Unequal Burdens and Unheard Voices: Whose Pain? Whose Narratives?

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It is more important to know what person has the disease than the disease itself.

Sir William Osler

Very early in my medical school career, I (like other medical students) learned about the importance of listening to the patient’s story. However, no clear instructions were given on how to do so. During the preclinical medical school years, we were told that listening carefully to the patient would lead to the diagnosis. We were commonly taught to ask patients such questions as: “How does that make you feel?” Once we entered the clinical years, that practice went by the wayside. Listening became less important. The philosophy proposed and the values expressed were in clear contradiction to what we practiced and how we were rewarded. For instance, the faculty responsible for grading and observing our patient history and physical examinations implored us to focus our questions so that we would obtain specific responses.

Overall, quantitative measures prevailed over qualitative ones during my medical school training. The ability to obtain pertinent and concrete information in a minimal amount of time was rewarded. In contrast, allowing patients to ramble without direction or to tell stories about their illness (without refocusing them) meant less sleep, more work, and potentially a poorer grade. There was a discrepancy between the values expressed regarding the value of listening to the patient and the behavior on my part that was in fact rewarded. However, we trainees rarely questioned the process or the contradiction.
When medical students and house officers present the patient’s story (i.e., the history of present illness), they often begin by detailing the patient’s age, race, gender, and presumed diagnosis. In an attempt to standardize the information obtained, we depersonalize the patients, stripping them of their uniqueness (e.g., “32-year-old white female with a diagnosis of —”). Beyond the patient’s height and weight, additional information is noted regarding the patient’s general physical appearance (such as whether the patient appears to be the age stated). Although objective quantifiable information was obtained, subjective information, our perceptions and our potential biases (often based upon our values and not necessarily the patient’s) were used to define the patient’s identity. Essentially, small fragments obtained from a focused history are synthesized, but the texture is lost in much the same way that a high school student’s book report lacks texture when the student uses simplified guides to the text (e.g., Cliff Notes) instead of reading the book.

When we summarize the patient’s story by focusing on its key points we distance ourselves from the patient and his or her illness experience. Furthermore, we never really get to know the patient because we fail to listen. Unfortunately, we all lose an opportunity to learn about ourselves and miss the therapeutic benefits that come from telling or listening to the story. Narrative medicine allows the patient a unique opportunity to tell his or her story and for the health care provider to feel. This chapter will present data regarding racial and ethnic influences on the telling of and listening to pain stories. Both quantitative and qualitative data will be used to illustrate why narrative medicine is particularly important for pain sufferers who are ethnic minorities as well as for their health care providers. It will also provide information on how narrative medicine can give a voice to a rarely heard and particularly vulnerable population.

THE STORYTELLER

When we hear or read stories, we make several assumptions without ever knowing the storyteller or his or her experiences. When we see pictures or hear stories, whether they are pleasant or unsettling, we make value judgments about the picture or story as well as about why the artist or storyteller is using this format to tell us this story at this particular time. Who is telling the story, who is listening to the story, and the storytelling method all matter, as well as the listener and storyteller’s interpretations. This is particularly important for pain stories. Without the patient telling his or her story, the listener has no context for what the illness means to the patient.
The first story illustrates how a patient perceived the events surrounding his pneumothorax and subsequent treatment.

Author: Tell me about the pain when your lung collapsed.

Patient: When my lung collapsed there really wasn’t much pain. The only thing when my lung collapsed, I just couldn’t breathe. There was no screaming or hollering, no pain—I couldn’t breathe, that was it. The pain didn’t start until they put the tube in. After they put the tube in—that’s when the pain started.

Author: How was it compared to when they put the tube in last time as compared to this time?

Patient: This time was nothing compared to last time. This time I didn’t feel anything. I didn’t feel anything until I came out of the anesthetic. Before, I went through the whole thing and I didn’t go out at all. I knew what they were doing and I could feel it. It was an awful lot of pain when they did it the first time on the left side—because they were in a hurry. This time they weren’t in a hurry. I assume they were in a hurry because of what I was told later, that the lung had collapsed and was trying to shut my heart down—it was pushing over on my heart. … They were in a little bit of a hurry.

