

CHRONIC PAIN: A LEGAL PERSPECTIVE

“Pain used to be a simple issue. It was caused by physical injury or disease and the sufferer had to rest and take opium.”¹

1. In today’s medico-legal world the issue of pain and chronic pain is no longer simple and whilst the possession of opiates and other drugs is occasionally justified by reference to their medicinal properties, such issues more often arise as part of a hastily put together defence to criminal charges rather than the treatment regime for which damages are claimed in the claimant’s schedule of loss.
2. The complexities of diagnosis, causation and prognosis of chronic pain conditions have been addressed by the medical experts. As indicated, pain is a quintessentially subjective symptom and it would appear that there exists no practicable test to verify its presence. Under the current medical regime of disease realism, most chronic pain is fragilely classified as a ‘syndrome’ rather than a disease.²
3. In the medico-legal context, the courts have now recognised that chronic pain is a compensatable condition. Guidelines have been published to assist judges in

¹ Merskey, ‘Pain Disorder, Hysteria or Somatization’.

² Syndromes consist of groupings of symptoms and signs whose causes have yet to be determined.

reaching the appropriate award for general damages for pain, suffering and loss of amenity. A range of conditions is listed and variously described as ‘chronic pain, fibromyalgia, complex regional pain syndrome.’³

4. With increasing legal and medico-legal awareness, the legal debate has shifted from asking whether the claimant has suffered a recognisable medical condition (*is what the claimant complaining about a recognised medical condition?*) to whether the claimant’s condition, whatever the label to be attached to it, was caused by the defendant’s tortious conduct (*is the Defendant responsible in law for the claimant’s condition*). The remainder of this paper looks at the issues likely to arise as a result of any such investigation and the approach to be adopted by a defendant, his legal advisors and insurers faced with such a claim.

THORP v SHARP⁴ - A Case of unidentified Chronic Pain?

5. Sandra Thorp sustained accident injuries at her employer’s place of work in October 2000 when she tripped whilst carrying a tray of hot food. She described hearing a crack and felt immediate pain in her right hip. She worked for a couple of weeks with what was said to be worsening pain. Eventually seeing her GP, X-rays showed no pathology, although the Claimant continued to complain of pain. Eventually, the Claimant commenced proceedings, seeking damages for continuing significant pain and disability affecting her right hip. Her ability to

³ It is to be noted that the JSB Guidelines list the above under the broad heading ‘Psychiatric Injuries’!

⁴ [2007] EWCA Civ 1433.

work was affected and the damages claimed were significant. The nature of the Claimant's condition was categorised by her legal advisers as chronic pain.

6. By the date of trial much of the standard investigations had been carried out and the evidence deployed was unsurprising. Both parties relied on medical expert evidence from an orthopaedic expert and from consultant psychiatrists. The Defendant relied upon covert surveillance evidence that was said to show a significant difference between the level of disability as reported to the orthopaedic experts and that revealed in the DVD; the Defendant also argued that the Claimant had made similar complaints of hip joint pain some years before the accident in question.

Orthopaedic evidence: There was agreement that the X-rays and other evidence failed to identify any obvious orthopaedic explanation for the Claimant's continuing complaints. An initial report from the claimant's orthopaedic expert has suggested some acceleration of pre-existing symptoms but this argument had been abandoned by the date of trial.

Psychiatric evidence: The experts agreed that the Claimant had no pre-existing history of psychiatric illness and was not suffering from any psychiatric illness at the date of examination. Both psychiatrists expressed dissatisfaction with the term or label 'chronic pain' (on the basis that it appeared to be more descriptive

rather than diagnostic) but in any event felt that a diagnosis of chronic pain could not be made “because they could not identify any psychiatric illness”.

Psychological evidence: A clinical psychologist was called by the Claimant.

He rejected a diagnosis of a pain disorder in the following terms:

“My reading of the orthopaedic expert’s opinion suggests there is no clear diagnosis of the cause of the claimant’s pain nor is there any convincing evidence of pathology that might be responsible. This is, of course, not to say that the claimant’s pain does not have its original in a medical condition or muscular, skeletal or neurological damage. However, in the absence of clear pathology, diagnosis of pain disorder resulting solely from a medical condition cannot be definitively diagnosed. For pain disorder to be formally diagnosed as a mental disorder then psychological factors are judged to have an important role in the onset: severity, exacerbation or maintenance of the pain in diagnostic criteria... From my review of her background and her medical notes but summarising the other expert opinion in this case, there is nothing obvious from a psychological viewpoint that suggests a psychological component to her pain, and therefore she does not meet diagnostic criteria for pain disorder, in my opinion.”

