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Compensation Claims Relating to Chronic Pain Part Two: Expert Evidence and the Role of the Expert Witness

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This is the second of four articles designed to assist the layperson in understanding compensation claims involving chronic pain. The first article offered an overview of chronic pain, litigation and an introduction to factual and medical causation. This article will focus more specifically on the position and role of the expert witness. The third article will then concentrate on specific examples of pain syndromes (including complex regional pain syndrome (CRPS), myofascial pain and fibromyalgia) and pain disorders, and in the fourth article we offer some further guidance in relation to chronic pain claims.

The context of expert evidence: why we need expert medical evidence

It is easily forgotten that the sole reason why the courts permit expert evidence is because there are areas in which (lawyers and) judges do not have enough knowledge to resolve issues in dispute. Medical causation[5] is so critical that no personal injury claim can be commenced without expert evidence.

In approaching the issue of expert evidence, it is critical to keep in mind two points:

(1) The court manages the expert evidence which is permitted under the ever-present duty to restrict such evidence to that which is reasonably required to resolve the issues in the case.[6]

(2) A medical expert of any kind who provides evidence in compensation claims has specific duties to the court, which *override* the duties owed to the party by whom s/he is instructed. In a nutshell, the duty is to provide a complete, neutral opinion on all matters within their expertise, and a range of potential opinions in relation to their opinion.[7]

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[6] Civil Procedure Rules '(CPR'), Rule 35.1.
[7] Practice Direction to CPR 35.

In many modest cases, with a complete recovery in a short time, a GP provides an expert report, which enables the parties to settle a claim. In cases with more significant injuries, perhaps a fracture with a slow recovery and some residual pain/restriction, an orthopaedic expert provides the necessary evidence. Also, in cases where the injury and compensation is likely to be relatively straightforward, there may be one 'joint' orthopaedic expert, who provides the expert evidence for the court on behalf of both parties.

We are concerned here with more complicated cases where pain persists in the long term, and in such cases experts in different disciplines are often required in order to provide an accurate picture of the claimant's injuries.[8] It is often the case that both 'sides', claimant and defendant, will be given permission to obtain expert evidence in like disciplines. That is often because: (i) the diagnosis of the symptoms is difficult or controversial (and have a wide range of opinion); (ii) the claim may be potentially substantial, for example in terms of past and future lost earnings (so that it is considered 'proportionate' to allow both parties to instruct their 'own' experts); and (iii) because by instructing an expert, a party can *test the evidence* in a meeting (usually called a conference) with the client, expert, solicitor and barrister.

'*Testing the evidence*' in that way can lead to a clearer understanding of the strengths and weaknesses of the case, and importantly can help the legal teams to satisfy themselves as to whether the original accident can be linked to the continuing symptoms. That, in turn, ought to lead the parties to be able to narrow down the issues in dispute and attempt to negotiate a reasonable settlement of the claim.

Experts (like lawyers) are well rewarded for medico-legal work. They must view preparing a report as just as important as any other aspect of their job. No claimant should be made to feel (by experts acting for either party) as if medico-legal work is an inconvenience at the end of a busy working day. In order that the expert can assist the party (and more importantly the court) to understand the issues, the expert must be comprehensively instructed and provided with all relevant notes and reports before the examination.

The importance of selecting the correct expert

Appropriate expertise and the risk of imbalanced expertise

If a person suffers a spinal injury, the most appropriate expert is probably a spinal surgeon, a neurosurgeon or orthopaedic surgeon with a special interest in spinal surgery. If one side instructs an expert whose day-to-day practice is spinal surgery and the other party instructs an A&E consultant (even an excellent one), there is already an imbalance of expertise. The spinal surgeon is probably likely to have more command of the narrow field in question, be more familiar with the studies and journals concerned with spinal practice, and be effortlessly authoritative in his report, and then if necessary in the witness box.

[8] In chronic pain cases, most often these are an orthopaedic, psychiatric and pain medicine expert.

