

Like a Fish out of Water: Managing Chronic Pain in the Urban Safety Net

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Abstract

The subjective nature of pain has always rendered it a point of entry for power and corresponding stratifying processes within biomedicine. The opioid crisis has further exacerbated these challenges by increasing the stakes of prescribing decisions for providers, which in turn has resulted in greater treatment disparities. Using the theoretical frame of cultural health capital (CHC) to account for these disparities in pain management as they unfold at both the macro- and the microlevel, we present findings from an interdisciplinary study of two complex care management programs in urban safety-net hospitals that serve high-utilizing patients. CHC, which considers the ways in which patient–provider interactions reflect and often reinforce broader social inequities, allows for a consideration of power as it circulates through and beyond the patient–provider encounter. Within the current sociopolitical era of pain management, attention must be paid to the stratifying processes that structure how suffering is addressed.

Keywords

complex care management, cultural health capital, disparities, opiates, pain

As the opioid overdose epidemic continues to draw political attention, pain medicine is undergoing a turbulent transformation.¹ The release of Centers for Disease Control and Prevention (CDC) guidelines drastically curtailing opiate prescribing (CDC 2016) and the subsequent warning to physicians from the surgeon general about the epidemic signaled an alarm to the medical community. In response, providers are transitioning their pain patients off of opiates. Subsequently, providers are searching for new solutions to the widespread problem of chronic pain (Volkow and Collins 2017).

Pain's invisibility has always rendered it both a challenging condition to treat and a point of entry for stratifying processes. The opioid crisis has further exacerbated these challenges by increasing the stakes of prescribing decisions for providers, which in turn has resulted in greater treatment disparities (Hoffman et al. 2016; Pryma 2017). The effects of pain, as well as the treatment options available, vary tremendously along axes of power and

privilege. This pattern is made even more apparent as widespread addiction to opiates places pain medicine against addiction discourses, which carry their own political values and agendas. This results in racialized and classed effects on prescribing patterns, in a regulatory as well as clinical sense (Hansen and Skinner 2012; Wailoo 2014).

Developing a social analysis of pain medicine means paying attention to the inherent power differentials that are evident in who is affected by pain and how they are treated for it. An ever-growing number of social scientific studies reveal consistent disparities in the prevalence, severity, and impacts

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of pain. Gender (Fillingim et al. 2009; Kempner 2014), socioeconomic (Blyth 2008), racial (Hoffman et al. 2016), and cultural inequities (Livingston 2012) in pain symptoms and their treatment have been well documented. Women report more persistent, severe, and disabling pain than men (Fillingim et al. 2009). Socioeconomic status is thought to be the strongest predictor of disabling pain (Portenoy et al. 2004). Black Americans are routinely undertreated for pain compared to white Americans, and racial bias among providers is consistently demonstrated (Hansen and Skinner 2012; Hoffman et al. 2016; Rouse 2009).

Further, pain's position as an often-contested and invisible condition places the burden of proof upon those who suffer from pain's effects. Numerous accounts emphasize the subjectivity of pain and the difficulty of translating felt sensations into tangible objects of biomedical intervention (Barker 2005; Buchbinder 2015; Kempner 2014). With no clear biomarker upon which to base veracity, pain resides in the intersubjective space between body and language. All patients struggle to articulate and demonstrate the intensity and nature of their painful symptoms; however, the consequences of this clinical uncertainty are stratified across social groups, with women and black Americans often receiving more scrutiny around their claims to pain than those in more privileged social positions (Crowley-Matoka and True 2012; Hoffman et al. 2016; Kempner 2014; Pryma 2017). These qualities of invisibility, intersubjectivity, and clinical uncertainty open pain up to practices that produce inequities in care, which are exacerbated within an era of pain management reform.

In order to account for these disparities in pain management as they unfold at both the macro- and the microlevel, this paper utilizes the theoretical frame of cultural health capital (CHC; Shim 2010), detailing how CHC is being activated and deployed within the current sociopolitical moment of pain medicine. CHC, which considers the ways in which patient-provider interactions reflect and often reinforce broader social inequities, allows for a consideration of power within the clinical encounter. The patients we observed and spoke with in urban safety-net clinics faced numerous obstacles to care, such as homelessness, multiple chronic health conditions, substance use, and low levels of social support. Pain patients in these settings grappled not just with physiological pain but also with trauma and social suffering resulting from challenging life circumstances (Thompson-Lastad et al. 2017). At the same time, providers working within these safety-net

clinics were often impeded by limited time and resources to effectively engage with high-needs patients. By describing the structural factors that impact and impede the pain experience of both patients and providers, and articulating the ways in which power circulates through the clinical encounter via the deployment of CHC, we contribute to conceptualizations of social dynamics within pain medicine, in particular, how inequities in treatment are produced and maintained, and how, ultimately, suffering is stratified.

BACKGROUND

CHC

CHC accounts for the relationship between social status and healthcare interactions, linking micro and macro forces of inequality, and can therefore help articulate how relations of power manifest in the treatment of pain. CHC argues that "certain socially-transmitted and differentially distributed skills and resources are critical to the ability to effectively engage and communicate with clinical providers" (Shim 2010:1–2). CHC builds upon Bourdieu's (1977) theory of capital, which he describes as accumulated labor which has a tendency to persist and which is "a force inscribed in the objectivity of things so that everything is not equally possible or impossible" (Bourdieu 1986:241). Bourdieu identifies multiple forms of capital that contribute to the maintenance of power relations. *Cultural capital* refers to a range of cultural practices and products, the deployment of which results in the accumulation of social status and consists of dispositions, skills, and qualities that one accumulates over a lifetime of social experiences. Capital is context specific, wherein skills and attributes acquire value based on the social field in which those skills are deployed. Fields are specific social arenas or contexts in which hierarchies and power relations are configured and rules and norms are mapped. In a given field, agents negotiate capital based on the particular arrangements of that field, which vary across time and space. Thus, what constitutes capital in one field may not be similarly valued in another field. Bourdieu compares the attainment of social privilege to a stratified game. The rules of this game, then, are socially determined and enacted in order to maintain configurations of power and reinforce the inequitable distribution of power.

