

The role of the pain expert

History

When I first started doing personal injury work, over 25 years ago, chronic pain cases from soft tissue injuries were very much in the domain of orthopaedic surgeons.

Some orthopods said that soft tissue injuries would cause symptoms forever, some said six months, some said somewhere in the middle. None of them were particularly able to give an explanation.

The orthopaedic surgeons also advanced arguments as to acceleration, namely that if somebody did develop painful symptoms then this would have happened anyway due to underlying degenerative disease. They argued that this had been accelerated by reason of the index accident, which had rendered a previously symptomatic condition to be symptomatic. There was then an a disagreement between claimant and defendant orthopaedic surgeons as to when this would have occurred with the orthopods dusting off their crystal ball with no real science behind it.

Usually the claimant expert would say it was accelerated by 20 years, the defendant expert would say two years, the orthopaedic surgeons would attend court, have a quick discussion in the corridor, agree upon 12 years and both go off for lunch together.

The Woolf Reforms were brought in as a consequence of this, so that the range of opinion had to be stated in reports and the joint statement was designed to narrow the issues.

Orthopaedic basis

Even with the advent of stating a range of opinion in joint statements, the orthopaedic surgeons continued to say that, where a claimant did not go on to make a full recovery and there was no organic explanation for this, then it would have happened anyway and the damages were limited on that basis.

Many claimants were genuinely baffled as they could not understand why, having got to age of 50 with no real symptoms, they were being told that had the accident not have happened they would have had this level of symptomology in five years' time in any event.

Further, there was a suspension of belief, in that many orthopaedic surgeons considered that the severity of symptoms which would take people off work and require care, etc., would have happened in any event when, quite patently, the whole population did not get to 55 and then suddenly find themselves unable to work.

Only a few orthopaedic surgeons bought into the concept of chronic pain. Most of them were dismissive and frankly disbelieving. If they couldn't give an explanation for the pain, then clearly it could not possibly exist. The claimant was exaggerating!

Functional overlay

Where the symptoms spread or became far worse then orthopaedic surgeons were forced to say that they could not give any real explanation and said that the case descended into the realms of psychiatry and it was named 'functional overlay'.

The psychiatrist thereafter picked up the baton and argued as to pre-existing vulnerability, different differential psychiatric diagnoses and, again, whether there was an acceleration.

Arguments as to whether somebody would have developed the symptoms in any event took on a Monty Pythonesque feel. An expert would say that the claimant would have developed chronic pain in any event. When asked why, it was stated because they did develop chronic pain therefore it was always going to happen. The trauma appeared to be almost incidental.

Pain consultant

20 years ago it was almost impossible to get a report from a pain consultant from a DJ. The DJs looked genuinely puzzled when told that an orthopaedic surgeon could not give an explanation and used to say, well, in that case there can be no organic basis and therefore no claim.

Arguments against a pain consultant included that they were not able to give a diagnosis, they were not able to talk about causation and they could only talk about treatment. I have heard this argument on numerous occasions and gradually it has been possible to convince courts that this is totally fallacious and that not only can pain consultants give a diagnosis but they can also talk about causation, treatment and prognosis.

It has taken years to persuade the courts that not only is there a role for a pain expert but that that piece of evidence was the crucial piece of the jigsaw necessary to understand what was happening with the claimant. The pain expert could explain the medicine of why a claimant might go on to develop a chronic pain condition after trauma, from which it would ordinarily be expected that there would be a full recovery.

From the Defendant's point of view the pain expert was able to say that there were other potential causes for the pain other than the trauma contended for. The Defendant's pain expert would assess the Claimant's pre and post accident condition and other vulnerabilities and factors that could lead to the development of a pain condition in any event, thus rebutting the Claimant's claim that she was fine before the accident and terribly affected afterwards with the assumption being that the accident had been the cause of the decline.

Progress

Due to the reporting of cases, numerous applications and running cases, gradually the courts' view as to the concept of chronic pain cases has been accepting. There has been a marked sea change in the approach taken by courts.

The Judicial Studies Board Guidelines looked at chronic pain simply as being a facet of psychiatric injuries. All the editions up to the 10th Edition simply had chronic pain as an adjunct to the chapter on psychiatric damage.

The 11th Edition changed this and chronic pain suddenly had its own chapter. This was in no small part due to the recognition of the fact that chronic pain cases were separate from orthopaedic injuries and separate from psychiatric injury.

