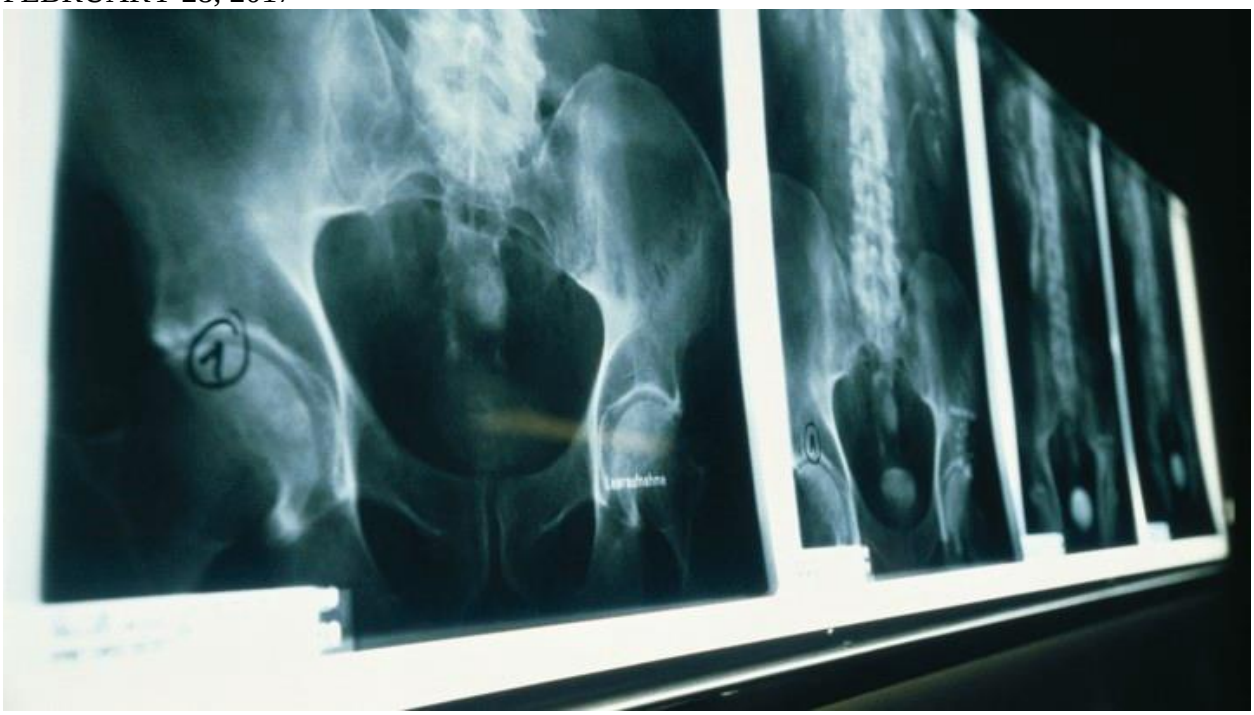
THE ATLANTIC

The Long History of Discrimination in Pain Medicine

X-rays and other “objective" instruments influenced controversies about whose pain should be believed.

SARAH ZHANG
FEBRUARY 28, 2017



SAGEL & KRANEFELD / GETTY

Pain is sometimes easy to understand. You break your arm, and it hurts. It gets better. It hurts less. But pain can also be incredibly hard to understand. Chronic pain. Pain that lingers long after an injury should have healed. Pain that resists an easy association between injury and hurt.

While this kind of “pain without lesion” has long puzzled doctors, the 19th century ushered in a whole new era of controversy, argues the bioethicist Daniel Goldberg in a recent paper, “Pain, objectivity and history: understanding pain stigma.” The era also brings technological developments—“objective” instruments like the X-ray—that rendered previously unseeable injuries seeable.

This idea of objectivity in assessing pain plays a major role in the debate over "railway spine," a constellation of symptoms suffered by people in train collisions. (It's sometimes likened to 19th-century whiplash.) Railroad companies were not keen to compensate victims for these vague symptoms. The emergence of objectivity influenced the stigma around patients who suffered from pain without visible injury—and this stigma ends up overlapping with stigma that already exist along race, gender, and class lines. The same issues reverberate today, in how doctors discount women's pain or prescribe opioids to African Americans less frequently.