In her articulation of CHC, Shim (2010) extends the concept of cultural capital into the field of healthcare, specifically examining the ways in which capital is activated and exchanged via the

clinical encounter. She argues that patients' deployment of certain inequitably distributed and socially transmitted skills and resources may result in more favorable interactions with providers. In the current context of U.S. healthcare, qualities of CHC may include knowledge of biomedical information, linguistic facility, and a proactive stance toward managing one's health condition. It is important to note that while CHC can sometimes be deployed deliberately by patients, many others are acting in largely habituated ways of organizing action based on culturally transmitted schemes of perception.²

CHC has been taken up to describe the process of resource exchange in a number of healthcare situations, including the negotiation of substance-use stigma (Chang, Dubbin, and Shim 2016) and dynamics of patient-centered care (Dubbin, Chang, and Shim 2013). Each of these illustrations emphasize the increasing relevance of CHC within contemporary U.S. healthcare, where providers are "being asked to do more with less, while patients are being asked to shift from being seekers of healthcare to informed consumers of medical services" (Dubbin et al. 2013:114). Within this consumerist logic, patients and providers alike are being called upon to leverage and exchange CHC in order to produce favorable health outcomes. A system in which resources are inequitably distributed, among both patients and providers, makes this exchange increasingly challenging. CHC illuminates some of the mechanisms by which "macro-structural inequalities in social status and power manifest in micro-interactions through shaping what confers advantage and how advantage is itself generated and regenerated in those situations" (Shim 2010:12). The situation of contemporary pain medicine exacerbates some of the inequities already embedded in the healthcare system. Pain's invisibility and corresponding uncertainty are compounded by the opioid epidemic and therefore make interactions between patients and providers all the more subject to stratifying processes. An analysis of how CHC is distributed and leveraged in treatment allows for an understanding of the ways in which macrolevel patterns of power circulate in the micro-level arena of pain medicine.

The following analysis traces key aspects of CHC as they appear in our data, elaborating upon the theory's basic premise that the qualities that make up CHC are context specific. We demonstrate the difficulties of managing pain in the current U.S. healthcare system, in which patients need to self-present as low risk in order to maintain agency over decision making and in which quantifiable

measures are necessary in order to take clinical action on an invisible health condition, such as pain. We build upon Shim's (2010) assertion that capital accumulation is deeply relational, describing situations in which providers actively cultivate CHC in their patients and emphasizing that patients and providers alike are caught up in complex processes that are deeply embedded in stratified cultural values and resources. Thus, throughout the analysis, we articulate the duality and relational components of CHC—that patients attempt to leverage CHC in pursuit of pain management while institutionally situated providers work to foster and induce particular (perhaps preferred and more recognizable) forms of CHC among their patients. In illustrating these aspects of CHC, we aim to demonstrate how social dynamics and relations of power operate within the current context of pain medicine.

A Social Analysis of Pain Medicine

In an effort to replace pharmaceutical therapy, clinicians have begun to focus on the *biopsychosocial* aspects of pain, highlighting the notion that psychosocial interventions may prove just as effective as biomedical treatments (Gatchel et al. 2007; Turk and Monarch 1996). Biopsychosocial interventions for pain management address the complex relationships between physical health, psychological well-being, and social factors and, in so doing, attenuate patients' experiences of pain. However, what constitutes the social within the biopsychosocial remains thinly conceptualized. Most analyses stay solely at the level of the individual, with little acknowledgment of the social hierarchies that produce these conditions in the first place.

Chae and colleagues (2011) reformulate the biopsychosocial model, forefronting structural, social considerations of health and advocating for a consideration of causality, "in which social inequalities generate unjust patterns in disease distribution" (p. 65). This new model, described as a socio-biopsychological approach, accounts for broader stratified social systems and relations of power that shape and structure the U.S. healthcare system. Focusing specifically on the effects of racism upon health, the socio-biopsychological approach articulates the ways in which "historical processes, institutional forces, and personally mediated as well as internalized forms of racism" stratify disease patterns along racial lines (Chae et al. 2011:66). This process can be understood through the framework of CHC, whereby "non-whites and the poor may be

less able to convert the cultural resources and skills that they have into healthcare advantages” (Shim 2010:10) as a result of discriminatory patterns enacted in clinical settings. Viewing the current moment in pain medicine through the overlapping frames of both the socio-biopsychological model and CHC, then, allows for a theoretical consideration of the social within medicine.

Extending upon the socio-biopsychological model (Chae et al. 2011), this analysis takes as its premise that social factors—such as racial, economic, and gender inequality—can exacerbate chronic pain. While Chae and colleagues (2011) successfully pivot and broaden the biopsychosocial model to privilege a social analysis of medicine, we build on their assertions by describing instances in which structural factors contribute to, produce, or intensify already-existing disparities in care. We do so by describing instances in which the distribution of CHC is stratified along lines of race, class, and gender, whereby those in privileged social categories are afforded more of an investment of providers’ time and, in turn, more agency over medical decision making. Within the current sociopolitical era of pain management, attention must be paid to the stratifying processes that structure how suffering is addressed.

