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Patient Health Care Disparities in Shoulder Instability Surgery

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PURPOSE

To synthesize how race, ethnicity, sex, socioeconomic status, insurance, geography, health literacy, and trust shape access to, treatment of, rehabilitation after, and patient experience across shoulder instability care.

Background and review approach

Why this review matters

Surgical stabilization can restore stability and function after recurrent anterior shoulder instability, yet access to treatment and outcomes remain unequal. Orthopaedic research frequently underreports race, ethnicity, and socioeconomic context, limiting precise estimates of inequity.[4,8]

In a survey of 305 American Orthopaedic Association members, 12% believed patients received different care based on race or ethnicity, and only 1% reported disparities in their own practice.[9]

Review approach

PubMed-based narrative review. We identified and synthesized papers examining how race and ethnicity, sex, socioeconomic status, insurance, geography, health literacy, language, and trust influence shoulder instability care.

Instability-specific studies anchored the synthesis. Broader shoulder and orthopaedic evidence supplemented areas where direct evidence was sparse. Associations do not establish a single cause, and several barriers may affect the same patient.

How disparities accumulate

1. **Limited specialty access**
   Insurance restrictions, geography, and clinic availability
2. **Delayed evaluation and imaging**
   Missed follow-up and slower access to advanced imaging
3. **Recurrent instability and structural damage**
   Additional dislocations, bone loss, and cartilage injury
4. **More complex treatment and recovery**
   Delayed surgery, rehabilitation barriers, and poorer experiences

Multiple barriers may affect the same patient and compound across the course of care.[11,13–15,18,19]

Preoperative disparities

Preoperative barriers can delay definitive care and allow recurrent instability and structural damage to accumulate. The strongest shoulder-specific evidence concerns access, utilization, and disease burden before surgery.

Specialty access and follow-up

Only about half of patients received orthopaedic follow-up after an emergency department visit for shoulder dislocation. Patients without private insurance were less likely to undergo stabilization, and Medicaid patients often waited until specialty consultation for advanced imaging. Medicaid clinic availability fell as low as 18%; patients passed 5.5 fellowship-trained surgeons on average and traveled up to 51 miles, versus 14 miles for private insurance.[11,13,14,19]

Timing and surgical utilization

White patients were 2.47 times more likely than Black patients to undergo stabilization in the same calendar year after emergency presentation. In another study, Medicaid patients waited 1,640 days from injury to surgery compared with 1,237 days for patients with other insurance and were 3.3 times as likely to experience five or more instability events before surgery.[11,14]

Disease burden at presentation

Black and Asian patients presented with more glenoid bone loss, Hill-Sachs lesions, and prior dislocations; Black patients also had more articular damage. Greater social deprivation was associated with recurrent instability and lower early surgical utilization.[15,18]

Gender-based referral patterns, trust, and communication

Women experienced lower referral and surgical utilization in orthopaedic care; only 5.8% of practicing orthopaedic surgeons were women in 2018. Shoulder-instability-specific evidence by sex remains limited. Racial and ethnic minority patients have reported lower trust and perceived bias, which can weaken engagement and satisfaction.[17,20]

Intraoperative disparities

Operative time and length of stay

After total shoulder arthroplasty, Black patients had longer operative times and hospital stays than White patients after adjustment. Black patients also had longer operative and discharge times after arthroscopic rotator cuff repair. These differences have not been established for shoulder instability procedures.[4]

Pain management

Broader pain-care literature reports racial and ethnic differences in opioid prescribing and specialist referral. Direct shoulder-instability evidence is sparse, so these findings identify measures for focused study rather than a cause.[21,22]

Postoperative disparities

Rehabilitation and physical therapy

Greater socioeconomic deprivation was associated with more missed physical therapy visits after arthroscopic shoulder labral repair.[26]

Complications and readmission

Across orthopaedic procedures, the 30-day unplanned readmission rate was 4.2%. Minority status and Medicaid insurance were among the strongest predictors.[23]

Treatment after failure

White patients had the highest revision and recurrent-instability rates after Bankart repair in one cohort. Clinical risk and access to corrective surgery may both shape this pattern.[25]

Patient experience and satisfaction

Median satisfaction after Latarjet was 98.5%, while 6.3% reported poorer experiences associated with factors including socioeconomic status. Race, ethnicity, and language may also influence trust and satisfaction.[20,27]

Future directions

Shoulder-instability-specific research remains limited in intraoperative care, pain management, and sex-specific outcomes.

- Standardize collection of race, ethnicity, language, socioeconomic, insurance, and geographic measures in shoulder instability cohorts.
- Measure operative processes, pain management, rehabilitation access, and patient-reported outcomes across groups.
- Test multilingual education, care navigation, and specialty-access interventions.
- Expand sex-specific research and improve diversity within the orthopaedic workforce.

Conclusion

Disparities can accumulate across access, surgery, rehabilitation, and patient experience. Because several barriers may affect the same patient, equity efforts should connect specialty access,

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