# The growing role of pain medicine in personal injury claims

Specialist pain medicine experts can help not only with determining condition and prognosis, but also, in complex cases, with diagnosis, says **Dr Rajesh Munglani**

The persistence of pain after injury is one of the major reasons for long-term suffering and disability, yet treating it, assessing it and its attribution, or otherwise, to an index event, and giving a prognosis is challenging both for medical experts and the courts.

If an injury or trauma that is being litigated is the cause of the persistent pain, disability and suffering then, if possible, this must be compensated for. If, on the other hand, such pain would have arisen but for the accident, perhaps at some stage in the future, then it would be unjust to attribute all the pain disability, and suffering to the index event.

The costs of treating pain and care costs make up a substantial amount of any settlement these days so understanding the causation, attribution, condition and prognosis of a pain and its ensuing disability is often a medico-legal case.

The courts increasingly recognise that consultants in pain medicine have a valuable set of clinical skills which help to determine condition and prognosis in high-value cases, but what about causation and attribution?

## Diagnosing pain syndromes

It has been said, rather erroneously, that consultants in pain medicine can only give advice on condition and prognosis but are unable to diagnose. Such a view misses the point of the training that consultants in pain medicine undergo and the skills that we obtain through years of experience. We are able to diagnose both simple and more complex pain syndromes including neuropathic pain, complex regional pain syndrome, myofascial pain, spinal pain syndromes including whiplash and back pain. Importantly, for legal purposes, we can also advise on the severity of the pain and relate this to physical impairment and disability.

Because of the skill-set of a consultant in pain medicine, an orthopedic surgeon may ask a pain medicine consultant whether a patient is suffering from usual post-operative flare or if he is developing early complex regional pain syndrome. If it is possibly a complex regional pain syndrome, does it meet the Budapest criteria? This more stringent set of criteria was meant to help define patients for research protocols by selecting those that definitely had complex regional pain syndrome (CRPS) from a subset of patients. It was never meant to be a medico-legal test. However the Budapest criteria are increasingly being used to advise the court on the presence or absence of CRPS.

While tending to give a superficially attractive black and white answer, unfortunately not all significant cases of CRPS will qualify for the Budapest criteria even though on balance likely to be part of the CRPS spectrum. This is where a pain consultant can help the court to decide whether a more obscure and disabling set of symptoms is likely to be real or not based on his experience and understanding of the ever-changing literature.

Does the pain consultant rely just on the patient's complaint of symptoms or objective measures that one can use? Are a certain set of symptoms consistent with the supposed physical impairment and disability that the patient complains of, and are the imaging and other investigations consistent with this?

Assessing and diagnosing pain is not like looking at a magnetic resonance imaging scan. There is unfortunately no direct relationship between imaging and pain. While pain consultants often understand the detailed mechanisms of pain, sometimes even we accept the fact that a patient might have severe pain and we simply do not understand the exact detail of why that patient is in severe pain and another not. However, our knowledge of the mechanisms of pain help the court in terms of causation and attribution in a way that other experts cannot.

Recently a greater understanding of the molecular responses of the body to trauma have led us to great insight that even CRPS, which most pain consultants have considered to be an almost random event after trauma with an incident rate of 0.1 to one per cent, may be best described as an auto-immune response triggered by trauma possibly with a genetic predisposition in

some patients.

The Court of Appeal has recognised that even if the mechanism of chronic pain is not fully understood, if it is accepted by an experienced clinician that it exists then so long as the criteria for causation and attribution are there then it will be accepted.

## High prevalence of pain

It is also clear that the prevalence of pain is very high in the community, though the disability associated with this is very low. In a lifetime 60 per cent of us will have had an episode of significant back pain. Current evidence suggests that anything up to 40 per cent of the population at any one time is likely to have some neck and back pain, but not 40 per cent of the population is either off work with severe neck pain or back pain. This figure of 40 per cent also applies to various other musculoskeletal pains and widespread body pain.