DATA AND METHODS

This qualitative study is part of a larger multimethod project that seeks to understand the interactions, processes, and organizational arrangements of two complex care management (CCM) programs developed to meet the needs of high-utilizing patients, or patients with frequent hospitalizations and emergency department visits. Each CCM program is embedded in an urban safety-net hospital that primarily serves low-income patients who rely upon Medicaid and/or Medicare. These programs seek to address the fact that 1% of the U.S. population accounts for 20% of healthcare expenditures (Cohen and Yu 2012), targeting this population of “super utilizers” with the aim of improving health-related behaviors and decreasing healthcare expenditures. CCM programs are made up of interdisciplinary teams of healthcare providers (including physicians, nurse case managers, social workers, and health coaches) who work to improve health outcomes by promoting self-management of chronic conditions. However, in this analysis, we refer to all members of the CCM teams as CCM staff, so as to distinguish from the primary care providers (PCPs) and specialists who were not associated with the CCM program.

Two ethnographers at each site shadowed providers, staff, and patients, both at the clinic and in patients’ homes, in order to attain an understanding of how patients and providers navigate care within and beyond the CCM program. Approximately 1,500 hours of observations were conducted between January 2015 and June 2017. Observations and informal conversations were recorded in detailed field notes in which the identities of individuals were anonymized. In addition to observations, initial and follow-up interviews were conducted with 75 patients. Of the patients observed in this larger study, approximately 40 of them struggled with issues related to chronic pain. During fieldwork, researchers identified patients who would be eligible for semistructured interviews. Eligibility requirements included being age 21 or older, fluent in either English or Spanish, and willing to engage in two 30- to 60-minute interviews over the course of the study period. Multiple interviews allowed the research team to track patients’ progress over time, changes in their health status or social situations, and evolving perspectives on their healthcare. All interviews took place at a location convenient for the patient, and participating patients were reimbursed with a \$25 gift card. Interviews were audio-recorded, translated if conducted in Spanish, and professionally transcribed verbatim.

Initial and follow-up interviews were also conducted with 51 CCM staff and non-CCM providers. Provider interviews occurred twice over the duration of the study, approximately one year apart. Researchers identified providers who were affiliated with the CCM program, either directly as CCM staff, as a referring physician, or as a provider at a partnering community-based organization. Provider interviews focused on interactions with the CCM program and its related departments, challenges in providing care, and organizational aspects of the clinic. All provider interviews took place in a location convenient to the participant and lasted between 30 and 60 minutes. Interview participants were given a \$25 gift card in appreciation of their time. All interviews were recorded and professionally transcribed verbatim. All study procedures were approved by the institutional review boards of the appropriate university and the two institutions where the CCM programs were housed.

Data were coded and analyzed using grounded theory methods (Charmaz 2006; Strauss and Corbin 1998) and the computer software ATLAS.ti. Analysis began with open coding, in which all potentially significant phenomena, actions, and

meanings were labeled with codes. Each ethnographer coded their own field notes and interview transcripts, cross-checking their codes with the research team, and differences were resolved in team meetings. An initial codebook was developed as a result of inductive and deductive coding, memoing, and team discussion. ATLAS.ti “queries” were conducted that enabled thematic comparisons between data tagged with specific combinations of codes. Based on this process of refinement and elaboration of the codebook, a code labeled *chronic pain* emerged and was queried for this analysis. Line-by-line coding of these data was then conducted and subcodes emerged, such as *negotiating treatment* and *describing consequences*, which were then the subject of team discussion and analytic memos.

RESULTS

As with CHC more generally, the qualities that make up CHC with respect to pain medicine are context specific and shaped by the present political and economic transitions occurring within this domain of healthcare in United States. We describe three context-specific factors that shape the mobilization and impact of CHC in the field of pain medicine. First, we illustrate the contextual nature of what constitutes a resource, skill, or asset. Second, we demonstrate how the organizational structure of clinical practice has bearing upon the extent to which certain attributes or skills are cultivated between provider and patient and, in turn, have the potential to result in exacerbated disparities in care. Third, we describe how contemporary pain medicine intensifies extant concerns regarding pain’s invisibility, thereby heightening the importance of CHC and considerations of the social within the biopsychosocial.

Contextual Attributes of CHC

In her articulation of CHC, Shim (2010) identifies a number of qualities that tend to be rewarded in clinical encounters. These include knowledge of biomedical vocabulary, a proactive disposition toward one’s health, belief in the value of self-discipline and self-surveillance, and the skill to communicate efficiently with healthcare providers. We found that these attributes are increasingly valued within the current moment of pain management in the U.S. biomedical complex. Often, deployment of these skills and resources results in more agency and decision-making power over the distribution of pain medication among participants in our study. Failure

to demonstrate these qualities typically led to patients being labeled as high risk and consequentially having less control over decisions surrounding their pain management. We observed a number of instances in which patients were either effectively leveraging the specific resources of CHC or not, with correspondingly divergent results.

