



Airing Pain

Edition 142: Societal Inequalities and Disparities in Pain Management

Paul Evans: This is *Airing Pain*, a programme brought to you by Pain Concern, the UK charity providing information and support for those of us living with pain, our family and supporters, and the health professionals who care for us. I'm Paul Evans.

Dr Jonathan Hill: In some areas, the prevalence of chronic high impact pain is as low as 5%. And in others it's between 30 and 35%, a fivefold difference.

Dr Ama Kissi: Evidence actually indicates that children of colour, and black children also, tend to receive poor pain care compared to their white peers.

Dr Whitney Scott: What are the cultural narratives? What are the policies? What are the inequities in access to treatment and services that are putting people with pain at risk of being stigmatised or discriminated against?

Evans: In this edition of *Airing Pain*, I'll be looking at how differences in gender, ethnicity, disability and locality can impact the access and quality of pain care. According to the Office for Health Improvement and Disparities (OHID), musculoskeletal (that's joints, bones and muscles) conditions are the leading cause of pain and disability in England. These types of conditions account for one of the highest causes of sickness absence and productivity loss. In its 2022 research, using data right down to individual GP practice level, the OHID reported significant inequalities and disparities in musculoskeletal pain care right across the board. Dr Jonathan Hill is Director of Research for the School of Allied Health Professionals and is professor of Physiotherapy in the Keele School of Medicine. Speaking to delegates at the 2023 British Pain Society annual scientific meeting, he focused on disparities and standards of musculoskeletal pain management in primary care.

Hill: There's a huge variation happening in GP practice. But, also, when you look at the public health data, you can see five times greater difference in the burden



of musculoskeletal problems within some communities than others. Therefore, you would expect two GP practices: one working in an area with a high burden, one working with a very low burden, to have very different sorts of rates of referral, or rates of imaging, or rates of opioid prescribing because you've got such differences in the population they serve. I mean, musculoskeletal pain is increasing. It's higher in women, it's higher in some ethnicities, but the really big-ticket items are the most deprived areas. It's much higher, particularly women, in those most deprived areas. It's much higher in people with Class 2 obesity and those who aren't being physically active. You know, rates are above 25% with chronic long term MSK (musculoskeletal) pain in those groups. We've done some work at Keele University, some colleagues of mine, where they've been looking at population surveys and then mapping that. And of course, you get, people who are overweight, people who are physically active, and people in deprived areas being grouped together in some communities much more than in others. And they're finding in some areas local to us the prevalence of chronic high impact pain is as low as 5%, and in others it's between 30 and 35%, a fivefold difference. We're starting to really explore that data, particularly for musculoskeletal patients.

Evans: When we started this conversation I thought, 'OK, well, this is something that would be great for patients to look up. I've got a bad back, which GP should I go to?'. But you're looking at it from completely the other side, all the external factors, maybe from the social factors.

Hill: Absolutely. What I'm interested in is saying, 'Well, how can we improve primary care?'. Part of it is to be aware and understanding that each practice serves a very different population. At the moment, integrated care systems, which sort of oversee what's happening within an area, are often making demands of certain GPs. Perhaps your referrals are too high, but they haven't got the contextual data. So, if we're going to be wise and make good decisions, particularly integrated care systems, they need that kind of data. One of the things that I'm very excited about is a dashboard that would allow trusts and ICSs all over the country to upload data from local GP practices, then being able



to explore how the practices are doing in the near future. With that data not really being at our fingertips yet, what data do we have looking at the differences across the last five years in areas? Data such as whether or not patients feel that they were communicated well. Were they listened to, were they involved in the shared decisions, what was their overall experience like?