“The claimant’s significantly elevated disclosure and debasement scores and her very low desirability score are suggestive of the concealment of positive aspects of her functioning and the amplification or exaggeration of negative aspects to her functioning, including pain and related impairment. I have no reason to suspect that this was an intentional or deliberate ploy. Experience of pain is very subjective. Pain consists of physical discomfort, the labelling and cognitive interpretation of the meaning of pain, the consumption of attention resources by pain and a set of strategies that are utilised in coping.”

The judge concluded by saying

“The conclusion I have formed that she [that is the claimant] is not lying. There is ample evidence, including from medical

men, that she is suffering pain. She is plainly a poor historian, which is the way I regard her, completely overlooking the fact that she had returned to work for various periods after the accident because, as I say, I do not think that was a deliberate intention to mislead because it would be perfectly plain that her employment records would be with the defendant, as her counsel submits. But it seems to me to be not inconsistent with the psychologist's assessment of her general IQ. It is perfectly plain that, however, unintentionally, the claimant is exaggerating her symptoms of pain. Firstly, there was clearly an apparent resolution after two to three months, (inaudible) [in original] evidence of the account taken by the physiotherapist and later visits to her general practitioner in that period. Secondly, the descriptions given by her in her evidence in court and, indeed, in accounts to the various medical men she has seen are really not borne out by what I have seen on the evidence of her activities on the DVD. Thirdly, Mr Spooner's psychological testing suggested exaggeration and, as I say, I was impressed by his report, and that seemed to tally with the DVD evidence. Of course, the exaggeration may have a considerable effect on any claim for care provided by the family about which I heard evidence, not only from her but also from her husband and son."

7. The Claimant's case was advanced on the basis that:
 - (1) The judge had found that her complaint of continuing pain was genuine albeit that she may have exaggerated the level of pain and her restrictions.
 - (2) The pain had a temporal link with the accident.
 - (3) Although the orthopaedic experts had not identified the precise cause of the pain, they had not identified any non-accident, pre-existing or supervening cause for her symptoms.

- (4) The psychiatrists had not identified any alternative psychiatric explanation for the Claimant's continuing problems.
 - (5) The link in time, the fact that there were genuine problems and the absence of any alternative explanation was sufficient for a finding that, on the balance of probabilities, the accident was the cause of her continuing symptoms.
8. The Defendant advanced the simple and ultimately persuasive argument that the Claimant had failed to prove, on the balance of probabilities, that the accident was responsible for the symptoms. It was contended that the Defendant had no burden of explaining the symptoms on some basis consistent with a non-accident origin. The Claimant had and failed to discharge the burden of establishing causation.
 9. The Defendant's argument was accepted by the trial judge and upheld on appeal. The approach adopted by the trial judge, requiring the Claimant to identify the likely cause of her pain and the causative link with her fall, was supported in the Court of Appeal, it being found that the Claimant had failed to establish a causative link between her symptoms and the accident in question.

10. A reading of the Judgment suggests that the approach to the medical issues by the experts may have assisted the Defendant's position. However, the case illustrates the important components in arriving at a finding of liability in these cases and the importance of identifying and addressing the same. A reading of the case suggests that this exercise was performed well by the defendant's team and poorly by the claimant's.

Foreseeability

11. It is highly unlikely that this issue will be of any importance or benefit to the defendant. Whilst it is a pre-requisite to any claim in negligence that injury of the type sustained was reasonable foreseeable, ever since Page v Smith,⁵ recovery for psychiatric injury has been allowed where the Claimant is a primary victim provided some injury, whether physical or psychiatric, was reasonably foreseeable.⁶ It is simply no answer for the defendant to say that only a minor strain or whiplash injury was anticipated from the minor fall or low velocity impact of the collision.

⁵ [1996] AC 155.

⁶ The absence of any legal distinction in relation to foreseeability has, to some extent, stifled the debate as to whether chronic pain should be viewed as a physical, psychiatric or even psychosomatic disorder.