Reading the patients’ words and hearing their stories can change us. But how? How do we feel about this patient’s story? Does chaos result if we insert or change a few sociodemographic variables? Despite noble statements such as “we treat all patients the same,” we must acknowledge that if we are truly honest with ourselves, this is not the case. We realize that changing any of the sociodemographic variables can make us feel differently about the patient. As an exercise, let’s consider the following questions in the context of the story that we just read.

Do we like this patient? Why or why not? How old is this patient? If the patient is 8 years old, 40 years old, or 85 years old, does it change how we feel about the patient’s experience? Is the patient a man or woman? Does it matter? If so, why? Is the patient an educated person? What does the patient do for a living? Do we feel differently about the patient if the patient is a physician, a professor, a waiter? Where does the patient live? A mobile home, your neighborhood, a ghetto? Are we willing to hear the patient’s story if he or she is poor? An immigrant? A minority? Is the patient brown or white? Does it matter? If so, why? Does the type of pain matter? If so, why? Is there a reason to blame the patient for the circumstances surrounding the
illness? Do we trust this patient? Why or why not? Why is the patient telling us this story now?

Some time after I became an attending physician, I started asking trainees (medical students and house officers) who were carefully reciting the history of present illness (in much the same way I was taught) a simple question. Why? Why were they providing information about the patient’s race or ethnicity when the chief complaint was not associated with either? Trainees stated that it was important and that this was how they were taught. However, they could not provide data as to why this information was important to the patient’s presentation. They further struggled when I asked them whether they liked the patient or if they felt that they knew the patient. This question is important because our behavior and perceptions often change based upon our comfort level. We empathize more with people who are like us and are more comfortable hearing their stories than we are with those who are not like us. As simplistic as it sounds, we are also more likely to provide better care for people that we like and are comfortable with.

It is common to conjure up mental images about who “other” people are. We do not understand people who are not like us, and we often speculate about who they are. Important assumptions are often made about the patient based upon superficial appearances, such as their skin color or attire. The terms most often used to describe a patient’s skin color—race, ethnicity—are often used interchangeably, but they are not interchangeable. Race is a social construct based upon phenotype, while ethnicity is defined as a group of people sharing a common ancestral heritage. Race and ethnicity are often closely correlated with socioeconomic status, education, employment, lifestyle habits, and culture (beliefs, customs, and behaviors). However, we rarely ask the patients how they would define themselves. In general, we have a picture frame and we insert the picture that is most comfortable for us into this frame. These images are not necessarily based upon reality. In fact, these images are often based upon our experiences or even upon stereotypes. This subjective and superficial information allows us to decide who the patient is without the patient’s input. For instance, we never realized that there were “white” blacks nor did we spend time looking beyond surface appearances. In general, we never questioned the data’s validity or reliability. Yet, this basic and subjective information influenced the patient’s health and medical care and conveyed important information about his or her presumed social status or power. When eliciting pain narratives for patient care, we must strive to go beyond our comfort area, stereotypes, and imputations.
DISPARITIES IN THE PAIN EXPERIENCE

The medical advances and interventions that have allowed non-Hispanic whites increased longevity and enhanced quality of life have not uniformly been translated into improvements in health or quality of life for racial and ethnic minorities (James et al. 1992; Lillie-Blanton et al. 2000). When compared to non-Hispanic white men, racial and ethnic minorities have a decreased life expectancy, increased disability, diminished quality of life, and often receive lesser quality medical care. They also have reduced access to specialty care including pain management specialists (Cleeland et al. 1997; Collins et al. 1999). Stark differences in health and the health care experience based upon race and ethnicity are well described.

