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A medico-legal problem

Pain can be either acute or chronic. *Acute pain*, while deeply unpleasant, is vital to our survival; when it is no longer necessary, acute pain goes away. *Chronic pain,* on the other hand, serves no useful function, except to demoralise the sufferer, put a strain on the family and burden the nation's health resources.

Chronic pain is not just a symptom: it is a disease in its own right and one which demands treatment. Chronic pain is bad enough, but it can also trigger psychological problems, including depression and anxiety, producing a most unpleasant state of affairs for both the sufferer and his/her family and friends. On the other hand, chronic pain can also appear as a result of mental illness such as depression.

Pain is not just an unpleasant sensation; it is also an emotional experience *(suffering)*, which often generates altered behaviour. Thus it is not just the chronic pain that needs to be dealt with, but also all the other unpleasant effects that it generates.

Chronic pain and the many physical and psychosocial changes and complications associated with it constitute a major healthcare problem. It also constitutes, at least in the UK, a major medico-legal problem, since British Courts award claimants compensation for pain resulting from personal injuries.

Pain, especially chronic pain, is very much a personal experience. The same condition may cause different types of pain in different individuals – and what's more, what one person considers to be severe pain may be quite moderate to another. How someone feels pain is influenced by psychological, emotional and cultural factors – even by their own personality.

It is virtually impossible to prove the presence of pain or to measure it objectively. Hence the problem which pain creates in medico-legal cases.

Measuring pain

There is no direct, objective way of measuring pain; indeed one of the main problems in medico-legal work is that, to a large extent, you are relying on what the claimant tells you.

Some individuals may, intentionally or otherwise, mislead the expert. One, therefore, needs to be very attentive when questioning claimants; one also needs to make a detailed examination of previous clinical records.

The Visual Analogue Scale (VAS) is a very simple way of quantifying or measuring pain; however, it is very limited, for it only measures one dimension, i.e. pain, without taking anything else, such as the emotional trauma inflicted by the pain, into account.

Many pain clinics use a variety of questionnaires in their bid to log the whole of the unpleasant experience i.e. pain, more accurately.

Quite apart from the difficulty of putting a numerical value, pain does not always appear at the spot where the problem occurs i.e. *referred pain*.

Types of Pain

There are three categories of pain, namely:

- Nociceptive pain;
- Neuropathic pain;
- Non-organic (or psychological) pain.

Nociceptive pain is essentially pain caused by damage to body tissues in the presence of a totally normal nervous system. There can be damage to the body framework – *somatic* - or it can be due to damage to the body organs - *visceral*.

Neuropathic pain (*'Nerve Pain'*) is pain "which arises as a direct consequence of a lesion or disease affecting the somatosensory system."[1] Neuropathic pain refers to pain which is due more to a sensitisation of the nervous system. The damaged nerve(s) and sometimes even nearby undamaged nerves become oversensitive and can then be 'set off' by various stimuli, sometimes as innocuous as light touch.

Continual bombardment of the spinal cord by repeated barrages of nerve impulses coming from these affected nerves can make the spinal cord very sensitive so that it starts to magnify the intensity of the pain impulses it transmits to the brain (*windup);* as seen, it can also distort innocuous sensations, converting them into pain.

It is important to remember that even if the damage, which triggered off the nerve problem in the first place has healed, one of the sequelae can be that the nerve(s) remains in this hyper excitable state. In neuropathic pain, therefore, the pain is being caused by the damaged nerve and not by the original injury.

