UNDER-TREATMENT OF PAIN IN BLACK PATIENTS: A HISTORICAL OVERVIEW, CASE-BASED ANALYSIS, AND LEGALITIES AS EXPLORED THROUGH THE TENETS OF CRITICAL RACE THEORY

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ABSTRACT

Pain, also called the "fifth vital sign" is an important topic in healthcare settings. It requires urgent attention and treatment to minimize agony and discomfort. Unfortunately, multiple clinical studies conducted over the last few decades have repeatedly shown disparately inferior pain management in Black patients in medical settings when compared to White patients with similar pain levels. This Article utilizes Critical Race Theory to examine the understudied issue of under-treatment of pain in Black patients. It discusses the story of a real patient, Jacqui, who was under the medical care of the author. It examines her unfortunate experiences with poor pain management throughout different stages of her life, including a blood disorder as a child with, a traumatic arm fracture as a teen, during childbirth, and finally, later in life with advanced cancer.

Three points are addressed in this Article: first, a discussion of Jacqui's experiences, and an analysis of those experiences through the available clinical data. This Article reveals the extent to which Black patient's pain is undertreated, and how it led Black patients to mistrust our healthcare system. Second, the Article explores malpractice based legal analyses to these issues based on federal and state legislation. Third, various proposals to correct various systemic discrepancies in medical-education and clinical settings to minimize such racial biases in pain management are discussed. It concludes by talking about the final part of Jacqui's clinical journey.

INTRODUCTION

Jacqulyn Dillon, who preferred to go by Jacqui, was a 46-year-old patient with a history of Sickle Cell disease with multiple painful crises during her childhood. About three years ago (at the age of 43), Jacqui was diagnosed with breast cancer, that had spread into her liver and bones, including her spine and ribs. Jacqui had previously received chemotherapy and radiation to treat her cancer, but unfortunately, the disease continued to spread. During our first meeting, Jacqui's provided details regarding her clinical case, who was on a Phase-1 clinical trial after her cancer further grew on the last line of chemotherapy.

A clinical trial under her circumstances, is a treatment regimen whose safety and efficacy has not been completely proven. Clinical trials are administered as a last resort to treat the patient's untreatable cancer, but its primary intent is to

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determine its safety and side effects in humans. Also, clinical trials determine whether such treatments will stop the growth of a specific cancer. In short, clinical trials are an attempt to primarily see if future patients will benefit from that particular treatment. At the start of the trial, and if the trial was unsuccessful, Jacqui's likely clinical prognosis was six months.

I have worked closely with Jacqui over the last year, managing her pain and providing supportive oncological and palliative care, providing support as she gradually moved towards a terminal stage of her cancer, which led to her death a few months later.

Pain has been called the "fifth vital-sign" in clinical settings.[1] Over the last few years, clinical research has shown significant under-treatment of pain in Black patients compared to White patients under similar clinical circumstances.[2] This Article examines various angles of pain undertreatment in Black patients through the lens of tenets of Critical Race Theory ("CRT"). Racism in pain management settings, whether conscious or unconscious, is a permanent part of medical care for Black patients, which involves all imaginable primary and specialty healthcare settings in the United States. It is later discussed how Black patients are disadvantaged from a medication supply and pharmaceutical availability standpoint in their neighborhoods. It investigates deeper into the underlying causes of such disparity, looking at how news and entertainment media feed into a false narrative. It also discusses how the medical education system has failed to correct many long-standing fallacies relating to pain management in Black patients.

This Article also explores the understudied issue of undertreatment of pain in Black patients through a case study of a real-life patient, Jacqui, and her encounters with disparities in pain management as a Black patient. Part I provides key medical definitions and understandings regarding pain. Part II introduces the tenets of CRT, which this paper which will be used to discuss the undertreatment of Black patients. Part III introduces Jacqui and narrates her various health conditions, and her experience receiving care for pain associated with her medical issues. Part IV contextualizes Jacqui's experience by providing a historical and medical research-based overview of poor medical care in Black patients, which analyses the disparity, its social impact, and its role in subsequent mistrust of the healthcare system by the Black community. Part V examines the legalities and issues with malpractice in similar clinical scenarios by looking at legislation and case law. Part VI focuses on approaches to minimize this discrepancy on various levels of clinical education, training, and healthcare management from an administrative and procedural standpoint.

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[1] Natalia E. Morone & Debra K. Weiner, *Pain as the Fifth Vital Sign: Exposing the Vital Need for Pain Education,* 35 CLINICAL THERAPEUTICS 1728, 1728-32 (2013).

[2] Shoshana V. Aronowitz et al., *Mixed Studies Review of Factors Influencing Receipt of Pain Treatment by Injured Black Patients*, 76 J. ADVANCED NURSING 34, 34-46 (2019).

I. UNDERSTANDING THE MEDICAL TERM "PAIN"

Before venturing into a deeper analysis of the disparity of pain care among Black patients, it is important to understand how pain is defined as a medical term in healthcare settings. This will help gather a better grasp of the issue from a technical aspect moving forward.

A. The Definition of Pain and the Subjectivity of its Interpretation

International Association for the Study of Pain ("IASP") defines pain as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage".[3] Pain is a sensory perception often in combination with an emotional component. This is the same emotional component that makes us scream, cry, and experience apprehension and distress when pain becomes overwhelming. Furthermore, this definition adds that this combination of emotions may resemble something that is associated with actual or potential tissue damage. This adds the necessary subjective range to prior definitions of pain, where objective physical damage, and signs of actual trauma or disease were required to make a patients pain legitimate, while a lack of damage, or merely an emotional experience, previously made the pain less concerning, not receiving urgent attention, or even deemed as illegitimate or a sign of malingering.[4]

This addition of subjective and emotional range correctly recognizes previously missed aspects of pain, and sheds light on the subjective and variable interpretation of pain by clinicians. This is the same interpretation that leads to the dilemma of undertreatment of pain based on subjective clinical interpretation. In certain cases, it may even be based on objective data, while seen from a prejudiced subjective angle, consciously, unconsciously, or via implied bias, giving rise to disparate impact as the meaning of the word bias implies, it skews a clinician's judgement.[5] If viewed from a racial standpoint, such clinical bias distorts judgement in a direction that affects certain populations much more than the others from a therapeutic stance.[6] In the case of clinical pain management, bias is skewed to significantly affect the Black population more than White population, where data continues to show that undertreatment of Black patients' pain is actually a norm, and not an anomaly.[7]

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[3] *IASP Announces Revised Definition of Pain*, INT'L ASS'N FOR STUDY PAIN (July 16, 2020), https://www.iasp-pain.org/publications/iasp-news/iasp-announces-revised-definition-of-pain/ [https://perma.cc/996F-C8ZP].

[4] Srinivasa N. Raja et al., *The Revised International Association for the Study of Pain Definition of Pain: Concepts, Challenges, and Compromises*, 161 PAIN 1976, 1979 (2020).

[5] *Id.* at 1980.

[6] Elizabeth N. Chapman et al., *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504, 1507 (2013).

[7] Kelly M. Hoffman et al., *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, 4301 (2016).

B. Options for Pain Management and Its Skewed Use in Clinical Settings

Practitioners impliedly provide equal care, but unfortunately, bias results in separate and lower-end modality of treatment given under the umbrella of the word "care."[8] This is very reminiscent of *Plessy v. Fergusson*, where the constitutionality of "separate but equal" was upheld by a 7:2 Supreme Court ruling.[9] For clinicians, there is data available to predict the efficacy of various treatments in certain painful conditions, ranging from its total benefit and the duration of the benefit, to the burden of these treatments and their side effects.[10] This is the same data that is used when various oversight committees and expert panels make recommendations for first, second, and third line treatments for certain diseases and conditions.[11] However, clinicians are often implicitly biased when interpreting these recommendations and in providing certain treatments to Black patients versus White patients.[12] To address this discrepancy, and to provide decisional defense, certain words, including "based on clinical circumstances," or "individually tailored treatments," are often documented. This usually implies that their prescribed treatments for Black patients are different but equal when applied to an individual Black patient. Decades of clinical research data shows Opioid medications as the "Gold standard" for managing cancer pain.[13] However, the outcomes are disturbingly different, with White patients having a greater likelihood of receiving Opioids as early line treatments compared to Black patients who get separate over-the-counter medications, non-opioid medications, or treatments with lesser pain management potential in cancers, often described as an equal treatment to their similar White counterparts.[14] This leads to undertreatment of pain, which is often guised as equal, but circumstantially separate or individually tailored treatment.

C. Use of Liberal Terms to Cover Bias in Pain Management on Various Levels of Healthcare System

The term "individuality" refers to the difference in circumstances or

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[8] William J. Hall et al., *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes*, 105 AM. J. PUB. HEALTH 60, 71 (2015).