Generally, for most of the experienced things, musculoskeletal is roughly doing the same as some of the other long-term conditions like cancer, diabetes, and cardiovascular. The good news is we're a bit ahead of mental health, so those patients aren't getting as good of an experience, except for two areas where we are really lagging behind, from the national data coming through the GP Patient survey. That's getting a care plan agreed for people with long term MSK conditions, and it's also patients feeling that they had a consultation where they discussed what mattered to them, not just what was the matter with them. What are they doing in diabetes, which is 20% or so better in terms of patient experience around those two areas than we have in musculoskeletal? What are the lessons to learn? Some of the ideas I've been thinking about is that it's to do with their practice nurses doing diabetic clinics. It's to do with them having a GP annual review where you can have a health check. Diabetes gets monitored, assessed and there's some accountability. This isn't happening for patients with long term MSK conditions.

Evans: Well, I can tell you truthfully, because I have type 2 diabetes and I have a chronic pain condition. I have fibromyalgia. Once you tick the diabetes box, the level of care is excellent, but not for other conditions.

Hill: No, and I think this is the challenge. We need to challenge our integrated care system leaders, to say, 'This can happen for diabetes. Why is it not happening for musculoskeletal?'. And they will come back to us and say, 'Well, you help us upskill our primary care workforce'. One of my key messages today was about this upskilling. This integration of the knowledge and skills that you get in very specialist pain services is not available. At the moment, the cavalry that's coming into primary care for musculoskeletal are these people that have



these first contact practitioner roles. That's what we call them. They're usually physiotherapists, FCPs for short. At the moment we don't give them very long and we are prioritizing what they do around triage and diagnosis. We haven't really differentiated yet a model where, as well as doing that, there's an opportunity for them to run something which looks a little bit like the clinic that you're talking about run by the practice nurse treating the patients with diabetes. I think it might not be the FCP, it might be someone else in the primary care team to consider. But there's a real job to do to work out how we upskill them and how we set up the structures to allow that kind of clinic to work. Clearly, the national data at the moment is saying we're some way behind in terms of patient experience for musculoskeletal than we are for diabetic care. Well, what is it that they say works, when you interview the practice nurses, the ones who are doing the diabetic clinic?

I came up with a lovely study done by Hall and Tolhurst and they had looked at essentially some key themes that emerged from that. The first one was that these people really need good skills of communication. That's the key thing. Empathy, understanding, tailoring the need. They also need to have better access to support for those with complex needs. We know that it's the same in diabetes as it is for musculoskeletal pain. They also really had some reservations about the massive push for digital, saying they're finding out that patients don't really want to use these apps. There's still lots of need for humanity in terms of contact, that personal interface. And the last thing that they really pointed out was medication is such a big part of the management. It is for MSK, for long term MSK problems, and yet these clinics are often run by people who are non-prescribers where there's a bit of a problem there. Particularly, if the cavalry we are bringing in is physios who are usually non-prescribers, they need to collaborate with pharmacists. This is so that whoever's running those clinics we're not missing the medication piece.

Evans: With a disease like diabetes there is a tick point. There are numbers. There are tests. You are now diabetic. Is there anything like that with musculoskeletal pain?



Hill: It's interesting. In something like diabetes you've got some really key blood tests that allow that. In musculoskeletal, the truth is that the diagnostic, the equivalent of the blood test, is actually a very thorough physical examination. That's what these FCPs are kind of often doing, a very thorough physical examination. If it's not thorough enough there, then you can often go through to one of these integrated care services where that thorough examination is going to happen.

There's something I didn't tell you which I really want to bring up. Claire Fuller has written this stock take report on primary care and she's really done a fabulous job. One of the things that she says is we've got to differentiate better between people who are accessing primary care infrequently and people who've got the long-term complex conditions. I think that if you bring that back to the musculoskeletal context, we need that differentiating happening right from when you've got a long-term musculoskeletal pain problem, then you need to be hooked into these annual reviews. These clinics that do these reviews, are very different from you going in with an ankle sprain or something short term, a bit of tennis elbow which should be better in three or four months and you just need the right advice, the right knowledge to know what to do. So how do we streamline the care for those infrequent attenders? For the infrequent attenders, think about digital systems and not just digital for patients, but to think about digital for clinicians. In a survey I had recently done with GP practices local to where I work at Keele University, what we found was the things that they felt that they had really good access to for all these patients with musculoskeletal problems, most of them, the vast majority being infrequent users, was things like social prescribing which is great to hear. Services such as generic mental health, IAPT, and other sorts. MRI scans and joint injections which are perhaps questionable particularly for spinal problems. They're perhaps better for things like knees and shoulders. But they felt that they really struggled to get good access to some very high value things like pain services, escape pain programmes, vocational support, things like yoga, Pilates, and tai chi for back pain. They just didn't have that available unless they just signposted the person



