When a child experiences a fracture and seeks emergency care, one would expect that a standard approach or algorithm exists to ensure pain is controlled adequately and consistently, regardless of race or ethnicity. Is that what actually happens? Goyal et al (10.1542/peds.2019-3370) conducted a 3-year retrospective cross-sectional study of children less than 18 years of age with long bone fractures seen at 7 emergency departments that were part of the Pediatric Emergency Care Applied Research Network Registry (PECARN). The authors reviewed more than 8500 patients to determine if any analgesic was used, whether an opioid was given, whether there was a 2-point reduction in a ten-point pain score, and whether the patient experienced optimal pain reduction on reassessment of their pain. Although 86% of patients got an analgesic, non-Hispanic blacks were more likely to receive an analgesic compared to non-Hispanic whites and achieve more than a 2-point reduction in pain, and yet were less likely to receive opioids or achieve optimal pain reduction.

Why is this? We asked Drs. Jean Raphael and Suzette Oyeku to share their thoughts about this in an accompanying commentary (10.1542/peds.2020-0512). They provide several reasons for these racial and ethnic differences but focus their commentary on the role that implicit bias may be playing, meaning perceptions, often stereotypical ones, that act on us in an unconscious manner—and can manifest themselves in the differential management of pain experienced by different ethnic and racial groups. The good news is that Drs. Raphael and Oyeku don't just provide a rationale for the differences in pain management but also offer suggestions to reduce these differences and overcome our implicit biases. With the explicit bias of knowing you will learn from this study and commentary, take a break (just not a fracture), and link to both articles.