C.R.P.S. – All in the mind?

1. Chronic pain presents difficult challenges for both Claimant and Defendants if there is no obvious organic explanation for the continuing pain. The orthopaedic experts may have shrugged their shoulders and the psychiatrists may have diagnosed no psychiatric condition. In such circumstances, the Defendant may begin to suggest that the Claimant is exaggerating or malingering, even if the medical or other evidence doesn't allow an allegation of malingering to be pleaded or pursued with full confidence. How, then, should both parties manage the claim? In answering this question, consideration is given to the relevant legal principles, the possible causes of chronic pain and the tactics to be adopted.

The Law

2. What has to be proved by a Claimant to establish sufficient injury to create entitlement to an award of damages? Plainly, if a Claimant can establish an identifiable condition, such as Complex Regional Pain Syndrome or Fibromyalgia, then that is sufficient injury to found a cause of action. However, what if the Claimant can only establish that they suffer from persistent pain, for which no continuing organic cause can be identified? Provided that the pain had its origin in a physical injury, and the Court accepts the Claimant's evidence that it is continuing, then there is no problem in principle for a Claimant. In *Thorp v Sharp* [2007] EWCA Civ 1433[1] the Court of Appeal has recently reiterated that it is sufficient that the pain is a consequence of the injury, regardless of whether its causative mechanism can or cannot be explained by medical evidence.

3. In the, admittedly rare, situation where the Claimant suffers no physical injury that acted as the original trigger for the pain, then the situation is slightly more complex. In *Page v Smith* [1996] 1 A.C. 155 the Claimant suffered the exacerbation of his ME when he was involved in a RTA where he was reasonably foreseeably exposed to the risk of suffering physical injury but in fact did not do so. The House of Lords held that it was sufficient that he might foreseeably do so to be able to claim damages for psychiatric injury alone.

4. If there is no qualitative[2] threshold that the Claimant must overcome in order to claim damages for chronic pain, is there a quantitative one[3]? This issue arose in the early RSI cases (as they were then called). In *Mountenay v Bernard Matthews PLC* [1994] 5 Med LR 293 HHJ Mellor held that, in the absence of an established rheumatological condition, Claimants could recover damages for pain going beyond:

> *"the ordinary aches and pains of life".*

5. The case law on chronic pain cases suggests that the courts approach any claim where the Claimant has medically inexplicable symptoms with a degree of scepticism. *Thorp v. Sharp* and *Lodge v. Cook* [2007] EWHC 655 (QB) are recent examples of cases where the inability to prove a physical or psychiatric cause for the Claimant's persisting pain proved fatal to the assertion of causation.

6. In cases where the Defendant does not challenge the veracity of the Claimant's account of continuing symptoms, judges must be careful not to allow their own scepticism about the genuineness of a Claimant's symptom to cloud issues of causation. In *Lougheed v Safeway Stores PLC* [2001] EWCA Civ 176 the Court of Appeal allowed an appeal where the judge had allowed his very considerable reservations as to the Claimant's truthfulness, where the

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[1] Pill L.J. at paragraph 23.
[2] I.e. a recognisable rheumatological condition is not required.
[3] I.e. does the Claimant have to suffer symptoms of a certain level?

Defendant did not challenge the same, to colour his assessment of causation. This case is perhaps best viewed as an object lesson that, even where the medical experts seem persuaded as to the Claimant's truthfulness, that issue is ultimately one for the Court and the Court may take a different view from the experts.

7. Perhaps the starkest example of a court rejecting a Claimant's truthfulness, despite a heavy preponderance of supportive medical evidence, was *Burridge v Blighline Ltd* (26/3/1999 QB, unreported) where Wright J. held that a man, who had sat through the trial in a special recliner chair due to his allegedly intolerable pain, was a malingerer. Of the 8 expert witnesses called, only one seems to have unambiguously alleged conscious exaggeration on the part of the Claimant. Despite there being no damaging video surveillance of the Claimant and in the face of the Claimant having undergone extremely unpleasant procedures and apparently based almost exclusively on the lack of muscle wasting in the Claimant's legs, the judge held that the Claimant was consciously feigning much of his alleged disability.