back into the community. And in terms of digital, what they were really telling me was, well, the best thing that they had was patient self-management resources that they could click to send people to. But that was only half of the GP practices. And things like knowing when to refer, when to send them for a scan... There's a great piece of kit called I Refer that GP practices can have that helps them to only refer within guidelines. That was just not being rolled out and isn't available. So, there's some real challenges there. The other thing is that with the tech, what's happening is we're increasingly seeing examples of innovation happening through small companies. The one I gave was one called Auto Pathways where what you do is you install onto the GP system this bit of software that takes the clinician through an assessment in real detail. I gave the example of showing the back-pain pathway which is, you know, hugely complicated. But it's all written, it's all available for the clinician, and therefore even the practice nurse or the non-physio, and non-GP can know what to ask the patient. And when they get to the end of it, there's a whole set of recommendations for the particular conclusion they've come to in terms of the key messaging to the patient. Where in the process to signpost them, what management to think about and what follow up they should be considering for this particular individual. So, there's all of that. The challenge then is Does the workforce want to operate to algorithms and to pathways, or would it prefer to be much more fluid in the way that it operates? What we certainly know from my experience is GPs aren't that keen, but some of the other primary care clinicians do seem to be much happier to use those sorts of things. We've got a big clinical trial at the moment testing the ortho pathways both quantitatively and qualitatively to look at it and we'll be interested to see what the results come up with.

Evans: So, what could you do to make those GPs more interested in the online stuff? Time, maybe?

Hill: Absolutely, time, pressure. They have got so much that they've got to do and what we're doing, and what you see happening nationally now, is first contact practitioners coming in to reduce the burden for musculoskeletal. I



spoke to a GP recently who told me he doesn't see musculoskeletal patients anymore. It all goes through to one of these other healthcare professions sitting in general practice. And so, I think that's where the innovation will come, not that GP colleagues couldn't do it because they actually do a fabulous job. But a lot of the innovation is likely perhaps to come with the people with the new roles, who are much more open. But I think what we need to do is make sure that those new roles are not just focused on the diagnostic piece. We also have this care, this support, this slightly more long-term condition approach, we've differentiated what does that look like for primary care, how do we treat patients with complex problems much better?

A trial that's got me really excited just recently is called the Restore Trial, just published in The Lancet. Peter Kent was the first author, and essentially a team in Australia between Perth and Sydney did this very big trial. What they were looking at was whether it was effective to upskill mainstream physiotherapists with psychosocial skills to treat the complex chronic back pain patients. And absolutely, they found it was. But what excites me about Restore is that they managed to do that really effective training piece. Not only was it clinically effective, but once again they've shown it was incredibly cost effective to do this. Roughly it costs four times as much to send someone through a pain clinic, as it does to send them through a physio clinic. We just don't have capacity in the pain clinics. So, I was urging the conference here to think about integration where we use the skills in the pain teams to upskill, just like they have with the Restore trial. What did they do in the intervention? Well, they gave them seven sessions of physio, an hour at the beginning and 30 to 40 minutes for follow up. But they focused on three things. The first thing was they trained the physios to really help the patient to make sense of their pain. And you know, understanding their beliefs, their fears, what they were avoiding, was there protective guarding going on? Were there activities they were avoiding because of their condition? They discussed their sleep routines and their dietary habits. All of that piece. They really got the physios to take a slightly different approach and to look at that with the patient telling their story. The next thing they taught them to do



