



**The DEI Shift Pain Management Special Episode:
Addressing Bias and Disparities in Pain Management
*Script***

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Guest: Dr. Amber Brooks

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Learning Objectives:

- Define Acute Pain and Chronic Pain
- Describe different bias that can manifest in treating those with chronic pain
- Summarize some of the ways we can address disparities in groups that have been historically marginalized, such as those with limited English proficiency and Sickle Cell Disease
- Explain how a mobile phone intervention can be used to address disparities in populations with limited transportation

[0:00-0:46] Disclaimer

Dr. Brooks: Before we begin, our guest for this episode, Dr. Amber Brooks uses the term provider during her interview. We reached out to her for clarification after the show wrapped and she mentioned that she uses it to be inclusive of those who may be involved in the care of chronic pain patients in the outpatient setting including physicians, nurse practitioners, clinical psychologists, and/or physician assistants.

Though this term is used interchangeably by many in the medical community, The DEI Shift podcast team endorses and supports the use of physician in place of provider where applicable as outlined in ACP policy. More information about this policy can be found in the show notes. And now, onto a great discussion about pain management and DEI.

[0:47-1:54] Introduction

Dr. Gaines: Welcome to another special episode produced by members of the DEI Shift podcast team for the American College of Physicians supported by an independent education grant funded by Pfizer, Inc., in partnership with Lilly USA, LLC. Our mission at the DEI shift is to shift the way we think about diversity, equity, and inclusion in the medical field.

I'm Dr. DJ Gaines, an internal medicine hospitalist and a co-producer of the DEI Shift joined by my cohost.

Dr. Sprott: Dr. Candace Sprott, a med peds outpatient physician.

Dr. Gaines: This episode is part of ACP's new curriculum on pain management, which you can access anytime on their website, acponline.org. For this episode, we have a fantastic guest, Dr. Amber Brooks. We will touch on a wide array of topics, such as common biases seen and treating those with chronic pain, disparities and chronic pain treatment, and how we can advocate for this community. This episode is full of wonderful pearls, and we can't wait to share them with you. We hope you enjoy.

[2:09-3:14] Introducing Dr. Amber Brooks

Dr. Sprott: Dr. Amber Brooks is a board-certified anesthesiologist and comprehensive pain management physician who is currently appointed associate professor of anesthesiology at the Wake Forest School of Medicine in Winston-Salem North Carolina. Her clinical research focuses on developing non-medication treatments for older adults with chronic pain.

She has received three grants from the National Institutes of Health to support this research. She's the current associate editor for Pain Medicine Journal Section of Pain and Aging. In addition to her clinical and research roles, she serves as the Justice Thread Director for the Wake Forest School of Medicine, as well as the Vice Chair of diversity, equity, and inclusion for the department of anesthesiology at Atrium Health Wake Forest Baptist.

Originally from Chicago, she's a transplanted southerner, an avid century cyclist, and continues her work in reducing healthcare disparities, through community outreach and education via her CIF for PE MD group. We are honored to welcome Dr. Brooks to the DEI Shift.

Dr. Brooks: Thank you so much for having me.

[3:15-5:14] Step in Your Shoes

Dr. Gaines: Thank you so much, Dr. Brooks for, uh, being on the show. We're really excited to have you here. So we can't wait for this, a fantastic discussion that we're about to have, but first, before we get into it, we want to get to know you a little better, uh, with a segment that we do call it step in your shoes. And this allows our audience members to flex their cultural humility muscles, and learn a little bit about yourself, um, as well. So Dr. Books, is there anything you want to share with us?

Dr. Brooks: You know, I was thinking about this and, and one of the things that I think is relevant to share with you all with regards to what we're going to talk about today is I have had the privilege and honor of traveling all over the world, but one of my most memorable travel experiences was when I was a medical school student. I spent two months, um, in Addis Ababa, Ethiopia. I worked in a medical clinic that serviced a variety of different health conditions. And I was young. I was in my early twenties and this was really my first introduction to healthcare outside the walls of the United States.