According to Dr Alan Basbaum (a leading American pain specialist), "*The nervous system after injury, with respect to the processing of pain, is a very different nervous system to that which existed before it was injured."*[2]

Non-organic (psychological) pain happens due to alterations in the normal function of the nervous system as a result of non-organic (psychological) causes. On the whole, most people can handle physical pain more than they can handle psychological pain. It is this latter kind of pain which often causes the most controversy in medico-legal cases. An individual under severe emotional pressure, for whatever reason, may readily convert his/her stress into pain and project this pain to a specific part of the body e.g. the back, by a process called *somatisation.* A person who converts 'emotional pain' into physical pain is called a *somatizer*. In these cases, the patient may feel severe pain in some part of his/her body without any identifiable cause in that part. A patient already suffering from chronic physical pain in a part of his/her body e.g. the back, can more easily become a somatizer, as the pre-existing physically painful locus presents a ready focus for somatisation. Thus, a pre-existing low back pain may get worse if the patient finds him/her self under stress.

A patient may have chronic pain in one area of the body due to an organic cause and this can then trigger non-organic pains at other sites. Thus a patient may start off with a back problem and after some time start complaining of pain in many other areas of the body – so called *global pain* or *total body pain.* Fibromyalgia is a condition classically associated with total body pain.

In some cases, there may be no physical cure available for a painful problem and in such cases, the patient must be taught how to live with and cope with his/her pain.

This is done by means of specialised multidisciplinary '*Pain Management Programmes.'*

A Pain Management Programme is a psychologically-based rehabilitative programme for people with chronic pain which has remained unresolved by currently available methods of therapy. Its main aim is to reduce the disability and distress caused by chronic pain by teaching sufferers physical, psychological and practical techniques to improve their quality of life.

A Pain Management Programme differs from standard pain clinic therapy in that pain relief is not the primary goal, thus the patient is taught that his/her pain is never going to go away; having accepted this basic premise, he/she is then taught how best to cope with the pain.

A Pain Management Programme tackles various factors, namely, exercise/ physical fitness, activity planning, cognitive therapy, reduction of medication and relaxation.

I now wish to highlight a few topics of specific interest to medico-legal practitioners:

1. Chronic pain and psychological factors;
2. MRI scan changes in spinal pain;
3. Waddell's signs in low back pain.

1. Chronic pain and psychological factors

In medico-legal work, we often come across the interplay between chronic pain and psychological factors. Thus, it is not at all uncommon for a claimant to suffer a relatively minor injury and yet to complain of persistent pain for an inordinately long period of time. A number of whiplash cases fall into this category.

The defendant's legal team will inevitably maintain that the claimant is 'making it all up' in order to embellish his/her case, i.e. that he/she is malingering; in a number of cases, the defendant may very well be proven right by independent surveillance evidence. However things are not always as simple or as clear cut as that.

Thus,

1. The claimant may have suffered a major trauma and have an undisputed, non-controversial reason for his/her chronic pain. All the experts in the case are in agreement; end of problem!
2. The claimant may have suffered trauma, which generated a genuine physical cause for continuing pain; the physical cause persists, but the pain is totally out of proportion to the said physical cause.
3. The claimant may have suffered trauma which generated a genuine physical cause which produced 'physical pain'; the physical component, although still present to some extent, has decreased substantially, but the level of pain it produces is out of proportion to that physical component. In this case, the psychological component, although not *creating* the pain, is maintaining it.
4. The claimant may have suffered trauma which generated a genuine physical cause which, however, has produced pain for an inordinately long period of time, long after the said physical cause has disappeared; thus, in the absence of a *continuing* physical

cause, psychological factors are now both *creating* and *maintaining* this pain.

So, we now need to look more closely at these 'psychological problems.' In some cases, there may undoubtedly be an element of deliberate profit-seeking exaggeration, but in others, the psychological factors may be quite genuine.

The expert has to look closely at the pre-accident state of the claimant; for example, does he/she have a long track-record of repeated visits to the GP with a host of (often) trivial complaints? Is there a history of psychological problems e.g. self-harm, marital strife, substance abuse? Has the claimant seen a psychiatrist or psychologist before? Has he/she received counselling for whatever cause? Such individuals are regarded as having *vulnerable* personalities and are prone to blowing things out of all proportion, a process called *catastrophization.*

These individuals are also more likely to convert psychological problems into physical problems; this process, as discussed, is called *somatisation.*

It is also possible that the claimant develops a *Pain Disorder*. There is some confusion on what constitutes a '*Chronic Pain Syndrome'* and a '*Pain Disorder.'*

Chronic Pain Syndrome

Chronic pain is pain that is unlikely to resolve, or pain that lasts longer than the usual healing time; pain is generally accepted as 'chronic' if it has been present for at least three months.