I spoke to Goldberg, who teaches at the University of Colorado, about the history of pain stigma and how it informs his experience teaching medical students. A transcript of our conversation, condensed and edited for clarity, is below.

Sarah Zhang: In one of the cases you write about, a lawsuit over railway spine makes it to the Wisconsin Supreme Court in 1888. The woman initially wins $7,000—only to have the state's supreme court rule the damages excessive in part because doctors can't find any visible injury. How were aspects of her identity used to discredit her?

Daniel Goldberg: Isn't that a doozy of a case? It's not subtle. First it's railway spine, so you're immediately injected into this contested illness. She was a woman, which is immediately going to make it less likely that her pain is going to heard or believed. We know that is true today; I think we have very good to reason to think that would have been true at that time as well.

She was fat. We know that, then and now, people who live in fat bodies are at a much higher rate of being stigmatized, of being disbelieved, as being regarded as not credible. (Just so we're clear, when I use the word "fat," it's a political choice. I'm using it the way fat studies scholars and fat activists use it, not the medicalized term "obesity.")

And she was "unchaste." In the late Victorian era, all these things would have been killers. In fact, that's exactly what happened. The court basically said this woman is not credible at all. There's no way that the amount of damages that was awarded to her could possibly be consistent with the truth of her illness. Therefore, we're going to reduce the damages.

Zhang: Was her case typical? Did doctors discount any pain didn't have a visible injury?

Goldberg: It's not true that 19th-century neurologists widely denied their patients' pain experiences. But we do have good evidence that belief in people's pain experiences did follow social strata. If you were a wealthy white man, you were more likely to have pain complaints believed in the 19th century, just as you are today. If you were person of color in the 19th century, in the southern United States, your complaints were much less likely to be taken seriously.

If they couldn't connect their patients' pain complaints to these material pathologies they could see, you were much more likely to have your pain regarded as false, or duplicitous, or deceptive. That increasing likelihood is connected to changes in objectivity.

Zhang: You write, “Objectivity has a history.” Why does the idea of “objectivity” emerge specifically in the 19th century? You have new technology, like X-rays, and this idea of “mechanical objectivity,” right?

Goldberg: Mechanical objectivity basically says, if you want to know the truth of the matter as it exists in nature, the way is to remove all human influence from that object—to make it look just as it appears.

With these scientific imaging techniques—stethoscopes, photographs, X-ray, microscopes—the point of all these is to locate the natural objects of disease. How do we know whether or not this particular illness complaint is true? The answer is we can connect the patients symptoms to material pathologies in objects that we can image. That's how we can distinguish truth from falsities.

Zhang: We have even better tools for imaging the body now, but patients still walk into clinics with back pain that doctors can’t explain. Where is there a change, if there is one, in which doctors realize their instruments are not objective and all-seeing, at least for locating a source of pain?

Goldberg: I know that some people will disagree with what I'm going to say. I think health-care providers are well aware that we have illness complaints that defy objective modalities. Of course there are! And they know in the abstract that doesn't make them less real.

But that cognitive knowledge—I don't think that necessarily translates into practice as well as we might like. The entire practice of health care is the anatomo-clinical method. What do we do? We objectify illness. We try to find using all sorts of objective tools—whether it's imaging, whether it's lab tests, blood draws—we try to find material pathologies that we can clinically correlate with their illness complaints.

Zhang: It strikes me that it’s not just doctors who want to find the physical source of pain. It’s patients, too. You have studies, where if a patient in an MRI machine can visualize activity of their brain’s pain center, they can better manage the pain.

Goldberg: Absolutely. Patients want medical imaging, especially people dealing with contested illnesses. Why? Because seeing it confirms the truth of the matter for them. These are the people experiencing it—they don't have the luxury of denying the reality of their own pain but they kind of do deny the legitimacy of it, especially when everyone else is denying the legitimacy of it.

That's how stigma works. When everybody else is stigmatizing you for something—day after day, week after week, year after year, guess what? You tend to internalize it. Seeing the image, the pathology, the object confirms the truth of the matter to them.