Causation

12. This is undoubtedly the most important legal issue in any claim of this type. It is crucially important for those facing these claims to identify and seek answers to the following issues:

- (a) Was the accident or incident, the subject matter of the claim, the cause of the claimant's injury?⁷ It is irrelevant that the defendant's conduct is not the main or predominant cause.
- (b) Once the claimant has established that the accident has made a material contribution⁸ to his/her symptoms, the defendant will be legally responsible for the loss flowing from the condition, subject only to any quantum defence.
- (c) The defendant may advance and thus will need to explore a number of causation issues relating to quantum.⁹
- (d) Absent the defendant's tort is there a chance that the claimant would have developed the same or similar symptoms?¹⁰

⁷ Causation in this sense is established if the defendant's tortious conduct is found to be a cause of the development of the condition. See Shorey v PT Ltd [2003] 197 ALR 410. Also, Simmons v British Steel [2004 UKHL 20].

⁸ Any impact that is not considered to be *de minimis* is material.

⁹ The medical experts will have a crucially important role to play in this analysis.

¹⁰ This issue is not determined on a balance of probabilities. It is sufficient that the defendant show that there was a chance, even if less than 50%.

- (e) Where the claimant was vulnerable to symptoms of chronic pain and other disorders, it will be necessary to look closely at the likely development of any such condition absent the accident.

- (f) Although there is some jurisprudence to support the proposition that the tortfeasor's liability to compensate the victim only for the damage cause may require apportionment, even if on a rough and ready basis;¹¹ more recent judicial thinking suggests that this rough and ready approach to apportionment is unlikely to be applied to psychiatric injuries.

Quantification

- 13. The apparent intractable nature of these conditions will very often lead to large claims in respect of loss of past and future earnings and the cost of care. The prognosis in respect of these poorly diagnosed conditions is a crucially important feature that must be explored with the defendant's medical experts.

The Appropriate Medical Experts

- 14. This is a crucial, if not the most crucial, decision that needs to be taken in any case.¹² A focused approach is required. It is very often the case that an orthopaedic consultant is instructed initially at a time when the claimant's condition and prognosis is poorly understood, when an assumption is made that

¹¹ **Rahman v Arcarose Ltd** [2001] QB 351.

¹² There is likely to be an array of disciplines from which to choose, including orthopaedic, psychiatrics, psychologists, pain clinicians, neurologists, rehabilitation clinicians.

the symptoms will resolve ‘in the usual way’ and a prognosis is provided as a substitute for any proper attempt at a diagnosis. By the same token a hasty diagnosis should be avoided. Where the claimant’s symptoms are not readily explicable within the expertise of the orthopaedic consultant, this should be stated without any attempt to make a diagnosis outside the expertise of the expert. An orthopaedic report that concludes with a psychiatric diagnosis might be viewed as ‘helpful’ in understanding the claimant’s condition but might later prove somewhat dangerous. It is important for the orthopaedic expert to be alert to the signs that the case may not be a simple or straightforward one.

15. A psychiatric opinion will very often be required. A correct understanding (and explanation to a court) of the range of psychiatric diagnoses for enigmatic chronic pain is crucial in order to avoid confusion. Somatoform disorders are recognised mental disorders. It is suggested that persons suffering from these disorders unintentionally produce somatic symptoms that mimic the ‘medical’ illness. Within the somatoform disorders is a diagnostic classification devoted especially to those whose principal somatic symptom is pain.¹³ Courts are generally not familiar with these concepts and require educating. Lawyers and insurers should not be shy in asking the medical experts to explain. If the defendant’s team is confused the likelihood is that the judge will be too!

¹³ The diagnosis of this condition assumes that the ‘pain’ is attributable substantially to psychological factors. The presence of some general medical condition that may explain the pain prevents a conclusive diagnosis.

16. A pain management clinician and/or a psychologist may be required to advise on treatment plans and outcome. Early intervention is very often said to provide the maximum opportunity for recovery and/or assessment as to the genuineness and/or severity of the claimant's symptoms.

17. An early case conference with relevant medical experts is crucial. The role and boundaries of the various medical expert opinions need to be fully understood. Addressing the issues comprehensively will often involve a team approach. Much of the process of diagnosis is exclusionary.

18. The issue of 'somatising' of symptoms and 'malingering' must always be considered.¹⁴ Although the issue as to whether the claimant is deliberately feigning or exaggerating a disability for the purpose of enhancing compensation is ultimately one for the court, many experts wrongly assume that they cannot express an opinion on this ultimate issue. This is incorrect. Instructing solicitors, insurers and the medical experts need to understand what the medical report can and cannot say.
 - 18.1 An orthopaedic expert can and must comment on whether the claimant's complaint of pain and/or restriction of movement are consistent, and explicable by reference to orthopaedic understanding of organic pathology.

¹⁴ These concepts are often poorly understood by lawyers and judges. The distinction between conscious and unconscious manufacturing of symptoms is not always easy to identify.

