4. Apfelbaum JL, Chen C, Mehta SS, Gan TJ. Postoperative pain experience: results from a national survey suggest postoperative pain continues to be under managed. *Anesth Analg*. 2003; 97:534-540.
5. Filos KS, Lehmann KA. Current concepts and practice in postoperative pain management: need for a change? *Eur Surg Res*. 1999;31:97-107.
6. American Society of Anesthesiologists Task Force on Acute Pain Management. Practice guidelines for acute pain management in the perioperative setting: an updated report by the American Society of Anesthesiologists Task Force on Acute Pain Management. *Anesthesiology*. 2004;100:1573-1581.
7. Gordon DB, Dahl JL, Miaskowski C, et al. American pain society recommendations for improving the quality of acute and cancer pain management: American Pain Society Quality of Care Task Force. *Arch Intern Med*. 2005;165:1574-1580.
8. Seers K, Crichton N, Carroll D, Richards S, Saunders T. Evidence-based postoperative pain management in nursing: is a randomized-controlled trial the most appropriate design? *J Nurs Manag*. 2004;12:183-193.
9. Sauaia A, Min SJ, Leber C, Erbacher K, Abrams F, Fink R. Postoperative pain management in elderly patients: correlation between adherence to treatment guidelines and patient satisfaction. *J Am Geriatr Soc*. 2005;53:274-282.
10. Stomberg MW, Wickstrom K, Joelsson H, Sjostrom B, Haljamae H. Postoperative pain management on surgical wards: do quality assurance strategies result in long-term effects on staff member attitudes and clinical outcomes? *Pain Manag Nurs*. 2003;4:11-22.
11. Meissner W, Ullrich K, Zwacka S. Benchmarking as a tool of continuous quality improvement in postoperative pain management. *Eur J Anaesthesiol*. 2006;23:142-148.
12. Vila H Jr, Smith RA, Augustyniak MJ, et al. The efficacy and safety of pain management before and after implementation of hospital-wide pain management standards: is patient safety compromised by treatment based solely on numerical pain ratings? *Anesth Analg*. 2005;101:474-480.
13. Taylor S, Voytovich AE, Kozol RA. Has the pendulum swung too far in postoperative pain control? *Am J Surg*. 2003;186:472-475.
14. Taylor S, Kirton OC, Staff I, Kozol RA. Postoperative day one: a high risk period for respiratory events. *Am J Surg*. 2005;190:752-756.
15. Lucas CE, Vlahos A, Ledgerwood AM. Kindness kills: the negative impact of the Visual Analog Scale. *J Am Coll Surg*. In press.
16. Belter R, McIntosh J, Finch A, Saylor C. Preschoolers' ability to differentiate levels of pain: relative efficacy of three self-report measures. *J Clin Child Psychol*. 1988;17:329-335.
17. Oucher! http://www.oucher.org/. Accessed May 2006.
18. Varni JW, Thompson KL, Hanson V. The Varni/Thompson Pediatric Pain Questionnaire, I: chronic musculoskeletal pain in juvenile rheumatoid arthritis. *Pain*. 1987;28:27-38.
19. Gilbert CA, Lilley CM, Craig KD, et al. Postoperative pain expression in preschool children: validation of the child facial coding system. *Clin J Pain*. 1999;15:192-200.
20. Gagliese L, Melzack R. Chronic pain in elderly people. *Pain*. 1997;70:3-14.
21. Scherder E, Oosterman J, Swaab D, et al. Recent developments in pain in dementia. *BMJ*. 2005; 330:461-464.
22. Zwakhalen SM, Hamers J, Abu-Saad HH, Berger M. Pain in elderly people with severe dementia: a systematic review of behavioural pain assessment tools. *BMC Geriatr*. 2006;6:3.
23. Zubieta JK, Heitzeg M, Smith Y. COMT val158met genotype affects mu-opioid neurotransmitter responses to a pain stressor. *Science*. 2003;299: 1240-1243.
24. Craig AD. A new view of pain as a homeostatic emotion. *Trends Neurosci*. 2003;26:303-307.
25. Jackson PL, Meltzoff AN, Decety J. How do we perceive the pain of others? a window into the neural processes involved in empathy. *Neuroimage*. 2005;24:771-779.
26. Allcock N. Factors affecting the assessment of postoperative pain: a literature review. *J Adv Nurs*. 1996;24:1144-1151.
27. Donnelly WJ. The language of medical case histories. *Ann Intern Med*. 1997;127:1045-1048.