Appropriate and relevant expertise

The point is even more important in cases concerning chronic pain. First, having an eye to the court's duty to restrict expert evidence, a party must be careful to select an expert with appropriate expertise. But it is not always easy to know who is the appropriate expert in any given chronic pain case. It might, for example, be a rheumatologist[9] though it is now more increasingly likely to be a consultant in pain medicine.[10] The final answer to this question is likely to be dictated in the first instance by the diagnosis/opinion of the original medico-legal experts (often an orthopaedic consultant) together with a careful reading of the medical records, which almost always contain relevant insights from treating clinicians.

An example – long-term 'whiplash'

Take an example of a young woman who suffers a moderate localised trauma to her neck and shoulder (not untypical of a rear-end road traffic accident (RTA), giving rise to a so-called whiplash injury). Most orthopaedic experts will anticipate a recovery over a period of weeks or a few months, and this will prove to be the case in the vast majority of patients. In some individuals, the symptoms may last longer (perhaps up to two years). For a small minority of unfortunate individuals, the symptoms may continue, sometimes becoming more severe and/or increasingly more widespread throughout the body.

In such situations, often the orthopaedic expert will ask for scans to rule out a significant 'bony' injury. If the scans prove 'normal' that expert often seems to suggest either that: (i) this claimant is one of a very small minority of individuals who can continue to experience symptoms in the longer term, even permanently; or (ii) it is now likely that the claimant's symptoms are being caused by something other than the original soft tissue injury. This is the point at which another expert is likely to be required, not least because the orthopaedic expert is having some difficulty – *from the standpoint of orthopaedic medicine* – in supporting the continuing link between the accident and the symptoms.

There are other clues which can help the injured person's representatives decide where to turn next to understand the relationship (if there continues to be one) between the original accident and the continuing symptoms. Sometimes, the examination by the orthopaedic expert reveals some signs suggestive of a medical condition. One example might be the discovery of a number of 'trigger points'.[11] Another outcome of the examination might be that the claimant reports pain from a part of the examination, which should not have been capable of causing that person pain.

If the claimant's examination by the orthopaedic expert did not reveal any apparent unusual features, then the next port of call is likely to be a pain expert or rheumatologist *depending on the precise nature of the symptoms*. The choice can sometimes be sensibly narrowed down by reference to the post-accident clinical

[9] '… a doctor who specialises in diagnosing and treating arthritis and diseases related to rheumatology. There are over 200 different diseases that affect the joints, bones, muscles and other soft tissues' (see generally www.arthritisresearchuk.org).

[10] A doctor, often with a background in anaesthetics and specialist training within a Faculty of Pain Management, with broad experience in diagnosing and treating patients with long-term pain, including pain with orthopaedic or neurological origins.

[11] Sites which cause particular pain during examination, often in a pattern which is typical of a specific diagnosis.

records and notes, and discussing which treatments, if any, have afforded the best results to the claimant.

If, on the other hand, there are some unusual features in the orthopaedic examination (typically a claimant reporting pain which is impossible to explain by physical – structural – abnormalities), it may be that the origin of the pain lies in either one, other or both of physical and psychiatric causes. It is worth noting that a *purely* psychiatric origin of chronic pain is extremely rare.

It is worth noting that in many chronic pain cases, both rheumatologists/pain experts on the one hand and psychiatrist/psychologists on the other recommend reports in each other's discipline to assist in understanding the correct diagnosis. This is also a product of the fact that in such cases *causation* can be elusive and/or controversial.

Taking the above example a little further, it may be that the claimant's pain is physical in origin, diagnosed by a pain consultant as 'neuropathic pain'[12], or perhaps 'nociceptive pain'[13] and responds to medication (and/or perhaps carefully targeted injections) so that it improves with time. However, it may be that, on careful examination, the pain clinician does not find any apparent *physical* cause to account for the pain at all. At this point, typically, the psychiatrist's perspective can be crucial.