was to really give effective graded exposure to the feared movements, the feared activities, really building strategies and build confidence for patients. Show them that yes, they could do that, from working them through things that they felt confident about initially to the things they were really scared of, and just take them through that programme. The last thing they really focused on was lifestyle change. Thinking broadly for the patient, what would they like to do around physical activity? What was their preference? What could they get them hooked into? Could they adopt healthy sleep and dietary habits? Could they think about stress management? Could they think about social engagement where relevant? With those physios there was a much more holistic approach than they were normally doing. And yet they found this huge impact on the patients when they did that. Now I don't think that's rocket science, but the truth is it's not something that patients are getting. Too often at the moment patients are only seen just over two times on average with physio. We've got to push back to rehabilitation type physio, physio that differentiates. And if you're an infrequent user, yeah, you get a short, 'Here you go'. But if you have got a long-term complex problem, we really do give you the sort of treatment like what the Restore trial shows which makes a difference.

Evans: That's Dr Jonathan Hill, Director of Research for the School of Allied Health Professionals at the University of Keele. Another one of the speakers in that British Pain Society annual scientific meeting was Dr Whitney Scott. She's a Clinical Psychologist at Kings College London and has a clinical role at the Input Pain Management Unit at Guy's and Saint Thomas' Hospital. Her session looked at the impact of stigma and discrimination in people living with pain, and it's that word stigma in the context of chronic pain that intrigues me.

Scott: Chronic pain as a condition, particularly when there are not clear kinds of pathophysiological causes which in many cases is the basis of chronic pain as a condition. This goes against what we expect of pain, particularly in Western societies. We expect that there's a clear relationship between pain and injury. That can be a context where people's pain can be invalidated, not believed, judged, and those are kind of the stigmatising aspects of pain. And of course,



broader societal views about disability, that kind of comes into the role of stigma and the related concept of discrimination. So, we know that disability is one factor for which people can experience discrimination. And of course, there's also a range of other factors, such as a person's age, their gender, and their ethnicity. Those can all intersect with the pain experience to make a person with pain more likely to experience discrimination and the adverse impacts of that.

Evans: Well of course, the first thing I guess we have to take into account is that with many chronic pain conditions the pain is invisible.

Scott: Definitely. And I think that's one of the reasons that stigma can be common because people can't see pain and they expect that if someone is in pain, there should be some "objective" way of identifying that. But that's just not how pain works. It's a very difficult thing to recognise and communicate for people that don't have pain. It's a very complex thing, and as humans we don't grapple with complexity all that well. We like quite simple answers and pain very much goes against all of that. We have to try and wrap our heads around that, if we are to support people holistically and effectively in a very compassionate way.

Evans: So, if I were to stick a notice around my neck, a simple sentence, 'I have chronic pain'. Well, the first thing that needs justifying is I would have to say 'What is chronic pain?' You can't see it. This is how I feel. This is how it's affecting me. I'd have to have an awfully long notice board hanging around my neck.

Scott: Yeah. You know, I'm a psychologist so I'm in the business of talking to people about their experiences. It's never enough time, but we spend a fair amount of time doing just that. It's not a notice board, but it's a conversation about what's the pain like for you? How long have you had it? What does it feel like? And most importantly, how does it impact your life? What are the wide-ranging areas that it impacts? That's again not something you can just have in a quick sentence or a quick phrase on a notice board. It also requires trust



because telling the wide-ranging impacts of your experience, that's not necessarily something you're going to do with someone you've just met. You might not even do it with people that you're closest with because that's a very personal thing. So, I think in being compassionate, not being stigmatising, there are relationships that we need to build. There's trust, there's empathy, and all of that's very, very important when we're supporting people with pain.

Evans: In your research, have you spoken to lots of people who feel stigmatised?