Although there are no generally accepted criteria for diagnosing a chronic pain syndrome, Rice et al[3] specify the criteria which are required for the diagnosis of a chronic pain syndrome. These include the following:

- Persistent pain of longer than two to four weeks' duration;
- Pain behaviours, both verbal and non-verbal;
- Vague, inconsistent and inaccurate reporting of pain, indicating non-specific pain;
- Substance abuse and/or dependence;
- Depression;
- Muscular dysfunction and de-conditioning, resulting in secondary pain of musculo-skeletal origin;
- Withdrawal from work, recreational and family endeavors;
- Dependence on physicians, spouses and families.

Thus, co-existing physical or mental disease can be modified or, indeed, amplified by the presence of chronic pain, further complicating the picture. In addition, perceptions of pain may be altered by anticipation, age, medications, environment and physical status. Culture and belief also alter the way chronic pain co-morbidities manifest themselves.

Pain Disorder

In some cases, the psychological component of the patient's problem becomes very prominent and sometimes overwhelming. Psychiatrists then speak of a "*Pain Disorder*". A pain disorder is a response with definite psychological features and *possibly,* also some physical features to ongoing pain. It can only be formally diagnosed by a psychiatrist, with specific reference (at least in the UK) to the *Diagnostic and Statistical Manual of Mental Disorders* (the 'DSM').[4]

The perception of pain, for a variety of reasons, becomes exaggerated in the patient's mind; he/she becomes increasingly depressed and despondent. This further worsens the perception of the pain so that a vicious cycle is set up. If one component of this vicious cycle - either physical or psychological - can be broken, then the other component tends to improve *pari passu*.

Two things should be pointed out with reference to a pain disorder. Firstly, it is generally (although not universally), accepted that a pain disorder is a genuine medical condition. It is as much psychological (if not more so) in origin as physical but it is, nonetheless, a specific medical condition. Secondly, it is a condition distinct from malingering, in that the patient with a pain disorder really does *perceive* the pain in his/her own mind and consequently *suffers* the disability. The patient behaves in just the same way whether he/she is being observed or not.

Of course, it can be sometimes very difficult to decide between a patient who is a genuine victim of a pain disorder and someone who is malingering. This is, ultimately, a matter for the court to decide. We might in fact, be witnessing a *Conversion Disorder* or a *Factitious Disorder*.

A **Conversion Disorder** implies somatization, i.e. the patient converting his/her psychological issues into pain. During my Army days, I saw a few cases of this when dealing with Far Eastern Prisoners of War (*FEPOW)*, who suffered unimaginable horrors at the hands of their Japanese captors; guilt from survival was a powerful somatizer. One individual, who, I remember vividly, suffered chronic pain as a form of atonement to make up for surviving; previously, his mate, was made to kneel next to him and was decapitated with a sword. But for the fortunes of war, that victim might well have been him. He felt intense guilt at his survival and somatized his guilt into total body pain. Such somatized pain is based upon unconscious motives and emotional conflicts.

In some cases the cause of the pain is obvious and in others it is not so obvious; in other words, there is a split in the psychological processes between what is known and what is unknown, i.e. between the symptoms and the conflict

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that has caused it. It is an *Extreme Behavioural Response*, by which the patient expresses any stress, tension or unhappiness in life by focusing on physical symptoms.

In some cases, somatization can become an illness in itself; we then have a *Somatization Disorder.* A *Somatization Disorder*, previously called *Briquet Syndrome*, or *St Louis Hysteria* is a psychosomatic disorder where mental turbulence expresses itself in physical symptoms, rather than psychiatric complaints; this leads to abnormal illness behaviour and a pattern of multiple, unexplained, symptoms, including pain.

