

The Possibility that Men and Women Experience Pain Differently Has Significant Legal and Ethical Implications

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A recent Washington Post article reported on the growing recognition that men and women likely “process pain information differently and act on it differently.”¹ While this notion has enjoyed a quasi-official imprimatur since at least 1998, when NIH convened a panel on the subject, several different studies and a recent University of Maryland Dental Conference have all provided mounting evidence for a clinically important difference in pain qualia between men and women.

Of course, establishing a statistically significant difference is only the first step in a very long journey, which would need to include much more specific information, given pain’s extremely complicated, multivariate nature. “Researchers are still trying to learn how much of the rise is sex-related and how much is tied instead to such factors as age, personality and overall health.”² Given the ineluctably subjective nature of pain, it is somewhat unsurprising that there is significant variability between men and women, though admittedly such variability is not predicted by the significant individual variability in pain qualia and response.³ This is in part what makes the need to disentangle the well-known individual variability of pain qualia from a general, statistically and clinically significant difference in pain qualia across gender so important.

Though the article cautions that “there is not enough evidence to steer patients toward different pain relief options at the start of treatment on the basis of sex alone,”⁴ the potential applications of a statistically and well-understood difference in pain qualia between men and women raises significant clinical and research questions:

For example, since studies show that men’s tendency to delay pain treatment increases their risk during a heart attack, should pain scales be sex-specific to ensure more-prompt care? Or should women in a clinical trial of pain medication all start painkillers on the same day of their menstrual cycle so that researchers can factor in how estrogen might relieve or exacerbate pain – and whether women need different doses of pain relievers than men?⁵

¹ Francesca Lunzer Kritz, *Not Feeling Each Other’s Pain*, WASH. POST, Dec. 19, 2006, at HE01.

² *Id.*

³ As the article notes, “[c]linicians are increasingly aware, however, that one person’s pain reliever may not do the job for another.” *Id.* Given the epidemic of undertreatment of pain in the U.S., one might question just how aware clinicians are of this, but the general point (that, because pain is a subjective experience, what works for one individual may well work less well or not at all for another individual) nevertheless seems sound.

⁴ *Id.*

⁵ *Id.*

There are also legal implications of a potentially significant clinical difference between the way men and women experience pain. The undertreatment of pain is currently a nationwide⁶ epidemic. Though the myriad reasons for this deficiency are both intricate and, at this point, poorly understood, there are some legal barriers to adequate pain management that are under close examination. The Pain and Policy Studies Group (“PPSG”) at the University of Wisconsin released a 450-page report in 2003 detailing the statutes and regulations regarding opioid management on both the state and the federal level.⁷ The PPSG’s recommendations are aimed at promoting the principle of “balance” on the policy level:

The principle of *balance* is fundamental to international and national drug control policy and asserts that efforts to prevent abuse of opioid analgesics, while necessary, should not interfere with medical practice and patient care. Balanced policy recognizes the legitimacy of controlled substances prescribing for pain management.⁸

If men and women experience pain differently, and if that difference can be translated into clinical practice in terms of divergent treatments for pain based partly on gender, that would necessarily seem to have implications for the balance that is sought between legal efforts to prevent opioid abuse and the need for opioids in the provision of legitimate medical care. That is to say, the existence of a clinically significant difference in pain qualia between men and women might well justify different balancing in pain policy across gender.

A different kind of balancing might carry a number of different legal and policy ramifications. First, there are the obvious differences that the DEA might have to adopt with regard to preventing diversions depending on the client base the given provider is serving. If, for example, a pain clinic or even an individual provider limits their practice to either men or women, one might expect to find over time that such entities end up prescribing different kinds and different dosages of opioid analgesics.⁹ The DEA might

⁶ The problem is arguably global, as numerous industrialized nations (Canada, Denmark, Japan, etc.) report significant undertreatment of pain in, for example, elderly populations. See, e.g., Betty R. Ferrell & Bruce A. Ferrell, *An International Perspective on Pain in the Elderly*, in PAIN IN THE ELDERLY 119 (Betty R. Ferrell & Bruce A. Ferrell, eds., 1996).

