



The fifth vital sign: A complex story of politics and patient care

In this issue of the *Journal*, Dr. Marissa Galicia-Castillo (page 443) discusses the use of opioids in older patients with persistent (formerly known as chronic) pain. Even though she devotes one and a half pages to the side effects of chronic opioid therapy, I am sure that in the current environment many readers will perceive her as expressing a surprisingly supportive tone regarding the use of these medications. The times have changed, and the difficulties and complexities of trying to help patients with ongoing pain have increased.

In the mid-1990s, the American Pain Society aggressively pushed the concept of pain as the fifth vital sign.¹ Their stated goals included raising awareness that patients with pain were undertreated, in large part because in the Society's opinion pain was not regularly assessed at physician office visits or even in the hospital after surgery. Half a decade later the Joint Commission and others hopped on this train, emphasizing that pain needs to be regularly assessed in all patients, that pain is a subjective measure, unlike the heart rate or blood pressure, and that physicians must accept and respect patient self-reporting of pain. Concurrent with these efforts was the enhanced promotion of pain medications—new highly touted and frequently prescribed narcotics as well as nonnarcotic medications re-marketed as analgesics. Opportunistically, or perhaps wielding inappropriate and sketchy influence, some drug manufacturers in the early 2000s funded publications and physician presentations to encourage the expanded use of opioids and other medications for pain control. In a recent CNN report on the opioid epidemic, it was noted that the Joint Commission published a book in 2000 for purchase by doctors as part of required continuing education seminars, and that the book cited studies claiming “there is no evidence that addiction is a significant issue when persons are given opioids for pain control.”² According to the CNN report, the book was sponsored by a manufacturer of narcotic analgesics.² Lack of evidence is not evidence supporting a lack of known concern.

Step forward in time, and pain control has become a measure of patient satisfaction, and thus potentially another physician and institutional rating score that can be linked to reimbursement. This despite reports suggesting that incorporation of this required pain scale did not actually improve the quality of pain management.³ I suspect that most of my peers function in the outpatient clinic as I do, without much interest in what was recorded on the intake pain scale, since I will be taking a more focused and detailed history from the patient if pain is any part of the reason for visiting with me. The goal of alleviating a patient's pain, whenever reasonable, must always be on our agenda. Yet, while we need to respond to scores on a somewhat silly screening pain scale, the hurdles to prescribing analgesics are getting higher.

The latest data on opioid-related deaths are sobering and scary. Organized medi-

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cine must absolutely push to close the pain-pill mills, but is the link really so strong between thoughtful prescribing of short- or even long-term opioids and the escalating “epidemic” of opioid complications that we should not prescribe these drugs? Does the fact that we don’t have good data demonstrating long-term efficacy mean that these drugs are not effective in appropriately selected patients? Is it warranted to require regular database reviews of all patients who are prescribed these medications? Is it warranted, as one patient said to me, that she be treated like a potential criminal begging for drugs when her prescriptions are up, and that she be “looked at funny” by the pharmacist when she fills them?

An increasingly discussed concept is that of central generalization of pain, and patients who have this may be opioid-resistant and, perhaps, prone to developing opioid hyperalgesia. It has been studied in patients with fibromyalgia and is now felt by some to include patients with osteoarthritis and other initially localized painful conditions. Whether or not this concept ultimately turns out to be correct, it adds another dimension to our assessment of patients with pain.

The time has come to move past using a one-size-fits-all fifth vital sign (“How would you rate your pain on a scale of 1 to 10?”) and reflexively prescribing an opioid when pain is characterized as severe. But, if the patient truly needs the drug, we also need to move past *not* writing that prescription because of headlines and administrative hurdles. This is a much more complex story.



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1. **American Pain Society Quality of Care Committee.** Quality improvement guidelines for the treatment of acute pain and cancer pain. *JAMA* 1995; 274:1874–1880.
2. **Moghe S.** Opioid history: from ‘wonder drug’ to abuse epidemic. www.cnn.com/2016/05/12/health/opioid-addiction-history/. Accessed May 16, 2016.
3. **Mularski RA, White-Chu F, Overbay D, et al.** Measuring pain as the 5th vital sign does not improve quality of pain management. *J Gen Intern Med* 2006; 21:607–612.