Informing practice

Does a diagnosis or understanding of the mechanism of pain mean that we can predict disability?

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I wish to thank those who have taken the trouble to write after the last Peterhouse medico-legal conference held on 13 September 2012 in Cambridge.

The articles by Mr Julian Benson, barrister, Guildhall Chambers, Bristol, and George Couch, medical student, Downing College, Cambridge, in the December 2012 issue of *Pain News*, along with the article by Dr Lourdes Gaspar, Consultant in Pain Medicine, in this issue, highlight the importance and indeed increasing role of pain medicine in the legal world.

There is no doubt that our understanding of pain has increased immensely over the last few decades, the current insightful article of Dr Gaspar illustrating the neuro biological changes that take place both within the spinal cord and the brain revealed both by neuro anatomical mapping and functional magnetic resonance imaging has contributed much to explaining why certain patients, particularly with genetic tendencies, may end up with more pain than others, despite suffering very similar traumas.

The intense exchange between two well-respected medics that took place at the last conference, one a consultant in pain medicine and the other a consultant psychiatrist, encapsulated the two issues of the day.

What does it mean medico-legally to be in pain?

It sounds rather a silly question does it not, but perhaps many of you probably do not realise that until very recently chronic pain was listed under the heading of *psychiatry* in the publication that helps court define how much to compensate somebody who suffers from a pain condition after an injury.[1] The fundamental shift in the thinking of the courts in recognising the validity of pain as a robust and recognisable diagnosis along with a definable mechanism underpinning it is something to be welcomed – and in one sense a natural consequence of what has happened in pain medicine generally. Now we have a Faculty of Pain Medicine within the Royal College of Anaesthetists and, of course, specialists in pain medicine from a variety of backgrounds including anaesthetic, psychological, psychiatric as well as nursing and physical therapy are evident.

However, this shift from viewing pain as a purely psychiatric manifestation to recognising that it is a diagnosis with a definable mechanism in its own right will, of course, be accompanied by the tension that accompanies any change.

As Dr Gaspar says, there are still many gaps in understanding of knowledge, but gone are the days that unfortunately I remember as a junior doctor when somebody with a grossly deformed limb of a complex regional pain syndrome

would be considered a manifestation of a severe psychiatric condition and their symptoms regarded as a form of Munchausen's or self-mutilation.

Does a diagnosis of pain fundamentally tell us anything about disability?

As will be discussed at the next Peterhouse conference, it may come to us as a surprise that a diagnosis of pain in terms of medico-legal value is relatively small, although complex regional pain syndrome is usually associated with large amounts of compensation compared to, for example, neuropathic pain. The real issue is of quantum, which in this particular case will be defined, for example, as requirement for future care due to ongoing disability and lost opportunity, for example not been able to take up or follow a career that was planned 'but for' the index event.

It is these aspects that are incredibly important in defining the large amounts of compensation that are often associated with these cases.

We all recognise in pain medicine that a diagnosis is not predictive of disability. The 'intense discussion' encapsulated the issue as to whether the validity of a diagnosis of chronic pain would tell us anything about how much care or lost opportunity would be required.

Bogduk, who pioneered the understanding of the generation of spinal pain and also its treatment, talked about the 'dignity of a diagnosis'. I remember my early days of practice in interventional pain medicine in a setting when it was not particularly well accepted and was met by incredulity by some of my colleagues, along with undying thanks from some of my patients in whom I had diagnosed and effectively treated a cause of pain leading them to be pain-free after many years of suffering.

However, sometimes the 'dignity of a diagnosis' may well promote disability. We have all had patients who after being told a diagnosis, have very rapidly settled into the worst-case scenario associated with that diagnosis, usually aided by the internet. Unfortunately, many of us will recognise that this latter tendency seems to be more prevalent when there is a medico-legal case ensuing, along with the diagnosis of pain after injury. In this regard, as well as recognising the validity of a diagnosis of chronic pain along with its neurobiological mechanism, one needs to also recognise that the disability is not simply defined by the diagnosis but is affected by multiple other factors.

It is these latter factors that we often have to modify by the use of social environmental and behavioural/psychological techniques, along with the more conventional drug and other therapies, particularly when we can do no more in reversing the effects of the injury.

Dr Gaspar quotes the work of the eminent scientist Irene Tracy at Oxford who uses functional magnetic resonance imaging. Even her work has recently shown, along with others, that the power of expectation is far greater in terms of predictive affect on the level of function of the effect of a drug that is the pharmacological effect.[2] The BBC news correspondent did a very good public-orientated interpretation of this, mentioning: 'A patient's belief that a drug will not work can become a self-fulfilling prophecy, according to researchers.'

One of my favourite quotes is from the Bible from the book of Job who had already understood the work of Irene Tracy: 'that which I greatly feared has come upon me' (Job 3:35). When all is essentially done, it is clear that the mind is very powerful in determining long-term function in chronic pain states, and our role as pain medicine specialists is to remove that fear – such as removing the fear of movement, but also removing the fear of the medico-legal process and fundamentally removing the fear of the diagnosis in whatever way we can within our therapeutic armamentarium and providing control and hopefully returning a quality of life to the patient.

The next 'not-for-profit' Peterhouse medico-legal conference, to be held on 27 September 2013 in Cambridge, will be entitled 'How certain can we be about condition and prognosis?' (see http://www.rajeshmunglani.com/conference.html). We have some very eminent and thoughtful speakers coming along, including one of the barristers who was involved in helping move pain from a subsection of psychiatry into its own heading in the legal sense in the Judicial College publication and another barrister who has written about how to minimise the harmful effect of the medico-legal process on patient/claimants. I hope more of you will join in the 'intense discussions' that will undoubtedly occur both throughout the day and during the evening feast.

References

1 Judicial College. *Guidelines for the Assessment of General Damages in Personal Injury Cases*. London: Judicial College, 2012

2 Gallagher J. Negative experiences can stop painkillers working. *BBC News*, 16 February 2001. Available online at http://www.bbc.co.uk/news/health-12480310 (Last accessed 28 January 2013)