And it was such an eye-opening experience to see the way in which people were being treated. Sometimes not in the best ways due to lack of access to healthcare. I saw patients who, for example, underwent labor, without any type of pain medications, things like that. And so, I think that really sparked some of my early interests into helping figure out ways in which we can better address healthcare disparities.

[5:24-6:16] Definition of Acute Pain and Chronic Pain

Dr. Gaines: So well, let's jump right into discussion. So, um, Dr. Brooks, can you help us get kind of a set level by defining the terminology, differentiating pain, acute pain and chronic pain.

Dr. Brooks: Absolutely. So traditionally we define acute pain that is associated with a trauma or, possibly a surgery, but it has a defined length of time, usually weeks, but doesn't last past three to six months. We contrast that to chronic pain, which is described as pain that extends beyond what we would consider the normal tissue healing process.

And that typically is defined as pain that lasts longer than three to six months and is present on most days after that time.

[6:17-12:02] Common Biases Seen in Pain Management

Dr. Sprott: In thinking about the pipeline of medical education from undergraduate to residency and speaking from your experience as an educator, researcher and clinician, in your opinion, where do you see biases regarding pain management crop up?

Dr. Brooks: Yeah, so I think this has a lot to do with the unique nature of treating pain management or treating patients with chronic pain. Let me, let me tell you a little bit more about what I mean. So, take, for example, someone who has diabetes, there is an objective way to measure their blood sugar levels.

You can look at a hemoglobin A1c or you can follow their blood sugars over time and that gives you an idea of the degree of their diabetes. It gives you some ideas about how compliant they may be with their medications. And we contrast that to many chronic pain conditions that don't have those objective data.

And thus, we have to rely heavily on a patient's lived experiences. We have to rely heavily on their report on how their pain is manifesting in their lives. And because of the subjective nature of that interaction between the provider and the patient, I think that there is an increased chance that provider bias is introduced, especially if the provider and patient don't have a whole lot in common, whether that be their race or ethnicity, whether that be their socioeconomic status, whether that be their religious status, their gender, so forth and so on.

I think that again, pain management is unique in the fact that I think there's this increased chance of introducing provider bias. I see this sometimes with my student and resident trainees and it manifests like this: they will be doing their due diligence prior to going in to seeing the patient and they'll review the chart and they may come up to me and they'll say, "Oh, Dr. Brooks, this patient's going to be really difficult and challenging. They've already been to five different providers. Nobody can help them with their pain. And they're on opioid medications. This is going to be just really hard. I don't know if we're going to even be able to help them."

This is a certain type of unconscious bias called confirmation bias. I call it the chart biopsy and it happens naturally from the way that we're trained. As physicians, we're trained to put the pieces of the puzzle together, and when the pieces don't fit really perfectly into our preconceived notion, then we start trying to fill in information to make it all make sense.

And so that's a slippery slope, especially when you're treating a population where you're already having to rely heavily on their lived experience. So I tell them, "Yes, we should always do our due diligence and review any kind of medical records, but we have to leave room for the patient to tell their story."

Dr. Gaines: I find something you said that really struck with me is about how the example you gave, especially the fact that some students and some residents will read the chart and they're already having these preconceived notions about a patient and I talk about this aloud with my residents about how bias can be transmitted in the EMR.

When you say certain phrases like opiate abuse or say chronic pain or on opiate replacement,. Some things have a stigmatizing context. And that can really, before you even see the patient, you can already, because like you said, that pain is something subjective in a lot of ways you already have a negative bias towards the patient.

And then furthermore, during our training as physicians, we see the reactions that some of our seniors and attendings have when they read about certain patients. And then we unconsciously continue those reactions during our training and perhaps even while we were attending.

I think this is very powerful, how just reading a few phrases or even seeing, uh, doing the chart biopsy, like you mentioned, can really change our opinions about a patient before we even meet them.

Dr. Brooks: Absolutely.

Dr. Sprott: I think I would just add that we put in the show notes that there is an article from 2016 that references true racial bias when it comes to trainees, looking at black patients and some false beliefs that have been attributed to biological differences, that are just not true.

