

## **The pain scale shares the blame for the opioid crisis in America**

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If you have ever had surgery or told your doctor about physical pain, no doubt you have heard the question: “How would you rate your pain on a scale of zero to 10, with zero being no pain and 10 being the worst pain you can imagine?” That sounds like a reasonable question, but everyone has a different pain tolerance. In extreme cases, there are individuals who are born with no feeling of pain at all. Therefore, one patient’s two could be another patient’s nine, and both could be telling the truth. **There are no other evidence-based findings for pain, especially for patients experiencing non-cancer pain syndrome. The pain scale is a useful tool, but it is certainly not ideal** and is adding to the opioid addiction crisis running rampant in our country today.

The fundamental fiduciary responsibility of physicians is to relieve patient pain. There were concerns in the early 1990s that health care professionals are not treating pain quickly and effectively in USA. We physicians were pressured to relieve all the pain as a result of the Fifth Vital Sign program started around 2000. Then, when prescription medication addiction levels rose above the street opioids like heroin, we were the ones to blame. According to the Centers for Disease Control, the amount of opioids prescribed per person in 2015 was three times higher than in 1999. The most serious problem now is physicians that are simply not prescribing narcotics to patients anymore, forcing them to resort to illegal drugs and risking overdoses.

Drug overdose is the leading cause of accidental death in the United States, with 52,404 lethal drug overdoses in 2015. Opioid addiction drives this epidemic, with 20,101 overdose deaths related to prescription pain relievers and 12,990 overdose deaths related to heroin in 2015. Recent data from the American Society of Addiction Medicine shows of the 20.5 million Americans 12 or older who had a substance use disorder in 2015, 2 million had a substance use disorder involving prescription pain relievers, and 591,000 had a substance use disorder involving heroin.

**To help curb this crisis, we need to move away from “the pain scale,” including the visual analog scale, and instead ask patients about their abilities to function at work, home and in other daily activities. This is the best way to assess chronic pain syndrome. We need to dive deeper into their physical capabilities, such as how their pain affects their job performance, if at all. We need to ask patients if they are able to hold their children or carry groceries to their car in order to assess the type of pain and how it truly affects their day-to-day lives.** With nearly 100 people dying each day from opioid misuse, we must start making changes now. We cannot wait for the right piece of legislation or rely on law enforcement to crack down on every neighborhood.

Medical schools and pharmacies have already made changes in response to the opioid epidemic. For example, Ross University School of Medicine is actively training future doctors with this issue in mind, offering courses and clinical rotations in drug addiction treatment and pain management. Our goal is to ensure future doctors understand the differences between situations where an opioid prescription is truly needed for a pain condition and when it is not the best option. **Understanding pain and how to manage it is more than just neurobiopsychology. Social, cultural, familial, economic and local community issues influence how pain is perceived and managed.**

We all took an oath to do no harm, and now we need to pledge to repair those patients who have been seized by this epidemic and make sure the cycle does not continue.

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