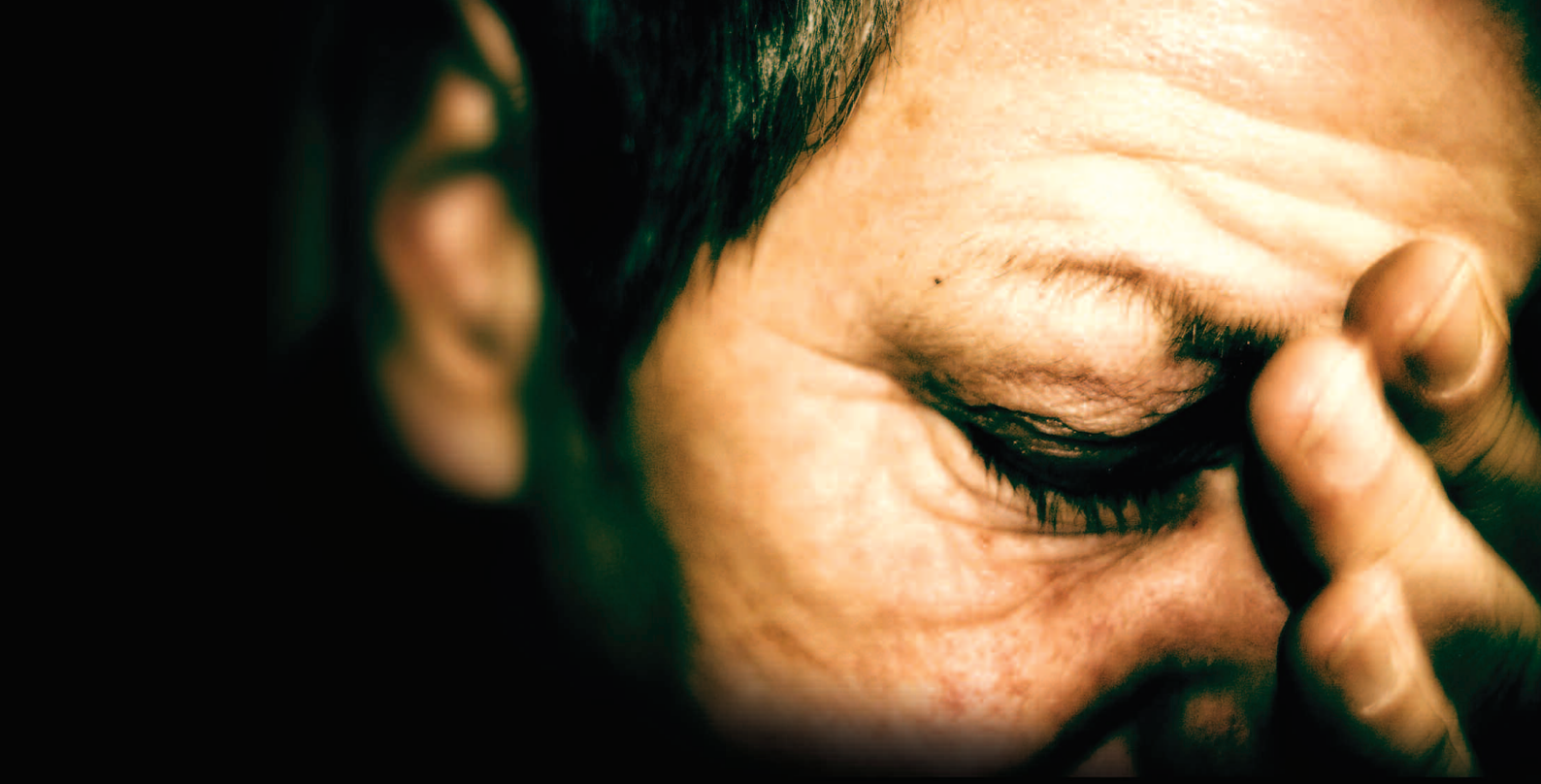

Expert Evidence in Chronic Pain

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Pain is 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage' (International Association for study of pain). Duration and prognosis contribute to pain being categorised as Acute or Chronic.

The overlap between orthopaedic and psychological/psychiatric opinion in cases of chronic pain, with significant functional impact, frequently cause lawyers and the court difficulties, in terms of diagnosis, severity assessment, causation and prognosis/treatment (Koch and Mackinnon, 2009). The authors have had considerable experience of chronic pain assessments, joint reports and/or joint cross specialty opinions to explain a claimant's ongoing pain experience and repeatedly encounter semantic and evidential difficulties.

