicity; lack of culturally sensitive assessment for pain; and expectations about racial and ethnic minority pain patients based on stereotypes [38]. Consequently, practitioners may underestimate and minimize racial minority patients' pain experiences. In a qualitative study, Native American individuals described their complaints of pain being dismissed, receiving inadequate care, and neglected aftercare [39].

Studies have also shown that the language and race/ethnicity of the healthcare professional influences pain management. For example, the ratings of pain tend to be comparable when the patient and healthcare provider speak the same language. When there is a native language, pain ratings tend to diverge. When literacy and language barriers are eliminated, assessment and treatment improves and racial and ethnic minority patients with pain fare better [40]. In addition, healthcare professionals' level of empathy appears to increase when the patient and healthcare professional share the same skin color or are of the same ethnic group [41; 42].

### Patient-Related Barriers

Patient barriers to effective pain management include fear and anxiety about substance misuse and addiction, cultural values such as fatalism (i.e., pain is inevitable), and ideas about being a good patient [31]. Cultural values about pain coping, definitions, expression, and experience may also be patient-related barriers. For example, those with a fatalistic perspective of pain are often stoic. A qualitative study of Somali women found that the participants felt wailing or crying about one's pain was a sign of weakness [43]. Similarly, Hispanics and African Americans are more likely to embrace the importance of being stoic and are less likely to ask for pain medication [28]. Studies also show that Hispanic and African American patients with cancer tend to under-report their pain for fear of being labeled as complainers or of distracting the physicians treating their illness [44]. Some patients will not ask questions for fear that would be viewed as challenging an authority figure [45]. Some ethnic/racial minority patients disclose that they avoid pain medications because they overestimate the risk dependence [45; 46; 47].

## ALTERNATIVE REMEDIES

Practitioners should explore both traditional biomedical pain management interventions and non-traditional alternative remedies (as appropriate) when working with racial and ethnic minority patients. Complementary self-management approaches for pain can be generally classified as mind/body approaches or natural products [48]. Mind/body approaches include meditation, yoga, acupuncture, and breathing techniques. Natural products include herbs, vitamins, and topical ointments [48]. Some patients may be more receptive to traditional healing methods (e.g., herbal remedies, traditional healers) [36]. In focus groups, Native American participants reported using a range of alternative therapies for pain, including acupuncture, massage, chiropractic treatment, and guided imagery [39].

Alternative remedies for pain can be classified into five different areas, and many can be used as adjuncts to conventional therapies [49; 50]:

- Alternative medications: Nonpharmacologic substances, such as those associated with homeopathic medicine, traditional Chinese medicine, and Ayurvedic medicine
- Mind-body interventions: Interventions that focus on using the mind to influence bodily symptoms, including biofeedback, meditation, music therapy, and guided imagery. Mind-body interventions help reduce pain and improve other comorbid conditions, such as depression.
- Biologically based interventions: Consumption of biologic products (e.g., herbs, vitamins, foods)
- Manipulation strategies: Adjustment of focused areas of the body (e.g., chiropractic measures, massage, acupuncture)
- Energy therapies: Balancing energy fields (e.g., electromagnetic therapy, reiki, qigong)

Some cultural groups subscribe to the hot/cold theory of disease, which argues that illnesses are the result of bodily imbalances and that foods and alternative medications are inherently "hot" or "cold." Pain is considered a "cold" disease, and some patients who adhere to traditional healing will take this into account when selecting and adhering to treatment approaches [51].

## END-OF-LIFE CONSIDERATIONS

Palliative care is the noncurative care provided to patients to relieve symptoms and improve quality of life [52]. The goal of palliative care is to not only meet patients' physical needs but also address their psychologic, social, religious/spiritual, and cultural needs [53]. Even across cultures, there appear to be common denominators for effective palliative care. In an analysis of studies on palliative care in various ethnic/racial minority groups, researchers found common cultural themes that cut across all groups in the area of palliative care [54]. These included:

- Pain management
- Support to achieve closure (i.e., resolve social and emotional concerns that are hindering well-being)
- Spiritual and religious care
- Support to family and friends
- Focus on the quality of life

One concept that has been helpful in pain management at the end of life is the idea of total pain. Total pain considers the contributions of physical noxious stimuli, affect/emotional discomfort, interpersonal conflicts, and nonacceptance of one's own dying [55]. A patient's cultural perspective can influence any of these factors and/or how they are conveyed. The most important consideration at the end of life is that the patient's wishes are followed, and this almost always includes a desire for a pain-free death, regardless of background and culture.

### Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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## *Evidence-Based Practice Recommendations Citation*

Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: part 2—guidance. *Pain Physician*. 2012;15(3 Suppl):S67-S116. Available at https://painphysicianjournal.com/2012/july/2012;%2015;S67-S116.pdf. Last accessed July 27, 2020.