Scott: This was specifically in the context of people living with HIV who also had pain that was connected to their HIV, either the illness itself or the treatment for HIV. In those interviews, even though we were asking people about their broad experiences of pain, not specifically about the stigma, stigma sort of came out loud and clear. People were talking about not wanting to tell other people about their pain. In some instances, because they were worried that that would reveal their HIV status, but in other instances it was the pain itself that they felt would be stigmatised. Maybe it was indicating that they weren't healthy or that they were older. Then we've done work looking at self-report questionnaires and people that attend treatment at the input pain clinic fill out questionnaires of items related to stigma. So, for example, 'I felt embarrassed about my illness' is one item, or 'Other people avoided me because of my illness'. Then we look at what those kinds of scores relate to. We find that first of all, people score quite highly on that kind of measure, suggesting that stigma is common in people with pain. That then relates to negative outcomes like greater levels of pain-related disability and greater depression. So again, this impact of stigma can be quite wide-ranging.

Evans: We sort of think that the issue is other people putting that onus on us to talk about the pain. But what about the person with pain?

Scott: I mean, these are really complex issues, aren't they? I think one of the real challenges that I've tried to wrap my head around with the work on stigma



and discrimination is individuals will experience similar events differently and the impact that it will have will be different. How they communicate that impact will be different and certainly some people may tend to kind of hold that quite close. They may not want to share things that they're struggling with others. That may be, you know, culturally influenced. In certain cultures when you say, 'I'm rubbish' or 'I'm not feeling well', that might not be met with the greatest of empathy or that might be something that's just not done. But I do also think we need to shift a little bit of the focus, or a lot of the focus, from the individual who has been stigmatised or discriminated against to thinking about these broader kinds of social structures or social systems that are enabling the stigma and the discrimination to continue. We really need to be looking at things like What are the cultural narratives? What are the policies? What are the kinds of inequities in access to treatment and services that are putting people with pain at risk of being stigmatised or discriminated against, if that makes sense?

Evans: Lots of questions there. How do you work with people with pain who feel stigmatised? And I'm sure there's not one answer.

Scott: Yeah, there's not one answer. I mean, as a psychologist, I am again in the business of supporting people who have experienced life adversities to move forward in the face of those adversities and still make the most of life. To live a rich and satisfying life in the presence of challenges. Sometimes that involves a great deal of what we would call self-compassion. So, bringing that kindness to oneself even when others aren't being kind to you, even when you might not be kind to yourself. So, if you have experiences of people invalidating your pain or stigmatising it, you may develop what we call this kind of internalised stigma or an inner self critic that tells you that you're no good. There is stuff that we can do to work with that and to develop that sense of kindness towards oneself. But I'm always interested in thinking about that alongside what needs to happen in society for society to treat people with pain better. Because I don't want the message to be that it's just a matter of the person in pain doing differently or doing better. I mean, we all just need to do better so that society is more compassionate and understanding.



Evans: Dr Whitney Scott. Now, for society to be more compassionate and understanding to resolve those inequalities in access and quality of pain care, it would have to resolve discrimination by gender, disability, locality, and of course ethnicity. Dr Ama Kissi was born in Ghana but she's lived in Belgium since the age of three. She is a post-doctoral fellow at the University of Ghent where she researches the mechanisms that could account for racial disparities in pain care. She's a Clinical Psychologist and as a Black person, around 50% of her clients are also people of colour who struggle with racism-related stress, discrimination, or trauma.

Dr Ama Kissi: If you look at the literature, what we see there is that the pain of Black people is often underestimated and undertreated, even if they report similar levels of pain intensity compared to white people. We see differences in how their pain is assessed and how their pain is treated. These disparities have not only been documented within the adult population. That's usually the population that we think of when we think about racial and ethnic disparities and pain care. But evidence actually indicates that children of colour, and black children also tend to receive poor pain care compared to their white peers.

Evans: Why is that? Is it misinterpretation on behalf of the healthcare professional, or is it that we as white middle-class doctors are just not asking the right question?

