C.R.P.S. *ET AL*: A CHRONIC PAIN FOR INSURERS (DEFENDING A CHRONIC PAIN CLAIM)

1. Defending a claim where the Claimant complains of chronic pain presents difficult challenges for an insurer. Often there will be an overwhelming feeling that the Claimant is trying it on but the medical or other evidence doesn't allow an allegation of malingering to be pleaded or pursued with full confidence. How, then, should the claim be managed so as to keep it to its legitimate value? In answering this question, consideration is given to the relevant legal principles; the important distinction between a malingering and a "misunderstood" Claimant; tactics to be adopted and, importantly, choice and management of expert evidence.

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 (formerly "Reflex Sympathetic Dystrophy") 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, 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".*

This is, it is suggested, tautologous. If pain is not due to a diagnosable rheumatological condition and does not go beyond the aches and pains of daily life, how can the Claimant prove that the tort has caused them any harm?

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

6. Courts must, however, be careful not to allow scepticism about the genuineness of a Claimant's symptoms (where that is not in issue) to cloud issues of causation. In *Lougheed v Safeway Stores PLC* [2001] EWCA Civ 176 the Court of Appeal allowed an

[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?

appeal where the judge had allowed his very considerable reservations as to the Claimant's truthfulness, where the 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.

MALINGERER OR MISUNDERSTOOD?

8. As *Burridge* shows, allegations of malingering are often the most fruitful response of a Defendant to an unexplained pain case. A judge who cannot find a medical explanation for complaints of pain may find deliberate exaggeration a more appealing conclusion than taking a leap of faith in the Claimant's truthfulness. However, medical evidence may not support the allegation of malingering. Despite the Court's decision in *Burridge*, decent surveillance evidence is nearly always a pre-requisite to a successful plea of fraud.

9. Even in the absence of clear evidence of malingering, video surveillance evidence can give a better insight into how the Claimant's alleged disability in fact affects their standard of living. However, where the surveillance does not support malingering, very careful consideration should be given to disclosing it. Claimants with chronic pain are often highly sensitive to the fact that nobody believes that their suffering is genuine. Nearly all Claimants resent being watched. If a Claimant is sensitive to the allegation that their symptoms are not real and resentful upon disclosure of video evidence, it can make a Claimant even more determined to prove their truthfulness. This can sometimes frustrate settlement. Accordingly, always weigh carefully the decision whether to disclose and rely on video evidence. However, when in doubt, disclose. Judges see fewer videos than insurers/Defendant solicitors and tend to be more willing to attach weight to them than might be thought.

10. If a video is to be obtained, always ensure that it is obtained at the time of, but shortly before, the medico-legal appointments. Then, ask the expert to elicit a careful history from the Claimant, with particular regard to activities of which the Claimant is shown to be capable. It is probably best not to send the video to the expert at the time of the examination, since it will then have to be referred to in the report as part of the instructions and may, thereby, become immediately disclosable. Better to wait until you have the report.

11. Even where a video shows inconsistency of complaint, it is always necessary to question the experts carefully about the discrepancies. Experts will not always conclude that even apparently marked discrepancies are due to malingering.

12. As *Burridge* also illustrates, the presence or absence of hard signs may be at least as important as a video in demonstrating malingering. There are a number of things that can be detected either on examination or by other investigations. These include:

- Muscle wasting,
- Hair growth/pigmentation change/sweating/temperature change (CRPS),

- Thermography /bone densitometry (CRPS).

If the expert does not comment on the presence or absence of these factors/advise further tests, then the utility of further investigations should be queried.

13. Where there is any real risk of the Claimant succeeding in proving that they are genuine, then the insurer may have to bite the bullet and consider paying for treatment. The sooner this is done the better. 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.

14. The only risk of offering such treatment is that, where it is intended to run an allegation of malingering and the video evidence is less than definite, the assessment notes that will be created in a pain management referral are often good ammunition for a Claimant seeking to corroborate their own expert's opinion. Ultimately, the trade-off between the potential for successful treatment and the damage that may be done to an allegation of malingering has to be weighed carefully.

15. The more extreme the reaction to pain, the easier it may be for a Defendant to allege that the Claimant was vulnerable to suffering similar ill-effects in response to any minor event, on the basis that "normal" people don't react adversely to minor incidents. Certainly in cases of somatoform disorders, the 4 symptoms clusters necessary to make the diagnosis must be established prior to the age of 30. Thus, identifying those vulnerable to the expression of a somatoform disorder consequent upon physical injury is made easier. Similarly, medical records will often show markers of those vulnerable to developing Fibromyalgia (e.g. gastro intestinal problems/IBS). These are important areas for the medical experts to explore.