One way we observed CHC operating in the clinical setting was through patients’ varied willingness to comply with medical advice. For example, Linda, a thin black woman in her late 50s, lived in an unregistered van with her long-time partner, Harvey.³ Much of Linda’s pain came from cellulitis on her hands and legs that she said burn “like an oven.” This cellulitis resulted from levamisole cut into the crack cocaine that Linda took to manage her pain, and the resulting wounds became infected because she did not have reliable access to water to clean them; she was only occasionally able to pay \$20 in order to shower. Thus, much of Linda’s pain derived from her living environment and the complex structural conditions that led to her homelessness. Complicating this was also Linda’s strong aversion to seeking out treatment for her various medical conditions, which stemmed from a serious childhood illness in which she was subjected to several long hospitalizations, as well as several involuntary surgical procedures in adulthood. This aversion regularly resulted in life-threatening states requiring emergency interventions.

We observed multiple struggles between Linda and her CCM nurse case manager, Chloe, about getting her infections treated. “The infections can get down to the bone, and that’s when it gets to the point where it can be life-threatening,” Chloe said to Linda as she stood on the street outside of her van. “You don’t have running water—” Linda cut her off: “I have a hose.” Linda’s aversion to medical care made her reluctant to go to the emergency department for her pain unless, she said, her body felt “like it’s trembling, like it’s about to fall apart.” She avoided the emergency department because she knew that there was a good chance she would be admitted to the hospital and, as she put it, “picked and poked.” Her fears were not necessarily unfounded. During one hospitalization that occurred in the course of our study, for example, a team of residents and an attending physician surrounded Linda’s hospital bed, talking quickly among themselves about draining her infected finger. The medical team did not respond to any of Linda’s repeated inquiries as to what they were doing. One resident accidentally waved a pair of scissors close to Linda’s face, causing a nearby nurse to wince and

rush to Linda's side. Later, a pair of dermatologists asked Linda about a scar on her neck, wondering whether it was from a needle. "Do you inject anything?" they asked. Linda responded, with thick sarcasm, "At the hospital, they inject all sorts of things." One dermatologist responded, "So you never inject anything at home?" Linda sighed deeply and snapped back, "What did I just say? What. Did I. Just say." The pointed, repeated—and arguably, discriminatory—questions about possible injection drug use on the part of the medical teams compounded Linda's existing distrust in the health-care system, and she frequently repeated that she would rather sleep in her van than in a hospital bed.

Linda was unwilling to play by what Bourdieu (1977) would describe as the "rules of the game" when it came to her health. She avoided biomedical interactions, even when they could have prevented more serious health problems. In CHC terms, Linda did not adopt a proactive stance toward her health. Moreover, when she did wind up in clinical care, she was frequently belligerent with the care team and therefore was dismissed by providers as a difficult patient,⁴ resulting in poor treatment, further cementing her aversion to care. Rather than seeking opiates from emergency departments (as many patients with contested chronic pain resort to when they do not feel they have the medication they need), Linda turned instead to drugs obtained on the street in order to manage her debilitating pain. Her partner, Harvey, reported that Linda's pain caused her to howl in her sleep, and he felt compelled to go out into the night's urban activity, hoping to find something that might help. This behavior demonstrated to some providers that Linda was not interested in becoming an active shepherd of her own pain by making future-oriented decisions about her health and well-being, such as seeking out wound care and sticking to the medication prescribed to her. Linda and Harvey said that they knew that she could not afford to get hooked on the pills she bought on the street, as they were expensive and often made her sick. Yet because she relied upon illegally obtained pharmaceuticals and narcotics to treat her suffering, providers placed Linda in a high-risk category, and the amount of agency that she had over her pain management decision making was consequently limited. While the health impacts of substance use are frequently framed as the result of individual choices within the healthcare setting, understanding of these choices can be augmented by adopting a socio-biopsychological approach, which includes acknowledgement of the political and economic environment in which such choices

are made (Bourgois and Schonberg 2009; Van Natta et al. 2018). CCM providers were able to consider Linda's decision to use crack cocaine alongside her structural conditions, advocating for a treatment plan that accommodated the limitations of her living situation. Non-CCM providers were not always granted the time or resources to do so.

By contrast, we observed numerous clinical encounters with Richard, a large and soft-spoken black and Native American man with diabetes and disabling chronic pain, who was consistently able to self-present as someone eager to comply with medical advice. Richard was enrolled in several case management programs, one of which he had chosen to use for medication management. Rather than manage his opiate prescription on his own, Richard had elected to go to the case management office closest to his house twice a day so that he could take his medications under the supervision of a social worker and a psychiatrist. During one home visit, Richard was late to pick up his pain medications and was notably uncomfortable as a result. He sat stoically in his easy chair, answering the intake questions that the nurse case manager posed. However, his hand gripped the armrest and beads of sweat rolled down his face. Responding to the intake questions, Richard reported that his pain was currently at a 9 out of 10, with 10 being the worst imaginable pain. When the nurse case manager paused to ask if he would like to cut their visit short so that he could go and get his pain meds, Richard quickly shook his head no. He took a deep breath and said that he could wait. Although Richard had a history of substance use, he never had any issues obtaining opiates to control his chronic pain. In the several case presentations we observed in which Richard was discussed, he was never characterized as drug seeking in the way that other pain patients sometimes were. Instead he was deemed to be low risk by the CCM staff in part because of the fact that he elected to take his pain medication under the supervision of the case management staff. Whether deliberately or not, Richard was able to demonstrate his willingness to play by the rules, deploying the capital necessary to maintain some level of autonomy over his treatment protocol.

Other patients reported being aware of the effects of their dispositions and could strategically self-present in such a way as to demonstrate clinically desirable qualities, which in turn resulted in more agency over medical decision making. Rita, a Latina in her mid-50s, described her approach to discussing pain medication with providers in an interview:

Rita: If I go to the [emergency room] and they give me something for the pain, I'll tell them, "Yeah, but you can't give me too much. You can give me about 10 of those but not too much because I'm going to get in trouble."