An emerging literature suggests that racial and ethnic minorities may suffer more impairment in their overall physical, social, and emotional health due to pain and may face additional barriers to pain care (Bonham 2001; Green et al. 2003a). The literature also indicates that racial and ethnic minorities have less access to pain management, are less likely to have their pain recorded, receive less pain medication, and are at risk for undertreatment of pain (Bernabei et al. 1998). Such disparities are aggravated by the increased disease burden for many comorbid conditions associated with pain, such as diabetes and cancer, that additionally and differentially affect the health and well-being of racial and ethnic minorities when compared to non-Hispanic whites (Lillie-Blanton et al. 2000; Mayberry et al. 2000; Smedley et al. 2003). Overall, these differences may lead to suboptimal pain assessment and treatment for all types of pain, contributing to poorer health status and reduced quality of life for racial and ethnic minorities when compared to non-Hispanic whites.

A recent selective literature review (Green et al. 2003a) revealed structural barriers to assessing pain and accessing quality pain care, difficulties with physician/patient communication, and unequal pain treatment across all types of pain (e.g., acute, chronic nonmalignant, and cancer pain) and treatment settings (e.g., the emergency room, outpatient clinics, and hospitals) for racial and ethnic minorities. In a recent study, African-American patients with chronic pain were more likely than non-Hispanic whites to believe that they should have been referred to a pain center sooner. African Americans also reported decreased access to health care and increased difficulty paying for pain care; they believed that their ethnicity influenced pain care more so than did Caucasian Americans (Green 2004).
PAIN ASSESSMENT

How race and ethnicity influence pain-management-seeking behavior is unknown. The literature suggests that physicians handle the pain complaints of racial and ethnic minorities as well as women less aggressively than those of non-Hispanic white men (Weisse et al. 2001; Riley et al. 2002). Disturbing racial and ethnic disparities in pain assessment and management have been identified (Edwards et al. 2001; McCracken et al. 2001). Todd et al. (1993) showed that Hispanics were more likely to receive no analgesics than non-Hispanic whites when receiving treatment in the emergency room for isolated long bone fractures (e.g., humerus, fibula). In a survey of 13,625 elderly nursing home residents with cancer pain, Bernabei et al. (1998) revealed that African Americans were less likely to have their pain assessed and were 63% more likely than Caucasian Americans to receive no pain medications. Yet, 40% of African Americans reported daily pain while 25% of them received no analgesics whatsoever. In another study, Morrison et al. (2000) showed that New York City pharmacies located in minority neighborhoods were less likely to carry opioid analgesics than those in non-minority neighborhoods. A similar study examining pharmacies across the state of Michigan (Green 2004b) also found that pharmacies in minority neighborhoods were less likely to carry opioid analgesics than those in Caucasian neighborhoods. Green and Ndoo-Brumblay (2004) also showed that African Americans used fewer complementary and alternative medicine techniques (including acupuncture) and significantly less manipulation, biofeedback, or relaxation training than did Caucasians for pain (Fig. 1). Thus,

![Bar chart showing use of complementary and alternative techniques for pain management by race.](image)

Fig. 1. Use of complementary and alternative techniques for pain management by race.
poor pain assessment and decreased ability to obtain pain medications complicate appropriate pain management for racial and ethnic minority persons and impair their overall health and well-being. In a study of 7,000 African and Caucasian Americans with chronic pain presenting to a tertiary care pain center, important differences were found in health based upon race and ethnicity (Green et al. 2003b,c). Overall, African Americans reported significantly higher pain scores and increased pain severity than non-Hispanic whites across the age continuum (Figs. 2, 3). The

![Fig. 2. Pain score at the present time by race and age (mean and standard deviation). AA = African American; CA = Caucasian American; Y = young (<50 years), O = old (50 years and older). * P < 0.05.](image)

![Fig. 3. Pain severity assessed by the McGill Pain Questionnaire by race and age (mean and standard deviation). * P < 0.05.](image)
African Americans also reported significantly more disability (impairment in activities of daily living) due to pain, and their emotional health was also more severely affected by chronic pain. Although both groups met criteria for clinical depression, the African Americans (regardless of age) were significantly more depressed (consistent with moderate to severe depression). They also reported more symptoms consistent with post-traumatic stress disorder than non-Hispanic whites across the age continuum. In addition, these findings remained regardless of gender. Since the majority of individuals with depression go without treatment, the reluctance of racial and ethnic minorities to seek treatment for mental health disorders decreases their overall health and has significant implications for their quality of life. However, the challenge with most measures used to assess pain in racial and ethnic minorities is that they lack cultural and linguistic sensitivity.

