Perceptions of pain

Cultural differences add to the challenge of treating patients’ pain.

By Suzy Frisch

When a patient presents with pain, physicians take part in a delicate dance as they attempt to assess the source and severity of the sensation and determine the best course of action. They want to alleviate suffering but don’t want to prescribe a drug that could be abused. When the patient’s culture or home country is different than the physician’s, the dance becomes much more complicated. There may be language barriers and differences in how people describe pain, how they self-treat and what they want from their physician.

Keith M. Swetz, M.D., sees it all the time at Mayo Clinic. An associate professor of medicine at Mayo Medical School and a palliative medicine specialist, Swetz treats people from many different backgrounds who are dealing with pain. And over the years, he has noticed there are cultural variations in how his patients describe what they feel. He’s learned that in some cultures, suffering is meant to be endured and that it’s common to minimize it. In others, people may be highly dramatic, making sure that medical professionals understand their pain and symptoms. “It’s hard to know if someone is markedly over-reporting what their pain is—even if that is their culturally appropriate response—versus someone who is very stoic and minimizes their pain and suffering, when indeed their symptoms far exceed what they are reporting,” he says.

Cultural issues come into play in other ways as well. When caring for Somali patients at the end of life, Swetz has seen conflict between those who want medication to ease their pain and their family members who want to make sure their loved one is conscious and able to converse and pray before they die. “You have to frame the conversation for the patient accounting for their own culture and past experience, and sometimes that’s hard to do,” he says.

As Minnesota’s population continues to become more diverse, physicians in every corner of the state are seeing people from a variety of backgrounds—a trend that only will continue. The Minnesota State Demographic Center indicates that one in every 14 people in Minnesota is foreign-born and projects that nonwhites and Latinos will comprise 13 percent of the population by 2015 and 25 percent by 2035. Minnesota already has the country’s largest population of Somali and Liberian residents and the second-largest population of Hmong residents, following Cali-
ork in culture when assessing and managing a patient with pain. Understanding patients’ cultural backgrounds is critical, notes an Institute of Medicine report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” According to its authors, failing to support and foster culturally competent health care can lead to increased costs for the individual and society because of more hospitalizations and complications. And with fears of opioid abuse unabating, it’s never been more important to factor in culture when assessing and managing a patient with pain.

**Talk it out**

Family physician Kara Pacala, M.D., sees patients from many ethnic groups and cultural backgrounds at the University of Minnesota Smiley’s Family Medicine Clinic in Minneapolis—with East African patients making up a large portion of her caseload. Many of her patients have experienced the trauma of war, living in refugee camps or being separated from close family members. She aims to learn their personal stories and pair that information with what she learns from the medical history and physical exam to better understand the source of their pain. She also considers cultural factors. She has learned, for example, that patients from East Africa tend to describe pain in terms of temperature; that is, a sore area feels hot or burns. Combining that information with other diagnostic methods, Pacala attempts to get at the root of her patients’ pain. That way, she’s not treating emotional or somatic pain in the same way she would that caused by an ulcer or migraine.

“We learned to look for red flags—things that compel me to say that this headache is the patient is experiencing might indicate something serious like a tumor. Or this is the headache of a woman who hasn’t had a decent night’s sleep in months or years,” Pacala says. “I’m learning to hear in between, based on an understanding of culture and the stories of the patient. That makes a difference in the diagnosis and how you treat so that you can treat appropriately.”

Jennifer Hines, M.D., also knows cultural factors need to be considered when assessing pain. An internist at Health Partners Midway Clinic in St. Paul, which serves a significant number of Hmong, African and Hispanic patients (she also worked at a free hospital in Phnom Penh, Cambodia, for six years), she knows that many Asian patients—especially older ones—are reluctant to communicate with physicians. They have abiding reverence for doctors, who are considered to be in the highest profession, and many don’t want to be disrespectful by bothering them with their troubles. So they understate their pain. Hines works hard to earn their trust and let them know that it isn’t disrespectful to tell her if they’re experiencing pain.

With her elderly Somali patients, she knows she has to tease out information. For example, she finds that many don’t understand the numerical scale used to describe the intensity of pain. So Hines gathers information by asking the patient to describe what’s happening at home. “I might have a conversation with the patient about her week and what she is able to do. How many hours did she sleep?” She uses the answers, along with observations on how active and communicative the patient is, to help her determine indirectly how much pain the patient is experiencing.

Elena Polukhin, M.D., a physical medicine and rehabilitation physician at Rehabilitation Consultants in Bloomington, says she often relies on interpreters to understand her patients’ concerns. A native of Russia, Polukhin sees patients from Eastern Europe and Africa as well as the United States, many of whom have both chronic pain and chemical dependency issues. And while she would struggle to do her job without interpreters, she knows they sometimes bring their own opinions into the exam room.

Once when Polukhin was talking to a Bosnian patient struggling with alcoholism—a big taboo in the mainly Muslim country—about injectable naltrexone, which blocks the effects of narcotics and alcohol, the interpreter who was translating became judgmental. “We were explaining...
Patients from other cultures aren’t so interested. Polukhin knows that her Russian Orthodox patients, for example, are not fans of acupuncture, noting that they “think needles are from the devil.” Her Hmong and Vietnamese patients, though, are willing to try acupuncture and healing touch. Polukhin also suggests nutritional supplements such as glucosamine microlactin as natural pain killers and finds that her American Indian and Muslim patients especially favor that kind of treatment.

Cultural and therapy choice
Physicians who treat patients in pain note that culture can serve as a guide when it comes to selecting appropriate treatments. In her practice, Hines finds it’s rare for Asian patients to take opioids because of their tendency to endure or live with pain. Pacala says she has learned that many of her East African patients associate going to the doctor with receiving treatment of some sort. You have an illness, therefore you get medication. That doesn’t necessarily mean those patients are seeking narcotics, she says. "But they think, ‘If you are sick enough to go to the doctor, you are sick enough to be given treatment.’ We’re learning to work with that and understand that.”

Many physicians treating pain patients use a combination of medication and complementary and other therapies—acupuncture, heating touch, chiropractic treatment, heat and ice. Whether a patient is open to a certain treatment may, in part, be influenced by their culture and background. Many of Pacala’s East African patients, for example, are willing to try massage and physical therapy, as long as the provider is of the same sex. They also will try heat, ice and topical medications when Pacala suggests them.

For example, when she asked a Somali patient if he was depressed, the interpreter translated the question to, “Are you crazy?”—leaving the patient shocked and appalled. The problem: There was no word for “depressed” in the patient’s language. Pacala has learned instead to ask patients if they are sad, if they have a poor appetite and whether they are sleeping well.

Trust and understanding
With any patient claiming to be in pain, physicians have to be both wary about potential abuse and sensitive to culture and background. They need to watch out for red flags such as patients who doctor shop, ask for specific narcotics, frequently lose medications or repeatedly ask for early refills, Swetz says. Yet at the same time, clinicians have to be attuned to their patients’ needs and preferences and their perceptions of pain and its treatment.

Pacala admits treating patients with pain can be tricky. “But it always comes back to the relationship you can form with the patient or family,” she says. “Try to establish trust and give the message that you’re trying to help and hope they understand the process. It’s complicated for everyone.” MM

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