Interviewer: Do they do it? Do they go along with what you . . .

Rita: Yeah, because I'm in pain. They can see I'm in pain.

Based on her previous experiences with her PCP, Rita had learned that downplaying her desire for pain medication resulted in more consistent allocation of opiates. Given pain's inherent invisibility, many pain sufferers struggled to demonstrate the intensity of their discomfort to their providers. However, Rita walked away from her medical encounter feeling as though the providers could *see* that she was in pain. By acting the part of the cautious and self-surveilling patient, whether strategically or not, Rita was able to attain the validation that so many pain patients seek and, in turn, was able to acquire the medication that she felt she needed to effectively manage her pain.

By contrast, we observed instances in which patients were less effective at acquiring the medication that they felt they needed to control their pain. Anna, a black woman in her 50s, who was admitted to the hospital after arriving at the emergency department with altered mental status, was widely perceived by the clinic staff as being a difficult patient. As one provider put it, Anna "has a history of getting down on the clinic floor and not getting back up." Following her hospitalization, Anna's pain medication needed to be adjusted because her kidneys were too compromised to effectively clear the medication from her system. As her providers tried to explain to her that her OxyContin dosage needed to be lowered to a safer level, Anna grew agitated. She began rocking and vigorously shaking her head back and forth. She hissed, "It's my body. Bottom line, I don't like nobody making all my decisions and making me feel stupid. I know my body!" She later admitted to doubling her dosage, and when her providers admonished her to follow the prescribed amount, she again grew angry. She began yelling, saying of the new, lowered dose, "This ain't nothin'! Weak ass shit." Anna referred to the numerous times when her opiate prescription had not been filled, and she consequently had to suffer through unanticipated cycles of withdrawal: "Middle of the night, asking for pain meds. I've been through this 100 times. Things always get fucked up. I'm lying on the floor, like a fish out of water."

While some patients, such as Rita, had learned through cumulative experiences and interactions how to effectively achieve their desired clinical outcomes, other patients had not acquired the CHC necessary to direct their clinical encounters. Anna's past history and present affect shaped the ways that providers perceived her. Further, her lack of demonstrated understanding of the negative side effects of OxyContin and her subsequent opposition to the safer, lower dose suggested to her providers that she was unable or unwilling to proactively manage her current medication consumption to prevent future negative health outcomes. All of this signaled to Anna's providers that she did not have the cultural know-how to effectively self-manage her pain; in turn, as we show below, many providers chose not to invest time and energy into cultivating Anna's capacity to leverage CHC. Throughout these exemplars, we see the ways in which participants' varied abilities to deploy CHC can result in differential care.

CCM: Structure of Practice

CHC is the result of numerous exchanges between provider and patient, a "collective achievement of patient-provider interactions" (Shim 2010:4). By communicating necessary health information to patients, and by signaling to them the type of patient that they would like them to be, providers can imbue patients with more agency, actively contributing to their capacity to mobilize CHC. Thus, CHC is in part a by-product of cumulative encounters between provider and patient. However, many providers are constrained within the current U.S. healthcare system from investing the time and resources necessary to impart valuable skills and information to patients. While our healthcare system would certainly function better if all providers were given the resources necessary to activate CHC in their patients, many providers—particularly those in safety-net settings—are also caught in the net of bureaucratic limitations that restrict their abilities to engage with patients in such a way that could effectively cultivate CHC. These institutional constraints, which impinge upon both patients and providers, may translate into deeper and wider gaps between those who are able to deploy the capital necessary in order to maintain agency over their pain treatment protocol and those who are given less say over how their pain is managed.

The CCM program that our study observed provided a window into the relational nature of CHC. The distinction between CCM staff and those

providers who were working in more traditional primary care or specialist settings was stark. The additional time and resources afforded to CCM staff allowed for a more active cultivation of CHC in patients, something that was not always possible within the time constraints of primary care or specialist appointments. One of the implicit goals of the CCM program was to transform high-utilizing patients into “activated” patients who would properly self-manage their conditions (Fleming et al. 2017; Thompson-Lastad et al. 2017). In this instance, proper self-management is defined by the administrators of the program, who are themselves responsible for quantifying, monitoring, and reporting on patient-level progress in order to remain fiscally relevant. Thus, we witnessed many situations in which CCM staff explicitly tried to imbue their patients with certain CHC qualities, such as health literacy and a proactive stance toward one’s own health. Due to the clinical arrangements of the CCM program, CCM staff were able to spend significant amounts of time with each patient, over a long duration, and therefore had a broader understanding of what capacities patients possessed and how best to cultivate those they did not. The structure of the CCM program allowed for deeper engagement with high-needs patients, such as daily phone calls and accompaniment to appointments with medical specialists. This type of care and attention would not have been possible in a conventional primary care setting, where full patient panels and limited time necessitate short and focused visits. Indeed, many non-CCM PCPs or specialists that we observed did *not* have the necessary resources to be able to invest in patients in the same way that CCM staff did. We observed many instances, then, of sharp contrast between the institutional arrangements that allowed CCM staff to work to cultivate CHC in their patients and the lack of ability on the part of non-CCM providers to do so. Thus, the CCM model of smaller patient panels, more intensive time with high-needs patients, and a team-based approach to care enabled CCM staff to better impart CHC to their patients through multiple interactions. Non-CCM providers, though often eager to foster CHC in their patients, lacked these infrastructural resources to consistently do so.