The next story illustrates the role that narrative medicine can play in how we assess any patient’s pain.

Author: Tell me about the pain that you had when you had to wait for your pain medicines. What was that like?

Patient: Now that was some pain. I never had any kind of pain like that before. It felt like a little guy had a knife, trying to get out from the inside. It was tough. You all have this “1 to 10” thing. You can’t measure pain like that. There was no “10” like that. That’s a “35”—it isn’t a “10.” It’s real pain. I was making noise.

Author: What do you mean you were making noise?

Patient: I was making noise! Some people grunt. I did everything but scream, but I came close. I made some noise. Usually I don’t make noise, I make faces with pain. But this time I made a little noise. There was some grunting and groaning going on. It came in stages. The first wave was “10.” The next wave was “14.” The last wave was “35.”

I made up a skit for this pain about how it feels when the pain starts. It was like there was this little guy with a dagger inside my chest and he was trying to poke his way out. He comes out of my chest and pokes on my chest. Then he goes back inside my chest to see if the morphine has come yet. He said, “No. No morphine yet!” He goes outside my back to poke on my chest some more. That pain is a “10.” He (the little guy) then sends Zorro out. Zorro has this knife—a sword. Zorro comes out and this pain is a little bit tougher. He goes slashing around. About that time, that pain’s a “14.” The “10” was the little guy. Zorro was a “14.” He goes back and says, “the morphine still
hasn’t come. You can go out there and do what you want to do. Then they send Thor out with the battle-ax. He comes out and he starts chopping—he’s trying to chop his way out of my chest. That pain’s a “35.” That’s the screaming and hollering pain. If that morphine don’t get there in a hurry, you gonna do a lotta screaming and hollering.

That’s all I’m saying about the pain medication. I think some of it has to be given—you just gotta take some pain medication if you can get it. You take it just in case the pain comes. The Vicodin is what you take when there ain’t no pain and you figure it might show up in an hour. Because once the pain starts, by the time that Vicodin kicks in, you jumped out the window already! Morphine is for when that pain hits. When that pain gets to you, you got to have the morphine unless you want to scream and holler for an hour until the Vicodin kicks in.

So however long it takes, I know one thing—it (Vicodin) ain’t fast enough. When you put your nurse button on to tell her you are having some pain and she shows up an hour or so later and offers you Vicodin, you say, “that Vicodin was for the 12 o’clock pain (when I first asked for pain medicine) and it’s now 1 o’clock.” Morphine is for the 1 o’clock pain.

Vicodin takes too long. I don’t know how long it takes, but it’s too long. Now when you have that kind of pain, it wears you out. You’re tired. About 20 minutes, no, within 10 to 15 minutes, you get tired. When [the pain] subsides you’re really, really relieved. You can really feel the relief.

The process of telling and hearing the story is therapeutic within itself and critical for healing. For this process to occur, however, we have to be able to listen to a different type of story than what we are accustomed to.

COMMUNICATION

Doctor/patient communication is critically important to ensuring appropriate pain care. Communication requires two parts—a sender and a receiver. The process of sending and receiving information can be problematic, fraught with misunderstandings and misinterpretations that affect both patient and physician behaviors as well as health outcomes. There are clear differences in the way that women, racial and ethnic minorities, impoverished persons, and elderly people communicate their pain experiences, especially if there is a language barrier. Differences in the way racial and ethnic minorities as well as women communicate their pain concerns may increase
the likelihood of their complaints being discounted, especially if the patient’s
gender, race, or ethnicity is not congruous with the physician’s. A health
care provider’s willingness to hear the patient’s story and the patient’s will-
ingness to discuss intimate details are critical to how we begin to understand
each other. Through this process we create new knowledge that provides us
with the opportunity to change and understand behaviors that promote the
patient’s health.

