associated with the use of invasive techniques in the treatment of postoperative pain, and how the clinician can properly weigh the risks and benefits of these techniques on an individual basis is uncertain. The study by Kaba et al. suggests that intravenous lidocaine may be considered as another option in this setting to accelerate acute rehabilitation and facilitate earlier patient discharge. Epidural infusions are certainly more expensive and invasive than intravenous infusions. Furthermore, modern thromboprophylaxis practice with low-molecular-weight heparins often preclude the use of continuous epidural therapy because of the concern over risk of epidural bleeding and hematoma with catastrophic outcomes due to spinal cord or nerve root compression. The safety of intravenous lidocaine for postoperative analgesia is far from assured by small studies such as those currently available, and there is an accumulation of lidocaine in the blood during the period of infusion, even at these low doses. Although many studies have reported that the therapeutic dose of lidocaine for ventricular arrhythmias remains well below toxic concentrations, whether this applies in the postoperative setting with the multiple influences on drug distribution and elimination remains unknown. Therefore, intravenous lidocaine is appealing as a simple and inexpensive method to gain the same benefits as more invasive and costly techniques, but we currently lack large numbers of patient exposures to define its safety and direct head-to-head comparisons to evaluate its efficacy.

As in all areas of medicine, we search in postoperative pain management for an ideal drug or technique that is effective, simple, inexpensive, and safe. Further studies are needed to clarify and establish where intravenous lidocaine sits in the spectrum of currently available agents in this regard. The best dose of lidocaine to obtain maximum efficacy for postoperative treatment of somatic and visceral pain and improved bowel function while minimizing adverse effects has not been defined. But studies like that of Kaba et al. with this relatively novel strategy using a long-established drug may help to develop and implement effective therapeutic management strategies to improve our treatment of postoperative pain and perioperative morbidity.

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Racial and Ethnic Disparities in the Quality of Pain Care

The Anesthesiologist’s Call to Action

ENSURING healthcare quality (i.e., access to health care, effectiveness, and efficacy) while optimizing health and quality of life has tremendous benefits to the individual and to society. However, the Institute of Medicine (IOM) series of books resulting from the Quality of Health Care in America Project provides startling evidence for medical errors, variability in healthcare quality, and a quality gap that puts patients at risk for increased morbidity and mortality.1,2 As documented in the congressionally mandated IOM report Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, stark differences in health and the healthcare experience based on race, sex, age, socioeconomic status, and community

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characteristics exist. In an increasingly diverse America, disparities in health and health care are critically important to our nation’s colloquial health. The IOM identifies two sources of disparities: (1) healthcare systems and the legal and regulatory climate in which they operate and (2) discrimination such as biases, stereotyping, and uncertainties in clinical communication and decision making. Using a statewide database, the article by Glance et al., “Racial Differences in the Use of Epidural Analgesia for Labor,” provides additional evidence for differential access to epidural analgesia. Overall, Glance et al. show that black and Hispanic women were significantly less likely to receive epidural analgesia during labor than white women. Although differential access to labor epidurals based on race were described previously, Glance et al. extend the literature by revealing that these differences persist even when insurance coverage, provider, and clinical characteristics are similar, thereby providing evidence for physician variability in decision making.

Among the many overarching goals stated in Healthy People 2010 is improving health and eliminating disparities in health care for all Americans. Several federal agencies (e.g., National Institutes of Health, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality) identified health and healthcare disparities as one of the nation’s top strategic priorities. They further supported several initiatives designed to reduce and eliminate disparities in health and health care. Clearly, creating new knowledge directed at understanding and addressing health and healthcare disparities is vitally important. Although the IOM study on healthcare disparities provides information on pain management, the committee’s work focused primarily on an acute injury and cancer pain model. Pain has significant socioeconomic, quality of life, and health implications; however, pain as a public health issue, the quality of pain care, access-related factors, physician variability in pain management decision making, and access to analgesics were not addressed in a substantive manner in the IOM reports.

Overall, disparities in health and health care increase healthcare costs and diminish quality of life while increasing morbidity and mortality. The Joint Commission on Accreditation of Hospitals and Healthcare Organizations standards seemed to be the tipping point for addressing pain complaints in a comprehensive and multidisciplinary fashion. However, the literature continues to document suboptimal pain assessment and the undertreatment of pain. Furthermore, the literature supports variability in pain management decision making and disparities in pain care for all types of pain, i.e., acute, chronic, and cancer pain, as well as pain associated with terminal illness, especially for racial and ethnic minority persons.

Overwhelmingly, the literature supports that the pain complaints of racial and ethnic minorities, women, and elderly persons are often unheard. The cornerstone for quality pain care is pain assessment, but the bulk of the literature supports that minorities are less likely to have their pain assessed, yielding an unequal burden due to pain. When their pain is assessed, minorities often receive less pain medication than their white counterparts, suggesting physician variability in decision making. When receiving a prescription for opioid analgesics, minorities are less able than whites to fill opioid analgesic prescriptions in their local pharmacies, regardless of income. Whereas income is protective for whites, income is not protective for higher-income minorities who experience problems similar to those of low-income minorities in obtaining prescription opioid analgesics in their local pharmacies but have less access than low-income whites. Many believe that most health and healthcare disparities are reduced or even eliminated when socioeconomic factors are controlled. Glance et al. confirm the role insurance plays in accessing labor epidurals where women with private insurance have the best access to this modality for pain relief. However, consistent with the literature, Glance et al. also reveal that insurance status may not be protective for black women. Although there was no difference in epidural use among black women with private health insurance and black women with Medicaid or no health insurance, black women with private health insurance had the same rates of epidural use as white women without insurance.

Despite the critical importance of race and ethnicity in health and health care and amid the success stories of improvements in quality, continuing disparities in health and health care provide a sobering reminder that we are not there yet. In fact, our failure to attend to disparities based on race, ethnicity, sex, age, insurance, socioeconomic status, and community characteristics contributes to increased morbidity and mortality while increasing healthcare costs. Throughout the perioperative period, anesthesiologists continue to provide innovative leadership in the continuous quality improvement and pain management arenas. However, in an increasingly diverse and aging America, few anesthesiologists have embraced our nation’s most important public health and quality of care problems: disparities in health and health care in...
Some Things Do Last

DO anesthetics protect the brain from ischemic injury? The answer to a seemingly simple question has eluded researchers for more than a quarter of a century. The contribution by Sakai et al.1 in this issue of *Anesthesiology* suggests that we may finally have an answer to at least part of the long-standing controversy—at least in rats.

Working with laboratory rats, Hiroaki Sakai and co-workers in David Warner’s laboratory at Duke University show conclusively that isoflurane is neuroprotective during focal cerebral ischemia and that, in distinction to several other influential studies,2,3 the protection from isoflurane is long-lasting, evident for a month after the experimental stroke.

To understand the significance of the article by Sakai et al., some history of investigations regarding anesthetic neuroprotection is in order. Disputes regarding whether clinical anesthetics confer neuroprotection in experimental models of brain ischemia date to the late 1960s. John Michenfelder at the Mayo Clinic argued that because even very-high-dose barbiturates do not reduce brain metabolism more than does brain ischemia, barbi-