[9] Plessy v. Ferguson, 163 U.S. 537, 552 (1896).

[10] Teus H. Kappen et al., *Evaluating The Impact of Prediction Models: Lessons Learned, Challenges, and Recommendations*, 2 DIAGNOSTIC & PROGNOSTIC RSCH. 11, 9 (2018).

[11] Richard M. Rosenfeld & Richard N. Shiffman, *Clinical Practice Guideline Development Manual: A Quality-Driven Approach for Translating Evidence into Action*, 140 OTOLARYNGOLOGY HEAD & NECK SURGERY 1, 43 (2009).

[12] Hall, *supra* note 8, at 76.

[13] Phillip J. Wiffen et al., *Opioids for Cancer Pain - An Overview of Cochrane Reviews*, 7 COCHRANE DATABASE SYS. REV. 1, 13 (2017).

[14] Dan P. Ly, *Association of Patient Race and Ethnicity with Differences in Opioid Prescribing by Primary Care Physicians for Older Adults with New Low Back Pain*, 2 JAMA 2333, 7-8 (2021).

difference in social or biological make up.[15] The concept of colorblindness, which is often verbally over-stated in healthcare settings, is disfavored. More culturally appropriate terms like "individually tailored" are used to discriminate among patients based on their biological or social circumstances, and to preserve the concept of equal but separate, under the guise of these liberal and technically sound terminologies.[16] This is further discussed in Part II, where such phenomenon is described under the CRT tenet of "critique of liberalism," where certain terms are used to cover for various discriminative practices.

II. TENETS OF CRITICAL RACE THEORY

The term "tenet" stands for basic principles or doctrines.[17] In relation to CRT, these tenets describe the basic principles that most critical race theorists agree upon.[18] This section discusses various Tenets of Critical Race Theory that are further explored and analyzed in this paper in relation to pain management in Black patients:

(1) the permanent nature of racism — racism, whether conscious or unconscious is a permanent part of life in the U.S.;

(2) whiteness as property — the benefits of being White, and how the judicial and governing system in the US has advantaged the White majority, so much so that being White can be considered a property interest;

(3) story telling counter to majoritarian views — a method of storytelling that tells the counter side of majoritarian views held as facts, interpreting majoritarian views as myths and false beliefs;

(4) interest convergence a means for benefitting Blacks are only sought when they also help with the interests and goals of the White majority;

(5) criticism of liberalism — a criticism of closely held liberal beliefs of meritocracy, colorblindness, and legal neutrality;

(6) intersectionality — the effect of the intersection of race and other defining characters like gender, age, and financial stability; and

(7) essentialism — a view that people have a set of attributes that identify them, also implying that social hierarchies reflect a naturally occurring structure, with particular prejudice against Black people.[19]

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[15] S. Denford et al., *Individualisation of Drug Treatments For Patients With Long-Term Conditions*, 4 BMJOPEN 3, 4 (2014).

[16] Marshall H. Chin et al., *Interventions to Reduce Racial and Ethnic Disparities in Healthcare*, 64 MED. CARE RSCH. REV. 7, 6-10 (2007).

[17] *Tenet*, *Merriam-Webster* (11th ed. 2012).

[18] RICHARD DELGADO & JEAN STEFANCIC, CRITICAL RACE THEORY: AN INTRODUCTION 8-11 (3rd ed. 2016).

[19] Adopted and modified from, Sonya Douglass Horsford, *Mixed Feelings About Mixed Schools: Superintendents on the Complex Legacy of School Desegregation*, 46 EDUC. ADMIN. Q. 287, 287-321 (2010).

III. JACQUI'S STORY

Story telling is an important part of Critical Race theory. Here, we discuss this disparity of under-treatment of pain in more detail in the form of a clinical case of a Black woman "Jacqui", who was under the care of this author for cancer pain management. This article will explore her experiences with disparity in pain treatment during different phases of her life. The names and other identifiers in this Article have been changed to comply with HIPAA privacy rules.[20]

A. Jacqui's Experience as a Black Child

Jacqulyn Dillon, who preferred to go by Jacqui, was a forty-six-year-old patient with history of sickle cell disease since her childhood. Jacqui was born in Trenton, New Jersey, in a predominantly Black neighborhood. She was the middle child of three sisters. Her father worked in a local factory, while her mother was a homemaker. Jacqui grew up in a strong Christian household where her parents took her and her sisters to their local church on Sundays. When Jacqui was eight years old, her father died of a sudden heart attack. Her mother worked small jobs to cover the financial needs of the family. It was about the same time when she gradually started feeling very weak and fatigued. Her mother took her to the local doctor, who after some blood tests diagnosed her with sickle cell disease.

Sickle cell disease is a hereditary blood disorder where the red blood cells, that carry oxygen in blood to various parts of the body, causing the red blood cells to become deformed and pointy in shape, which reduces their oxygen-carrying capacity.[21] Also due to their pointy edges, these cells block various small blood vessels in the body, causing severe pain crises.[22] Additionally, over time, this disease deformity leads to multiple long-term liver, spleen and bone-related complications.[23] Sickle cell is more common in Black Americans, where about 1 in 13 Black people asymptomatically carry the genes for this illness; but it fully expresses clinically in about 1 in 365 Black people.[24] Sickle cell disease expresses fully in patients (often children) whose parents are both asymptomatic, silent carriers and pass these genes to their children, who get the disease-related gene from both parents, but inherit the symptomatic form of this illness.[25] Since this disease is common in Black patients and causes repeated painful crises, opioid pain medications provide the best analgesia. However, opioid pain medication has developed a notoriously false reputation of causing the patients with this disease

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[20] 42 U.S.C. § 1320d (6).

[21] *What is Sickle Cell Disease?*, CDC (Aug. 18, 2022), https://www.cdc.gov/ncbddd/sicklecell/facts.html [https://perma.cc/KL8Q-A9RE].

[22] *Id.*

[23] *See* Paula Tanabe et al., *Understanding the Complications of Sickle Cell Disease*, 119 AM. J. NURSING 26, 26-35 (2019).

[24] *Data & Statistics on Sickle Cell Disease*, CDC (May 2, 2022), https://www.cdc.gov/ncbddd/sicklecell/data.html [https://perma.cc/8AP3-HZZA].

[25] *Id.*

to become dependent on such opioid pain medications.[26] These patients are often clinically referred to as opioid-dependent or drug-seeking.[27]

Going into the history of this disease, the research funding to finding an adequate cure for this Black-predominant illness has been far less than that for more White-predominant diseases with similar morbidity rates.[28]

Understanding how this disease got its stigma is also important here. Only about 5% of physicians in the United States are Black.[29] Thus, most sickle cell disease patients are treated by White doctors, who are not generally affected. This has led the disease to take an almost "alien disease" form, where the treaters are not aware of the horrors of pain and disability this disease can cause. When Black patients complain of repeated painful episodes, this does not invoke the same level of compassion in the treating physicians, leading to general undertreatment of pain.[30] In extreme cases, clinicians stigmatize the patients with feigning an illness, with the ulterior motive of receiving opioid painkillers.[31] Again, not having interest-convergence with White doctors makes the sufferers of this disease falsely portrayed as malingerers and drug-seekers for requesting adequate pain control.[32]

Coming back to Jacqui, during her first sickle cell crisis, she remembers being given a small dose of Morphine (a moderate strength opioid) and being sent home. She was not given any strong pain medications to take home in the event of a pain crisis, which is a common occurrence for this illness. At the age of fourteen, Jacqui had an episode of acutely worsening abdominal pain. She remembers doubling over in pain, and that is when her mother took her to a local emergency room, where the doctor diagnosed her with Acute Appendicitis. This disease has no documented association with sickle cell disease but based on her prior history of sickle cell disease, the emergency room physician decided not to give her adequate analgesia. Jacqui was taken directly for surgery, where the inflamed appendix was removed. Again, she was told to take over-the-counter

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[26] Matthew Zajac, *Sickle Cell Disease, Myths and Misconceptions*, SICKLE-CELL.COM (Dec. 6, 2020), https://sickle-cell.com/myths [https://perma.cc/YWY8-QTTZ].

[27] *Opioid Crisis Adds to Pain of Sickle Cell Patients*, NAT'L HEART LUNG & BLOOD INST. (Sept. 15, 2017), https://www.nhlbi.nih.gov/news/2017/opioid-crisis-adds-pain-sickle-cell-patients [https://perma.cc/4UKV-8NWE].

[28] Faheem Farooq et al., *Comparison of US Federal and Foundation Funding of Research for Sickle Cell Disease and Cystic Fibrosis and Factors Associated with Research Productivity*, 3 JAMA 1737, 1743 (2020).