16. In less extreme cases, proving vulnerability may be more difficult. Thus, the Claimant with an orthopaedic injury that lingers on beyond the time when it should have healed and who is left with rheumatologically and psychologically inexplicable pain will often not be as susceptible to the allegation that they were vulnerable to an adverse pain reaction to life's everyday events. It is this class of Claimant that is more susceptible to the allegation of malingering, however, since they by definition do not have medical evidence supporting their continuing symptoms. The more seriously injured may well have that evidence, in which case vulnerability may be a better argument for Defendants.

TACTICS AND APPROACH

17. 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 8th 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 £26,500 but that guidance seems to take no account of the range of severity with which the condition can present itself.

18. 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

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

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, Tony Reddiford and I have both recently dealt with such cases. In his case a teenage girl trapped the tip f her left thumb in a folding trampoline leg but suffered no orthopaedic injury. She became progressively disabled, took to a wheelchair with whole body pain and started suffering pseudo-epileptic fits. 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.

19. What is a defendant to do when presented with such a case? I suggest that the three keys to the management of such cases are: the claimant's medical records; objective evidence of the claimant's level of functioning; expert evidence. I shall consider each in turn.

20. Medical records. In cases 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 highlight any inconsistency in presentation to different medical practitioners and will 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.

21. The preparation of a detailed chronology from the medical records is also of invaluable assistance to the medical experts instructed in a chronic pain case. 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. There are experts in the field who are busy and short of time so that sometimes there is perhaps not quite the necessary attention to the detail of the medical records.

22. 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.

23. Objective evidence of the claimant's level of functioning. Such evidence is important for a number of reasons. First, it may establish sufficient discrepancy between the claimant's reported level of functioning and the actual level of functioning so as to give rise to potential allegations of malingering or, at least, symptom exaggeration. Second, objective evidence may provide a clearer picture of the level of functioning than is provided by the claimant's own account, thereby allowing a more accurate assessment of the value of a case. Third, the pattern of behaviour revealed by objective evidence may assist the medical experts in reaching a conclusion about the correct diagnosis.

24. Video evidence is the most obvious source of objective evidence. In addition, it is worth considering obtaining witness statements from people who may be able to shed light on a claimant's function. Employers, neighbours and others who have socially interacted with the claimant are potential sources of fruitful information.

25. Expert evidence. It is vital to have the right experts instructed on behalf of a defendant in cases 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 for defendants in such cases.

26. I would caution against instructing a Pain Consultant. 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.

27. 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.

28. I suggest that the second expert to be instructed should be a Psychiatrist or Neuropsychiatrist. All pain has some psychological element and in cases of chronic pain, this is frequently a significant, if not the overwhelming, factor. 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. This cannot be said of all Psychiatrists.

Experts: singing from the same hymn sheet

29. In order to defeat or to limit a chronic pain claim, it is necessary that the defendant's experts 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 or, perhaps more commonly, *vice versa*. I suggest that the appropriate course is to instruct the experts to prepare first a draft "advice to insurers" which can then be the subject of discussion in conference before preparation of the final reports for disclosure. It is my 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.

30. There are a number of different approaches to the case which may be considered with the experts in order to seek to defeat or limit the claim:

Symptom exaggeration
Intervening cause
Pre-existing vulnerability
Future improvement

31. Symptom exaggeration. Is the claimant malingering? In other words, is there conscious falsification of the symptoms? If not malingering, is there exaggeration of symptoms so that the true value of the claim is less than it otherwise appears?

32. Intervening cause. Does the medical history indicate an intervening cause of the symptoms which are attributed by the claimant to the index accident? In *Lodge v Cook*

[2007] EWHC 655 (QB) the court held that a viral ear infection was the true cause of the ongoing chronic pain.

33. Pre-existing vulnerability. In many cases of chronic pain, this is the key argument for defendants. 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. It is important that the Psychiatrist/Rheumatologist should be specifically instructed to consider the question of whether or not the claimant was vulnerable and the extent to which it was likely that such vulnerability would have been triggered sooner or later in any event. Thus, even where causation is established, there is scope to argue that the consequences should be limited in time on the grounds that the 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 it may be possible to find post-accident medical conditions which would have precipitated chronic pain in any event.

34. 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. However, the prospects for future improvement may be better where the psychological element is the overwhelming factor in the chronic pain, particularly if the claimant has not received treatment through a pain-management programme. Furthermore, common experience is that experts advise that the end of the litigation itself is likely to result in some improvement in the claimant.

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