18.2 The psychiatrist may be required to consider the complaint of pain, etc, in the context of opinion that excludes an orthopaedic or other ‘organic’ explanation. A number of psychiatric diagnoses require the exclusion of malingering before the diagnosis can be reached. If malingering cannot be ruled out then a diagnosis such as a ‘pain disorder’ should not be made.

18.3 A pain clinician will be able to cast an expert eye over the claimant’s medical records with particular emphasis on what is said (and unsaid) in the context of any pain management programme or treatment that the claimant has undergone. The performance of the claimant during this period may be of crucial importance in relation to overall credibility.

Surveillance Evidence

19. It is fact of life that surveillance evidence is here to stay. So prevalent is the use of surveillance that in cases where it does not feature it is often the subject of comment, it being argued that the claimant’s credibility is enhanced by the absence of the same.

20. Surveillance evidence can play a crucial role in assessing and perhaps undermining the credibility of the claimant. The basic purpose of surveillance evidence is to assess the claimant’s function in circumstances where s/he is

unaware of the fact that they are being observed and to compare and contrast this with the account given or observations of the claimant at formal medical consultation or the contents of a witness statement.

21. Diagnosis of chronic pain conditions will often involve detailed examination of the claimant's lifestyle and functioning. Any inconsistency between this history and the surveillance evidence is likely to be readily ascertainable. There are crucial decisions to be made in relation to the timing of the release of surveillance evidence to the medical experts. The following points should be noted:

21.1 Release of DVD or similar material to the medical experts will trigger the defendant's disclosure obligation (even if inspection of the DVDs need not be given).

21.2 Experts should provide a measured response to the disclosure and reporting on the contents of the surveillance evidence.

21.3 Disclosure of surveillance evidence should be full. A medical expert should be informed as to the circumstances of the DVD. Great care needs to be given in deciding what the medical experts are to be provided with. The basic rule is to ensure that the expert is not undermined or misled.

Bringing the Case Together

22. A fully prepared defence to claims involving allegations of chronic pain should be able to provide answers to the following issues:

- (1) Is the claimant's condition wholly or partly due to any organic process?¹⁵
- (2) Is the claimant's condition explainable by reference to psychological or psychiatric processes?
- (3) In either event, is the defendant's tortious act¹⁶ a medical cause of the claimant's condition?¹⁷
- (4) Are there any other causes of the claimant's condition?
- (5) Where other causes or potential causes are identified, what is the probable or likely evolution of the claimant's condition absent the defendant's tortious conduct?
- (6) Is the claimant's condition treatable?

¹⁵ The medical experts will need to be able to deal with emerging arguments of a 'biological process' for the explanation of chronic pain.

¹⁶ In the sense of accident or injury.

¹⁷ The concept of contributory cause will need to be understood.

- (7) Has the claimant exhausted all reasonable treatment avenues?
- (8) What is the prognosis for the claimant's condition assuming that s/he follows all reasonable treatment options?
- (9) What is the likely reasonable cost of the proposed treatment options?
- (10) Where, as will often be the case, the issue of the claimant's credibility arises, the following issues must also be addressed:
 - (a) Can the issue of malingering be excluded?¹⁸
 - (b) Does the evidence suggest that unconscious rather than conscious processes are at play?

Conclusion

23. Claims based on insufficiently explained persistent pain conditions are recognised as a compensatable form of personal injury. Awards are usually significant on the basis that the claimant's disability not only prevents remunerative work, but also demands care and assistance, ongoing medical treatment and change of accommodation.

¹⁸ In the context of a damages claim, the obvious "gain" is the prospect of a significant financial award and, of course, the ongoing financial benefits from the State.

24. There remains an element of judicial scepticism in respect of such claims and issues relating to causation and proof of injury remain at large in many of these claims. In **Thorp** the judge rejected the Claimant's claim notwithstanding a finding that the Claimant did have continuing pain emanating at the site of the original injury and those symptoms had some temporal link with the accident. The claim failed because the orthopaedic evidence excluded an orthopaedic cause and the psychiatric evidence failed to identify a psychiatric cause.
25. The position achieved in the joint medical reports was immediately helpful to the Defendant. The Claimant was left with the argument that, even though the mechanism and the cause of her symptoms were unexplained, the court should infer that the accident had something to do with the continuing symptoms and should be assumed to have caused them.
26. The rejection of the argument put that way is unsurprising; however, the more important feature of the case is the fact that properly marshalled evidence left the Claimant with this as her sole argument.

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