[29] *Diversity in Medicine: Facts and Figures 2019,* ASS'N AM. MED. C., https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018 [https://perma.cc/H94K-6TPG] (last visited Oct. 20, 2021).

[30] Elise Labbé et al., *Physicians' Attitude and Practices in Sickle Cell Disease Pain Management*, 21 J. PALLIATIVE CARE 246, 251 (2005).

[31] Jeremy Park et al., *Physician Use of Stigmatizing Language in Patient Medical Records*, 4 JAMA 17052, 17057 (2021).

[32] John T. Chang et al., *A Case of Malingering: Feigning a Painful Disorder in the Presence of True Medical Illness*, 1 PAIN MED. 280, 280-82 (2000).

medications two days after a four-inch incision was made into her abdomen. This decision was made because doctors had noticed that not giving strong opioids after surgery "facilitated a faster functional improvement," a liberal term of neutrality with the function of self-service, as described by CRT.[33] She remembers not being able to sleep for almost three days after surgery due to pain, especially when changing the bloody bandages on her abdominal incision. Jacqui had to brave through the pain, while not knowing that there were better options for pain management out there which were never offered to her.

Analyzing this from a clinical-research standpoint, under-treatment of Jacqui's pain, as a fourteen-year-old, during an episode of acute appendicitis, was not an anomaly, but it was a permanent norm described by CRT.[34] According to a study published in the Journal of the American Medical Association ("JAMA") Pediatrics in 2015, researchers reviewed emergency room records across the U.S. of approximately one million patients below the age of twenty-one.[35] Specifically, patients who had moderate pain with appendicitis, found that about 43% of young White children and adolescents received analgesia of any type versus about 20.7% of young Black children.[36] For severe pain, only 12.2% of Black children and adolescents received opioid analgesia, compared to 33.9% for White children and adolescents.[37] After adjusting for confounding variables, the odds of a Black child receiving opioid analgesia were one-fifth of that of a White child. Although the researchers did not address why such disparity existed, this data is still eye-opening. Arguments of drug abuse risk and diversion are presented to defend such practices, however, the likelihood of these risks occurring in young children is far less than in adults, and these risks do not justify under-treating a sick Black child's pain. This was a large study and appendicitis were the most common cause of acute abdominal pain in children,[38] making this data very disturbing when considering intentional or implicit bias in healthcare settings, even in pediatric settings.

There is clinical data showing that if pain is undertreated, it can lead to multiple long-term complications, including poor functional improvement after injury, higher rates of disability, poor healing, Post-Traumatic Stress Disorder ("PTSD"), and many other mood-related disorders including anxiety and depression.[39] Seeing the above trends of undertreatment of pain in Black children, makes one wonder how much disability and long-term mental issues have been caused by the undertreatment of pain, which has led black children to be more

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[33] DELGADO & STEFANCIC, *supra* note 18, at 18.

[34] *Id.*

[35] Monika K. Goyal et al., *Racial Disparities in Pain Management of Children with Appendicitis in Emergency Departments*, 169 JAMA PEDIATRICS 996, 996-1002 (2015).

[36] *Id.*

[37] *Id.*

[38] Joon Sung Kim, *Acute Abdominal Pain in Children*, 16 PEDIATRIC GASTROENTEROLOGY HEPATOLOGY & NUTRITION 219, 219-24 (2013).

[39] *See* Benjamin Morasco et al., *The Relationship Between PTSD and Chronic Pain: Mediating Role of Coping Strategies and Depression*, 154 PAIN 609, 609-16 (2013).

dependent on others and deal with PTSD later in life.

B. Jacqui's Experience as a Young Black Adult with Pain

Moving further with Jacqui's clinical history, she continued to have Sickle cell crises every few years, but fortunately, she was not admitted to the hospital again. Jacqui completed high school and went to pursue a Bachelor's in Education. Jacqui also worked as a waitress in a local restaurant while attending college. One day, Jacqui fell on her arm while carrying plates back to the kitchen. She heard a crack and a pop, followed by immense pain. Jacqui immediately went to the Emergency Room where x-rays were done on her arm. The x-rays showed a dislocated fracture of the bones in her right forearm. Jacqui was right-handed, so this was detrimental. According to the ER physician, after years of suffering with sickle cell disease, Jacqui's bones became weak, which is often a common complication of this disease, and this was why a trivial fall led to an extensive fracture and dislocation. Jacqui was again given over-the-counter medications and was sent home with a cast. A few weeks later, the x-rays showed non-healing of the fracture, and the surgeon decided that a surgery is necessary to address Jacqui's fracture. The weeks prior to the surgery, Jacqui experienced excruciating pain. Eventually, Jacqui had the surgery, and a metal plate was placed in her forearm with five large screws to realign the fractured bones. But again, post-operatively, Jacqui was not given opioid analgesics for pain. She talked to her nurse, who told her that the doctor had not placed any strong pain medication orders for her.

The next day, she talked to the rounding surgeon about being placed on stronger pain medications. The physician said that he did not think that she needed strong pain medications, because she is a young lady and can "brave through this temporary pain, because she will be back to being brand new in three to four weeks." She believed the surgeon's word and went home the next day taking some mild over the counter analgesics at home, even though her pain was unbearable after the surgery. She tried physical therapy, but the pain prevented her from moving her arm, so she took some time off from her work and education to regain her strength and recuperate from the injury and the surgery. She was young and motivated, but the healing process took six months, and the over-the-counter pain medications did not help much. She went back to live with her mother, and after twelve months, she started back with school, which did not make sense to her, since the surgeon had told her that she would be back to normal in three to four weeks. By this time, her forearm and hand muscles had become very weak, and she could not write much. Fortunately, over the next eighteen months after surgery, she eventually gained most of her strength, but it took a total of eighteen months rather than the three to four weeks as she was told.

Now, coming back to the research on management of fracture and trauma associated pain in Black patients, there is reasonable data showing that like pediatric appendicitis issues, the trauma and fracture related pain is significantly undertreated in Black patients compared to White patients.[40] A study published in Annals of Emergency Medicine in 2000 showed that Black patients were less likely to receive pain medications in the ER for extremity fractures—57% in Black patients versus 74% in White patients.[41] Also, the use of stronger opioids in Black patients was much less when compared to White patients for very similar upper or lower extremity fractures.[42]

There is also the issue of long-term loss of function, as it happened with Jacqui. There is evidence that Jacqui was undertreated for her pain, which led to her not getting appropriate physical therapy for her arm, causing muscle wasting and lower functional improvement. This led her to not only be in pain, but also lose a year of school, in addition to not being able to work and having to move back to her mother's place in Trenton, New Jersey. From a financial and employment standpoint, this was loss of income for her for a year after graduation, and loss of a teacher from the work force for a whole year, had she completed her degree on time. But as the study above shows, again, such discriminatory behavior is a norm, and not an anomaly, as seen through the lens of CRT. From another angle of CRT, this is where the intersectionality of being a Black woman also played a part, there is data that will be discussed in the coming sections about how this intersectionality further worsens the issue of undertreatment of pain in Black women worse than Black men.[43]

In addition to undertreatment, there is another factor that has been noted in average waiting times after arrival in emergency rooms across the United States A study published in Pain Management Nursing Journal found that even though the pain levels expressed by Black patients were higher, their wait times for initial ER treatment was significantly higher than for White patients.[44] Here, a few questions arise. First, whether White patients treated earlier because of their race, in what CRT describes as White privilege or Whiteness as a property. Second, whether these are delay tactics or implied biases against Black patients, where their pain is not considered as important of an issue to treat. We talk more about this issue further below in the section related to the history of disparity in pain management in Black patients.

C. Jacqui's Experience During Childbirth as a Black Woman

After completing college, Jacqui got married, and gave birth to Tanisha at the age of twenty-four. Jacqui remembers her eighteen-hour long process of labor,

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[40] Knox H. Todd et al., *Ethnicity and Analgesic Practice*, 35 ANNALS EMERGENCY MED. 11, 11-16 (2000).

[41] *Id.*

[42] *Id.*

[43] Charles S. Cleeland et al., *Pain and Treatment of Pain in Minority Patients with Cancer: The Eastern Cooperative Oncology Group Minority Outpatient Pain Study*, 127 ANNALS INTERNAL MED. 813, 813-16 (1997).

[44] Erlinda Wheeler et al., *Level of Pain and Waiting Time in the Emergency Department*, 11 PAIN MGMT. NURSING 108, 108-14 (2010).

having cramping labor pains, and not being offered Epidural injection/drip for pain. She remembered asking the nurse for pain medications to help with the pain, but she was told that her Obstetrician had not placed an order for it. When she talked to her obstetrician about pain control, she was told that most Black women are able to give birth without pain medications, and there was risk of her being drowsy with strong pain meds that would prevent her from herself pushing the baby out efficiently.