Causes of Chronic Pain

8. Chronic pain arises in many guises: Fibromyalgia, Chronic Pain Syndrome, Complex Regional Pain Syndrome, Chronic Fatigue Syndrome and Somatoform Disorder are all familiar terms. Indeed, each term appears in the 9th edition of the Judicial Studies Board guidelines in Chapter 3 under the general heading of "Psychiatric Damage" and under the specific sub-heading of "Chronic Pain". Each is ascribed a different bracket of suggested valuation for general damages, with little apparent logic differentiating one from another. Somatoform Disorder is said to be worth in the region of £29,000 but that guidance seems to take no account of the range of severity with which the condition can present itself.

9. Chronic pain not only arises in many guises and with different degrees of severity, but from an infinite variety of different originating causes. Many will have come across the scenario where a minor soft tissue injury to the spine has apparently produced chronic back pain. Fewer will have encountered the situation where the loss of a finger tip has left the claimant wheel-chair bound. By a strange coincidence, a colleague in Chambers and I have both recently dealt with such cases. In my case, a horse nibbled off the top of the claimant's little finger and within 12 months this apparently fit and healthy young woman was wheel-chair dependent with chronic pain in all four limbs.

10. The case of the finger nibbled by the horse illustrates the type of debate that can ensue between claimant and defendant. For the Claimant, the experts diagnosed Complex Regional Pain Syndrome. For the Defendant, the experts diagnosed somatoform disorder and contended that it would have manifested itself sooner or later in any event. The real issue between the parties was the extent of the psychological element of the Claimant's condition: was it principally organic or was it all in her mind?

11. Experts in the field of CRPS are somewhat taken aback to learn that we lawyers place CRPS and other conditions such as fibromyalgia in the "Psychiatric Damage" section of the JSB guidelines. Without denying that the psychological experience of pain is an important aspect, they point to the hard organic signs and the established diagnostic criteria for CRPS. There are a number of features of CRPS that can be detected either on examination or by other investigations. These include:

    - Hair growth
    - pigmentation change
    - sweating/temperature change
    - changes revealed by thermography or bone densitometry

Expert evidence

12. It is vital to have the right experts instructed in cases of CRPS or other types of chronic pain. This is a highly specialised area and it is clear from experience that there are many medical experts who do not have sufficient knowledge or understanding of pain to be relied upon as experts in such cases.

13. I would caution against instructing a Pain Consultant unless the expert professes particular expertise in CRPS. The majority of Consultants leading pain clinics in the NHS are Consultant Anaesthetists and, in my experience, when instructed as experts, tend to concentrate on the treatment of the symptoms without analysing in sufficient detail for medico-legal purposes the underlying cause of the pain. It is perhaps not surprising, on reflection, that an Anaesthetist should not descend into detailed diagnosis of the underlying condition, since the Anaesthetist is concerned with the management of pain rather than the treatment of specific medical conditions. Having said that, there are some Pain Consultants with a special interest in CRPS and its causes who can be safely instructed in such cases.

14. I suggest that the first expert to be instructed in cases of chronic pain should be the Rheumatologist, but not just any Rheumatologist. The expert must be one who will apply a rigorous approach to the diagnosis of the claimant's condition. There are specific diagnostic criteria for Fibromyalgia, Complex Regional Pain Syndrome etc and it is vital that the expert should be scientific in the approach to diagnosis as opposed to applying the broad brush which is sometimes encountered. No doubt we all have in mind individuals who would fit both sides of the bill.

15. It may become necessary to instruct a Psychiatrist or Neuropsychiatrist if the Rheumatologist does not come up with a specific diagnosis but simply points to chronic pain syndrome. From experience, it is convenient that the Rheumatologist should see the claimant first in order to identify whether or not there is a clear diagnosis of any particular condition, so that the Psychiatrist can then seek to explain pain not accounted for by the Rheumatologist's diagnosis. As with the Rheumatologist, it is vital to instruct a Psychiatrist or Neuropsychiatrist who has a good understanding of, and interest in, the causation of pain. It is not the case that this can be said of all Psychiatrists.

16. It is obviously necessary that the experts instructed by a particular party should give mutually consistent evidence. It is no good if the Rheumatologist says that the pain is wholly inorganic and the Psychiatrist says that the pain is wholly organic with no psychiatric element. I suggest that the appropriate course is to instruct the experts to prepare first a draft report which can then be the subject of discussion in conference before preparation of the final reports for disclosure. It is frequent experience that talking through the issues with both experts in conference reveals many points not previously considered and often results in a consensus view.