⁷ Pain & Policy Studies Group (“PPSG”), *Achieving Balance in Federal & State Pain Policy: A Guide to Evaluation*, 2nd ed. (2003), Executive Summary, http://www.medsch.wisc.edu/painpolicy/2003_balance/ (accessed Jan. 15, 2006). It is crucial to note here that while many of the legal barriers to pain management arise out of the strict regulation of opioid analgesics, there is virtually no debate that pain is managed optimally only through multidisciplinary efforts and modalities. See, e.g., William Breitbart et al., *The Network Project: A Multidisciplinary Cancer Education and Training Program in Pain Management, Rehabilitation, and Psychosocial Issues*, 15 J. PAIN & SYMPTOM MGMT. 18 (1998); accord MK Merboth & S. Barnason, *Managing Pain: The Fifth Vital Sign*, 35 NURS. CLIN. N. AM. 375 (2000) (stressing the importance of a multidisciplinary approach). Of course, many kinds of pain are best treated through opioid analgesics, which is partly what makes the regulation of opioids such an important factor in pain management. See PPSG Report, Exec. Summary (observing that “there is a medical consensus that opioid analgesics are indispensable for a variety of pain types, particularly if pain is severe”).

⁸ PPSG Report, Executive Summary.

⁹ Again, this assumes the existence of a clinically significant difference in pain qualia, and that such a difference can be effectively translated into clinical practice.

well have to tailor its enforcement policies to the different prescribing practices of providers who exclusively treat either men or women.

Second, the above concerns regarding the possibility that different levels of anesthesia might be needed for women then for men suggest some obvious implications for medical malpractice litigation. If solid evidence were to be produced showing that pain differs across gender, that would affect a fact-finder's determination of whether the application of a given amount of anesthesia violated the applicable standard of care (the prerequisite being that such findings of clinically significant differences as to pain qualia would change the standard of care).¹⁰

Third, and in turn, any possible changes in the liability and standard of care contexts would reverberate in all manner of quality control mechanisms for health care entities and insurers. Peer review committees would necessarily have to account for some of the relevant differences, and akin to the possibility that the DEA would have to adjust its enforcement policies depending on the prescriber's client base, insurers might have to adjust premiums to account for the same variables. Insurance is an industry devoted to assessment and management of risk, and insofar as the risk to the provider of prescribing pain medications or operating a pain management clinic fluctuates according to gender (as it might if DEA enforcement policy is tailored to address differences in prescription practices across gender), differing premiums may be needed.¹¹

Fourth, there is significant controversy regarding whether inmates being executed via lethal injection are undergoing so much pain prior to death so as to render the process unconstitutional.¹² Though the vast majority of Death Row inmates are men,¹³ the existence of a clinically significant difference in pain qualia might well suggest that different kinds or different levels of anesthesia might be needed for male inmates than for female inmates. Given the difficulties that several states are having convincing courts that their procedures for ensuring adequate anesthesia are sufficient, the mere possibility of an additional confounding variable in the debate is significant.¹⁴

¹⁰ Professors Koenig & Rustad have argued that tort remedies are gendered, and conclude that both tort reform efforts and regulatory action will have different effects for men and for women depending on whether the particular tort or set of torts targeted by the policy efforts are gendered male or female. See Thomas Koenig & Michael Rustad, *His and Her Tort Reform: Gender Injustice in Disguise*, 70 WASH. L. REV. 1, 87 (1995). If Koenig & Rustad's analysis is accurate, the specter of different standards of care across gender in malpractice cases involving anesthesia hardly seems far-fetched.

¹¹ While research does not reveal any articles addressing this possibility, Diane Hoffman argues that prevailing managed care and health insurance products may themselves constitute barriers towards adequate pain management. Diane Hoffman, *Pain Management and Palliative Care in the Era of Managed Care: Issues for Health Insurers*, 26 J. L. MED. & ETHICS 267, 267-68 (1998). One of Hoffman's premises is that pain management presents all sorts of difficult issues for health insurers. See *id.* at 268-271. If this is so, adding gender as an additional confounding variable may have important implications for insurance coverage and policy.

¹² Daniel S. Goldberg, *Controversy Over Lethal Injection Procedures Implicates Complicated Questions of Pain Assessment*, Health Law Perspectives, Jan. 08, 2007, [http://www.law.uh.edu/healthlaw/perspectives/2007/\(DG\)LethalInjection.pdf](http://www.law.uh.edu/healthlaw/perspectives/2007/(DG)LethalInjection.pdf).

¹³ See Death Penalty Focus, Women and the Death Penalty, <http://www.deathpenalty.org/index.php?pid=women&menu=1> (last visited Jan. 26, 2007).

¹⁴ See generally Goldberg, *supra* note 15.

Again, none of these possibilities should be read as predictions. The recent findings are preliminary, and do not yet constitute evidence that should guide clinical decision-making. The point is simply to suggest some of the myriad ways in which our assumptions and beliefs about pain influence law and policy, and to show that altering those assumptions and beliefs can have extensive effects in a variety of legal and policy contexts.

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