It may very well be that the individual was vulnerable to experiencing genuine chronic pain, but pain which has a different root cause. In general terms, a psychiatric expert will diagnose a *pain disorder*,[14] which in a nutshell reflects pain in which psychological factors are playing a significant role. The extent of this role may vary from, on the one hand, sitting alongside other physical factors in contributing to the pain (quite a common scenario in chronic pain patients) to, on the other hand, fully accounting for the pain (a much rarer scenario). The concepts of pain syndromes and disorders will be discussed in more detail in the third article but, for the present, it is critical to understand that just because a person's pain cannot be traced or linked to a clear physical cause does not: (i) mean the pain is not entirely real to the sufferer; (ii) indicate that the sufferer is aware of any vulnerability that they may have had to develop chronic pain; and (iii) necessarily break the link between the accident injury and the individual's chronic pain. Very often, as we shall see, vulnerabilities to pain disorders can arise from traumatic events in early life (typically abuse, but including bereavement etc.), and it is important that they are not ignored when trying to identify the correct diagnosis in a particular situation. In modern pain medicine, *purely* psychiatric causes for chronic pain are considered exceedingly rare. Similarly, it is not usual to seek to subdivide patients into 'pain syndromes', 'pain disorders' etc. in clinical practice (as opposed to medico-legal practice) – rather, it is better practice that treatment should be delivered by multidisciplinary teams including pain medicine consultants and psychologists/psychiatrists working together in a collaborative manner, often at a pain clinic.

[12] Pain described as 'neuropathic' arises from nerves. It may be caused by damage to a nerve itself, or the function of the nerve (such as the way in which it transmits pain messages to the brain). It is often described as burning, stabbing, shooting, aching or like an electric shock.
[13] Pain described as 'nociceptive' arises from damage to tissues themselves (such as a cut, burn, injury etc.), which activates the nerve endings which send messages to the brain (see generally www.patient.co.uk/health/neuropathic-pain).
[14] Pain disorder is a general term for chronic pain with a significant psychological component.

How to select the correct expert

Solicitors with expertise in compensation claims ought to be able to select appropriate experts, namely a person who will provide authoritative, persuasive opinion based on evidence. In some cases, a person may simply leave the choice of experts to the solicitor (typically where the solicitor has worked with the expert in the past).

In some cases, the solicitor and client may be based far apart, and the solicitor may not know the more local expert witnesses. In other cases, particularly those involving chronic pain, the solicitor may not be familiar with the claimant's symptoms and may not know experts with relevant expertise. In either situation, after making thorough inquiries, it is good practice to obtain an 'example' report from the intended expert (with the names deleted) so that your solicitor (and you) can ensure, for example, that the expert reviews the medical notes carefully, provides a clear balanced opinion and explains the opinions he expresses. No reasonable expert should object to sending such an example of his medico-legal work.

Even more care is required if a solicitor is considering instructing an expert who s/he has never used before, and yet more still if that expert has been provided by a medical agency rather than by a colleague or by an independent recommendation or accreditation.[15]

Difficulties in changing expert

The court rightly disapproves of the idea that either party in the litigation will 'shop around' until s/he finds an expert opinion, which supports their case. It has therefore determined that in order to rely upon a party's expert of choice in a given discipline, having already obtained a previous report (for the claim) from another expert, that party must disclose the first report to the other side (who is permitted to refer to it at trial).

It is therefore vital to choose the correct expert first time around, the more so because if the defendant obtains a report which concurs with your first expert, then there may be a worrying balance in the evidence 'against you', putting considerable pressure on your *second* expert, making it harder for them to defend the position that their opinion is the correct one within the *range of opinion* now voiced by the *three* reports.

Also, the presence of two opinions, which support the defendant's arguments, will exert pressure on your lawyers when they come to consider the value of your claim and the risks of failing to beat an offer.

It is also worth noting that even if you do disclose the opinion of the expert you want to abandon, the court will only permit you to instruct an alternative expert if you provide careful, sensible reasons. These might be that the first expert:

- did his job poorly (perhaps failing to read relevant notes, missing important points etc.);

[15] There are a number of organisations to whom experts can become affiliated, or by whom they can be accredited, which give an indication of their expertise in preparing medico-legal report.

- was not sufficiently 'expert' in the field in which he offered an opinion; or
- changed his opinion for no apparent reason.