That black patients have a higher threshold for pain or may have thicker skin or some of these things that are potentially perpetuated from, you know, pre kind of medical school training, but may even be perpetuated during the pipeline. So I think we have to acknowledge that biases exists in lots of different ways.

And when we see them right, as Dr. Brooks and DJ have mentioned, to really try to call that out because these patients in front of us, they're human human beings. So we need to start with that. So thank you for really bringing that up, Dr. Brooks, and sharing that with us.

Dr. Brooks: Yeah, I would, I would add to that. I always tell my students, um, especially when I'm teaching about this particular topic of bias and pain management that as colleagues, as a part of our Hippocratic Oath, we took this oath to do no harm and the same attention that we would give to, for example, not doing a wrong sided procedure, is the same type of intention and level of care that we should be giving to calling one another out regarding our unconscious bias. We have an obligation to call each other out in a respectful and constructive way about these biases. It's the only way that we'll be able to recognize our unconscious bias.

[12:45-20:58] Multimodal Approach to Chronic Pain

Dr. Gaines: Thank you so much, Dr. Brooks. Another question we wanted to ask. The multimodal approach to the treatment of chronic pain does not seem to be well understood amongst clinicians, as we were talking before. Many patients are still on opiate medications as monotherapy. So we're wondering if you could give an overview on the therapies you employ for chronic pain and touch on the tension that exists between the desire to treat a patient's pain and the growing knowledge that opiates are ultimately harmful in the long-term.

Dr. Brooks: Absolutely. So whenever I'm having conversations with patients about their pain management care, especially during their first initial consultation, I always stress the importance of first taking care of their pain with the safest options. And then two, treating their pain in a holistic approach.

And so what I mean by that is that everyone deserves to have this kind of discussion about the risk and benefits of different pain medications. And oftentimes that leads to a pretty extensive discussion about the risk and benefits and data available around the use of opioid medications, especially for chronic long-term pain.

Then I also express to them the importance of treating all of the different aspects that affect chronic pain. For example, we know that sleep and mood are intricately connected to chronic pain. And so if we're going to be successful in treating that chronic pain, we also have to make sure that their sleep is okay. We have to make sure that their mood is okay.

So in my practice, we employ several different non-medication options for treating their pain. Oftentimes I'll try to choose medications, for example, that will not only maybe target their chronic pain, but may also help with their depression, for example. There's a class of medications that can be useful for treating those two things simultaneously.

The other part is that we may incorporate different types of injection therapies to help their pain. And I also may send them for physical therapy to make sure that they're moving, they're moving their bodies and in a meaningful way that will help address chronic pain.

I am also fortunate to have a pain psychologist as a part of my practice. And so if patients are demonstrating that they are significantly depressed or there's some type of life stressor that seems to be exacerbating their pain, then I will make the referral to our pain psychologist.

I know not all practices have that as a part of this comprehensive pain management plan, but I'm fortunate that we do have it and many of my patients take advantage of it.

Dr. Sprott: It definitely sounds holistic and treating the whole patient. How do you set your patients up with the expectation for what does success look like and, you know, managing chronic pain?

Dr. Brooks: Yeah. So I work really closely with the patient and I first start by asking them: what are their goals? And if they tell me, "I just want to be out of pain." Then, I say, "Well, I hear you and when pain has been going on for a long time, sometimes it's impossible despite our best efforts to get rid of it completely. But hopefully we can help give you some tools to bring your pain level down to a level that allows you to do all of the things that you have to do and some of the things that you want to do." So we work really closely with that patient to come up with a plan that really centers around their goals.

Dr. Sprott: And do you find that when you approach it this way that the majority of patients have a somewhat straight line to where they're taking care of all of these areas that you've mentioned and feeling better, or is this more of a winding road for the majority of the patients you treat?

Dr. Brooks: I would definitely say this can be more of a winding road. It requires them constantly checking in about their goals because goals may change as time goes on. So I definitely would agree that it's more of a windy road, to accomplish their pain treatment goals.

