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INTRODUCTION

The Unequal Burden of Pain: Disparities and Differences

A recent report from the Institute of Medicine [1] described stark racial and ethnic differences in the delivery of health care services and in the experiences of those served. Although the report paid relatively little attention to clinical pain, most of the diseases covered (e.g., cardiovascular, cancer, and diabetes) are also associated with pain. A more recent review published in *Pain Medicine* [2] clearly showed that racial and ethnic differences described by the Institute of Medicine apply equally to people in pain contributing to a further health status and health care gap for racial and ethnic minorities.

Despite the increasing evidence that pain differentially impacts racial and ethnic minorities, the issue has been largely overlooked in scholarly documents. In response, *Pain Medicine* issued a call for papers relevant to racial and ethnic differences in the experience of pain or in its treatment. That solicitation elicited numerous high-quality empiric manuscripts. In fact, the volume of submissions overwhelmed the boundaries of a single issue. While a number of articles appear in this special issue, three articles will appear in an upcoming issue. The decision to place the latter articles in a separate issue reflects logistical and editorial considerations regarding the organization of topics, not differences in the quality of articles. Hence, readers can anticipate additional attention to the topic in the months ahead.

Each article in this issue is important for its unique contribution to the literature on racial and ethnic differences in pain. At the same time, these articles are unique in that they represent an attempt to concentrate attention on this important topic. Notwithstanding the ethical obligation to attend to racial and ethnic differences discussed by Allen Lebovits in his commentary, the articles were chosen primarily because they address a set of topics that broaden our understanding of this difficult but critically important issue.

The first article in the series, by Louis Sullivan and Barry Eagel, provides a global overview of the impact of health disparities on the individual and society, while presenting a convincing argument that disparities in pain care must be given the same consideration as other public health problems. The other articles cluster around three themes: pain perception, response to pain, and disparities in pain treatment. The article by Edwards and colleagues and that by Weiss and colleagues focus on pain perception. Each raises important methodological considerations that must be considered if research in this area is to progress. A number of articles address the broad area of racial and ethnic differences in response to pain. Several articles focus on this matter in nonclinical samples: Buchwald and colleagues in an American Indian sample, Ruehlmann and colleagues in a national survey of non-Hispanic whites and African Americans, and Hastie and colleagues in a sample of college students that also included Hispanics. Articles by Tan et al. and by Baker and Green bring the focus back to clinic patients. Most interestingly, each of these articles identifies commonalities in response to pain across racial and ethnic groups that can be easily overlooked in our efforts to identify differences. Finally, the article by Shaya and Blume and that by Chibnall and Tait bring our attention back to disparities in treatment that exist despite whatever commonalities exist among these groups.

From a public health perspective, there are tremendous benefits to examining the pain experience in racial and ethnic minorities. Sullivan and Eagle note that the elimination of disparities in pain management is consistent with federal, state, and local mandates to improve the nation's health. Recognition of the differential impact of pain on potentially vulnerable Americans can clarify some of the complexities inherent in pain assessment, a necessary step if we are to provide adequate pain management and eliminate barriers to quality pain care. In addition, more work is needed on interventions to insure that optimal pain management is available for those who are at most risk for the disabling effects of pain. Clearly, patient-related barriers must be addressed. At the very least, educational initiatives should be instituted and other channels identified that can improve patient collaboration in treatment. The public health benefits of attention to these issues include lower rates of disability and its medical and social

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consequences as well as societal savings in health care and social programs for the disabled.

This special issue represents a step towards understanding the unequal burden of pain born by racial and ethnic minorities. As Allen Lebovits notes in his commentary, the articles in this issue also bring into focus ethical considerations that are posed by the inequities that they describe. At the same time, this series of articles is only a start in the important work that remains to be done. For example, the participants in the research described in this issue constitute only a portion of the vulnerable patient population; racial and ethnic minorities who are impoverished, elderly, or female may be particularly vulnerable. Health care policy must address disparities in pain care for these and other vulnerable populations in a comprehensive manner. As suggested by Sullivan and Eagel, health force issues and the provision of culturally competent care for an increasingly diverse population is central to the discussion. In addition, as long as there is evidence that disparities exist, racial and ethnic identifiers should be implemented such that disparate treatments and outcomes can be identified and corrected. In a sense, disparities in treatment should be considered as a fundamental kind of medical error. These and other efforts must continue until disparities in pain care are eliminated and optimal pain care is available for all. As we approach the middle of the Decade for Pain Research and Control, we have yet another call for action.

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