Your representatives will also have to balance the danger of openly criticising the first expert when applying to use a replacement, which is, of course, that if they fail to convince the court, the defendant will legitimately use those very criticisms later in the case against the first expert that the claimant has not been permitted to replace.

Finally, it is vital not to underestimate the impact of the changes introduced into all civil claims from 1 April 2013, which have introduced higher hurdles when considering whether to permit the use of experts in new disciplines, and replacement experts.

It cannot be emphasised enough that any party seeking expert evidence must select and instruct experts with great care from the outset.

How to assist the expert to undertake the task

I: The letter of instruction

It is critical that an expert is skilfully instructed – in other words, that the letter requesting a report clearly sets out the factors which are relevant to his/her involvement, comprehensively, and where appropriate, chronologically. There is no reason why you should not see and comment on a letter of instruction if you wish to do so.

II: Medical and other records

Why notes and records are critical

It is worth remembering that in a case in which the two sides disagree about any fundamental issue, either they must reach some basis upon which to settle the claim, or the court will ultimately have to decide that issue. In order to determine issues, the court will, of course, consider factual evidence (usually from the injured person, family members, work colleagues and the like) and expert evidence (from the respective medical experts).

In any such case, when faced with factual evidence that is strongly challenged (e.g. a defendant does not accept the claimant's description of symptoms, pain etc.) and expert evidence which disagrees on the crucial issues (usually) of diagnosis, causation and/or prognosis, the court looks for additional clues to help in deciding the issues.

The most obvious helpful resource to assist the court is the claimant's pre-accident history. What these documents also do is to provide the court with a vital *context* in which the claimant suffered his/her injury. There are other reasons why they are so powerful, which particularly applies to GP records (including correspondence). They are:

- a full historical record of the person who then suffered the accident;
- contemporary, usually recorded during or immediately after consultations. They are, on the face of it, a significant improvement on memories of events which are likely to have dimmed over the years; and
- recorded by a person whose sole responsibility is to do their best to address the issues within the consultation – in other words, they are neutral.

It is immediately obvious why the expert must have all of the relevant (i.e. usually *all*) medical records of the injured person before expressing an opinion on *causation*. The same is true, if at all possible, as regards occupational health, and (where appropriate) Department of Work and Pensions ('DWP') records, including applications and decisions – as well as all investigations (typically x-rays, MRI and CT scans).

A couple of examples will illustrate these points. In a *back injury case*, the absence of pre-accident GP consultations for back (or any musculo-skeletal) suggests that the accident injury is likely to be responsible for the claimant's restrictions (to a greater extent than, for example, normal spinal degeneration). Conversely, a history of similar complaints may suggest that the claimant was likely to: (i) have suffered some continuing symptoms in the normal course of his work *even if the accident had not happened*; or, perhaps, (ii) that he would naturally have reached the same level of symptoms within a few years – again *without an accident*. (Pre-accident occupational health records are valuable for the same reason.)

In a *chronic pain case*, the experts will also look for pre-accident entries in the medical notes, and be particularly interested (when considering 'causation') to see any entries concerning longer-term pain in the past, perhaps after a fracture, or a sprain, especially if there is no obvious reason (such as delayed union of a fracture, or an infected wound) why the person would have suffered pain for longer than the period required to recover from the initial injury. Also, experts will be on the lookout for other notes or clues which might help to guide them to understand the person's symptoms, and to advise the court about causation (to what extent the accident is responsible for them) and the prognosis. These include references to a wide range of complaints in the past, all of which have the potential to influence a person's response to pain: irritable bowel syndrome; chronic fatigue; some psychological symptoms; etc.

To recap, in all these examples, the relevance is that while a defendant has to compensate *the person* he injures, he only has to compensate them for *the effects of the injury he caused*. If it is decided (between experts, or following a trial) that the claimant would, 'but for' the accident have suffered similar problems *in any case* then the compensation is limited to that extent, and/or that point in time.