Inherent within narrative medicine is vulnerability, trust, and communi-
cation. Negative experiences with health care providers and within the health
care system can damage the doctor/patient relationship and impair trust. The
Tuskegee syphilis experiments in the 1920s–1950s, which involved observa-
tions of untreated African Americans to characterize the natural history of
this disorder by public health physicians, provide a classic example of how
trust can be lost and relationships damaged (Northington-Gamble 1997). Beyond Tuskegee, the stories of racial and ethnic minorities have histori-
cally not been heard or were discounted in many health care systems. The
opinions of minority members were rarely sought and the health care rela-
tionship was often one-sided. Furthermore, patient attitudes often direct their
preferences, information seeking, decision making, and health care. Clearly,
the attitudes and misperceptions of both patients and clinicians can adversely
affect health outcomes and contribute to optimizing barriers to pain care.

PATIENT PERCEPTIONS AND ATTITUDES

Several authors have shown that racial and ethnic minority patients have
attitudes that are barriers to quality pain care (Cleeland et al. 1997; Ande-
son et al. 2003). For instance, Green et al. (2004a) showed that racial and
ethnic minority members with chronic pain tend to believe more so than
non-Hispanic whites that “good” patients avoid talking about pain and that
pain medications do not really control pain (Figs. 4, 5). These patients also
believed that this attitude affected the health and pain care that they re-
ceived. Narrative medicine provides a unique opportunity to understand and
examine what an illness means to a patient, as shown in the next story.

Patient: The chest tube looks like a spear. I don’t understand why they
make it like that. That thing is sharp. It looks like a big needle only it is
sharp—much sharper on the front, with holes in it. I’m thinking if you push
that thing in and it goes the wrong way, this point is setting up there like this
up against something. That point is scraping up against the chest cavity or
something. I can’t understand why they don’t make that thing some way to
make it easier to get in between the ribs. I would design it differently. I’ve
seen the one they put in me. It was sharp—really sharp. When they put it in, they kept telling me not to look. What the hell, you were messing around in my chest. I'm going to look. The nurse said, "This is a sterile area—you might breathe on it and contaminate it." So I didn't look. She put that thing in there. I don't know if she put the same one back in or not. I didn't see.

In the United States, nearly 40 million citizens have no health care insurance or are underinsured (Collins et al. 1999; Lillie-Blanton et al. 2000; Mayberry et al. 2000). Most of the poor people in the United States are non-Hispanic whites, but African Americans are disproportionately impoverished.
Health insurance coverage allows access to the health care system, and in general, people without health insurance have poorer overall health. Yet, health insurance coverage does not ensure health or adequate health care. When comparing elderly African Americans with Medicare to non-Hispanic whites with similar insurance, Collins et al. (1999) reported that African Americans rated their health as poorer. This finding is consistent with data provided by Green et al. (2003b) in patients with chronic pain who all had access to a tertiary care pain center; overall, the African Americans had diminished physical and emotional health when compared to Caucasians. In another study of elderly African and Caucasian Americans presenting to the same pain center for chronic pain management, Green et al. (2003c) showed that the African Americans had a more greatly diminished quality of life than Caucasians (Fig. 6).

In another study, Green et al. (2004a) showed that African Americans report increased difficulty paying for health care despite having insurance and access to a pain clinic. In addition, they reported that they could not afford health care and that chronic pain was a major problem for them, more so than for Caucasian Americans. African Americans also believed that race, ethnicity, culture, and gender influenced access to both health care and pain care. These disparate attitudes have significant implications in a potentially vulnerable population. However, the questions remain: Are these perceptions or attitudes based in reality? Have real life experiences contributed to the patient’s beliefs, or are they truly misconceptions? These attitudinal differences further emphasize the importance of asking questions and listening to pain stories in a way that only narrative medicine can provide. However, we need to be willing to listen to the whole story and hear a different voice. We need to listen to stories even when the subjects and verbs do not match.

