Chronic Pain Claims

Defining our terms

1. In relation to claims for damages, chronic pain can be defined in terms of pain resulting from compensable injury which endures for longer than 3 months. The term 'chronic' does not describe the severity of the pain.

2. Whilst the original injury will normally have resulted in damage to bone and/or tissue the chronicity of the pain cannot normally be explained in this way. Whilst the pain can be explained in some cases by organic/pathological factors e.g. where there is neurological damage, most claims relate to circumstances where the cause of the pain cannot be explained in organic or pathological terms.

3. Where physical factors cannot explain the pain, in part or at all, psychological and social factors need to be considered. This is known as the 'biopsychosocial model'.

4. In general the most important issue in medico-legal chronic pain assessment is *'If the claimant's condition is not explained on a biomedical (physical/organic) basis can it be reliably explained on a biopsychosocial basis?'*

Types of chronic pain disorder

1. There are a number of chronic pain disorders e.g.:

- Complex regional pain syndrome (CRPS)
- Somatic symptom disorder (SSD)
- Somatoform pain disorder
- Fibromyalgia
- Chronic pain syndrome

2. Somatic symptom disorder (SSD)

(i) This is one of several chronic pain conditions where the chronicity of the pain is explained by psychosocial factors. It is officially defined as *'a somatic (physical) manifestation of a psychological disorder'*. The process will often be:

Injury – psychological/psychiatric disorder – SSD

The claimant will display excessive thoughts, feelings and behaviours regarding the injury. There will be disproportionate and persistent thoughts about the seriousness of symptoms.

(ii) In Willisford v. Jones (2009) HHJ Main QC held:

'I think it can be accepted…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.'

(iii) There is generally a tendency to attribute all physical symptoms to the physical accident rather than a person's psycho-social difficulties. These behaviours will often be motivated by secondary gain. The accident is therefore not a cause but an opportunity and solution to a person's predicament.

(iv) SSD can result in significant symptoms. However, it is treatable. Treatment should be directed at the underlying psychological issues – physiotherapy, talking therapies, medication/withdrawal from medication especially opiates.

3. Complex regional pain syndrome (CRPS)

(i) There are two types of CRPS. Type II results from nerve damage. Type I results from physical injury which is often mild in nature.

(ii) In order to attract a diagnosis of CRPS the patient must satisfy the 'Budapest Criteria' (see slide). There must be pain disproportionate to any inciting event. The patient must display at least one symptom from a list of four categories. (In this context 'symptom' means a subjective view expressed by the patient regarding the presence of a medical condition). There must then be at least one sign in two categories from a second list. (In this context 'sign' means objective evidence of a medical condition). The four categories are:

- Sensory: hyperaesthesia (hypersensitivity), allodynia (pain from an innocuous stimulus)
- Vasomotor: temperature changes, skin colour changes
- Sudomotor/oedema: sweating and/or swelling
- Motor/trophic: loss of range of motion, hair/nail/skin changes

(iii) These conditions should be clear to observe (see slides). Reference is made to the case of Hope Gordon which has recently attracted media attention. Hope was diagnosed with CRPS in her left leg when 12. She had her leg amputated 12 years later having raised £10,000 by Crowdfunding to have the operation carried out under the private healthcare system. She is now a Paralympic canoeist for Team GB.

(ii) The diagnosis of CRPS in litigation is usually not straight forward. Often a claimant will receive a diagnosis of CRPS based on their subjective account of symptoms. The diagnosis can be seen as one of last resort and there are concerns in the medical profession that type I CRPS is over diagnosed. In March 2019 a medical paper was published by Chang et al in which it was said that *'It has been noted that in contrast to its extreme rarity in the clinical or research setting, CRPS appears frequently in the medico-legal context'*.