In the instance of pain management, this juxtaposition often played out around issues of medication decision making. Given the current landscape of pain management in the United States, providers were eager to transition their patients off opiates. This came as a shock to patients, who had long been dependent on opiates to manage their pain and cope

with daily activities. But on several occasions, we witnessed medical visits in which CCM staff were able to counsel patients around their pain management options in a more thorough and empowering manner than their non-CCM colleagues.

During an interview, one black patient described her experience at a previous, non-CCM care facility. A resident had placed her on methadone to control her pain, without presenting her with any alternatives. Unlike buprenorphine, an agent similar to methadone that is often prescribed to white patients with private insurance (Hansen and Skinner 2012), methadone requires daily office visits for each dose. Therefore, patients have less control over their treatment regimen, and accidental withdrawal from methadone is far more likely. Shortly after starting on methadone, this patient began to go through involuntary withdrawal. “[I] felt like a straight-up junkie,” she said. “I had the runs. I started sweating . . . I dug holes. I had dug a big hole right here on my leg.” Later, when she enrolled in the CCM program at her new clinic, she was presented with a wider array of options for managing her pain, including support groups, physical therapy, and acupuncture.

CCM staff frequently included patients in decision making about medication changes, with mixed success. Janelle, a black woman in her 20s with a painful autoimmune condition, met with her non-CCM PCP and her CCM nurse case manager together, in order to discuss her pain management strategy. Her non-CCM PCP, Dr. Wellin, told her that she was going to be transitioned off of oxycodone and onto buprenorphine. When Janelle asked for an explanation for this decision, Dr. Wellin responded that it was because she was experiencing highs and lows on her current medication regimen. Dr. Wellin outlined a plan for how they would manage her withdrawal from the opiates, and Janelle grew visibly upset. Later, when Dr. Wellin left the room, Janelle spoke with her CCM nurse case manager, Delia. Janelle expressed concern that this decision was made without her input, stating that she had not been experiencing highs and lows. “No one asked me,” she said, staring down at her hands. Delia listened and let Janelle know that she did actually have a choice in the matter. Upon hearing this from Delia, Janelle decided to remain on her current medication regimen rather than transition to buprenorphine, to the disappointment of her care team. Regardless, the CCM program found ways to try support her with her opiate use, even as she resisted intervention. In this instance, Dr. Wellin’s clinical time was not structured in such a way that

she was able to ask Janelle about her preferences or include her as an agential actor within the interaction. As a PCP, Dr. Wellin's goal for the clinical encounter was to ensure the long-term safety of her patient. Delia, however, had the additional goal as a CCM staff member of investing Janelle with the resources necessary to make her own choices about her care. Delia also knew that she would have ongoing contact with Janelle, whom she spoke with on the phone several times a week. She was therefore more confident in including Janelle in the decision-making process and communicating the measures that would need to be in place in order to ensure her safety as it related to opioid-related overdose. While Janelle's decision to maintain her opiate use may not be constituted as an unqualified success on the part of the CCM program, it does represent an effort to uphold the patient's agency over her medication decisions, something that could not be accomplished without the additional time and personnel resources afforded to the CCM team. Such an organizational context allows a CCM staff member the additional capability of investing patients with CHC that time-limited PCPs are not always able to provide.

For an additional illustration of the relational aspects of CHC, we return to the situation described previously, in which Anna had learned that her newly compromised kidney function meant that her opiate prescription would need to be significantly lowered in order to be safe. Anna sat on the side of her hospital bed next to Holly, her CCM nurse case manager. A young resident entered the room. He did not glance at Anna but rather directed his attention to Holly, introducing himself as Dr. Long. The two providers discussed the alterations in Anna's baseline status and the corresponding medication changes. Anna sat by and listened, her glance darting back and forth between Dr. Long and Holly. She heard Dr. Long say things like, "It's strange that . . ." and "We're concerned that . . ." Anna began to rock back and forth, growing increasingly agitated. Holly noted this and paused, taking a moment to sit down next to her patient. She placed a hand on Anna's arm and looked directly into her eyes. "I'm going to take a moment to talk to Dr. Long, and once I understand everything, I'll explain it all to you." Anna softened and her face brightened. "You know how I see things," she told Holly.

This is an instance in which Dr. Long, a resident, who may not have known how to include Anna, a patient with limited knowledge of her medical situation, in the conversation about her pain medication. He had limited time to get to know

Anna during her hospital stay and was under pressure to continue his rotations in order to attend to the other patients on the floor. Holly, however, had been working with Anna for many years and knew how to communicate with her in such a way as to both signal and elicit the type of patient behavior that would move the encounter along. Holly knew about Anna's history of acting out in clinical settings, and was able to engage with her in a meaningful and reassuring way, preventing Anna's anxiety from spilling over into an explosive scene.

The work of actively cultivating CHC is time and energy intensive, and many providers are not able to consistently engage in this work during their brief visits with patients. In her outlining of the concept, Shim (2010) recognized that the structures of the U.S. healthcare system place a large number of demands upon providers, who are constrained under the burdens of limited clinical time, extra administrative duties, and standards of efficiency. This is especially true for providers in safety-net settings, and "such constraints are likely to curb providers' abilities to work with patients to maximize the CHC available in the clinical encounter" (Shim 2010:6).