Prevalence of chronic pain

- (i) 1995 – Woolfe, USA – number in study 3,006, chronic widespread pain 11%, fibromyalgia syndrome 2%.
- (ii) 2000 – Lindell, Sweden – number in study 2,425, chronic widespread pain 4%, fibromyalgia syndrome 4.3%.
- (iii) 2004 – Gruppe, Germany – number in study 3,969, chronic widespread pain 13%, fibromyalgia syndrome 0.3%.

Statistics

In 2015/16, 770,000 RTA related PI claims were referred to the CRU, of those 680,000 involved soft tissue injuries to the neck or back.

In 2015, there were 22,137 accidents reported to the Police that were classed as causing serious injuries.

These statistics confirm what personal injury practitioners know, namely that the vast majority of cases brought are in respect of low-level injuries from minor accidents which settle quickly for a modest level of damages.

Pain Summit

The Pain Summit gave the statistic that in the UK, 7 million people suffer from chronic pain, *i.e.* approximately 10%. The average time for the patient to receive a satisfactory diagnosis is 2.2 years.

Growth of chronic pain PI claims

It is estimated that 5% of people with minor injuries do not go on to make a full recovery but continue with intrusive symptoms. If one extrapolates this to the number of injuries per year, this would correlate to approximately 35,000 cases per annum. These cases change from a portal case with a modest level of damages and costs to either a fast-track, multi-track or catastrophic injury case with a significant amount of damages.

Identifying pain cases

One of the major difficulties in chronic pain cases is identifying them in the first place. The average time for a satisfactory diagnosis of a chronic pain condition is 2.2 years. Often, symptoms will develop which, on the face of it, bear no resemblance or relationship to the initial injury and if they worsen often the claimant and the treating doctors do not necessarily think that there is a link. It remains up to the personal injury lawyer to be able to identify that there could be a link and thereafter to instruct the appropriate experts.

The role of the pain expert

Once there is a suggestion that there could be a chronic pain developing then the pain expert is invaluable. Gone are the touchy feely days when it is simply stated that somebody has pain and it should be accepted without any explanation. Now there is hard and fast science to show why people have pain even when there is nothing that can be shown upon scans or x-rays. The theory of central sensitisation of nerve damage which is too small to be detected by nerve conduction studies has been proven. There is substance P which occurs in people with chronic pain and in particular fibromyalgia. Professor McNaughton has identified a gene connected with chronic pain in his trials at Cambridge.

Pain experts give the explanation as the difference between nociceptive and neuropathic pain. They draw on the definitions by the American College of Rheumatology of fibromyalgia in 1990 and 2010 which are accepted by the courts. The diagnosis of CRPS using the Budapest criteria is accepted and used by the courts. The definition of chronic fatigue syndrome with the Fukuda definition has also been accepted.

Conclusion

The courts are now far more comfortable with and accepting of the fact that not all people get better, some people get worse and some people have devastating injuries as a result of relatively low-level trauma. The pain expert gives an explanation as to why this happens and can provide the science to explain and to support it.

Equally from the defendant's point of view, the pain expert can set out why the symptoms complained of might not be related to the trauma, raising the pre accident condition and post accident records together with presentation.

There arguments as to whether the claimant has developed a chronic pain conditions as a consequence of the accident include:

- (i) What was the claimant's pre accident condition?
- (ii) Was there an injury at the time of the accident?
- (iii) What is the diagnosis?
- (iv) Is there a temporal connection between the accident and the developing pain condition?
- (v) Is there a medically causative explanation?
- (vi) Are there other causative factors?
- (vii) Was the claimant on a trajectory to develop some sort of chronic pain in any event?
- (viii) Is there consistency of presentation?
- (ix) Interpretation of any surveillance;

(x) condition;

(xi) Treatment

(xii) prognosis.

The courts are now far more receptive to the idea of pain experts being involved in determining these issues.

Message

It needs to be for the legal fraternity to spot chronic pain cases evolving and identify when a pain expert is needed. Often the claimant will not have a proper diagnosis from their GP. The initial reports from the GP or orthopaedic surgeon may not spot that the claimant has an evolving pain condition. The claimant may not even appreciate it other than knowing that she has not been right since.

I know that cases are missed, because I see exacerbation cases where it is quite obvious that the chronic pain condition came about as a result of a previous accident. If these cases are not spotted then the claimant will be undercompensated, the case stays in Portal and there is a potential professional negligence action.

All file handlers need to be trained to spot these cases and to recognise that there is a need for a pain expert to be involved. Once identified a pain expert should be considered to be essential regardless of what the initial report from the GP says.