COPING

Racial and ethnic-based differences in coping have been identified. In a study by Green et al. (2003c), African Americans reported more suffering due to pain than Caucasian Americans across the age continuum (Fig. 7). These findings are particularly interesting because they denote differences in the ability to cope with pain. Older African Americans reported more ability to cope with pain than did younger African Americans and Caucasians of all ages (Fig. 8a,b). They also reported significantly less ability to control pain symptoms and more sleep impairment due to pain (Fig. 8a,b). John Henryism (a pattern of high-output active coping characterized by
Fig. 6. Mean health survey short form (SF-36) subscores by race in persons older than 60 years (mean and standard deviation).
working harder against a potentially insurmountable obstacle) has been demonstrated in African Americans and is speculated to have originated in slavery times (James et al. 1992). John Henryism has been associated with hypertension and bodily pain. Overall, gender, race, ethnicity, and age are known to influence social support and health relationships for many chronic conditions (e.g., diabetes) and may also play an important role in pain management (Ford et al. 1998).

The following narrative discusses fear, coping, and death. It further illustrates that although pain and dying are common to the human experience, the process is highly individual.

**Author:** Did the pain scare you?

**Patient:** No. I wasn’t afraid. I’m never afraid of anything like that. I don’t fear dying or anything like that because I know that when it happens, I won’t know anything about it anyway. You’re gone … I can’t worry about it. I can’t fear something like that. What I fear would be anticipating that kind of pain, knowing that it was coming, and you couldn’t do anything about it. I don’t know if that would be fear. That would be very uncomfortable if you knew that this kind of pain was coming and you couldn’t do anything about it. You look up at the clock. Now get ready, son. It’s 10 minutes to 2. At 2 o’clock Thor is going to come out and is going to try to chop his way out of your chest. That would be scary. But as long as you know there’s a way to relieve the pain, it’s okay.

What bothers me more than anything was when you tell people that there’s something wrong because I didn’t have any kind of pain over here on this
Fig. 8. (a) Control over pain and (b) ability to cope by race and age. AA = African American; CA = Caucasian American; Y = young (<50 years), O = old (50 years and older). * P < 0.05.

side and they don’t listen to you. There has to be something wrong in here. I said there is something wrong with that tube somewhere. They took X-rays and nothing happened. Finally they got ready to change the bandage. They were taking the tape off and the tube moved and that’s when the pain really got bad. Now I have pain and I need medicine. I start coughing, and coughing upsets it and it starts to hurt. A lot of times the pain will go away given time. But I don’t want to wait that long. Sometimes I wait a few minutes, it will subside and it will go away. Other times when I make a funny move, Thor comes right back.

PHYSICIAN DECISION MAKING

Although pain is a major reason why patients seek medical care, physicians are poorly equipped to treat their pain complaints. Several studies have shown that physicians, as well as other health care providers, receive very
little education directed at pain assessment and management (Green et al. 2001, 2002, 2003a,d; Green and Wheeler 2003). Despite the availability of many pain management guidelines and treatment modalities, the undertreatment of pain remains problematic. Racial and ethnic minorities are at an increased risk for inadequate pain treatment. In addition, physicians' confidence in their pain management is often misplaced and not based upon knowledge. As shown in Fig. 9, physician goals for pain management also vary based upon the type of pain (i.e., acute, chronic nonmalignant, or cancer pain). In addition, physicians have lesser goals for chronic pain relief and less satisfaction with their chronic pain management, and they provided lesser quality pain care for chronic pain complaints than for acute and cancer pain. Using several clinical pain vignettes (Green et al. 2002), the quality of physician-prescribed care for chronic pain was also shown to be less than the care provided for acute or cancer pain. Thus, physician perceptions and goals may lead to variability and the unintentional undertreatment of pain in general and for racial and ethnic minorities in particular.