A **Factitious Disorder** implies that the patient is feigning the symptoms or simulating an illness. This behavior is at a *conscious* level and is often motivated by psychological conflict.

An individual might be motivated to perpetrate factitious disorders in order to gain a variety of benefits including attention and sympathy that are unobtainable in any other way. All the above is in contrast to malingering, in which the patient deliberately and consciously feigns his/her symptoms in order to obtain an obvious material gain, which may include compensation following an accident.

Factitious disorder and malingering cannot be diagnosed in the same patient, and the diagnosis of factitious disorder depends on the absence of any other psychiatric disorder. Sometimes the medical court expert is very surprised when an apparent chronic pain sufferer is shown, in covert surveillance evidence, to be doing considerably more than he/she claims to be capable of. Only the court can decide if a Claimant is actually malingering.

2. MRI scan changes

A common bone of contention between medical experts is often the presence of MRI scan changes in cases of neck and back pain. In simple terms, the defendant's legal team will maintain that "… this claimant has pre-existing MRI scan spinal changes, he/she now has pain in that area, *ergo* his/her pain is not really due to the index accident, it would have happened anyway."

A simple extrapolation of MRI spinal scan changes to pain is rather dangerous! It is by no means as straight-forward as it would, at first, appear to be. A large proportion of totally asymptomatic patients can have significant changes in their MRI scans, including prolapsed intervertebral discs, so one cannot simply ascribe post-trauma pain to these 'pre-existing' changes. This being said, degenerative arthritis, as evinced by MRI scan changes, could *eventually* cause the patient *some* trouble.

The sooner after the index accident the MRI scan is carried out, the better; an early scan would be good evidence of pre-existing degenerative change. One could argue that, in the absence of the index accident, the claimant would, eventually, still have had some symptoms in the spine; thus, in these cases, one could opine that the index accident *accelerated* the onset of the pain. Factors to bear in mind when considering acceleration include any pre-existing injuries, the nature of accident, the *extent* of MRI scan degenerative changes (mild to severe), and whether the claimant is a smoker, together with his/her life-style.

Another thing to bear in mind is that as an individual grows older and degenerative processes appear and progress, due to the slow process involved, the individual may adapt and cope and thus experience minimal or no pain. A traumatic event, however, upsets the applecart and can then precipitate severe pain, which would otherwise, perhaps not have appeared or become a problem.

3. Waddell's signs in low back pain

Much is made of *Waddell's signs* in cases of low back pain by defendants' medical experts, in an effort to destroy a claimant's credibility. Waddell et al[5] described five categories of signs, namely, tenderness tests, simulation tests, distraction tests, regional disturbances and overreaction. Although Waddell's signs can detect a non-organic component to pain, they do not, *per se,* exclude an organic cause.

Clinically-significant Waddell scores are considered indicative only of symptom magnification or pain behavior but they are not considered a *de facto* indicator of deception for the purpose of financial gain. In fact, in a 2004 review, Fishbain et al concluded that "*there was little evidence for the claims of an association between Waddell signs and secondary gain and malingering. The preponderance of the evidence points to the opposite: no association."*[6]

Conclusion

In this day and age, no one should be told to 'go and live with their pain' until and unless everything possible has been done to reduce the level of their pain.

The pain specialist is an expert in understanding and managing pain, and all the emotional baggage that pain brings with it. A number of chronic pain consultants in the UK are involved in medico-legal work and compile reports on receiving solicitors' instructions, on behalf of both claimants and defendants, since UK Courts award compensation for pain arising from personal injuries; the situation in Maltese Courts, is, I believe, totally different.

In my opinion, the time has come for our legal colleagues to look at this. Compensation following a personal injury should not just be awarded for physical disability but also for genuine pain.

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