Although she wanted to believe the obstetrician, but now she was old enough to understand these pain undertreatment issues for herself, having been through prior experiences as a child with sickle cell disease and appendicitis, and later as an adult with an arm fracture. She had started to feel like she was not a preferable candidate for receiving analgesia for her medical issues. But instead of raising this issue further, she decided to stay positive through labor, mustered up courage, and went through eighteen hours of painful labor to deliver Tanisha. She felt like during this process of extensive pushing, she had damaged her back, which felt sore after delivery, but the doctor told her that it was temporary, and she should ". . . just put some ice on it, since that's how they treat such pain now," again using Liberalism as a shield (as described by CRT) to cover for systemic inadequacies in pain management. She went home, continued to work, and raise her daughter with her very supportive husband.

The data on the use of labor analgesia shows the same pattern of undertreatment of pain in Black patients.[45] A study published in Anesthesiology Journal in 2007 showed that the odds ratio for a Black woman to receive Epidural analgesia is 0.78 compared to their White counterparts.[46] Similarly, postpartum, there is clinical evidence of undertreatment of pain for Black women when compared to White women who were given more liberal opioid analgesia after similar child births.[47]

D. Jacqui's Pain Issues One Year Post Childbirth as a Black Woman

Jacqui's back pain continued to get worse after the birth of Tanisha. Being up at night nursing her daughter, and working as a teacher during daytime, she was on her feet all day. She felt like the pain, which was initially in the lower back, started shooting down her left leg. She initially ignored it, but later when she felt that her leg was becoming numb at times and getting somewhat weaker in strength than her right leg, she decided to go see a specialist.

Jacqui talked in detail about her limiting pain, and the functional issues related to her pain, and she was given similar advice on reducing her weight and applying ice. She tried it, but it was not helpful. Three months later she fell at work when her left leg suddenly gave out. She went to the ER, and after a long

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[45] Laurent G. Glance et al., *Racial Differences in the Use of Epidural Analgesia for Labor*, 106 ANESTHESIOLOGY 19, 19-25 (2007).

[46] *Id.*

[47] Nevert Badreldin et al., *Racial Disparities in Postpartum Pain Management*, 134 OBSTETRICS & GYNECOLOGY 1147, 1147-53 (2019).

delay, she got an MRI scan of her spine that showed a lumbar spine disc bulge and rupture that was pressing on the nerves coming down into her left leg. She was asked why she did not report this earlier, since she could have significantly avoided disability. She talked about talking to her Obstetrician and then to a Pain management specialist who did not do any imaging to see her spine. Physical therapy was ordered for her. It took Jacqui another six months of physical therapy after getting a back surgery to get improvement in her leg strength and to walk without support. She remembers this being a very tough time, having to deal with an infant, working full time, and dealing with this horrible pain and leg weakness. Jacqui's experience over this time again reminds us of Intersectionality between race and gender where being a Black woman probably led to her undertreatment/mistreatment on multiple levels.

To understand poor management of back pain from vertebral/spinal causes in Black patients, we look at the data from Spine Journal, who published a study in 2003 on the relation of race to outcomes and the use of healthcare services for lower back pain.[48] This study showed significant disparities in pain care for Black patients compared to White patients, even when Black patients reported higher pain and disability; Black patients' concerns were often invalidated by clinicians.[49] This study also showed that physicians believed that Black patients are less likely to have back pain and spine issues compared to White patients, and thus get less imaging, clinical care, and corrective surgeries for said issues. [50]

E. Jacqui's Cancer Diagnosis and Pain Management as a Black Woman

Jacqui continued her teaching job for another sixteen years. Around this time, her daughter had left for college. A few months later, Jacqui felt pain in her back, but this time her pain was in a different area. Jacqui was more tired and fatigued, and, as a result, visited her primary care physician. Her physician once again concluded that the pain is resulting from work stress and told her to take Tylenol. About two weeks later, Jacqui felt short of breath and went to the local emergency room. There, Jacqui spoke about her fatigue, and pain issues. A scan showed a large lesion in her thoracic (central) spine, along with some small lesions in her ribs. Soon after, Jacqui went through a full body scan, which showed presence of cancer in her breast, with further spread into her bones, liver, and lungs. Jacqui was informed that although she was not in a curative stage, chemotherapy may prolong her survival. Despite her serious condition, Jacqui felt that her pain was not adequately treated.

Here we look to expert panels, and specialty-based organizations who agree that Cancer pain should be adequately treated with opioids, especially when the disease is advanced, or widespread (metastatic).[51] Because cancer pain (due to

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[48] Timothy S. Carey & Joanne Mills Garrett, *The Relation of Race to Outcomes and the Use of Health Care Services for Acute Low Back Pain*, 28 SPINE 390, 390-94 (2003).

[49] *Id.*

[50] *Id.*

[51] Shalini Dalal & Eduardo Bruera, *Pain Management for Patients with Advanced Cancer*

cancerous lesions) is severe based on its underlying cause, and because most patients are considered terminal in advanced cancers, so the fear of long-term addiction potential is much lower than general population because of limited expected lifespan.[52] This is further evidenced by very low (much lesser than non-cancer pain) numbers of abuse/diversion related issues in research studies in these advanced cancers.[53] But unfortunately, the disparity of undertreatment of Black patients with advanced cancers is witnessed in this specific arena as well. A study done on outpatient pain showed that minority and Black patients continued to show higher pain levels, morbidity and disability due to cancer pain compared to majority White patients.[54] However, only 35% of these patients were given adequate analgesia for cancer pain, compared to 50% in majority White patients.[55] Again, minority women were the worse hit group with pain undertreatment,[56] reminding us of intersectionality as discussed in *Critical Race Theory*.[57] Similar outcomes were shown in a study done by Vallerand et al. that was published in 2005 in *Pain Medicine* journal.[58] This study showed that in addition to higher pain levels and disability showed by Black patients while being undertreated, there was much higher apprehension in Black patients regarding perception of control over their pain in these dire circumstances.[59] Pain centers in the brain are closely linked to mood areas in the brain, and data has shown that higher level of pain increases acute and long-term issues with anxiety, depression, and insomnia in patients.[60] So, in a way, undertreatment of pain further worsens the mood and sleep, which studies show is linked eventually to higher mortality.[61] The bottom line is that by under-treatment of pain in Black patients, we are increasing their mental health issues and leading to higher disease related mortality in these patients.

There have been multiple studies that show that Black patients with cancer have lower survival rates, and lower rates of curative treatments. [62]This is also true in other chronic illnesses like hypertension, diabetes mellitus, and HIV, where Black patients continue to have worse outcomes than White patients.[63] So,

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in the Opioid Epidemic Era, AM. SOC'Y. CLINICAL ONCOLOGY EDUC. BOOK. 24, 24-35 (2019).

[52] *Id.* at 25.

[53] *Id.*

[54] Cleeland et al., *supra* note 49, at 816.

[55] *Id.*

[56] *Id.*

[57] *See* Delgado & Stefancic, *supra* note 40.

[58] April Hazard Vallerand et al., *Disparities Between Black and White Patients with Cancer Pain*, 6 PAIN MED. 242, 242-50 (2005).

[59] *Id.*

[60] Marloes MJG Gerrits et al., *Pain, Not Chronic Disease, is Associated with the Recurrence of Depressive and Anxiety Disorders*, 14 BMC PSYCHIATRY 7 (2014).

[61] *Id.*

[62] *Id.*

[63] Alliance for Health Reform, *Closing the Gap: Racial and Ethnic Disparities in Healthcare*, 96 J. NAT'L MED. ASS'N 436, 436-40 (2004).

this problem is widespread in other diseases as well, showing that the healthcare system as a whole continues to fail Black patients as a whole. This again verifies the CRT tenet that racism is permanent and widespread in the US.

F. First Meeting with Jacqui – and Attempts to Improve Pain and Symptoms Care

After multiple failed treatments, Jacqui came to our Cancer center and pain clinic for comprehensive cancer care, and to enroll on a trial. In our first meeting with her, we found her to be a kind and knowledgeable person. She was up to date with all her medical records, and even though she was very weak and had lost almost thirty pounds of weight over the last six months or so, she was still able to manage all her affairs, and had continued to teach in her school remotely via online classes with COVID restrictions. She still had a great sense of humor, even though she understood that this was her final chance at slightly prolonging her survival. She was still praying with her daughter daily, who had moved back home, and had been a great support to her through these tough times. Jacqui also felt that her religiosity and spirituality helped her cope well with the stressors of her illness. But her un-managed pain continued to be a huge stressor for her. She was still using over-the-counter Tylenol, and Ibuprofen tablets, which she felt were not very helpful, and rated her pain 8/10 when she walked, which significantly limited her functional status and mobility.