Of course, a typical tension in claims is that a person may consider (rightly or wrongly) that his life was fine before the accident, in that he was healthy, or that he was well able to cope with any pre-accident aches and pains he may have been experiencing, while maintaining a high quality of life and that he would have continued working and would have avoided the chronic symptoms that he now

suffers, whereas the defendant will argue that the person was so predisposed to chronic pain that he was likely to suffer the same or substantially similar symptoms and restrictions even if there had been no accident.

Difficulties in practice: obtaining all relevant records etc.

It is often difficult for the solicitor to obtain records from many different sources (hospitals, GPs, therapists, for example, as well as the fact that notes of treatment will be constantly updated) and some of the medical reports may have to be prepared before all are available. For example, occupational health and DWP records become available later on, not least because in many cases benefit applications are not made until after the injury.

One of the potential difficulties when a solicitor obtains a medical report through a medical agency (which often happens when the claimant is based a long way from the solicitor's office) is that the agency itself obtains the medical records (rather than the solicitor doing so). This can appear convenient, and some agencies are professional and efficient, but it often presents difficulties for the solicitor in, for example, knowing precisely what the expert has been sent.

It is also very important indeed in chronic pain cases that *your solicitor must read through your medical notes with great care*, and discuss with you (and note your comments on) any entries which may appear incorrect or inaccurate. If the medico-legal experts think that all of the notes are entirely accurate, they are bound to place reliance upon them. It is, therefore, vital that any errors or inaccuracies are pointed out to them so that they can provide their opinion. They may help the court by providing their evidence based upon two alternative scenarios: (i) that the record is accurate; and (ii) that it is inaccurate – and then leaving it up to the court to decide which scenario is indeed correct and, therefore, which opinion to place more weight on. This point is further discussed below.

What should the expert do if the records are incomplete?

It can be a disaster if the expert unwittingly provides an opinion without having been provided with relevant records, scans etc. Solicitors and claimants must try to ensure that: (i) the expert has all of the relevant material; *or at the very least* (ii) knows what s/he does and does not have. Remember, there are cases in which the expert may not know that they are missing notes (the expert does not know every physiotherapist etc., the injured person might have seen), but that will not stop the 'other side' from criticising the expert if he has to change opinion at a later stage.

The best practice, where an expert has not received comprehensive records, scans etc., is for the expert to decide whether he can assist the court under the rigorous duties imposed by the court rules. If he thinks this can be done, the report should nonetheless explain that it is necessarily provisional, and list the material that is awaited. However, if appropriate, the expert can (indeed *must*) decline to provide an opinion if it really is not possible to do so without certain material.

For an expert to offer a confident (even strident) opinion without realising that he has not seen all of the notes is likely to make the expert look foolish. Even if the expert changes opinion, in keeping with the new material, there remains a sense (and a judge might later feel) that he should not have offered such a strong opinion before seeing relevant material.

Avoiding pitfalls with medical and other records

Ensuring the notes are accurate

Medical records sometimes contain important information that jogs a person's memory, or reminds them of information that they had long forgotten. The person writing down information, whether a GP, locum (i.e. stand-in) GP, physiotherapist, busy A&E doctor or consultant, will have tried to record what they were told, because the information was critical to determining treatment at that time (hence the power of the notes in the eyes of the court – see above).

However, they may occasionally have made a mistake, misunderstood something they were told or misplaced emphasis. In a difficult case (and most chronic pain cases are difficult) it is important that the solicitor reads the records himself and provides his client with a copy of them. This may seem like 'overkill', but it will give an individual an opportunity to review the notes to see whether they contain any significant errors.

If so, the issue must be raised immediately so that a claimant's solicitor can alert the defendant to the error before it assumes significance in the case (as well as raising it with the 'author' if that is sensible in the circumstances). In cases where diagnosis is controversial, or simply disputed, it is *always* far less satisfactory to complain about the accuracy of a note *after* an expert or other witness has placed reliance upon it.

Stages in litigation after the initial medical report is served

Questions

The court rules permit a party to pose questions to clarify an expert's opinion. Of course, when any party poses questions to an expert, they do so to improve their position, usually by trying to persuade the expert that one or more aspects of the opinion are incorrect or incomplete (e.g. drawing attention to a medical note, or scan, which may not have been taken into account). That is an entirely legitimate part of the process.