Dr. Sprott: And I can just imagine a lot of the emotions that come with this journey, patients that I've treated myself have sometimes a lot of anger, I think, and frustration. And how do you, as the treating physician, try to prevent maybe some of that transference that may happen at an initial visit when they're potentially unloading a lot of the things that may have happened or biases they may have experienced when they come to meet you?

Dr. Brooks: Absolutely. I see it all the time and that's why I always tell my students and trainees, I really do try to spend a good amount of time during that initial consultation number one, just listening. Doing a lot of confirmation with words, like, "I hear you." "Gosh, I've never experienced that so I can't even imagine how you're feeling." "I'm sorry that you've had to experience this. This sounds really difficult." Using those kinds of phrases to establish trust, to establish rapport, and to let them know that I care and I'm going to do my best to try to help walk them through this process.

Dr. Sprott: And do you mind expanding a little bit on the opioid piece? Because certainly I think that— I'm a primary care physician. and I think the idea is I want to get my patient out of pain, but I certainly know that in the last few years, opioids are really not for chronic pain. So I think there's two issues here. One, patients of color may be treated less aggressively with respect to their chronic pain. But other groups of patients may be on opioid therapy for much, much longer. How do you resolve that?

Dr. Brooks: Well, so I try to treat each of the patients as individuals.

Yes, we do have guidelines that help walk us through the process of figuring out who is safe to give opioid medications. And yes, the pendulum has most certainly swung over the last year, over the last few years towards not prescribing opioid medications. And I really try to have that discussion about risks versus benefits.

And I also, again, try to just really emphasize what I think is going to be safe for the patients. I do agree with you, Dr. Sprott, that there is, there's definitely, there's a documented disparity along racial lines of who has received chronic long-term opioid therapy versus those who have not.

And I most certainly acknowledge that when appropriate with some of my patients, but again, I just really try to stress what is safe for them? What we have learned in the last few years has changed and evolved dramatically and really relying on evidence-based medicine to guide clinical decisions.

[20:59-23:28] Disparities Seen in Patients with Chronic Pain.

Dr. Sprott: Absolutely. I wanted to move into a question around disparities. The discussions around disparities within chronic pain sufferers seemed to center on these treatment modalities. Can you take us through the lens of the disparities that you see with respect to diagnosis, education of chronic pain, and advocacy for patients with chronic pain?

Dr. Brooks: Absolutely. One of the things that I have observed and heard from patients is just the lack of referral to a pain specialist. Oftentimes it's patients having to remind their primary care providers or asking their primary care provider to be referred to a pain specialist. I think that speaks again to potentially provider bias where certain services are not, maybe not even consciously, but certain services are not offered to certain populations as often as they are to others.

So, number one would be lack of referral to a pain specialist and then access to healthcare is a huge part of this and not only access to healthcare, but there are sometimes, especially in certain neighborhoods or regions, there's this long history of mistrust between the healthcare system and the surrounding area in which that hospital is set in. And so that can be a major obstacle to overcome too. It's just, how do you establish rapport and trust between the healthcare system and the patients that you're treating?

I think also, we know there's documented evidence to suggest that in lower socioeconomic neighborhoods or poorer neighborhoods that pharmacies, for example, don't even stock the same types of pain medications as compared to other neighborhoods. So this is definitely multi-factorial in terms of the disparities and barriers to care for vulnerable populations.

Dr. Sprott: When you said that last piece about pharmacies, my eyebrows kind of raised it up because it wasn't something I had even considered. But as we're thinking about systemic barriers, certainly that would be almost insurmountable, depending on where you live. If you have to take public transportation, or if you have a job that's requiring you to get off easily, that's profound.

[23:29-25:45] Ways Disparities Manifest for Marginalized Patients whose English is not Their First Language

Dr. Sprott: Hmm. So when you consider marginalized populations that would most directly have more and larger obstacles to access health care and even navigating the system – this may be patients whose first language is not English, for example. How might those disparities that you brought up really manifest for them?