Before she was offered the clinical trial, we told her about the very low likelihood of the clinical trial helping her cancer, but she replied, '. . . I know that I may not be here in the next few months, but I feel strength through my spirituality, and even though this clinical trial may not work for me, but my participation in this trial will give important information to the researchers, which will be helpful for the next generation of breast cancer patients. So, I see participating in this trial more to give back to the world, rather than getting benefit myself at this stage . . .' To our team, it was an extremely powerful gesture. This woman, who had been mistreated in all walks of healthcare system throughout her life as a young child, to an adolescent, then to an adult with multiple medical issues, where she was discriminated against via multiple intentional and implied biases, she still wanted to give back to the same healthcare system.

We sat down and talked about her history for over two hours and got all the information narrated in above sections through her life. There were times, when her pain prevented her from being comfortable, but she wanted to make sure that she could answer all questions, that were required for her clinical trial candidacy.

We looked at her scans and saw that cancer her invaded all through her body, and had also spread into various bones, and even had caused multiple fractures in her spine. Based on her pain levels, and according to the NCCN guidelines,[64] we decided to start her on low dose Oxycodone 5-10 mg orally every four hours

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[64] Robert A. Swarm et al., *Adult Cancer Pain, Version 3.2019, NCCN Clinical Practice Guidelines in Oncology*, 17 J. NAT'L COMPREHENSIVE CANCER NETWORK 977, 977-1007 (2019).

as needed for her pain and gave her a prescription for 180 tablets for managing this pain. Since she had never been on long-term opioid pain meds previously and had no medication or drug abuse issues in the past, we had no concerns regarding any risk of misuse at this point.

Later that day, Jacqui and Tanisha took the prescription to a local chain pharmacy in their inner-city locality. The pharmacist told them they did not have this medication, so they went to another chain pharmacy, and got a similar response. This was odd, but they went to a few other pharmacies that were a little further away in their locality, and each pharmacy gave them the same response. Finally, they asked a worker at the pharmacy why every pharmacy was turning them away, and he told them that due to high risk of getting robbed, and issues with disposal, almost no pharmacies in their city carried controlled opioid pain medications. This was very surprising to them, so they called our clinic with the request to find a pharmacy where they could take this prescription to get it filled. We recommended a suburban chain pharmacy where most of our local patients got their controlled scripts filled. They went there, and within ten minutes, their prescription was filled. She called us back, to thank us for this help with finding a pharmacy.

This issue of pharmacies in predominantly Black neighborhoods not carrying important opioid pain medications is not new, but it has continued to worsen over time. A study by Camren Green, found that Black patients faced significant difficulty in finding opioid pain medications in their local pharmacies.[65] This issue was previously brought up by a study done by Sean Morrison, which found that over 50% of New York pharmacies did not carry opioid pain medications in mostly Black neighborhoods.[66] Similarly, a *Detroit News* survey[67] of hundreds of pharmacies in southeastern Michigan found that filling opioid pain medications prescriptions was much easier in suburban White neighborhoods than in Black inner-city neighborhoods. They also found that the likelihood of suburban pharmacies carrying certain long-acting opioid medications was four times higher than pharmacies in poor Black communities.[68] When asked for an explanation, pharmacists gave three chief reasons for this issue, one being inadequate supplies provided to these pharmacies, especially in bigger pharmacy chains' secondly, high risk of illicit use; and thirdly, having a high risk of theft.[69] This issue puts the legitimately sick patients with cancer in a very precarious situation, something that Jacqui and her daughter experienced first-hand in their own city. Again, this rings a bell with CRT tenet of 'Whiteness as property' and White privilege –

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[65] Camren R. Green et al., *The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain*, 4 PAIN MED. 277, 277-94 (2004).

[66] R. Sean Morrison et al., "*We Don't Carry That"--Failure of Pharmacies in Predominantly Nonwhite Neighborhoods to Stock Opioid Analgesics.* 342 NEW ENG. J. MED. 1023, 1023-26 (2000).

[67] J. Kurth et al., *Painkiller Drugs Scarce For The Poor*, THE DETROIT NEWS (Oct. 27, 2002).

[68] *Id.*

[69] *Id.*

where if you live in a White neighborhood, you are likely to easily get pain medications just for living there.

IV. HISTORICAL OVERVIEW OF POOR MEDICAL CARE IN BLACK PATIENTS, AND SUBSEQUENT MISTRUST OF HEALTHCARE SYSTEM BY THE BLACK COMMUNITY

Now that we clearly see the problem on multiple levels as with Jacqui's case, we move into the historic issues with healthcare, that have led to this very obvious disparity in healthcare provision for Black patients, resulting in their subsequent justified mistrust in the healthcare system in general.

Unfortunately, U.S. healthcare history is tainted with a long history of mistreatment of Black patients, and their exploitation in the name of healthcare. Most notorious among them is the 'Tuskegee study', which took place between 1932-1972 by the United States Public Health services (USPHS) and the Centers for Disease Control (CDC).[70] In this study, more than 400 Black men with syphilis were intentionally not treated with proper antibiotics for treatment of Syphilis to see the long-term complications of this disease, even when there was ample data for their efficacy in treating Syphilis.[71] Almost 100 Black men died due to this intentionally untreated disease, and many others were infected through further sexual contact.[72] Although there is evidence that such practices in not treating/undertreating Back patients was common, but this being a federally funded trial managed by federal agencies is considered one of the most blatant abuse of Black people via discriminatory practices in healthcare settings.[73]

Although there have not been more reports of similar trials since Tuskegee trial's intentional discrimination was made public, but there is significant active evidence that Black patients healthcare needs are not fulfilled at the same level as White patients.[74] As stated above, there is a much higher incidence of complications and death in Black patients from chronic diseases like Diabetes, Hypertension, and Ischemic heart disease.[75] Similarly, the incidence and complications from infectious diseases like Hepatitis C, and HIV (Human immunodeficiency virus) are much greater in Black patients.[76] This has subsequently led to significant differences in average life span of a Black person when compared to average lifespan of a White person in the US.[77] This widespread disparity confirms the first Tenet of CRT, that points to the

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[70] The Tuskegee Timeline, CDC, https://www.cdc.gov/tuskegee/timeline.htm [https://perma.cc/V459-TKKF] (last visited Oct 20, 2021).

[71] *Id.*

[72] *Id.*

[73] *Id.*

[74] Alliance for Health Reform, *supra* note 64.

[75] *Id.*

[76] *Id.*

[77] Julie Bosman et al*., U.S. Life Expectancy Plunged in 2020, Especially for Black and Hispanic American*, N.Y. TIMES (July 21, 2021), https://www.nytimes.com/2021/07/21/us/american-life-expectancy-report.html [https://perma.cc/QBL2-VUQR].

permanence of racism in the US.

Data suggests that Black patients receive less aggressive treatments when compared to White patients in similar circumstances.[78] In addition, there is data that Black patients are more likely to be offered less preferred treatment options like amputations than White patients.[79] This goes in line with pain management as well, where we see that Black patients are commonly under-treated for their pain related issues in different clinical settings. Earlier papers in medical journals talked openly about 'peculiarities' including thick skulls, less sensitive nervous system with respect to pain.[80] Dr. Samuel Cartwright in his 1851 paper 'Report on the diseases and physical peculiarities of the Ne*%o race', wrote that Blacks bore a specific "Ne*%o disease [making them] insensible to pain when subjected to punishment."[81] Similarly, many physicians believed well into recent times, that Blacks could tolerate surgical procedures with little or no pain at all, and they did not need anesthetics to be administered.[82] Although, such inaccuracies are, hopefully, not taught anymore in graduate medical education, but many students still believe that Black patients are biologically different from White patients.[83] A study done by Hoffman et al. at the University of Virginia, showed that a large percentage of undergraduate, graduate medical student, and some of the medical residents when asked about difference in Black and White body structures, agreed to the statement that Black patient's nerve-endings (receptors for pain perception) were less sensitive to pain than Whites, and Black patients' skin was thicker than White patients' skin, so they feel lesser pain.[84] Such reductive thinking falls into the terms of Essentialism which is well described as a tenet of Critical race theory (as discussed in Part II). There has been extensive experimental research data that has dispelled such false evidence-less myths. A study done by Lipton et al.,[85] at the Columbia University Medical Center in NY, published in journal of Social Science & Medicine in 1986 showed that there were no such differences in between different ethnicities, and patients from all ethnicities and racial backgrounds perceived equal sensations of pain.[86]

To understand the cause of such large discriminatory discrepancy, we must look at the grass root levels of US healthcare systems, and the factors associated with development of these pre-conceived notions by clinical providers towards Black patients. A study done by Aranowitz et al., published in Journal of

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[78] *Id.*

[79] *Id.*

[80] Samuel A. Cartwright, *Report on the Diseases and Physical Peculiarities of the Negro Race*, 7 NEW ORLEANS MED. & SURGICAL J. 691, 691-715 (1851).

