

No More “Fifth Vital Sign”: Is the New AMA Recommendation Helpful?



These days one can hardly open a newspaper or turn on the TV or smart phone without finding yet another story about the opioid epidemic. Government legislatures pass laws funding efforts to address this crisis. Politicians weigh in with their opinions on causes and fixes. And of course the medical community has to weigh in.

The recent American Medical Association (AMA) recommendation, which was announced during its annual meeting in Chicago in June 2016,¹ that pain be removed as a “fifth vital sign” in professional medical standards was distressing to me as a pain management physician. It tells us that the AMA has fallen victim to the one-sided approach to solving the drug abuse, addiction, diversion, and overdose death problems by laying the cause at the feet of physicians who prescribe opioids, and therefore concluding that the solution is to dry up the source of legally prescribed drugs.

The absurd method that the AMA recommends is simply not to ask. The principle behind this is that if we don’t know about a patient’s pain, we don’t have to deal with it! Don’t ask, bury your head in the sand, and pretend it doesn’t exist. The idea is that you will then have to write fewer opioid prescriptions, which will then solve the opioid crisis. The illusion that this announcement by the AMA will be efficacious will succeed only in preventing the AMA from putting additional effort into formulating a more effective plan.

Fifth Vital Sign—A Reminder to Ask About Pain

What’s wrong with advising removal of pain as the “fifth vital sign”? For one thing, it addresses the wrong setting—pain in the hospital. When it became apparent about 20 years ago that some hospitalized patients were receiving

inadequate treatment for their pain, the Joint Commission on Accreditation of Healthcare Organizations established pain as the “fifth vital sign” so that more attention would be paid to inpatients’ need for analgesia. But even now, despite improved treatment of acute pain in inpatients, too often we hear from our patients about inadequate treatment of their chronic pain during hospital or emergency rooms visits for acute problems.

In the office setting, pain has never been considered an objective “vital sign.” The other vital signs are measurable whereas pain is subjective. We try to pin it down by asking patients to rate their pain on a scale of 0-10. This is indeed useful in that it allows for some comparison of pain levels following the institution of some treatment. In my opinion, the utility of the “fifth vital sign” concept is that it reminds clinicians to pay attention to pain. Not only is it designed to get them to ask about pain, but it can also produce an increased willingness of health care professionals to listen to what patients say about their pain. After all, pain is the most common reason that patients see their doctor. And in some cases—those patients who don’t volunteer pain complaints, especially older patients—it encourages them to tell us what’s really going on.

The problem with hearing about pain is that dealing with it isn’t fast and easy. Although some clinicians do their best to avoid prescribing opioids altogether, many others do the opposite—any mention of pain results in automatic prescription of opioids. And for patients with chronic pain, mention of increased pain results in an increase in dosing of pain medications. What is forgotten is that pain is a symptom and requires additional information. And this means additional involvement on the part of the clinician.

Only the Start of A Conversation

Hearing about pain constitutes only the “start of a conversation,” as I like to say. It requires a diagnostic evaluation and then determination of optimal treatment approaches. This means not only getting the details of the symptoms, but, importantly, getting to know your patient. Just having a number from 1 to 10 is not enough. What is your patient’s day-to-day life like at present? What activities are they able to perform and what are they unable to do? What type of job do they have? How is their sleep? What physical, psychosocial and/or financial stressors are present in their life? If they are able to walk their dog, how big is the dog and how long do they walk?

It is crucial to assess function when treating chronic pain. One example is the new patient with 10/10 chronic back pain who is prescribed an opioid. On the next visit he states he is improved to 5/10, and then returns on the subsequent visit and says the pain is now 8/10 so he needs more. Why? Too many prescribers will immediately think “tolerance” or “noncompliance.” Did you?

Most commonly, the explanation is that the decreased pain resulted in increased activity, which then resulted in more pain. The patient’s function has improved. In this case, increasing the dose is appropriate.

As my colleague Bennet Davis, MD, has pointed out, function is the universal measure of outcome success in the treatment of COPD, heart failure, diabetic neuropathy, fatigue, headache, etc. And function needs to be the ultimate measure of success in treating pain.

At the initial presentation of a chronic pain problem, it’s useful to ask the patient about the history and to obtain records of prior evaluation and diagnostic tests, as well as treatments

tried. But it’s not enough to simply make a list of what medications or physical therapy (PT) attempts “didn’t work.” Was the medication stopped because of side effects? Or was it simply never increased to effective doses? Was PT “ineffective” because the patient never followed through on home exercises? Such questions need to be asked.

Diagnosis often yields other effective strategies besides opioids. When it comes to chronic pain, patients may benefit from PT and a home exercise regimen, behavioral health assessment and therapy, massage, and alternative approaches. Neuropathic pain may be alleviated with anticonvulsants. Interventionalist pain specialists can provide injections and other interventional strategies. Patients who have difficulty engaging in their treatment, in making lifestyle changes regarding smoking, weight, etc., and in following through with medications and referrals will most likely not benefit from opioids unless and until they participate in behavioral health treatment.

Patient Education About Pain

Another important element is patient education. Many patients with chronic pain mistakenly believe that an achievable goal is to bring their pain level down to zero. Such patients will never be satisfied with their treatment regimen, continuing to ask for an increase in doses. They need to be taught what realistic outcomes are. For example, I’ve explained to my patients that a new treatment that reduces pain by 30%-50% is good enough to publish!

Of course, some patients abuse or misuse their prescribed opioids. Some are addicted, some are using opioids to solve their financial problems, some are taking opioids primarily to treat anxiety. That’s why prescribing chronic opioids requires the practitioner to know the individual patient and to

“trust but verify.” Urine drug screening and following through on unexpected results; querying your state’s online Prescription Drug Monitoring Program website to learn the patient’s prescription history; and documenting no-shows, requests for early refills, reports of lost or stolen prescriptions—all this must be done.

This leaves clinicians with several choices:

- In an attempt to “help” your patients who have pain, simply increasing their dose when they ask you without further assessment, adding other sedative drugs, not paying attention to the patient’s function, and keeping on doing more of the same—increases the risk of drug overdoses and diversion.
- In line with the new AMA recommendation, don’t ask patients about their pain level. Or don’t ask about pain at all, so that you don’t

have to address the pain problem and can thus avoid the possibility of having to deal with prescribing opioids.

- Recognize that rather than simply eliminating a single question about pain level, we need better approaches to assessment and treatment of chronic pain in our health care system and to prescribing opioids. We need more focus on function, and on providing truly patient-centered care.

Which will it be? Yes, it’s more efficient to bypass diagnostic evaluation, and it’s even simpler to just not ask so that you don’t have to address the pain problem at all. But are these approaches in the patient’s best interest? Surely the belief that not asking about pain is an effective solution to the opioid abuse problem is the antithesis of caring about our patients. Instead of issuing recommendations that just look like they’re doing something,

our professional organizations need to widen the scope of education they sponsor.

To really help a large proportion of patients (those with chronic pain), clinicians need more education about the outpatient management of pain and the key role of function. Recommending discontinuing calling pain the “fifth vital sign” will do nothing to advance the cause and instead may be a step back. ■

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Reference

1. American Medical Association. Physicians take steps to address opioid overdose epidemic. *AMA Wire*. <http://www.ama-assn.org/ama/ama-wire/post/physicians-steps-address-opioid-overdose-epidemic>. Accessed July 5, 2016.