Dr. Brooks: Yeah. So the example that comes to mind is treating the Latinx or Hispanic population around the time of delivery of their child during labor. And there is this – oftentimes this assumption that medical care providers have historically held that Hispanic or Latinx women do not want epidural analgesia or pain management during their labor experience.

And I think that these assumptions are exacerbated when the patient does not speak English. I think their exact sort of exacerbated when there's not an interpreter, and these assumptions are also exacerbated when there's a time crunch. And so I think that there are several things as providers that we have to make sure that from a systems level are available.

We need to have interpreters who are well versed in helping translate the risk and benefits of pain management during the time of childbirth.

Dr. Sprott: Yes, I think it makes so much sense. Just the use, the regular systematic use of interpreters, medical interpreters. I think even if it's easily available, I think some of our biases will even prevent us from using them, like, "Oh, they're okay."

They speak enough English, right? Or they've communicated with me just fine and really making that a force function that if your language is not English as your preferred language, we don't even attempt to speak to you in that because I don't want anything to get missed. So I love that you're bringing that up.

[25:46-32:41] Addressing Disparities Seen in Those with Sickle Cell Disease

Dr. Sprott: I also think about patients who have come up with a condition that may predispose them to chronic pain. So I'm thinking about patients with sickle cell anemia from childhood and who are now adults and advocating for themselves during pain crises. Just personally something I saw during my training is that it was just rife with bias. Really thinking, well, they don't need that much pain medication. How would you go about counseling, and I don't want to presume, but I'm wondering, do you have patients in your practice who are dealing with sickle cell as adults and how do you manage their expectations and their advocacy?

Dr. Brooks: Absolutely. We see a fair amount of sickle cell patients in our practice and the outpatient setting as well – as oftentimes in the inpatient setting, especially when they present for a sickle cell pain crises. And I think one of the ways in which our institution has tried to address what we've known for a long time has been not optimal care of this patient population is to really increase communication between the patient's hematologists, their inpatient provider as well as any other person who is involved in their care.

And so we did a retrospective look at the care that we've providing to about 30 patients. And we realized that they had longer hospital stays, for example. Their pain wasn't as well-managed. And so we instituted a protocol that involved an individualized care plan that the patient helped be a part of as well as a protocol that if this patient is admitted to the hospital, pain management must be consulted and here are a list of non-opioid medications and occasionally opioid medications that we have available that we've known from past experiences that may be helpful for treating this pain.

And what we found was that we were able to decrease hospital length of stay and that we were also able to improve their overall satisfaction with their pain care, which is really, really important. So I think this is an example of system level strategies for helping address pain in a vulnerable population.

Dr. Gaines: That's amazing that you guys are able to create that care plan for these patients. I know somebody in my institution does as well and is very, very helpful. And actually one time we had a patient with sickle cell disease share with us their experience in the hospital.

One thing that she brought up that really stuck with me was that sometimes they're in so much pain that they don't know how to express themselves. And sometimes she's could be in nine out of 10 pain, but she happens to be on her phone and sometimes, a physician or a resident will see them on their phone and they'll be like, "Oh, wow, they're not, they must not be in that much pain," and that kind of perpetuates the bias that we were talking about before. So I guess my question to you is like what are some pitfalls that you commonly see in terms of addressing patients who are suffering from an acute sickle cell crisis?

Dr. Brooks: I think the number one pitfall that I see is just providers not listening to patients. Not listening to them and then when they are telling them what their previous experiences have been, because again, many patients with sickle cell, they've known for many years that they've had sickle cell. They've had lots of interactions with the healthcare system. And so they are very oftentimes very knowledgeable about what helps and what doesn't help.

And so again, just making sure that you're leaving room for that patient to share their lived experience. Letting them tell you what their experience has been with what works and what doesn't work. And then again, stressing, number one, you're going to do what you think is going to be safe for them. And then number two, that you're going to use multimodal pain management to try to get them into a better place.