Variability in pain treatment based upon patient sociodemographic variables can lead to poorer health and pain management outcomes for racial and ethnic minorities (Ng et al. 1996a,b). Schulman and other investigators identified disturbing differences in treating chest pain based upon the patient's age, race, and gender (with women and racial and ethnic minorities receiving lesser quality pain care) (Schulman et al. 1999; Chibnall et al. 2000). Physician variability and suboptimal treatment strategies for all types of pain (especially chronic pain) may lead to increased suffering and adversely affect the overall health of racial and ethnic minorities and other special populations including children, the elderly, women, and impoverished people. These sociodemographic variables influence pain assessment, impede access to pain care, and put patients (especially racial and ethnic minorities) at additional risk for inadequate pain management. Thus, physicians' pain

![Graph](chart.png)

**Fig. 9.** Michigan physicians' goals for pain relief by type of pain.
management goals are important to consider. Physicians may be less likely or willing to hear the story of any patient with chronic pain in general, and those of racial and ethnic minorities in particular, contributing to suboptimal pain care. The next story illustrates a patient’s experience with pain control.

*Author:* Tell me about what it was like after you had pain medicine after your bladder surgery.

*Patient:* After bladder surgery, I never felt nothing after bladder surgery until they decided that they were going to take me off whatever the medication was. That’s when I had that little button. Every time I felt like I needed medication, I pushed the button. I didn’t feel anything until they decided to take me off whatever was in that IV. Whatever they were feeding me—I think it was morphine coming out of that bag—whatever it was, they decided to take me off of that and give me, I think it was Vicodin, it didn’t work. I was almost screaming and hollering but that wasn’t as bad as this pain. That pain just felt like someone had my testicles and was squeezing them. This was a different kind of pain. It wasn’t a screaming and hollering pain. That pain was a making faces type of pain. But then they put me back on morphine, I guess.

This story supports the work by Ng et al. (1996a,b) showing that when patients are given the opportunity to medicate themselves appropriately, they will do so, and disparity in treatment disappears.

**DO DIVERSE POPULATIONS NEED NARRATIVE MEDICINE?**

Who needs narrative medicine? The patient, the physician, the researcher, or someone else? We are all vulnerable, but especially patients. In the right relationship and in a safe place, most people need to tell their story to heal. What people value, their relationships, faith, previous experiences, and history are important and may determine when and how they tell their story. Narrative provides a unique opportunity for patients not like us, as well as those like us, to tell their story. However, we must be willing and able to listen to a different type of story than what we are comfortable with. We may have to be uncomfortable while we actively listen in an appreciative fashion. Narrative medicine provides a potential mechanism to fundamentally transform the health care system from the patient’s perspective as well as an opportunity to understand and eliminate disparities in health.

It is imperative that we push past our limited views of the world and challenge our assumptions when using narrative medicine. Our brains are
constantly trying to make sense of the world. We think in biomedical or biopsychosocial models. However, we need to feel and go beyond our own tribes (where we feel safe and secure) if we are to work globally. Thus, there is much to understand regarding the use of narratives in pain, but clearly the voice does matter. Narrative medicine has a unique opportunity to provide a voice to a vulnerable population. How to provide a thoughtful and listening ear so that we hear a different voice is our collective challenge if we wish to be inclusive. First, we must strive to understand ourselves (including our misconceptions and biases) if we are to hear words in the patient’s voice or see pictures through the patient’s eyes. This effort can help us to reduce and eliminate disparities in ways that no medical test or quantitative measure can. If we fail to overcome these barriers, then narrative medicine will fail as so many other medical models have failed vulnerable populations at risk for inadequate pain care.

*Of all the forms of inequalities, injustice in health is the most shocking and the most inhumane.*

Rev. Dr. Martin Luther King, Jr., Chicago, Illinois, March 25, 1966

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