[81] *Id.*

[82] MARTIN PERNICK, A CALCULUS OF SUFFERING: PAIN, PROFESSIONALISM, AND ANESTHESIA IN NINETEENTH CENTURY AMERICA PAGE CITED (Colum. Univ. Press, 1986).

[83] Hoffman et al., *supra* note 7.

[84] *Id.*

[85] James Lipton & Joseph Marbach, *Components of the Response to Pain and Variables Influencing the Response in Three Groups of Facial Pain Patients*, 16 PAIN 343, 343-59 (1983).

[86] *Id.*

Advanced Nursing in 2019, explored the factors that influenced clinical decision making.[87] The factor that stood out most prominently was a clinicians 'assumed criminality of Black patients.[88]

Further analysis in this study found that recent news and media attention on 'Opioid crisis' in the US and its 'War on drugs' made connections between Black people who are incarcerated 6 to 10 times more for substance-related crimes in the US compared to White people.[89] Such skewed data and information makes people believe that Black people were more active in such substance related criminal issues. But data shows that Black and White people use drugs at the same rates in the US.[90] Based on such common representations, clinicians who were earlier told that opioids prescribed by them were the 'gateway drugs' felt that there was a higher risk of abuse and diversion when these medications were given to Black patients, so they became more reluctant in giving pain medications and other controlled substances to these patients.[91]

Another detail that makes things worse via entertainment media is the significantly higher proportion of negative characters, gang members, and drug offenders that are portrayed by Black actors.[92] This is probably another medium through which general population and even clinicians get influenced by feeling that there is high likelihood that Black patients will have more criminal tendencies towards use of their narcotic medications.

V. LEGAL ANALYSIS OF RACIALLY DISCRIMINATORY PRACTICES TOWARD PAIN MANAGEMENT

Now the issue is getting clearer that clinicians are obviously not giving adequate analgesia to Black patients; so, are there repercussions for such clinical mismanagement? Upon expansion of this question, we get a few more focused questions. Firstly, does this add any liability or malpractice issue for their discriminatory acts? Secondly, what is the law and legal precedent on this issue, and is something being done about it? If no to the above inquiries, then thirdly, are there any guidelines or case precedent relating to disciplinary action from medical boards or some other governing medical agencies on such

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[87] Aronowitz et al., *supra* note 2.

[88] *Id.*

[89] *Criminal Justice Fact Sheet*, NAACP, https://naacp.org/resources/criminal-justice-fact-sheet [https://perma.cc/S6JH-RUCA] (last visited Oct. 20, 2021).

[90] German Lopez, *Black and White Americans Use Drugs at Similar Rates. One Group is Punished More For It.*, VOX (Oct. 1, 2015), https://www.vox.com/2015/3/17/8227569/war-on-drugs-racism [https://perma.cc/LN6E-CGBV].

[91] Julie Netherland & Helena B. Hansen, *The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse.*, 40 CULT MED. PSYCHIATRY 664, 664 (2016).

[92] Zachary Crockett, "*Gang Member" and "Thug" Roles in Film are Disproportionately Played by Black Actors,* VOX (Sept. 13, 2016), https://www.vox.com/2016/9/13/12889478/black-actors-typecasting [https://perma.cc/XZA5-32TQ].

discrimination? We look at these specific questions below under the following legal analysis section.

A. Malpractice Liability for Clinicians for Undertreating Black Patient's Pain?

We did a detailed literature search on this issue on Westlaw and LexisNexis and looked at medical regulations and case law. The short answer is that, theoretically, a clinician can be asked why they did not provide adequate analgesia to a patient under certain circumstances, but there are many defenses that a clinician can raise, and successfully quash any such concerns.[93] We further explore this issue below.

Legally, when looking at malpractice liability as a tort action, we look at the four elements of such an action.

1. A Professional Duty Was Owed to the Patient

Here the patient proves that he was owed a professional duty, and will present how they were in pain, and the clinician did not provide coverage for that pain. However, we know that with pain being very subjective without much objective evidence, a clinician can raise the defense that they did not believe certain factors that the patient presented qualified them for certain pain medications. In addition, they can put in findings that would show that there was a high likelihood that patient was feigning, their pain was not real, or there was a high risk of ulterior motives of medication misuse by patient. Expert witnesses can be brought in, but there is a good likelihood that clinicians spot judgement on this case will be given precedence here, especially when public policy programs like 'opioid crises, and 'war on drugs' are heavily funded and backed by federal and state legislatures.

2. Breach of Duty

In this element, the patient will say that their pain was not treated, and it was breach of duty. The above clinician defense presented in element 1) will likely still stand for this as well and quash any basic arguments for this element.

3. Above Breach Led to Injury

In this element, the patient will argue that say that a certain pain and suffering was caused by the breach, but in the likely absence of element 1) and 2) above, it will not go this far into the third element.

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[93] David Brushwood, *Failure to Provide Adequate Pain Relief*, MEDSCAPE (Apr. 24, 2009), https://www.medscape.com/viewarticle/591048 [https://perma.cc/Z6KD-YW3D].

4. Damages

Again, unlikely after unproven elements 1) and 2), the court will even look to this element.

Looking at Westlaw and LexisNexis for cases of undertreatment of pain specifically in Black patients or minorities did not reveal any relevant case law. So clearly, there is minimal reprimand for the clinician in these circumstances for their undertreatment of pain, which as we noticed above caused significant injury to our patient Jacqui.

Moreover, there are adequate federal and state laws that stress more on not providing opioid pain medications when the clinician deems it inappropriate, and 'feels' (extremely subjective) that there is a risk of abuse and diversion. Clinicians are also provided objective tools like ORT (Opioid Risk Tool),[94] and SOAPP- R (Screener and Opioid Assessment for patient and pain- revised),[95] which ask for subjective information, and clinician can easily use these tools to their defense in undertreating or not treating pain for any patient.

Sadly, however, on the flip side there is a large case precedent on reprimands and successful malpractice suits for clinicians when they inappropriately prescribed. In addition, although initial case data was mostly related to civil and other malpractice issues, more-recent cases have been charged under criminal statutes for death of a patient due to incorrect prescribing habits.[96] This element of fear, when combined with assumed criminality in Black patients leads to more discriminatory undertreatment of pain in these patients.

B. What are the Laws and Legal Precedent on This Issue?

Here, we look at the laws, and their scarcity or disparity that leads to this potential discriminatory treatment process.

Historically, Medicare and Medicaid are covered under the Title VI of the Civil Rights Act of 1964,[97] which was instrumental in desegregation, especially in healthcare settings where often Black and White patients at the time were not even allowed to be in the same room.[98] It provided that for eligibility in such federal programs, the hospitals and healthcare systems under this payment

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

[95] Stephen Butler et al., *Validation of the Revised Screener and Opioid Assessment for Patients with Pain (SOAPP-R)*, 9 J. Pain 360, 360 (2008).

[96] Arielle Dollinger & Mihir Zaveri, *Doctor Who Prescribed Pain Pills is Charged with 5 Counts of Murder*, N.Y. TIMES (Mar. 5, 2021), https://www.nytimes.com/2021/03/05/nyregion/george-blatti-overdose-deaths.html [https://perma.cc/FE3T-4W2K].

[97] 42 U.S.C. § 2000(d) (prohibiting exclusion from participation in, denial of benefits of, and discrimination under federally assisted programs on ground of race, color, or national origin).

[98] Philip R. Lee, *Battling for the Right Health Policy, Then and Now*, 39 GENERATIONS: J. AM. SOC'Y ON AGING 15, 15-20 (2015).

umbrella could not racially discriminate among patients.[99] Nevertheless, as in other legal issues, going down to the State legislation, the picture becomes very murky with different laws that indirectly effect the quality of pain management, and the level of clinician discretion, especially when applied to pain management. We look at some of these laws below.