Kissi: They all seem very relevant to look at. It could be misinterpretation of pain signals. It could be indeed that there are differences in how the pain is assessed, what we look at, or that the difference is in the way that pain is expressed, or not asking the right questions. I think those are all interesting mechanisms to look at. But then if you really look at the evidence that is available at the moment, I think it's fair to say that we do not have a clear understanding of the mechanisms that could explain these disparities in pain care. There have been studies that have really looked at racial biases like hostile or negative attitudes that perhaps white people can have towards black people. These studies have considered that those could be mechanisms that could



explain these disparities. But to be fair, we don't know a lot about these things and that's why we want to do the work that we're doing. Our work really focuses on trying to unravel and understand the explanatory mechanisms of these disparities in pain care.

Evans: Do you have any insight into what might be going on?

Kissi: Yeah, I do think that there are so many factors that might play a role. First of all, I think these racial biases, like prejudice and stereotypes, all of these things might definitely play a role because we see these factors playing a role in other domains, so I definitely think that that's a thing. I also think that there might be cultural differences, perhaps in how we communicate or talk about our pain, and that could also play a role. Also, there might be differences in how healthcare providers that, let's say, are white, perceive or code the pain expressions of people that do not belong to their racial or ethnic group. I think that might also play a role there. Another factor that I think also plays a role is empathy or perspective taking because we know from literature that people tend to have difficulties demonstrating empathy or taking in the perspective of 'the other' when that person does not belong to their own racial or ethnic group. I think that, that could be a very relevant mechanism in that regard. Within our line of research, we really want to tap into that and zoom into that, but we haven't gotten really to that point where we have a systematic research approach towards that. But that's on the agenda. We want to examine that. But at the moment we've been focusing on attentional processing as well, attentional processing of facial expressions of pain.

Usually people look at these implicit biases, these thoughts that people have. But I mean when you're confronted with a pain patient as a healthcare provider, the first thing you need to do is pay attention to that individual, right? And then it's not only initial attention, you also have to sustain your attention and really look at that person and try to understand what the internal experience is of that individual, what that individual is trying to communicate to you. Because of the importance of attentional processing, we were like, 'OK, we need to examine



that and look at what's going on'. I think there are so many factors that play a role: on the side of the healthcare provider, also on the side of the patient and then structural as well. For example, there is the fact that in some countries if you don't have the legal documents to stay in a country, you perhaps cannot use the healthcare systems. These are also factors which play a role.

Evans: What are your experiences of healthcare?

Kissi: As a patient, whenever I go in and talk about my complaints when I'm ill, I always feel like I'm not always taken that seriously. But my partner is white and when he's there I feel like the consultations always take longer or they tend to direct their attention towards him and talk to him more. I don't think it's an intentional thing that people do, but it's just my observation. Also, I gave birth two years and a few months ago to my son, he's an only child. My son is mixed race. My birth experience was so traumatic. I had a C-section. After receiving the surgery, we went back to my room in the maternity unit and on the first day I got pain medication. On the second day, I was so focused on keeping that little human being alive and, I'm trying to breastfeed. It was during mid COVID time so my mom was not there to help me. My partner and I, we had to figure everything out. I remember being in so much pain. I felt like, 'OK, is this normal?'. Nobody came in that day to ask me how my pain was. Nobody came in to ask me if I needed pain medication or anything. In the late afternoon a nurse came in and she was like, 'I saw on your chart that you haven't received any pain medication today'. I had just had surgery! I remember feeling so sad because I was really in pain. But it made me also so sad because I realised that I was one of the cases or one of the participants, that I had been reading about in my research. For me that was like, 'Wow, this is really happening'. There were so many biases that people had, like, 'Oh, wow, black moms do an amazing job when they give birth'. And yeah, like, 'Black people, I know you guys can endure a lot of pain and you look so athletic, wow'. And I was like, 'that is just all so irrelevant'. I felt like people already had this notion or this idea that, 'She's good, because she's black. She can take it, they're used to enduring hardship'. That was my feeling. I'm not saying it was the case, but that was my feeling.



