DEFENDING CHRONIC PAIN CLAIMS

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Chronic pain defined

Chronic **organically unexplained** pain

But c.f.

- Whiplash – no objective signs
- CRPS – multiple objective signs

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Terminology

- Complex Regional Pain Syndrome
- Fibromyalgia
- Myalgic Encephalomyelitis/Chronic fatigue Syndrome
- Chronic pain syndrome

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CRPS

Previously:

- Reflex Sympathetic Dystrophy
- Sudeck's atrophy
- Algodystrophy
- Causalgia

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CRPS

2 (or 3) types:

- Type I – no lesion to major nerve
- Type II – lesion to a major nerve

Budapest criteria/Atkins criteria:

Complex Regional pain syndrome in adults RCP May 2012

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CRPS: diagnostic criteria

Beware:

- CRPS – NOS (Not Otherwise Specified)
- Some C experts use it where diagnostic criteria not met.
- RCP Guidelines: only where previously met diagnostic criteria.

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Fibromyalgia

Diagnostic criteria:

- severe pain in three to six different body areas, or milder pain in seven or more different areas
- symptoms have stayed at a similar level for at least three months
- no other reason for symptoms has been found

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Chronic pain syndrome

Physical injury but with symptoms of greater:

(a) chronicity and/or

(b) Severity

than is physically explicable.

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Chronic pain syndrome: explanations

- Psychiatric explanation (somatic symptom disorder – DSM 5)
- Psychological explanation: HHJ Main QC in *Willisford v Jones & MIB:*

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Chronic pain syndrome: psychological

"I think it can be accepted, on the balance of probability, that where patients have experienced severe pain due to organic injuries, the mechanism of the patient laying down a psychologically induced blue print of that pain experience is recognised…In effect, it is the anticipatory effect in the mind producing a fear of suffering a recrudescence of similar pain, which conditions these types of pain responses. Where the same person also suffers from additional psychological disturbance and change of mood, then the chronic pain problem becomes a reality." (HHJ Main QC *Willisford v Jones*)

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Chronic pain syndrome: explanations

- Psychiatric explanation (somatic symptom disorder – DSM 5)
- Psychological explanation: HHJ Main QC in *Willisford v Jones & MIB:*
- Biological explanation: Leighton Williams QC in *Everett v London Fire Authority*

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Chronic pain syndrome: biological

"In cases of acute pain...a signal is transmitted to the brain, first to the bottom part of the brain and then higher up in the brain where emotions are handled...where the pain does not cease, changes may occur in the way that pain is registered or perceived by the brain. Those changes may result in signals being amplified, changing in character and becoming more intensive, so that the are perceived by the brain as different from the original signal...The signal itself was not pain. Pain was the emotional reaction to the signal...Pain was all to do with how the individual responded to the signal...this process, described as `central sensitisation`, was now thought to be the most important factor in the development of long term pain.

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Chronic pain syndrome: biological..cont

...one of the most important factors in pain is the attention which the brain gives to the signal...It was important to decrease the sensitisation which was why pain patients were encouraged to lead a normal life. CBT and Mindfulness were treatments now employed, the ultimate purpose of which was to abolish these abnormal signals.

To the extent that pain was an emotional reaction treating it as a physical matter was to approach the problem the wrong way round."

Leighton Williams QC in *Everett*

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Chronic Pain: genetic pre-disposition

`Shared genetic factors underlie chronic pain syndromes`

Vehof, Zavos, Lachance, Hammond and Williams Pain 30th May 2014

- Twin study
- Higher incidence of CPS in identical than non-identical twins
- Useful when alleging vulnerability

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The law

*Qua*ntitative threshold:

- *Mountenay v Bernard Matthews PLC* [1994] Med LR 293

Anything going beyond *“the ordinary aches and pains of life”.*

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The law: causation

Qualitative threshold:

- *Thorp v Sharp* [2007] EWCA Civ 1433

Only need to establish causation of pain on B of Ps. Not aetiological link

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The law: causation/apportionment

Hatton v Sutherland [2002] All ER 1

Hale LJ at paragraph 41: if possible to identify a number of causes: apportion

But c.f.

Dickins v O2 [2008] EWCA Civ 1144

Smith LJ at paragraph 33-34

Brown v London Borough of Richmond [2012] EWCA Civ 1384

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The law: causation/apportionment

- Is it good law?
- Does it apply in chronic pain (i.e. Is it a divisible condition)?

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The law: vulnerability

Malvicini v Ealing Primary Care Trust [2014] EWHC 378 (QB) Robert Francis QC

- 10% discount on whole claim to reflect vulnerability

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Practice: medical/other records

- GP/hospital
- Complementary/alternative treatment
- Counselling records
- OH/Personnel file
- DWP records
- Local Authority (social services/benefits)
- School records

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Practice: medical/other records

Identify any previous history:

- Musculo-skeletal history
- Unexplained bodily symptoms
- Abdominal
- Stress/psychological
- Childhood problems

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Practice: medical/other records

Chart the onset of symptoms:

- Contemporaneity

  (*Goodman v Faber Prest Steel* [2013] EWCA Civ 153)

- Other stressors

- Pattern of other unexplained symptoms

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Medical experts

- Primary injury: define the “unexplained” element (orthopaedic/neurological/etc)
- Psychiatric (**not** psychological)
- Rheumatological/pain management
- General physician re. “unexplained” history

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Instructing the expert

Ask to consider:

- Previous history/vulnerability (percentage chance)
- Genetics: ask C re family members
- Anticipate psychiatric: can everything be explained?
- Diagnosis: diagnostic criteria:
  - Budapest/Atkins in CRPS
  - DSM IV/5

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Instructing the expert

- Contemporaneous records: onset
- Apportionment between causative factors
- Extent of disability: explore can't do vs. doesn't do
- Treatment (but be careful to ensure consistency or approach: psychotherapy v pain management)

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Surveillance

- Most Cs not malingerers
- Many exaggerate to convince not deceive (especially with CPS) – need to know true function
- Insurer's Codes of Conduct/compliance with principles of Regulation of Investigatory Powers Act 2000/RIPA code of practice

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Surveillance: authorisation

- Good cause:
  - Background checks
  - Medical experts
  - Fraud v exaggeration
- Proportionate
  - Early ascertainment of value
  - Choosing the right opportunity (medical examination)

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Rehab/treatment: damned if you do...

The conundrum:

- C wants treatment during litigation
- If fails, C's case for future losses enhanced
- What incentive for C to succeed?

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Rehab/treatment: damned if you don't

The evidence:

- RCP's CRPS Guidelines, p. 27:

"Litigation tends to fuel stress, which may adversely affect outcomes and ability to engage in rehabilitation."

- Guidelines for Pain Management Programmes for adults: *An evidence-based review prepared on behalf of the British Pain Society* November 2013:

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Rehab/treatment: heads I win...

"Ongoing litigation may place participants in a dilemma in that improved function will reduce their anticipated compensation payment. Participants receiving benefits which depend on poor function are often in a similar position. Evidence is mixed on whether this affects outcome."

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Rehab/treatment: ...tails you lose

Practice:

- Get expert(s) to deal with the point and cite research
- Make assessment of likelihood and extent of improvement
- Co-ordinate treatment: psychotherapy then pain management (*Koelen*)
- Long-term prognosis if treatment fails

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Spot the chronic pain Claimant

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