Over 7 million people in the UK are affected by chronic pain, which is the second most common complaint cited by claimants on incapacity benefits. Chronic pain is also associated with conditions such as arthritis and cancer as well as traumatic events such as road traffic accidents, work related incidents and medical accidents.

Psychological factors not only contribute to how pain is initially perceived but are also predictive of how individuals will cope long term with ongoing pain (Koch and Hampton, 2011).

Medico-Legal issues associated with chronic pain

A) Pre-existing pain

When carefully distilling through the self-report and medical evidence associated with a claimant 'in pain', the medico-legal issues, which arise, include:

1. The 'egg shell skull' principle – a claimant must be taken 'as they find him/her', even if index-event complaints are aggravated by previous health problems.

2. The alternative ' predisposition' model in which a claimant's vulnerability to ill health or pain could be considered causative of a post index-event condition and that it would have been triggered by another further occurrence in any event e.g. somatoform personalities.

These two issues have been considered in a number of cases, e.g. Page v. Smith (1996); Giblett v. Murrays (1999). The key test of causation, arising out of these deliberations and in case law is whether the index-event, on the balance of probability, caused or materially contributed to or increased the risk of the development or prolongation of the symptoms of a pre-existing pain disorder, physical or psychological/psychiatric.

Claimant Vignette:
Since the accident I have had excruciating pain in my lower back, and sharp pain down my left leg – they told me this is because of pressure on my sciatic nerve. It's the worst pain I've ever had. I can't sit still and can't settle on anything. I can't imagine how this pain could be worse than it is – on a scale of 1 to 100, the severity of the pain is 110! I've had back pain before but never as bad as this.

Orthopaedic Expert Vignette:
As soon as I saw Mrs Jones, she looked in pain. She had difficulty walking to the examination room and gasped a lot on the way. She got up several times during the interview to walk around. It was strange as one test I did on her resulted in two different results (one more mobile than the other) depending how I did the same test – medically this is unusual, if not impossible – I wonder if psychologically she is finding this pain so difficult to cope with that these 'unusual medical results' occur?

B) Diagnosis of pain-related disorders

Typically much of pain experience will have an organic/medical cause, which will be assessed, and diagnosed by a 'medical' expert e.g. GP, Orthopaedic surgeon. In some cases, despite an initial medical diagnosis, the continuation of the pain experience will be difficult to explain in organic terms or becomes a chronic condition which is so complex and confounded by social and psychological factors that the original cause has less, if any, meaning. It is at this stage that a psychological/psychiatric opinion is typically sought. A further Pain Management report from an anaesthetist may subsequently also be commissioned. Referring to DSM V, one of the two main classification systems of mental disorders (APA, 2000), disorders involving pain fall into seven categories: -

- **General medical condition -**
  Fully accounts for the physical complaints.

- **Somatoform Disorder -**
  A history of many physical complaints over several years in different body sites, plus gastrointestinal and sexual/reproductive areas and not fully explained by a known general medical condition.

- **Pain Disorder -**
  Typically pain is adversely affected by psychological factors such as anxiety and depression, in otherwise robust personalities.

- **Generalised anxiety disorder -**
  Characterized by worry not limited to, but including, physical symptoms.

- **Panic disorder -**
  Somatic complaints occurring only during panic attacks.

- **Depressive disorders -**
  Somatic complaints that are limited to episodes of depressed mood.

- **Schizophrenia or other Psychotic disorders -**
  Somatic concerns that are of a delusional nature.

In addition:

- **A psychological organic pain processing disorder:-** is recognised, but is very rare.

C) Assessment Issues

When interviewing a claimant whose presentation has been described as one of chronic pain, the following areas require investigation: -

1. Clear history of site-specific pain onset.
   This is obtained from claimant self-report plus GP (and other medical) attendance information.

2. Evidence of unrelated prior attendance to, typically, medical practitioners for one or more

somatic complaints and associated frequency of such attendance.

3. Evidence of social factors including partner and family response to the pain and associated difficulties.

4. Interview data on how the claimant presents and verbalises his/her pain.

5. Claimants awareness of how psychological factors (ways of thinking, self-confidence, optimism, behaviour and social activity) impacts positively or negatively on the claimants coping strategies and perception /tolerance of pain.