Zhang: A recent study of medical students and residents found that those who had false beliefs about the biological differences between blacks and whites rated the pain of black patients in mock cases lower. How do you trace these attitudes historically?

Goldberg: I thought that paper was phenomenal, in part, because it was an experimental study that showed the influence of our historical attitudes, practices, and beliefs about back bodies in the United States and its connections to contemporary pain management.

We know these beliefs are old. A really stark example of this is Samuel Cartwright. He was a Louisiana physician, and he was just a vicious racist, to be honest. He had all of these beliefs about the reasons why black people and black bodies were less sensible to pain. It had everything to do with 19th-century beliefs about orders of civilization. So white people, especially white affluent people, they were more civilized. And because they were more civilized, they had gotten farther away from a more primitive state. And because they had gotten farther away from a more primitive state, they were able to endure extremes a lot less than people who lived in states which subjected them to the these extremes.

Another really important example in the history of pain is J. Marion Sims, one of the fathers of obstetrics and gynecology. Among other things, he's particularly famous for his experiments with vesicovaginal fistula, a serious complication from childbirth. He had a lot of white patients but he never tested any of his experiments on his white patients. He only tested on slave women on his estate and on neighbors' estates. We actually know two of their names—and I think it's important to name people like this—their names are Betsey and Anarcha. He also did them without anesthesia, even though anesthesia was available. Why didn't he do these tests on white women? And it's almost certain part of it was these beliefs about sensitivity to pain.

These beliefs endure. They continue to shape our practices even on unconscious and implicit levels.

Zhang: Doctors are under pressure to prescribe fewer pills with the opioid epidemic. How do we do that without discounting the real pain people suffer?

Goldberg: Histories about anxieties of opioid addiction are, guess what, about 150 years old, and they are almost exactly chronologically co-extensive with the some of the histories of pain and skepticism. Concerns about morphine and malingering are very consistent. There's a clinical case from the 1860s or 1870s, where the doctor is trying to find this lesion, he can't find the lesion, he can't find the lesion, he's doing all these amputations, he can't find the lesion, he can't find the lesion. Finally, after basically amputating this guy's leg all the way to his hip, he decides that he guy is malingering so that he can get opium.

Those attitudes, practices, and beliefs are handed down, and of course, they're also racialized. One of the things we know is that persons of color, especially black people in the U.S., are much less likely to receive opioids than white people. As it turns out, it might actually be good for them.

Zhang: Right—and that's one of the reasons why the opioid epidemic has been centered around white communities.

Goldberg: Yes, people of color might be missing some of the opioid epidemic than comparably situated white people, that's a public health gain, but they're also experiencing pain stigma, and that's a public health loss.

One of the things I've been arguing about pain is we have two public-health problems. One of the problems we have is the safe and effective use of opioids. And that is a big public health problem. The other public health problem, is the inequitable under-treatment of pain. We have proceeded to regard them as the same problem under the idea, in fixing our problems with prescription drug misuse, we would magically our fix our problems with the inequitable under-treatment of pain. And what I have been arguing that is wrong. We have reason to believe that even if we fix all of our problems with prescription drug misuse, we would still have substantial problems with treating pain equitably.

Zhang: Given all this, what do you teach your students?

Goldberg: Whenever I teach about stigma, I like to do two things: First, I take us away, and then I give us back. Stigma is structural. It is based in the foundation of our social structures. The whole idea is if you really want to resolve stigma, you have to do something about the fundamental inequalities. That's me taking away because individual health providers are not by themselves going to resolve inequalities, which doesn't mean they're powerless.

So then I give us back. Well, what can you do? I say actually lots of things work. That's the funny thing about stigma—almost everything works. When I say “works,” I don't mean fixes it or makes it go away. What I mean is it seems to help: Education about stigma and how it operates. Contact—the more contact you have with people who have been stigmatized, it can reduce stigma.

Having express anti-stigma policies. For example, an express policy with weight stigma, which is a huge problem, is having an universal design policy in a clinical setting: having chairs that fat people can sit in as a policy. All of those things probably help with stigma. They don't fix it but they help.