Contemporary Pain Medicine

As pain management undergoes a transition as a result of political and economic forces, the qualities that make up CHC with respect to pain patients are also undergoing a transition. As political narratives of the opioid crisis intensify, many hospitals are taking steps toward curtailing prescribing practices, particularly for patients deemed to be high risk; at the same time, contemporary health discourses and practices conflate disease and risk (Aronowitz 2009; Fosket 2004; Rose 2009), producing the always-already-at-risk patient. This was especially evident in the safety-net setting of our study sites, as providers attempted to mitigate the risks that they perceived surrounded opiate prescribing. Substance use in the CCM population makes providers vigilant against any attempts by patients to acquire more pain medication than is deemed medically necessary. Regulatory attempts to curb the opioid crisis require that providers be accountable for the medications they dispense in ways that they had not been before. The ongoing dynamic of substance use combined with the changing landscape of regulated prescribing makes the deployment of CHC even more important and consequential in contemporary pain medicine.

In the shifting landscape of opiate regulation, providers are more on guard when it comes to

potential diversion of opiates. Diversion, or the transfer of prescription medications from legal to illegal channels of distribution (Inciardi et al. 2009), includes the practice of selling pain medication on the street. This means that pain patients need to present themselves as low risk, managing any suspicion that they may be the type of patient who would take to reselling their pain medication. This translates into being willing to engage in a u-tox, or urine toxicology test, whereby providers are able to ascertain whether or not a patient is taking the prescribed medications (Ceasar et al. 2016); when u-tox results come back negative, diversion is suspected. While some patients ungrudgingly accept the requirement of a u-tox, others resist undergoing the test, for a variety of reasons.

We observed one situation in which a patient denied the results of her recent u-tox. Michelle, a black woman in her late 50s, was meeting with Dr. Smith, her CCM PCP, to discuss pain management options for her numerous musculoskeletal conditions. Toward the end of the visit, Dr. Smith noticed that Michelle had tested negative for opiates during her recent hospitalization. "I'm looking at your discharge summary, and they didn't find any Norco (an opiate medication) in your system," he said. Michelle grew agitated and told him that she takes her Norco. "I know better than any test that I have Norcos in my system!" She complained that he was treating her dismissively and that he could not possibly understand the pain she was experiencing. Dr. Smith responded, "I'm sorry you see things that way. How about I prescribe you one week of Norcos now, and then if your u-tox confirms that you are taking your medication, I'll prescribe you three more weeks' worth of pills?" Michelle was not satisfied with this proposal. She announced that she planned to find a new doctor and no longer wanted anything to do with the clinic. After she left the office, Dr. Smith said, "Michelle's brother sells drugs in a major way." Another patient had alerted the clinical team that this may be the case, and Dr. Smith suspected that Michelle was diverting a large portion of what he prescribed her. While Michelle did eventually decide to remain Dr. Smith's patient, their relationship remained tenuous, especially with respect to pain medication.

In this case, we see that both provider and patient are constrained by the current political and economic situation of pain management. The increased federal regulation on analgesic strategies often translates into hypervigilance on the part of the provider. Further, stories that circulate about diverting patients overdosing while hospitalized—as a result

of being given the prescribed amount of opiates rather than the amount they are actually taking following diversion—increases providers' concerns about patient safety. Providers, then, are expected not just to provide care but also to surveil and enforce, monitoring patient behavior typically relegated to law enforcement. In turn, patients are expected to self-present as low-risk, law-abiding citizens who are not a threat to the integrity of the provider's practice. Thus, in current pain management settings, CHC includes qualities of compliance with the law, not just with biomedical advice.

By contrast, we observed one instance in which a patient who was suspected to be diverting his opiate pain medication met with little resistance from the clinical team. Edgar, a black man with intense chronic pain from his lifelong struggle with sickle cell anemia, was living in a hotel. During case presentations on Edgar, providers mentioned their suspicions that he was diverting his meds, but they were not overly concerned about the risks associated with Edgar's practice of selling opiates on the street. His nurse case manager shrugged and stated that Edgar was being prescribed his opiate prescriptions from hematology. "I know the opiates are a problem," she said, but her assertion that he was working with hematology reinforced that they were not her problem, *per se*. Moreover, Edgar's pain was the result of a medical condition that could be scientifically verified. The extent to which pain can be categorized as a contested illness (Brown 2007) is contingent at least in part upon its lack of a biomarker, or a way in which it can be made visible via scientific practices. In the case of Edgar's sickle cell, in which a lab test would reveal sickle-shaped hemoglobin in his red blood cells, the resulting pain is not contestable.⁵ However, whether or not pain can be made visible is not enough on its own to determine how much agency a patient will have over treatment, as we see through the previous example of Linda, whose hands were covered in noticeable wounds but whose active substance use and unwillingness to comply with medical advice resulted in her having little say over her care. The specificity of Edgar's medical condition also meant that he was under the care of a specialist, which lightened the burden on his team of general medicine providers. While providers' concern about diversion is by no means exclusively a reflection of their potential culpability, in this instance, being able to share the risks associated with opiate misuse with another clinical team resulted in less pressure on Edgar's primary care team to monitor and surveil his prescription. These factors, all favorable on

their own, were then seemingly compounded by Edgar's personality: his case manager went on to tell the others at the clinic meeting that "he has good language skills. He can hold a conversation—it's stimulating." While we cannot know for sure the balance of factors that worked to remove Edgar from the weight of their surveillance (if not wholly from their suspicion), the nurse's report that he could engage in stimulating conversation, among other things, resulted in Edgar having more say over his pain management protocol. This illustrates that, in terms of CHC, whether and how patients can manage their interactions are never based on one factor, such as race or active substance use, but on how those are balanced and negotiated against and in combination with other CHC attributes.