Dr. Sprott: I think this makes so much sense and just the part of asking our patients, what works for you and we might be surprised because I think the fear is they're gonna ask for really high doses of opiates. But if we just ask the question, we're going to be surprised to find there are probably a number of things in there and they may include nonmedical treatments. Right? Let me have a particular playlist that I want to hear. You know, let me have a therapy dog when I'm there. So I think just the voice of the patient and including them, which truly that's why we're all here, that just resonates so much with me and makes so much sense on a deep level.

Dr. Brooks: Absolutely. And I think that, especially as attending physicians or faculty physicians, you know, I think sometimes we are worried about opening that can of worms. Like if I ask them this open-ended question, I'm going to be in here forever. But what I have found is by asking those open-ended questions upfront will save you so much time in the end, right? Just spending those first initial encounters with the patient, spending a little extra time, we'll just save the patient heartache and misunderstanding, and we'll save the physician a lot of time. And I also tell my trainees, especially the medical school students, like you oftentimes are the one on the service who have more, who have the most time to spend with the patients and to really hear that patient's story. And so you are an important catalyst or liaison between the patient and the service that is taking care of them. Your voice and the way that you share that patient's story

is really, really important because again, the students and the trainees may have more time than the attending physician does.

Dr. Gaines: Oh, absolutely. I a hundred percent agree with that. It's so important. And kind of on that topic of advocacy, you can kind of say in a way that the residents are advocating for the patient because they are able to take the extra time to listen to the patient and really get a sense of their needs. And I think it's very important in this vulnerable population

[32:42-36:24] Steps Can We Take to Dismantle Bias Towards Patients with Chronic Pain

Dr. Gaines: So another thing I wanted to ask is what's something that each listener can do tomorrow to help dismantle the bias and barriers that exist with respect to their patients with chronic pain. And how do you counsel a patient with chronic pain to advocate for themselves or for their loved ones to do the same?

Dr. Brooks: Yeah. So I think there's two ways to approach this. What we can do as individuals and then the systems that are available. And I just spoke a little bit about the systems that we have at our disposal here locally at my institution with regards to protocols and individualized care treatment plans.

And I think at the individual level, like I was saying earlier, it is so important that we hold each other accountable, and we call things out if we hear something that's not quite right. And that if you're on the receiving end of that feedback, that you should be open, not defensive, but open to receiving that constructive feedback and making changes moving forward in the way that you practice. The other way that I encourage my trainees to try to identify their biases is really stepping out of their comfort zone.

So experiencing something that may be different from yourself, whether that's a cultural experience, but just stepping out of your comfort zone. Expanding your lived experiences so that you may be able to relate to patients from a variety of different backgrounds, just because you, yourself have had an opportunity to step outside of your comfort zone.

With regards to the patient advocacy piece, I always tell my patients that the more information that you come armed with, especially in written form, that you can show your providers, especially during that initial consultation because most of my patients are referred from a variety of different specialists. Some of them are not within the Wake Health System.

And so having some information about what has gotten them to this point can be so helpful and can really help them advocate on behalf of themselves. Arming themselves with all— helping their physician on better understanding their story by presenting all of the information.

Dr. Gaines: And actually kind of a follow up question. I know that some institutions – they may lack resources to appropriately address chronic pain.

So for those physicians who may be at institutions that lack the resources, how would you recommend they advocate to get the resources they need to appropriately treat those suffering from chronic pain?

Dr. Brooks: Yeah. I mean, I think that having examples from other institutions about what successful strategies have been.

So I think that's why it's so important for us as those of us who are in academic medicine to really disseminate the things that we are doing to better help care for patients. And so relying on those known evidence-based practices and saying, "Hey, several institutions have done this. They've done it effectively. They decreased hospital length of stay. They decreased your bottom line."

All of those things, I think really help when you're trying to build resources and the structure to take care of patients with chronic pain.

[36:29-39:51] How Mobile Phone Interventions Can Address Disparities

Dr. Gaines: And actually on that, when we talk about the different evidence-based ways of treating those with chronic pain. We were reading some of the research you've done, and particularly, with the mobile intervention, which I think is fantastic. So I was wondering if you could speak a little bit about the mobile interventions you had done to help reduce this chronic pain in patients, and also how you see that perhaps being implemented in those who may be suffering disproportionately with chronic pain.

