

Ensuring Color-Blind Care

An African-American patient receives inadequate pain relief in this case example, which the author uses to illustrate ways you can combat this problem in your emergency department.

By Alan Heins, MD

Pain is the most common reason for seeking medical care, and as a presenting complaint, it accounts for most emergency department visits. Unfortunately, pain is often inadequately treated in the emergency department. Studies suggest that children and the elderly receive less pain treatment with analgesics. Studies also show that patients in ethnic minority groups are at risk for inadequate pain relief.

Although analgesic use in emergency departments has increased over the years, white patients are still more likely to receive opioid prescriptions than minority patients. This disparity was first recognized in the early 1990s and still exists today. For example, a nationally representative study published in 2005 revealed that opioids were prescribed for 40% of white patients in emergency departments compared to 32% for all other ethnic groups. A similar study in 2008 showed that 52% of non-Hispanic whites received opioids for long-bone fractures compared to 45% of blacks, and 72% of non-Hispanic whites were prescribed opioids for nephrolithiasis compared to only 56% of blacks. These discrepancies occurred even though an objective cause of severe pain is evident in patients with long-bone fractures and nephrolithiasis.

In most emergency department studies of analgesic disparities, race and other patient characteristics are evaluated as predictor variables. However, the influence of the provider's race and other provider charac-

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teristics on analgesic-prescribing practices has received less attention. Studies of other medical specialties and health care settings have examined the influence of provider race on quality and patient satisfaction with care, but no clear themes or trends have emerged.

Why do nonwhite patients often receive inadequate pain medication? Studies suggest a racial bias, but this is difficult to prove because practitioners understandably will not admit to it. The reality is, though, that they may suspect that minority patients are more likely to divert prescribed drugs for illegal purposes or to exaggerate the severity of their pain for some secondary gain, such as sympathy or pleasurable intoxication. To further complicate matters, physicians may not realize that various cultures react to pain differently. For example, Hispanics are often very vocal about their pain, while Native Americans tend to bear pain stoically.

The case study presented here describes a black patient with an ankle injury who receives inadequate pain medication in the emergency department.

PATIENT PRESENTATION

Mr. R, a 38-year-old African American, presents to the emergency department at 6:45 p.m. for evaluation of a right ankle injury. He says that he inverted his ankle a short time ago while roller skating during his child's birthday party. His ankle is swollen bilaterally and he is unable to walk on it. He reports a pain score of 8 on an 11-point (0 to 10) verbal pain scale. He receives a nursing assessment and his condition is categorized as semi-urgent. *continued*

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An ice bag is placed on Mr. R's ankle and he is transported to the registration area by wheelchair, with his leg elevated, to complete the necessary paperwork. Unfortunately, all emergency department beds are full, so he has to sit in the waiting room until 8:35 p.m. before being moved to a treatment room for physician evaluation. On examination by the physician, the patient's ankle demonstrates bimalleolar swelling and tenderness at the distal tibia and fibula, with no ligamentous laxity or foot tenderness. Other physical and neurologic findings are normal. No additional pain assessment is made, and no one asks the patient if he wants an analgesic.

The physician orders 500 mg of oral naproxen, which is administered at 9:05 p.m. He also orders an ankle x-ray film, which reveals a minimally displaced bimalleolar fracture. He applies a stirrup and a posterior short leg splint, refers the patient to the on-call orthopedist for an appointment in two days, prescribes naproxen for pain (500 mg every 12 hours for up to 10 days), and discharges the patient home.

DISCUSSION

The case above reveals several missed opportunities for improved pain management in the emergency department setting. Although no clear evidence of racial prejudice exists, Mr. R's experience of being prescribed a nonopioid analgesic for an obviously painful injury is common among blacks and other racial and ethnic minorities. His case highlights the importance of timely treatment for acute pain, repeating pain assessments and asking patients if they want analgesia, and administering the most effective analgesia.

Mr. R's treatment got off to a good start. He received a timely initial pain assessment and appropriate nonpharmacologic pain treatments. But after that, things went awry. The patient waited 2 hours and 20 minutes before receiving

any analgesia. No one reevaluated the intensity of his pain, asked him if he wanted an analgesic, or tried to determine if the analgesic provided was effective.

Finally, the oral analgesic agent (naproxen) given to Mr. R in the emergency department and then

prescribed at discharge was probably inadequate for the treatment of severe pain from a long-bone fracture. A parenteral or high-dose oral opioid while in the emergency department and an oral opioid at discharge would have been more effective.

How could Mr. R's care have been improved? By making a few simple changes in the emergency department care process and the physicians' approaches to pain management. For example, standing orders or triage protocols can allow prompt treatment of acute pain in spite of emergency department overcrowding. Several studies in the United States and Australia have evaluated the effectiveness of analgesics given at triage, including oral opioids by standing order and parenteral opioids with physician consultation. The studies showed that analgesics were administered more quickly and patients' pain was relieved sooner.

Another effective change is building periodic pain assessments into the nursing care, including at discharge. Repeat assessments allow nurses and physicians to recognize increased pain due to the injury or disease process and reductions in pain intensity related to analgesics.

A further strategy that has also proved successful is having emergency physicians document their own pain assessments and also review the nursing assessments to help guide their care of patients in pain. A key aspect of this strategy is to ask patients about their desire for analgesia and then, after treatment, to ask them about the adequacy of their pain control. Unfortunately, patient preferences have not been well studied, but a patient-centered approach will obviously result in more effective care.

Finally, nurses and physicians should realize that opioids are highly effective in the treatment of acute, severe pain and use this knowledge to improve care for all emergency department patients. Titration of parenteral opioids allows rapid, safe relief from even the most severe acute pain. After control of acute pain is achieved in the emergency department, patients who are expected to have ongoing pain for some time due to the nature of their condition may be effectively treated with oral opioids after discharge.

Emergency department pain care is often inadequate and prone to racial disparities, but these shortcomings can be overcome with simple system-

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atic changes in the processes of care and alterations in the physician's approach to pain management. □

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