In contrast the incidence of severe pain in the population is properly in the region of one per cent for neuropathic pain to three, five or ten per cent for severe musculoskeletal pain including neck pain and back pain. And there is also a background incidence of fibromyalgia of about five per cent in the population, the incidence of widespread body pain of a milder form may be anything up to approximately 25 per cent.

set in the context of the general aches and pains that are present within the general population, that is the effects of an index event may be time limited thus long-term attribution of an index event may also be time limited particularly if the persisting symptoms are mild.

## Not just for claimants

In my experience this type of balanced approach is much more fruitful and realistic for the defendants. Recognising the high level of symptomology of pain in the general population may explain why claimants continue to have symptoms, rather than simply denying the claimant is suffering symptoms at all.

These are important counter arguments to claimants' common belief that all symptoms after an index event are due to the index event. But it is important to realise that sometimes continuing symptoms may bear no relationship to the index event and would have occurred anyway. This of course helps to work out the impact of the index event in terms of duration, exacerbation or acceleration.

Does the claimant have a past history of being polysymptomatic? Did they go to the GP frequently with complaints of musculoskeletal pain? Would they have been vulnerable to developing a pain syndrome had it not been for that index event? Significant back pain in some studies suggest a 60 per cent chance of a future episode of significant back pain but for the index event; similarly, a past history of sexual abuse may lead up to a five fold increase in the chance of developing a chronic pain syndrome but for the index event.

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My experience as a consultant in pain medicine is that the question is whether the residual symptoms after an index event are on balance likely to be attributable to the index event or whether they fall into the category of being 'the normal aches and pains of life'.

Why does this patient have pain after a surgical operation, was it likely to happen anyway or were there factors peculiar to this particular surgery that cause them to develop pain? In these situations the pain medicine consultant will work alongside a surgeon in establishing a diagnosis and in particular causation and probably then give an opinion on condition and prognosis.

Is the pain medicine expert only for the claimant side? Not at all. The long-term consequence of the index event needs to be

This of course is the 'egg shell' argument that the condition was just waiting to happen, and the index event just happened to be the trigger.

Is a patient who complains of pain for which there is no obvious orthopedic or neurological cause suffering from a recognised pain syndrome or is it really just a somatoform pain disorder? Understanding that pain doesn't have to be completely explained on psychiatric grounds but can represent a more understandable disorder of the central nervous system can be helpful in many situations, often on a background of pre-existing vulnerability.

There are plenty of people with neuropathic pain and CRPS who are able to work and get on with life. A diagnosis alone does not define the level of physical impairment or disability. The three are very different things. In many situations I am presented with patients who have CRPS and having tried to self-diagnose on the internet have essentially become disabled as a result of the diagnosis. Unfortunately in certain situations a diagnosis does promote disability. CRPS is not always a devastating diagnosis, improving in about one third of cases while a further third have an undulating course and a third progress to a more severe form.

Since consultants in pain medicine manage patients with severe pain and disability into the long term, we are particularly well placed to advise the courts on the likely future treatment requirements and success rates of injection therapies, including radiofrequency techniques, neuromodulation techniques, long-term pharmacological and physical therapy support as well as advising classically on rehabilitation and pain management programmes.

Treatments are often expensive, and I have come across cases where a pain medicine consultant was not instructed and subsequent reviews revealed an inadequate level of compensation for the injury. On the other hand, is it worthwhile putting aside a lot of money for the treatment if the success rates for treatment are likely to be low in that particular case?

It has to be considered whether the claimant will be able to work again. Does a diagnosis of CRPS, neuropathic pain, whiplash or back pain mean that the claimant cannot work again?

Pain medicine consultants can give invaluable insight, particularly into the more high-value cases, both in terms of diagnosis, causation including attribution, condition and prognosis including capacity for work and can specifically advise on the likely requirements for various therapies to help treat the pain, physical impairment and disability that patients often have.

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