

# Pain as the Fifth Vital Sign: Will Cultural Variations Be Considered?

The directive has gone out. Change is in the air. Action is finally being taken some 3 years after James Campbell (1996) gave the following presidential address to the American Pain Society:

Vital signs are taken seriously. If pain were assessed with the same zeal as other vital signs are, it would have a much better chance of being treated properly. We need to train doctors and nurses to treat pain as a vital sign. Quality care means pain is measured and treated.

Health care organizations are now heeding that call and directing that pain assessment be included in the basic and frequent assessment of patients. Now would seem an ideal time for healthcare professionals with expertise in the cultural aspects of care to become involved in developing guidelines for this new emphasis on pain assessment and treatment. It is now, during the developmental stage of new policies and procedures, that we can have the most lasting impact on practice.

One of the most common tools being adopted for pain assessment is the 0-to-10 Numeric Rating Scale (NRS). When using the NRS, the provider asks, "On a scale of 0 to 10, with 0 = no pain and 10 = the worst possible pain, what is your current level of pain?" An extension of the NRS is the Adjective Descriptive Pain Intensity Scale (APS), in which descriptors such as mild, moderate, and severe are assigned to the numbers on the 0-to-10 NRS. The advantages of the NRS and APS scales are that they are easy to use, take seconds to complete, and correlate well with other measures of pain intensity. In addition, as a numeric value, it easily fits into a small box on the vital signs flow sheet or as a point on the vital signs graphic record, accompanying the blood pressure, pulse, respiration, and temperature.

However, not all cultures find it so easy to reduce such a subjective sensation to numeric quantification. Some cultures need to express a constellation of feelings, symptoms, and consequences of the pain to convey the nature of pain. Others,

culturally instructed to be either stoic or very expressive of pain, might underrate or overrate their pain accordingly when using such a scale. Furthermore, the assigning of adjectives to specific numbers on the scale may represent the prevailing culture's values of those numbers, but those same adjectives may be defined by different numbers in another culture.

It is recognized and documented that ethnic minorities are one category of patients whose pain is consistently undertreated (Cleeland, Serlin, Nakamura, & Mendoza, 1996). Now is the time to try to rectify those statistics. We as health-care professionals need to get involved in developing the guidelines for pain assessment for all cultures, in teaching both the experienced and new practitioners that there is cultural diversity to the expression and management of pain, and in continuing the research on this diversity. We need to strike while the iron is still hot.

## REFERENCES

- Campbell, J. (1996, November 11). *Presidential Address*. Speech given at the American Pain Society, Washington, DC.
- Cleeland, C. S., Serlin, R., Nakamura, Y., & Mendoza, T. (1996). Effects of culture and language on ratings of cancer pain and patterns of functional interferences. In T. S. Jensen, J. A. Turner, & Z. Hallin-Weisnefeld (Eds.), *Proceedings of the 8th World Congress on Pain* (pp. 35-51). Seattle, WA: IASP Press.

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