As already mentioned, another historical specific and contextual aspect of current U.S. health-care shaping the mobilization and influence of CHC is the fact that conditions need to be quantifiable in order to be actionable. This poses complications for pain patients, who are not yet able to point to a biomarker in order to demonstrate veracity of their symptoms. We observed how the challenges of pain's invisibility, for both providers and patients alike, play out in the clinic. For instance, when patients were checked in for their visits, the medical assistant (MEA) consistently asked pain patients to rate their pain on a scale of 1 to 10. "Eleven" was a common response. This was met with raised eyebrows, and the MEA sometimes reflected back, "Eleven? Then you should be in the emergency room." To this, patients responded in a variety of ways, often in an effort to make their pain more concrete. Sometimes, patients launched into the origin story of their painful condition, recounting traumatic and violent stories. "I got hit with a baseball bat when I was younger," recounted one patient. Another patient recounted a history of domestic violence. This augments findings that black pain patients will often engage in moral boundary work to lay claim to their symptoms, referencing trauma and discrimination, as opposed to the biomedical evidence pointed to by their white counterparts (Pryma 2017). The skepticism on the part of the MEA was perhaps tied to narratives about the "chronic pain player" that are so deeply embedded in the context of the urban public hospital. Providers are inundated with experiences and shared stories about patients who are trying to work the system, so to speak, and get high dosages of pain medication for resale on the streets. Many providers also hold concerns about addiction, abuse, and the risk of overdose, given both the opioid epidemic and their

own prescribing experiences. This in turn produces vigilance in providers about patients that are characterized as high risk, which is determined based on the patient's social attributes (Crowley-Matoka and True 2012).

DISCUSSION

As the opiate crisis continues, patients and providers alike face additional restrictions when it comes to pain management. As one provider put it, when presenting a patient with a plan for transitioning her off of opiates, "We'll lay out your options, so you fully understand what you're up against." This odd juxtaposition—pairing "options" with the sense of being "up against" something—captures the constrained circumstances that many patients and clinicians feel when trying to treat chronic pain.

The power differentials illustrated through the examples presented above indicate a widening gap between those who possess CHC and those who do not, in the arena of pain medicine. While capital is accumulated through individual interactions and experiences, these experiences are organized by social position. In other words, "our everyday actions today are shaped, though not determined, by our structured, stratified pasts" (Chang et al. 2016:105). A lack of ability to mobilize CHC begets fewer opportunities to acquire more capital, which in turn results in less favorable clinical encounters.

It is not incidental that Anna, Linda, Janelle, and Michelle are all black women living in extreme poverty. As the literature demonstrates, those in structurally disadvantaged positions are more likely to experience the ill effects of disparities in pain management. Indeed, opiates have long wreaked havoc within communities of color, and reforms were introduced only after national attention coalesced around the widespread opiate addiction of the suburban middle class (Hansen and Skinner 2012). While many of the safety-net patients we observed were navigating the treatment of chronic pain, the cases of these and other black women emerged as relevant for an analysis of power within the arena of pain management. Those who occupied different status positions were more likely to achieve their pain management goals, such as was the case for Rita, Richard, and Edgar described above, who were either not black or not female. As described by both Shim (2010) and Chae et al. (2011), race impacts a patient's care through both macro and micro effects, as institutional racism is often refracted through the clinical encounter, stratifying pain management along racial lines. By

extension, we observed much of this same process occurring with respect to gender and socioeconomic status. While a history of substance use often played a role in stigmatizing patients, this varied along with a patient's ability to mobilize CHC (Chang et al. 2016), as we see in the distinctions between Linda's and Edgar's care.

Empirical support for the traditional formulation of the biopsychosocial model, with its emphasis on individual characteristics, was not reflected in what we observed regarding pain management in this urban safety-net setting. Instead, we saw a situation that much more closely mirrors Chae and colleagues' (2011) reformulation of the model, which attests to the broader structural factors that impinge upon psychological and biological health. The social aspects of health—represented here by institutional arrangements, political valences, and inequities of care—were evident through many of the clinical encounters we observed.

The subjective, internal nature of pain has always rendered it a challenging condition to treat and always an entrée point for stratifying processes. In the midst of the opioid crisis, pain becomes even more complicated to manage, and treatment even more stratified, leaving providers and patients constrained by social and political circumstances. A move toward the biopsychosocial model of pain management may in fact be an appropriate transition, given the fallout from an overreliance on pharmacological solutions. However, as long as the biopsychosocial model fails to account for the structural conditions brought about by the inequitable distribution of CHC described here, application of the model runs the risk of reinforcing neoliberal notions of patient responsibility and empowerment discourses. As pain medicine evolves and transforms, an understanding of how power circulates through and beyond the clinical encounter is necessary in order to avoid exacerbating the stratification of suffering.

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NOTES

1. We conceptualize pain medicine as a transdisciplinary arena, in which the expert knowledges and practices of multiple disciplines coalesce around a single problem (Max-Neef 2005).
2. Cultural capital is embodied in one's habitus, or social position, which in turn shapes one's actions and often reinforce that position. However, while habitus informs behavior, Bourdieu was clear that people still possess agency and thus their social positions are not determined (Chang, Dubbin, and Shim 2016).
3. All names are pseudonyms.
4. Studies have demonstrated that when pain patients present as "difficult" or untrustworthy, the quality of care that they receive is diminished (Buchman, Ho, and Illes 2016).
5. While the literature on sickle cell reveals racial disparities in pain management (Rouse 2009), the uncertainties identified as contributing to these disparities does not include uncertainty of etiology. When pain results from an unidentified source, the complex relationships between race and cultural health capital can exacerbate disparities in care.

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