It is also entirely legitimate for a solicitor to discuss any questions posed to the expert before they are answered, or to request draft answers and a discussion with the expert before they are finalised. (The defendant can and should do exactly the same with their own experts.)

Some experts appear rather 'old school' about this, and resist what they perceive as 'interference' in their role. However, providing the lawyers acknowledge the expert's duties *and do not interfere with them*, it is entirely permissible to explore the expert's reasoning with him/her before the answers are finalised.

Joint reports

The court invariably orders experts in the same discipline to discuss their respective opinions and produce a 'joint report'. The express aim of the process, and the joint report, is to try to narrow down (or even eliminate) the areas on which they disagree, and to clarify the remaining areas of disagreement.

The discussion takes place privately, and neither party's legal representatives ought to interfere in the process once discussions have begun.

Of course, the very nature of the discussion means that one or other party could be extremely disappointed by the outcome. The worst situation for one or other side is when 'their' expert completely changes his opinion following a formal discussion with the other side's expert. This can happen in any case, but it is far less likely where the experts are professional and have been provided with all relevant material when reaching their original opinion. If it does happen, the expert has a duty to explain the precise reasons for his change of opinion, so that the party instructing him may decide what to do next.

Indeed, 'cracks' most often seem to appear in an expert's opinion in the joint report when one expert:

- Has given an overly supportive opinion in the first place.
- Is embarrassed by an error in the original report, and does not relish being cross-examined at trial.
- Was not provided with complete instructions and/or medical notes when finalising the original report. If one expert has (for whatever reason) missed something relevant, it will inevitably make his/her position more likely to change following discussion, and/or more likely to be vulnerable to challenge if it does not.

In rare cases, one expert is completely persuaded by (and 'to') the opinion of the other party's expert, so that the 'joint report' expresses a single opinion ('we agree that …'). That effectively ruins that party's case, unless:

- another expert can be found to express a supportive opinion; and
- permission can be obtained to rely upon a further expert report at so late a stage in the case.

As explained above, it is increasingly difficult to change experts as the claim progresses, especially towards the end of a claim, when joint reports are inevitably provided.

There can also be a feeling from the 'joint report' that the more 'generalist' expert has been 'outgunned' by the more specialist expert, and again there may be a suspicion

that the generalist might not want to undergo cross-examination at trial, knowing that someone with more command of their subject will also be addressed by the court.

Helping the expert to prepare for the joint discussion and report

It is vital that both experts are thoroughly prepared for the discussion. Often experts are clinicians in active NHS practice, and their medico-legal work is conducted after a busy and stressful day. For that reason, it is sensible for your lawyers to do what they can, within the rules, to assist in the run up to the joint discussion:

- Have a conference (even by telephone) with the expert before the joint report – it never hurts to remind the expert of the critical issues, and discussing them so that they are fresh in his/her mind before the joint discussion.
- A party can provide a neutral agenda for the discussion (or better still a jointly agreed agenda), to make sure the experts cover all the areas in dispute. This will ensure, especially in a complicated case, that the parties do not have to waste weeks posing questions after the joint report just to make sure all necessary areas are discussed.
- If an agenda cannot be agreed, the parties may provide rival agendas to each expert, in which case the unfortunate experts may have to deal with all the points raised. However, they may well choose to deal with the issues in their own way, especially if (as often happens in contentious cases) one or other agenda seems slanted in favour of one party.
- If there are a large number of points to discuss, or a party wants to ensure that 'their' expert remembers important points which assisted his/her reasoning in the original report (or weak points in the other expert's reasoning), they may instead provide 'their' expert with an 'aide memoire'/notes *for his use only*, helping to remind the expert of those issues (again, making sure to remain within professional boundaries).

Having now explained the overall context of litigation, and the vital role of expert evidence, the third article in this series will focus on more specific medical aspects of chronic pain in litigation.

Conflict of interest disclosures

Disclaimers and conflict of interest policies are found at: http://bit.ly/1wqiOcl

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