Tactics and approach

17. **Surveillance:** A judge who cannot find a medical explanation for complaints of chronic pain may find deliberate exaggeration an easier conclusion than taking a leap of faith in the Claimant's truthfulness. For that reason, Defendants will seek to investigate the bona fides of the Claimant. The Defendant's expert should be asked to comment on the surveillance in a draft supplementary report before a decision is taken to rely upon and disclose the surveillance.

18. If a film is disclosed which shows apparent inconsistency of complaint, it will be important for the Claimant's advisers to take their client's instructions because there may be a simple explanation: medication, pain the following day, a "good day" etc. Any explanation should be put into a statement and used as the basis of putting CPR Part 35 questions to the Defendant's expert if an adverse opinion is expressed about the film. Experts will not always conclude that even apparently marked discrepancies are due to malingering.

19. **Rehabilitation**: Although most regional hospitals offer pain clinics/out patient pain management, the quality of the services are often said to be mixed. We are fortunate to have in our locality one of the best-regarded pain management programmes in the country: The Bath National Hospital for Rheumatic Diseases[4] runs an in-patient pain management programme at a cost of under £10,000. It also has bespoke CRPS treatment courses, which include pioneering work in the use of mirror boxes, originally devised to combat phantom limb pain in amputees, in the treatment of CRPS.

20. The assessment notes that will be created in a pain management referral can be relied upon by both parties in the litigation. It is only the initial report which is outside the litigation process.

21. **Pre-existing vulnerability**: In many cases of chronic pain, this is the key argument which defendants will seek to run. Where the medical evidence is that there has been an extreme and continuing reaction caused by a trivial injury, it is often the case that it is possible to argue that the claimant must have had a pre-existing vulnerability which would probably have been provoked sooner or later by another trivial incident in ordinary life. The greater the psychological element in a chronic pain case, the easier it is to run this argument, so a Defendant is likely to emphasise the psychological aspect of the condition at the expense of the organic.

22. Even where causation is established, it is open to the Defendant to argue that the consequences should be limited in time on the grounds that a pre-existing vulnerability would have become manifest relatively soon in any event. The more bizarre and extreme the reaction, the easier it is to argue for a shorter period before the claimant would have been in an equivalent position in any event. In this regard, the post-accident medical history is as important as the pre-accident history since the Defendant may seek to argue that there are post-accident medical conditions which would have precipitated chronic pain in any event.

23. **Medical records:** In cases of CRPS and other kinds of chronic pain, a detailed scrutiny of all the medical records is essential. Very often there are important clues as to the Claimant's current condition buried in the hand-written scrawl of the GP records. Claimants with chronic pain will frequently have been seen by a bewildering variety of doctors, physiotherapists, osteopaths etc and it is important to expend considerable effort in tracking down all the available records so as to be able to draw up a detailed chronology of the presentation and evolution of symptoms. Such a process will be of great benefit to the medical experts in their diagnosis and elucidation of your client's condition and will also bring to light any other potential causes of the continuing symptoms. In *Lodge v Cook* [2007] EWHC 655 (QB), the defendant managed to limit the claimant to damages for three months' of pain following a whiplash injury by identifying from the medical history an intervening ear infection three months after the accident which was held to be the cause of the subsequent chronic pain.

24. If the chronology is cross-referenced to a paginated bundle of records then the expert has an extremely useful and labour-saving tool for the preparation of the medical report. The

[4] http://www.rnhrd.nhs.uk/departments/pain_management/pain_management.htm

experts in the field are busy and short of time so that sometimes there is perhaps not quite the necessary attention to the detail of the medical records.

25. A good example of the utility of a detailed record is a case where there is a possible diagnosis of Somatisation Disorder. The DSM-IV diagnostic criteria for Somatisation Disorder require a history of many physical complaints beginning before the age of 30 that occur over a period of several years and must include 4 pain symptoms, 2 gastrointestinal symptoms, 1 sexual symptom and 1 pseudoneurological symptom, none of which can be adequately explained on conventional grounds. It is plain that in determining whether or not Somatisation Disorder is an appropriate diagnosis, it is absolutely essential that the expert should have ready access to as detailed a medical history as possible.

26. **Future improvement:** If the claimant's pain has a sound organic basis, then the prospects of achieving any significant improvement where the pain has been chronic for some years may be slim. On the other hand, if there is a significant psychological component, then the prospects for improvement may be greater. Furthermore, common experience is that experts advise that the end of the litigation itself is likely to result in some improvement in the claimant. These are issues which you should ask your experts to address with care.

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October 2008