(iii) The question is why? It is because CRPS is considered to be a condition that cannot be cured, is chronic and gets worse. In fact against all medical norms it is a condition that can spread so that the pain starts to affect parts of the body not injured in the original accident. Counter-intuitively this scenario is positive for claimants in terms of litigation so far as it relates to the damages that will be awarded.

<u>Defending chronic pain claims</u>

1. Establish the cause of the chronicity of the pain? Why is the pain being maintained? In the majority of chronic pain disorders the answer will be psychosocial factors such as anxiety, depression, fear avoidance, catastrophising, unemployment/problems at work, relationship problems, bereavement etc. These issues should be treatable (post litigation).

In the case of CRPS the cause is unknown. One school of thought is that it is driven by psychological factors. That may then mean that the condition has been given the wrong label. Is the claimant catastrophising or somatising? What is the role of iatrogenesis? Note that the Budapest Criteria states the diagnosis should be CRPS where '*There is no other diagnosis that better explains the signs and symptoms'*. The other school of thought is that the cause is organic or

pathological. This is described in terms of a *'central sensitization where there is a neuroinflammatory process'*. The cause can, of course, be a combination of both psychological and physical factors.

2. Does the claimant have a pre-existing vulnerability to the onset of chronic pain following a minor insult? This argument will require a detailed analysis of the claimant's medical records. The purpose of this line of enquiry is to establish either an acceleration or exacerbation argument.

Note must be taken of the case of Malvicini v. Ealing PCT (2014). The claimant suffered from fibromyalgia prior to the accident. She was then injured at work and was diagnosed as having a chronic pain disorder. The judge said it was necessary to ask the following question:

'In the absence of the index triggering traumatic event, or other equivalent compensable life stressor, what is the chance in broad percentage terms that this patient would have succumbed to a similarly disabling chronic pain condition?'

The judge applied a 10% discount. That is likely to be the starting point in any negotiations based on this type of argument unless an identical pre-existing problem has been made worse by the accident.

3. Is the claimant exaggerating or malingering? A judge will allow for a degree of exaggeration in chronic pain claims. The question is whether the exaggeration has the purpose of trying to convince or is evidence of dishonesty? Experts will often apply the vas pain scale (visual analogue scale) in which the patient selects a number from 0 to 10 to reflect the intensity of the pain. In litigation the answers are often around the 7 to 10 mark where 10 represents the worst type of pain. Surveillance and social media searches will assist with investigating this issue.

4. The role of secondary gain should be investigated. The type of gain will include compensation, not having to work or providing an explanation why unemployed, support and sympathy from family and friends. A further gain may relate to providing the justification for the prescribing of pain relief medication. Medical records might reveal a dependence/addiction to pain relief medication including opioids. Look for the prescription of drugs such as Tramadol, Fentanyl, Codeine, Oxycodone and Diamorphine.

5. Rehabilitation and treatment of the claimant must be considered. Traditional forms of treatment include physiotherapy, occupational therapy, talking therapies including CBT and attendance at a holistic pain management programme.

The timing of treatment requires careful consideration. If the treatment succeeds the level of damages will decrease. If it fails damages increase and the duration of symptoms increase. In such circumstances treatment post litigation may well be the best option.

An increasingly popular form of treatment for organically mediated chronic pain, including CRPS, is spinal cord stimulation (SCS). It can be a treatment of last resort, as can CRPS be a diagnosis of last resort. A spinal cord stimulator is a type of neuromodulation where an electrode is implanted into the spinal cord in order to block pain signals to the brain. It is a very expensive method of treatment if paid for privately and has questionable benefit in cases where the pain is due to psychosocial factors.

6. The evidence required to defend chronic pain claims includes:

- Records: medical, work, DWP
- Surveillance/social media
- Expert evidence: orthopaedic surgeon, neurologist, rheumatologist, psychiatrist, pain management consultant.

August 2019

CHARLES MARTIN (Partner)

Kennedys Law

charles.martin@kennedyslaw.com

020 7667 9162

07818 512306