Pain, Power, and Prejudice in the United States

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The relationship between patients and physicians is necessarily grounded in a power-knowledge relationship. One way of understanding this is through Foucault's concept of power-knowledge. This is the idea that power and knowledge are inextricably linked; knowledge begets power and power begets knowledge. Within the culture of biomedicine, practitioners leverage an imbalance of knowledge with respect to patients, giving them increased power over the lives of their patients. Foucault once stated,

> "The judges of normality are present everywhere. We are in the society of the teacher – judge, the doctor – judge, the educator – judge, the social worker – judge; it is on them that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects to it his body, his gestures, his behavior, his aptitudes, his achievements" (Foucault, 1977, p. 304)

Foucault suggests that this power wielded by doctors comes from their control of information, their choices about what constitutes ‘normal’ or ‘appropriate,’ and their access to valuable resources. Patients are conditioned to view biomedical practitioners' knowledge of medicine as justification for paternalism towards patients – in other words that, 'doctors know best.' Patients lacking formal medical training are not necessarily empowered to contest a physician's recommendations, and those who attempt to educate themselves in order to do so may be viewed unfavorably by practitioners.

The “WebMD Patient” has become a stereotype: Patients who educate themselves about their own conditions are frequently not taken seriously. The physicians’ advanced training creates a sharp distinction between practitioner and patient, and a power imbalance occurs. Furthermore, patients tend to assume a ‘sick role,’ described by Talcott Parsons: on account of being sick, a patient has societal obligations to both get well and to seek assistance from a medical professional, which furthers a patient’s dependency on their physician’s advice (Parsons, 1951).

When this power-knowledge imbalance is coupled with conscious or unconscious racial bias, the disparity between patient and physician grows even greater. It should come as no surprise that this imbalance of power-knowledge, reinforced by long-standing social norms and coupled with a mixture of conscious and unconscious racial bias, inevitably leads to the crushing disparities in care experienced by Black patients in the United States.

Racial bias is often difficult to understand, frequently lurking beneath the surface, and may languish unnoticed even by those who harbor it.. "When racial bias is implicit, referring to attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner, it is all the more insidious and difficult to ameliorate" (Staats, 2015). Treating pain provides an illustration of this dangerous problem. Although pain scales such as the Stanford Pain Scale or the Numeric Rating Scale (NRS 11) attempt to reduce subjective descriptions of pain down to a number understandable by physicians, doctors interpret responses, and are then liable for believing the patient is exaggerating or is otherwise untruthful when reporting their pain, leaving open an avenue for biases to seep into treatment plans.

A dangerous trend is that Black Americans’ pain is underrated in several

dimensions, ranging from severity to frequency; Black Americans reported greater back pain on average than White Americans but were rated as having less back pain by their clinicians (Wyatt, 2013). In fact, in terms of prescription rates, Black people are 10% less likely than White people to be prescribed opioids between 2003 and 2007 (Mossey, 2011). Studies have linked this disparity to unconscious racial bias: physicians with greater measured unconscious racial biases tend to prescribe less pain medication to non-White patients (Sabin and Greenwald, 2012).

One can imagine how this chronic underprescribing of pain medication to Black patients could lead to doctors failing to follow-up with these patients and individuals finding other ways to cope with chronic pain. These methods might include illegal drugs, excessive alcohol, or obtaining prescription medication on the illicit market. When one understands that Black Americans are 2.7 times as likely to be arrested for drug-related offenses, despite using and selling at roughly the same rate, one can see how these disparities in medical care and specifically pain-management might be linked to misleading perceptions of addictive behavior among Black Americans.

Truthfully, this phenomenon is not just limited to pain management: an upsetting number – up to 73% of physicians endorsed at least one false distinction between Black and White people. Some of these disparities included: that Black people have more collagen than White people's skin, or that Black people have stronger immune systems (Hoffman et. al, 2016). Although revising coursework to correct blatantly incorrect assumptions is a laudable step, this alone cannot dismantle systemic racial bias.

Philosophically, the collection of knowledge, the totality of the reality that we understand and perceive, is not limited to empirical fact. There is a subjective component, a component buttressed by symbolic interaction, arising from assigned meaning that is not solely construed from visual imagery or auditory signals, meaning that requires cultural context (Berger and Luckmann, 1966).

Here, deep within the cultural influence over subjective reality lies the disease of racial bias, shaping physicians' schemas of appropriate treatment for their patients, consequently bestowing de facto power over patients. It is critical that we recognize and learn from the stories of those who have endured medical discrimination – like Serena Williams' whose near-fatal symptoms were not

believed after she gave birth to her daughter (Lockhart, 2018), or the shameful experiments like the Tuskegee Syphilis Study where Black men with syphilis were never informed of their diagnosis and never provided treatment. These stories shine as real-life examples that racial bias is still endemic to the medical community.

Stories like these are important in recalling how distrust has historically been sown within the Black community against medical practitioners. A history of discrimination contributes to this mistrust, but so does medical discrimination, which continues to this day. It is up to the medical community to keep these stories in mind and hold themselves accountable in ensuring that preexisting racial bias is corrected for when administering treatment or designing experiments.

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