6. Reliability of claimants history giving – many people have difficulty recalling or giving accurate history of their pain, due to memory and lack of specificity issues, rather than a wish to mislead. Untruthfulness of claimant's history giving is differentiated from 'Reliability', although it is clearly at the end of the reliability continuum. This is typically for secondary gain such as financial gain and is 'conscious' ie, intended to mislead.

Since the gate control theory (Melzack and Wall, 1965) opened up the view that pain was not purely a physical experience a new definition of pain developed "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (Merskey et al, 1979, p.217). This definition acknowledges the role of meaning and subjectivity in the pain experience. Wall (1999, p.179) stated that the practical question of controlling pain cannot 'be answer satisfactorily until we understand the context in which pain resides. Pain is one facet of the sensory world in which we live.

Assessment of a claimant's experience of pain and their beliefs is important in the prognosis and or/treatment outcome (Skevington, 1995). Beliefs around coping with general adversity can be informative for how they cope and management with pain.

Cultural beliefs can be mediators of how pain is experienced. Shi'ite Muslims can believe the pain experience as enabling them to come closer to God whereas Sunni Muslims preferred to seek pain relief (David, 1998).

The chronic pain experience has also been described in relational terms in that Mason (2004) differentiates people's relationship with the pain and significant others in terms of 'primary' and 'secondary' relationships. When the relationship the person (and the significant other) has with the pain is primary, it can mean the pain is all consuming and other important relationships become secondary to that primary relationship with the pain. In a sense the pain dominates and rules over the person's life which can further impede and increase the severity and intensity of the pain but also accentuate the difficulties in pain management. Interventions with patients who experience chronic pain can be assisted in exploring their relationship with the pain away from a primary relationship to a secondary and that important relationships remain at the foreground or primary thus improving the prognosis. Similarly the fit between the beliefs about the pain (e.g. how the pain should be managed by each of them, and their expectations of the other) between the person with the pain and significant others is also important in their experience and coping with pain. Assessment of the relational component therefore e.g. family members beliefs about pain management can be informative in assessments, management, treatment outcome and prognosis.

D) Treatment and prognosis of chronic pain
Psychologists and pain management specialists are activity engaged in providing psychological (and medical) interventions in cases of chronic pain, addressing the several psychological (cognitive, emotional, behavioural) and social aspects of disability. This can be offered either on an individual (one-to-one) basis or as part of a multi-disciplining hospital –based pain management intervention.

Example Pain Assessment Trail during litigation process

GP → Orthopaedic → Psychological/Psychiatric → Pain Management (Anaesthetist)
↓
Multidisciplinary Management Treatment (Medical and Psychological CBT)

Coping with pain: A Vignette
Since my accident two years ago, my back continues to hurt and stops me doing things at home and work. In the first few months, I saw it as a medical/physical problem only, but since going to the local pain management clinic I have learnt how to use distraction, and other cognitive (thinking) techniques to put the pain into a context which doesn't define me. I pace myself – stopping, resting and starting again. I take every opportunity to tell myself if I have achieved something. The pain has changed a little but the main thing is I think I'm managing the pain better.

Pain-related Joint Orthopaedic/Psychological assessment and opinion
To address comprehensively the several medical and psychological aspects of chronic pain, some orthopaedic/psychologist teams are currently offering 'joint appointments' to lawyers. Such appointments have the advantage of:

- Same day appointment with orthopaedic specialist and clinical psychologist.
- Separate report with agreed conclusions following case discussion between experts.
- Appointment within 6 – 8 weeks.

These assessments cover:

Orthopaedic

- Location of pain – anatomical, organ system
- Temporal characteristics of pain and pattern of occurrence.
- Aetiology.

Psychological

- Psychological experience of pain.
- Impairment in social and occupational functioning.
- Psychological factors in onset, severity, exacerbation and maintenance of pain.
- Exclusion of factitious disorder or malingering.
- Use of pain coping strategies and readiness to change.

Joint Opinion (orthopaedic/psychological)
On occasion, the court will instruct an orthopaedic and psychological expert to discuss their separate, independent opinion and prepare a 'Schedule of Agreement and Disagreement' relating to the claimant's chronic pain. Despite the different clinical background of the two experts, discussion views on the interface of physical and psychological explanations and prognosis can be invaluable to the court's deliberations.

Conclusion
Ensuring accurate and reliable assessment of pain experience and associated level of social and/or occupational description require careful, often multi disciplinary expert opinions. In particular, the liaison and collaboration between psychologists and orthopaedic surgeons who understand each other's view-point is essential. Currently these authors are looking at how reliability of both specialties and their joint opinions can be enhanced. Results will be published in due course. ■

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