Under the concern of opioid abuse epidemic, State laws have developed a strict oversight on opioid usage for pain, although abuse and pain management are completely different issues. However, since both issues involve the same opioid or opioid based pain medications, unfortunately they fall under the same umbrella of State oversight. For example, in New Jersey, since 2019, the law N.J.S.A. 36:2-367, which is named as 'Knock Out Opioid Abuse Day', states that October 6th will be known as this day, and education will be given to healthcare care workers, lawmakers, and general public about the harms of opioids.[100] Such efforts and laws even if passed for eventual good, impact the prescription practices of the clinicians, and makes them biased towards certain minorities. Among the same lines, some states have further made laws on how much opioid pain medications can be provided to patients, and for how may days. Alaska, for example, has state law § 08.68.705, known as 'Maximum dosage for opioid prescriptions', which puts above restrictions on prescription of opioids for pain for Nurse Practitioners.[101] On the contrary, there are also some rare state laws that push for adequate analgesia for patients, and provide accommodating rules for clinicians in those states to provide adequate analgesia for their patients in pain. For example, in California, § 725 provides immunity from disciplinary actions for physicians and surgeons in treating intractable pain with opioid medications while in compliance with other related laws.[102] The underlying theme for this rare state law was a pain management issue between an internist Dr. Wing Chin, and a terminal patient Mr. William Bergman.[103] Dr. Chin was accused of undertreating Mr. Bergman's pain and causing him to suffer. The case went to trial, and jury reached a $1.5 Million verdict against Dr. Chin.[104] The thing that made this case different was the fact that an advocacy group 'Compassion in Dying' filed suit on the patient's behalf to push for this discrepancy. But, prior to that Medical Board of California had declined to bring disciplinary action against Dr. Chin.[105] As stated above, this was an isolated case.

However, under the usual clinical circumstance, there is no liability for the clinician for undertreatment of pain. Going back to our case about undertreatment of pain in Black patients. In a case from New York, *Verley v. Goord*,[106] the court

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[99] *Id.*

[100] N.J. STAT. ANN. § 36:2-367 (West 2022) ("Knock Out Opioid Abuse Day").

[101] ALASKA STAT. § 08.68.705 (2019) ("Maximum Dosage for Opioid Prescription").

[102] CAL. BUS. & PROF. CODE § 725 (2022).

[103] Jeffrey Wishik, *Chronic Pain: Medical and Legal Aspects*, 53 R.I. BAR J. 23, 23 (2004).

[104] *Id.*

[105] *Id.*

[106] Verley v. Goord, No. 02Civ.1182, 2004 WL 526740 at *21 (S.D.N.Y. Jan. 23, 2004); *see also* Verley v. Goord, No. 9:05-CV-1251, 2008 WL 4279498 at *13 (N.D.N.Y. Sept. 15, 2008).

stated that plaintiff did not have grounds for damages for undertreatment of pain under the reasoned Equal Protection Clause, since pain is not covered by the language of the clause. Similarly, in a Louisiana case, State v. Kennon, the court addressed the issue of a discretion-based rule that could be used by district authorities to change charges against narcotic abuse related issues.[107] However, the records in this case showed that the use of this law was strongly biased against Black people by the authorities[108].

This racial bias in pain management and oversight does not just go unilaterally against black patients, but it also goes against Black clinicians. This issue was raised by Dr. Ernest Bonner, a Black pain management doctor in California against Rita Aid pharmacy.[109] In *Bonner v. Rite Aid Corporation*, 202 WL 2836487, Dr. Bonner accused Rite Aid pharmacies to be discriminating against him and not filling prescriptions for this patients, even though he had followed all the regulatory laws, and had all necessary documentation for such prescriptions for his patients.[110] He stated that White doctors in the area prescribed more opioid pain medications, but he was isolated and discriminated against by virtue of his race.[111] Again, this was a very subjective issue, and the burden of proof was too high for him to prove through data and statistics.[112] But this clearly shows a bias directed even towards black clinicians in the field of pain management.

C. Availability of Guidelines Relating to Disciplinary Action from Medical Boards for Such Discrimination?

As above, there was not much in the realm of legal malpractice for undertreatment of pain, so we looked at State Medical Board statutes across the U.S. relating to this disparate practice.[113]Upon our review, there were many common things in most of the regulations across states, such as all state medical boards required that clinicians do a thorough examination, and document their findings, and based on those findings make their decisions.[114] Similarly, most state medical boards talk about treating every patient without bias, and not to discriminate based on age, sex, race, or religion.[115]

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[107] State v. Kennon, 194 So.3d 661 (La. App. 2d Cir. 2016).

[108] *Id.*

[109] Bonner v. Rite Aid Corporation, No. No. 2:19-cv-00674, 2020 WL 2836487 at *1 (E.D. Cal. June 1, 2020).

[110] *Id.*

[111] *Id.*

[112] *Id.*

[113] David E. Joranson et al., *Pain Management, Controlled Substances, and State Medical Board Policy: A Decade of Change*, 23 J. PAIN & SYMPTOM MGMT. 138, 143-45 (2002).

[114] *Id.*

[115] *FSMB Statement on Diversity, Equity and Inclusion in Medical Regulation and Health Care*, FED'N STATE MED. (Apr. 15, 2021), https://www.fsmb.org/advocacy/news-releases/fsmb-statement-on-diversity-equity-and-inclusion-in-medical-regulation-and-health-care/

Regarding pain management, they often stress on appropriately treating pain, and some of them even use the word 'suffering' synonymously with pain. But again, they all lay much more stress, and provide clear guidelines on not overprescribing, and not prescribing for inappropriate reasons. Similarly, there is significant case data that has been decided by state medical boards where clinician was deemed to be inappropriately prescribing, and was reprimanded for it by fines, probations, and even cancellation of medical licenses.[116] So, this not only gives clinicians full control of the treatment of pain, but in various ways stresses them to preferably under-prescribe, or not prescribe at all for painful conditions. Under these circumstances, most clinicians again connecting the dots with assumed criminality in Black patients undertreat their pain habitually.

This brings us to the next question. With all this press and social media drives in the age of twitter and open media, has there been a change recently in such practices? The short answer is 'yes'. Although a very limited, and a very superficial yes. On a federal level, Federation of State Medical Boards (FSMB), put out a diversity, equity and inclusion statement in 2021 that affirmed its stance on above issues.[117] Similarly, AMA in June 2021, put out its guidelines that confront systemic racism in medicine.[118] However, as stated above, both efforts appear to be more outward statements with no legislative support on disciplinary actions relating to clinicians for their discriminatory acts. On a state level, California, [119] Texas,[120] and Oregon[121]-[122] have webpages on their efforts to prevent such discrimination and to file complaints. Nevertheless, there is nothing linked to those pages on statistics related to the outcomes of such actions and complaints, which again unfortunately makes them just words at this point.

Therefore, after looking at Legal Tort-Malpractice and State Medical board regulations, and their existing case precedent, one can understand why such disparity exists resulting in undertreatment of pain in Black patients. It clearly again falls under the first tenet of CRT, that racism is permanent, and it's all

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[https://perma.cc/8HBN-RGTD].

[116] Jack Richard & Marcus M. Reidenberg, *The Risk of Disciplinary Action by State Medical Boards Against Physicians Prescribing Opioids*, 29 J. PAIN & SYMPTOM MGMT. 206, 206-07 (2005).

[117] *Id.*

[118] *AMA Adopts Guidelines that Confront Systemic Racism in Medicine*, AMA (June 15, 2021), https://www.ama-assn.org/press-center/press-releases/ama-adopts-guidelines-confront-systemic-racism-medicine [https://perma.cc/U87B-CXUH].

[119] *DHCS's Efforts to Reduce Health Disparities*, CAL. DEP'T HEALTH CARE SERVS. (May 23, 2022), https://www.dhcs.ca.gov/dataandstats/reports/Pages/DisparitiesInterventions.aspx [https://perma.cc/N3JD-NDDY].

[120] *Filing a Discrimination Complaint*, TEX. HEALTH & HUM. SERVS., https://www.hhs.texas.gov/about/your-rights/civil-rights-office/filing-a-discrimination-complaint [https://perma.cc/VK5L-REDJ] (last visited Aug. 26, 2022).

[121] *Cultural Competency*, OREGON.GOV, https://www.oregon.gov/omb/Topics-of-Interest/Pages/Cultural-Competency.aspx [https://perma.cc/R8LL-3AZ5] (last visited Nov. 12, 2022).

[122] OR. REV. STAT.§ 676.850 (2021) ("Mandatory Cultural Competency Education").

around us, and the system propagates such practices to not only survive but thrive.