But then the fact that I did not receive pain medication when I should have received it, that was for me a red flag. That was the realisation for me at that moment that 'Ok, this is reality'. And I knew it was reality, but then I had really experienced it in a very clear manner. It also motivated me to continue this line of research because I felt like this needs to change. This shouldn't happen to anyone.

Evans: You were saying earlier about your partner, who is white, and the focus of the consultation being to the white partner, not the black partner. Did he notice it?

Kissi: He noticed it, yeah. At the same time, he noticed it but he didn't do anything with it because he was, at that moment, just engaging in the conversation and talking. Of course, because he wanted to help me. I'm his partner. I'm sick. He's like, 'Let me give the information that is needed to help this doctor make a good assessment'. So, it's double in the sense that he does realise it, but at the same time he's perhaps so used to situations in which people do listen to his thoughts or what he wants to share at that moment. But I'm happy that he noticed it and I knew that it was not just me, that I wasn't imagining stuff.

Evans: You're doing a workshop with healthcare professionals at this scientific meeting with the British Pain Society tomorrow. What are you going to do?

Kissi: I want to make people aware of the existence of racial disparities in pain care and how it manifests. The fact that it's a widespread problem that we see across different settings like emergency departments, paediatrics, maternity units, so many different settings, in different ages and across different genders. It's just such a pervasive, widespread problem. I want to make people aware of this problem. I want us to really think critically about the research that we're conducting. We need to think critically about who are the people that we are testing. Are they primarily white people that we are testing or not? Because that impacts the knowledge that is generated. It can lead to a point where there is a



bias in what we know about, let's say, chronic pain and perhaps that knowledge that we have does not generalise to all of the population. I want people to be really aware and think critically about who are the people that we're testing. Where did our knowledge come from and to what extent do we really understand or try to understand the lived experiences of people of colour? And How are we including them in our research processes?

I've been here at this conference and my students and I, we presented a poster to actually promote more racial diversity in pain research. When I looked around, at all these different posters, the research that was conducted, or at least the research that they were describing, I don't know, I just felt like I wanted to know more about the people behind the numbers. Who are these people? Are the people that were being tested, people that look like me? Where do I fit in? If I have this knowledge, what can I do with this knowledge? Does it tell me something about my lived experiences or those of people that look like me, or people that I love like my mum, or my son, or my siblings? Those are the questions that I have. It's a bit disappointing to walk around and to see that there's not a lot of research being conducted on the experiences of people of colour. I think that's sad, and I hope we change that in the future.

Evans: Ama Kissi. As in every edition of *Airing Pain*, I'd like to remind you of the small print that whilst we in Pain Concern believe the information and opinions on *Airing Pain* are accurate and sound based on the best judgments available. You should always consult your health professional on any matter relating to your health and well-being. They're the only people who know you and your circumstances and therefore, the appropriate action to take on your behalf. Now, it's important for us at Pain Concern to have your feedback on these podcasts so that we know that what we're doing is relevant and useful, to know what we're doing well or maybe not so well. So, do please leave your comments or ratings in whichever platform you're listening to this on, or the Pain Concern website, which is www.painconcern.org.uk. That will help us develop and plan future editions of *Airing Pain*. Last words in this edition of *Airing Pain* to Ama Kissi:



Kissi: It's okay for me to come to this conference, talking about these disparities, trying to create awareness and stuff like that. I think it's invaluable and it's necessary to do that, but it can't stop there. I think we all need to rethink the way that we're conducting research, rethink the way we approach and treat our patients. On a societal level, we need stakeholders, we need leaders to really rethink our healthcare system and make sure that everyone, irrespective of their background, can actually enjoy good quality healthcare. That is one of our human rights. I think we have to really take that seriously and we need to look at ways in which we can make sure that right is executed or that people can enjoy that right.

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