Dr. Brooks: Absolutely. So this study that you're referencing was a study designed to help older adults treat their pain with a variety of non-medication treatment options. And we were targeting older adults who had chronic pain, who were also overweight. We know that being overweight and being older with chronic pain puts you at increased risk for decreased physical function and mobility.

And we also know that older adults have very unique circumstances. They may have barriers to care like transportation and things like that. We wanted to make sure that we were reaching this vulnerable population. And one of the ways that we were able to do that was by leveraging technology. Older adults, even lower socioeconomic status, tend to have mobile phones.

And so our intervention was primarily delivered via their cell phone. We also had an intervention component in which an interventionalist called and checked on them and made sure that they were reaching their stated goals. But again, it was one of our ways to try to attempt to reach these older adults, where they are by providing them tools within their household that they could use to try to address their pain.

Dr. Sprott: That's so timely, I mean, given how we've all pivoted to virtual care. This really is something that in a lot of ways people say is not going away, but I like the fact that it's something that really does reach people where they are and can allow them to get care even potentially outside of the United States when they need it.

So, you are really just on the forefront of that, and I'm hoping that as a country, we can continue to move forward because you're right. Sometimes, you know, if you, transportation is a big issue, but I can call you on the phone or we can set up a video link, I can see how you're doing. Then, I think that that is still a touch where people feel heard and seen and cared for.

Dr. Brooks: Absolutely. I mean, we've all had to pivot during these last two years, and I will be quite frank. Prior to the COVID pandemic in the clinic, we were not utilizing telehealth to the same extent that we are now. And just like you were saying, Dr. Sprott, oftentimes there are patients who we may be medically managing, who may not require an onsite, in-person visit, but just keeping a contact with them, just having a finger on the post so to speak via this tele-health visit can be so powerful.

[39:52-42:38] Take Home Points from Dr. Brooks

Dr. Gaines: So thank you so much, Dr. Brooks, it was such a wonderful discussion. I really appreciate your time here. So we're wondering, are there any take home points you wanted to share? Any resources you wanted to share?

Dr. Brooks: Yeah. So I think the major take home points from today is that we all have an obligation to our patients and to one another to call each other out when we hear that there's something not right. Those are the ways that we're able to help address our individual biases. It's one of the tools that we have.

The other important thing that I would leave as a take home point is the importance of listening to our patients, leaving room for them to share their lived story and using those affirming words to say that I hear you, especially during those initial interactions that can really make or break care moving forward.

There were several resources that we shared during our discussion today with regards to some of the systems level issues or a system level solutions for addressing pain, especially in sickle cell disease. That particular paper was published in *Pain Medicine* this year. I also published, along with some colleagues here at Baptist, an educational series around teaching our trainees about pain management and pain bias. And so I encourage you all to take a look at that. That was published about two months ago and also in the *Pain Medicine Journal*.

Dr. Sprott: Well, we are just so thankful for your time, for the work that you're doing and impacting the lives of the patients around you. And also helping to educate the greater audience about how we can all join the fight about helping to treat our patients with chronic pain in a holistic, human-centered approach.

So from all of us here at the DEI Shift, we just want to say thank you again.

Dr. Brooks: Thank you all so much for having me. I appreciate it.

Dr. Gaines: Thanks again for listening to our pain management episode. As a reminder, you can access ACP's pain management curriculum anytime online at aconline.org.

Dr. Sprott: You can check out all the prior episodes from *The DEI Shift* podcast on our website, thedeishift.com – DEI is spelled D-E-I – or anywhere you get your podcasts. And thank you for listening.

[42:39-43:55] Closing

Dr. Gaines: *The DEI Shift* podcast and its guests provide general information and entertainment, but not medical advice. Before making any changes to your medical treatment or execution of your treatment plan, please consult with your doctor or personal medical team. Reference to any specific product or entity does not constitute an endorsement or recommendation by *The DEI Shift*.

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