VI. APPROACHES TO MINIMIZE DISCREPANCY IN PAIN MANAGEMENT IN BLACK PATIENTS

The first step to fixing any problem is to recognize that it's a problem. So, recognizing that there is bias in management of Black patients, especially in the field of pain management, will be the first step towards resolution of this dire problem.[123] We already have enough data from multiple research papers and clinical studies that shows that undertreatment of pain is a widespread healthcare issue, rather than an isolated issue. There also has to be recognition that this is part of continuum of racism towards Black patients, which is not as obvious as it was some decades ago, but it still plays a hidden yet important role in creating implicit biases that are often not visible to the clinicians themselves. A recent point of view paper published in New England Journal of Medicine by Dr. Oluwafunmilayo Akinlade, talks about the need of clinicians to take the implicit bias test to get a better understanding of their unconscious underlying biases.[124] As busy clinicians in busy clinics and hospitals, sometimes we need to sit down, take a moment, and reflect on our clinical encounters, and think through what the patient was trying to convey through his words and body language. So, clinically training clinicians in active listening exercises and improving their understanding of the patients' issues is paramount.[125] From a pain management standpoint, this is very important especially in Emergency rooms and urgent care settings. There must be an understanding that like other patients, Black patients come to these acute care centers for management of their acute issues, most often in severe distress, and allaying this distress at times can help get a better understanding of their deeper underlying clinical issues. Similarly, such interventions should be made in Pediatric settings where there is evidence of undertreatment of Black children's pain in acute settings. This will prevent PTSD and other long-term complications from poorly controlled pain, and hopefully create a better sense of trust in healthcare settings at a younger age.[126]

From a medical education and training standpoint, it is imperative to remove old myths regarding differences in Black and White patients' bodies and their perception of pain. These fallacies should be pointed out earlier as part of medical school curriculum, and actively dispelled to uproot any later clinical

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[123] David Williams & Toni Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21 HEALTH CARE FIN. REV. 75, 75 (2000).

[124] Oluwafunmilayo Akinlade, *Taking Black Pain Seriously*, 383 NEW ENG. J. MED. 68 (2020).

[125] Ana-Belén del Río-Lanza et al., *Information Provision and Attentive Listening as Determinants of Patient Perceptions of Shared Decision-Making Around Chronic Illnesses*, 5 SPRINGERPLUS 1386, 1386-87 (2016).

[126] Aimee K. Hildenbrand et al., *Posttraumatic Stress in Children After Injury: The Role of Acute Pain and Opioid Medication Use*, 36 PEDIATRIC EMERGENCY CARE 549, 557-58 (2020).

misconceptions.[127]

It is also very important to continue to collect data on the pain management disparity from an individual clinician basis to a large healthcare system basis. These internal audits will help these entities understand their flaws and help develop strategies to curb these issues with active education and training on an individual, and a system wide level.

From a legal standpoint, there needs to be reprimand for clinicians for intentional undertreatment of Black patients' pain. Better laws need to be passed to curb generalizations about Black patients that lead to poor pain care of these patients. The presence of these regulations and following case precedent will help prevent poor pain management based on individual biases. In the same note, having similar regulations in state medical board guidelines with reprimands ranging from monetary fines and probations on medical licenses will likely prevent intentional discrimination towards Black patients.

It is also very important to remove stigma of drug seeking behavior from Black predominant painful conditions like Sickle cell disease. Similarly, improving research funding for these diseases,[128] and adding more education and training relating to these illnesses in medical curriculums will improve early diagnosis, clinical management of these diseases.

Also, improving pain scales which are more relevant to Black populations, and using language in these scales which is more understandable and applicable to their conditions will help improve pain care for these patients.

From a decision-making standpoint in managing these illnesses, rather than an individual discretion, team approach should be taken, so that one person's individual implied or unconscious bias does not affect the pain treatments for Black patients.

Over-portrayal of negative Black characters in media that are involved in substance abuse, and drug paraphernalia should be corrected, since this causes further conscious and unconscious bias in clinicians and community members who then related Black people to higher risk of criminality and illegal drug activities.

From a healthcare access and delivery standpoint, improving Medicaid payments (which are a more common source of insurance for Black patients) will increase their acceptance by clinicians, which will subsequently improve quality of healthcare facilities for Black patients.[129] Similarly, improvement in quantity and access towards mental health and substance recovery facilities, via improved funding will help reduce issues related to PTSD and mistrust relating to clinical

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[127] Williams & Rucker, *supra* note 102, at 85.

[128] Faheem Farooq et al., *Comparison of US Federal and Foundation Funding of Research for Sickle Cell Disease and Cystic Fibrosis and Factors Associated with Research Productivity*, 3 JAMA NETWORK OPEN 3, 8 (2020).

[129] Gideon Lukens & Breanna Sharer, *Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities*, CENTER ON BUDGET & POL'Y PRIORITIES, https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial [https://perma.cc/56DN-9Q5L] (revised June 14, 2021).

care in Black patients.

In the same line, having all pharmacies carry opioid pain medication irrelevant of their locations in various parts of Black neighborhoods or in White predominant suburbs will create a sense of equality among Black patients who sometimes must travel long distances to get their medications filled for legitimate needs.

Most importantly, there is a great need for an increase in the number of Black clinicians in the community and large healthcare systems. Blacks make up for almost 14% of US population, but we only have 4% Black physicians in the US,[130] which is a huge discrepancy. Improving pathways for black students to join medical schools and residency training programs will help resolve this issue over time. This will later also improve Black leadership in hospitals and clinics which will hopefully improve the power balance, improve recognition of black patients' clinical issues, and help larger healthcare systems better cater to the needs of Black patients.

CONCLUSION

Coming back to our clinical case, we continued Jacqui on Oxycodone initially, and then added some long-acting Morphine for her pain as well. She felt that with better pain control, she was able to walk more, eat better, and get more restful sleep at night. She was very thankful for the compassionate care, and appropriately liberal pain management. Jacqui continued to come weekly to our clinic for the next 3 months, getting blood draws, clinical exams, and CT scans to see the response to the experimental clinical trial. She initially did well and was able to visit her sister in North Carolina when COVID-19 infection incidence decreased. She spent her birthday there with her husband, Tanisha, and both her sisters.

Upon return from North Carolina, she continued to do well for a few weeks. But later she started feeling short of breath and fatigued. We did blood draws and scans, and it showed that she was very anemic, and her disease had further spread in her liver and lungs. She later required Oxygen for breathing comfortably. About 2 weeks later, we heard that she was getting *weaker,* and felt that she could not come to the cancer center for more treatments. We did a telemedicine visit with her via computer. She looked very weak and frail. Tanisha told us that she had stopped eating a few days ago and was only able to sip some water. Even with all this happening, she seemed to have her sense of humor, and said that she' . . . talked to God last night, and he told her that he has a room for her in heaven . . .'. We talked to her and her family in more detail, and she said that she wanted to focus on comfort at this point. She also stated that she did not want to be placed on ventilators or other life support machines and wanted to go naturally and peacefully. We ordered some more Morphine for her at home, in addition to

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[130] *Diversity in Medicine: Facts and Figures 2019*, ASS'N AM. MED. CS., https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018 [https://perma.cc/RZD3-D335] (last visited Sept. 14, 2022).

requesting home hospice care. Three days later, Tanisha called us stating that Jacqui had passed comfortably in her sleep, and she wanted our team to come in for her funeral service. We all went there after work on a Thursday, and saw her resting comfortably in the open casket, looking blissful with a beautiful smile on her face. They had pictures of her with our team during her last six months, probably the toughest months of her life. But I think that she had seen tougher years growing up as a Black girl with Sickle cell disease, and Appendicitis where no one acknowledged her pain, and later as an adult when her pain complaints after a large fracture and Vertebral disc rupture were ignored. She braved through it all, the pain, the ignored complaints, and the subsequent suffering and disability. But she continued to serve her community as a schoolteacher even through all these troubling times. Clearly, after all that she had been through her life, Cancer was just a walk in the park for this brave lady.

Under recognition and under treatment of Black patients' pain is a sad reality for a healthcare system that prides itself in inclusion and liberalism. It is a national embarrassment for the US, that major health outcomes including adequate pain management for Black patients are significantly poorer when compared to their White counterparts. This paper talks about discrepancies in pain management in various fields of medicine through the lens of tenets of CRT. Through the clinical case of Jacqui, it describes various difficulties faced by Black patients in getting their pain recognized, and adequately treated.

By looking at these disparities in pain management for Black patients through the tenets of CRT, we can see that there is a huge need for grass root effort to recognize this disparity. In addition, there needs to be an improvement medical education system, healthcare funding, and research to correct the fallacies that bias clinicians in their pain management approaches when treating Black patients. Also, there needs to be improved mental health and substance abuse resources available for these patients who have been stigmatized and mistreated in the US healthcare system. In addition, there needs to be better perception of Black people in media and news, where a new and more positive image needs to be portrayed to eliminate the currently displayed criminal portrayal that biases everyone including the healthcare providers. More importantly, there is a dire need for creation of pathways to improve representation of Black physicians and healthcare leaders that help improve these discrepancies from top down.