

Addressing Cancer Pain Inequities Through Intervention

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The Power Over Pain–Coaching (POP-C) intervention was developed to improve functional status and decrease pain and pain-related distress among ambulatory African American patients with cancer. By bypassing the effects of disparities, the POP-C intervention may help to decrease suffering among African American patients with cancer pain; consequently, it contributes to improving quality of life and addressing social and other determinants of health among members of this population.

Pain management is difficult to attain, and its solution is elusive, as has been seen with the emergence of the opioid crisis. Among a complex of causal factors, patient race certainly contributes to pain disparities (Goyal, Kuppermann, Cleary, Teach, & Chamberlain, 2015; Lee, Lewis, & McKinney, 2016; Moskowitz et al., 2011; Sabin & Greenwald, 2012; van Ryn & Fu, 2003), and cancer pain is no exception (Meghani et al., 2012). Although upstream solutions to address factors leading to these disparities are a long way off, available approaches toward decreasing race-based disparities in pain control include employing interventions, such as the one discussed by Vallerand, Hasenau, Robinson-Lane, and Templin (2018) in the article “Improving Functional Status in African Americans With Cancer Pain: A Randomized Clinical Trial.”

In an earlier work, Vallerand, Hasenau, Templin, and Collins-Bohler (2005) identified perceived control over pain as a potential mechanism to bypass the effects of race-based health disparities and improve distress and functional status. The Vallerand et al. (2018) article in this issue of *Oncology Nursing Forum* describes and evaluates the Power Over Pain–Coaching (POP-C) intervention to improve functional status among African American patients with cancer-related pain in the outpatient setting.

The project is a two-arm randomized, controlled trial measured at three time points with perceived control over pain as a mediator between the intervention and pain, pain-related distress, and functional status outcomes. The intervention arm consisted of three

individualized biweekly home visits (weeks 2, 4, and 6) addressing medication management, pain advocacy, and living with pain. The intervention also included telephone calls in the weeks between the home visits (weeks 3 and 5). Primary measures were collected at each of these five time points. Intervention and control arm participants had intermediate measure data collection at weeks 1, 7, and 12. All outcome measures showed improvement between baseline and end of the intervention (week 7) in both study arms, and pain continued to improve at the durability assessment (week 12). Although no difference in pain improvement was noted between the two groups, the intervention group did experience a statistically significant improvement in distress and functional status over the control group.

The findings of this study (i.e., improved function and decreased distress because of perceived control over pain) and their potential applications are exciting. However, some limitations should be noted. The intervention group was older and had an almost 50% longer time since diagnosis than the control group. In addition, those in the intervention group tended to be more likely than members of the control group to be disabled and to have metastases. More than 25% of the participants at enrollment (32% in the intervention group, 22% in the control group) were lost from the study. Although attrition is expected, it was affected by a greater number of participants with metastases in the intervention arm.

Despite these potential limitations, the intervention shows promise. Pain during and after cancer treatment can be one of many chronic conditions experienced by patients, and patients and their families can only benefit from more available tools to ease the burdens associated with cancer. Improved function and decreased distress do not mean that the effects of pain are overcome, but improvements in various areas of health-related quality of life may ease some of the suffering.

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Perceived control over pain is a helpful and necessary addition to pain management, but it should not be viewed as the end goal for any pain management strategy. Hope still exists for pain management approaches that control pain without sacrificing function (e.g., cognitive, gastrointestinal), even though such interventions are not widely available for most pain conditions and this type of control is more difficult to attain with moderate to high levels of pain. Pain is one among many areas of race-related health disparities in the United States, which is attributable, in part, to the racial bias that is a part of societal structures (race is not biologic, genetic, or biogeographic) (Tishkoff & Kidd, 2004). This bias is learned through stories, media, music, educational curricula, and interpersonal interactions, and it is then reinforced through these very same mechanisms. In addition, this bias is evident in the incorrect misperceptions of even the most well-intending clinicians. African American patients are perceived as being less intelligent, as well as more likely to be nonadherent to treatment, to experience pain differently (e.g., being resistant to pain) (Hoffman, Trawalter, Axt, & Oliver, 2016; Sartin, 2004), to have less social support, and to abuse substances (van Ryn & Burke, 2000) than Caucasian patients. Racial bias in the United States leads to health disparities for people of color and contributes to inadequate pain control for African Americans with cancer-related pain.

Although Vallerand et al. (2018) did not intend to solve the problem of racial bias and its contributions to health disparities, they are helping to address upstream health inequities experienced by African American patients with cancer-related pain. The POP-C intervention is a promising tool that may be able to decrease suffering (by decreasing distress and improving function) among African Americans with cancer pain by bypassing the effects of disparities. The authors' rationale for using the perceived control-over-pain concept is based not only on their previous work (Vallerand et al., 2005), but also on the fact that it "may play an even greater role in minorities and patients with low socioeconomic status" (Vallerand et al., 2018, p. 261). Perhaps it may apply to any patient struggling with control of pain, regardless of race. Until society can begin to practically address the social and structural determinants of health (including the framing of the attitudes of clinicians, researchers, administrators, and policymakers), tools, such as the POP-C intervention, are welcome additions to improving the overall quality of life for patients of color in the United States.

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