Invited Critique

Emphasis on pain as the fifth vital sign has become the latest fad in medicine receiving undue attention among regulators and health care commentators. Kozol and Voytovich strike at the heart of this issue with a clear description regarding the differences between pain and other physiologic processes. As Kozol and Voytovich point out, pain is not a vital sign despite the popular new jargon; they elegantly describe the vital signs and how they are measured. Early in medical school, we are taught that signs are physiological processes that can be observed and measured. Symptoms are patients' subjective description of their disease state. Pain is a symptom and not a sign. As such, measurement tools will always fall short in precision and accuracy for pain assessment. Promoting pain as a measurable sign leads to misuse of pain measurement tools, overadministration of pain medication, and a rise in complications attributable to pain management.

We live in a society that is unwilling to accept risk and expects solutions for all problems that arise. Laypeople attribute uncontrolled pain to inadequacy of the health care system. Consequently, activists demand that physicians provide complete pain relief for those with chronic problems. Litigation has worsened the situation because inadequate pain management has become the basis of several successful lawsuits against physicians. Consider *Bergman v Eden Medical Center* (case No. H205732-1, Superior Court of California, Alameda County, 2001): an 85-year-old man with known compression fractures and a poorly defined pulmonary process was admitted to the hospital with pain. While in the emergency department, he nearly had a respiratory arrest following morphine administration. The admitting physician treated his pain with various combinations of fentanyl citrate patches, meperidine hydrochloride, and acetaminophen and hydrocodone bitartrate, being cautious because of the respiratory arrest. While in the hospital, the nurses documented his pain as ranging from 7 to 10 on the 1-to-10 Likert scale. The physician testified that he was reluctant to use too much pain medication because of the patient's advanced age, pulmonary disease, and prior morphine intolerance. Once the patient was home, the family sought more pain medications from another physician who provided morphine, and the patient died a day later. The physician who cared for this patient in the hospital lost a $1.5 million judgment for elderly abuse following the courtroom testimony of a physician expert witness who described his care as "appalling" and "egregious."

Documenting pain as a vital sign resulted in a medical record that, to a lay jury, appeared to be replete with objective evidence for an untreated malady: pain. They failed to grasp the physician's dilemma of balancing pain relief with respiratory depression. Although the physician's

concerns were valid (the patient died shortly after morphine administration), the jury focused on the untreated pain. Considerable harm can occur if we allow medical records to contain seemingly objective documentation of information, such as pain scores, which are inherently subjective.

What should we do? We must insist on proper use of terminology. The concept of pain as a fifth vital sign must be abandoned. Society has made it clear that pain management must remain an important aspect of medical care. The physician community should insist that pain assessment remains in the proper context: pain is a subjective reporting of a patient's sensation and cannot be objectively measured or scaled. The sensation of pain is highly variable from patient to patient and cannot be precisely quantitated. Pain assessment must include an evaluation of structural problems causing pain, underlying psychological factors that affect the patient's ability to manage their pain, and the likelihood that medications will be effective. Treatment of pain with opiates risks creating addictive behaviors. As a physician community, we must abandon the notion that pain can be objectively quantified. We cannot allow laypeople to believe that there is a risk-free solution to pain management and that pain can always be controlled.

Edward H. Livingston, MD

Correspondence: Dr Livingston, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd, Room E7-126, Dallas, TX 75390-9156 (edward.livingston@utsouthwestern.edu).

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