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Chronic pain handling guide

What is chronic pain?

There are numerous conditions which fall under the generic 'Chronic Pain' label. The conditions and the terminology have changed over the years as has the incidence of suffering amongst the population. Statistics suggest 18.8 million people are living with a musculoskeletal condition in the UK (Versus Arthritis statistics 2021).

'Pain' is more likely to be found in deprived areas with individuals from minority ethnic backgrounds and young adults amongst those now more likely to suffer.

This condition is a major issue in society with key points as follows:

- 42% of chronic pain conditions involve back pain.
- A percentage in pain rises as individuals age with 53% of those over the age of 75 suffering.
- Individuals with high impact pain are half as likely to be in paid work and 20 times more likely to say they are unable to work. Work can be a positive focus!
- Women are more affected than men in every age range.
- Ethnic minorities are more likely to suffer from chronic pain conditions.
- Obesity and lack of exercise increases chronic pain conditions.

The current focus is on holistic treatment training individuals on self-management of the condition. The goal is a personally adapted programme. The success of this is yet to be quantified.

NICE guidelines

This recommends as follows:

- Local NHS and social services to identify those with chronic pain.
- NHS to standardise the recording of chronic pain.
- Offer a holistic assessment and impact with review of underlying causes.
- If there is high impact chronic pain, create personalised care and support.
- There is a need for burden of chronic pain on the most deprived certain ethnic groups and women to be given priority.
- Promote health – physical, mental, obesity.
- Statutory and employer support.
- Chronic pain coordinators for every integrated care system in England.
- Data on prevalence and impact of chronic pain to be routinely collected and published.

The promotion of a holistic approach with rehabilitation and self-management is key. The difficulty arises in any provision being possible due to funding issues in the NHS.

Where there is an injury claim, we should recommend applying the NICE Guidelines particularly as many traditional treatments are often unsuccessful and/or temporary.

Overview of the more common pain conditions

Pain often has no organic basis and there are several key phrases and words to look out when reviewing medical reports:

Fibromyalgia

- This causes pain all over the body but has multiple causes. There will be increased sensitivity to pain, fatigue, muscle stiffness, difficulty sleeping, headaches, problems with memory, mental process and IBS. Commonly developed between the ages of 30 to 50 and can be constitutional and can appear for no particular reason. Appears to be widespread pain in both sides of the body above and below the waist and in the cervical, dorsal or lumbar spine for at least 3 months with pain in at least the 11 of the 18 specified trigger points.

Chronic pain syndrome

- This extends beyond the site of an injury. Discrete pain becomes widespread.

Complex regional pain syndrome

- This is characterised by severe pain, swelling and changes to the skin. Commonly there is burning pain, swelling and stiffness in affected joints, motor disability, changes in nail and hair growth, skin changes and atrophy.

Chronic fatigue syndrome

- Also known as ME or post-viral fatigue. There is no specific test, but key symptoms include muscle and joint pain, headaches, problems sleeping and flu-like symptoms. Therapy is a common treatment.

FND

- Historically called conversion disorder. This is a mental illness characterised by the loss or alteration of physical or cognitive functioning without any anatomical or physiological explanation. Symptoms are usually pseudo-neurological and where genuine are not intentionally feigned or consciously manufactured as outside of voluntary control. Symptoms can vary and include a wide range of physical symptoms including tics and fits.

Somatoform disorder

- This is a psychological disorder in which a person experiences physical symptoms inconsistent with an underlying general medical or neurological condition. FND is a type of somatoform disorder.

How do you identify a possible chronic pain case?

One or more of the triggers below may indicate a person is susceptible to develop or suffer a pain condition.

- Ongoing symptoms greater than 6 - 12 months.
- Pain and disability exhibiting without cause.
- Deteriorating symptoms.
- Pain and disability greater than can be explained by underlying physical cause.
- No anatomical or physiological explanation in some cases.
- 50% of neurology outpatients have a functional symptom.
- Are medical records being withheld without cause?
- Is there a 'diagnosis' or any reference to pain in medical records, comments made to experts by a claimant or by an expert generally.
- Look for possible motivational factors as to the benefits of being ill and/or disabled the need for reward for the disability.
- Is there any history of sexual, physical or emotional self-harm, eating disorders, IBS, marital and family problems or financial issues.

Work

- Is the claimant back at work? Full or Part time?
- If not, how long have they been off work?
- Were there any repeated absences from work prior to the accident.
- Is there an ongoing loss of earnings claim.
- Can an expert comment that a return to work would be beneficial where possible. Reference to the NICE guidelines may assist here.

Treatment

- Has there been any treatment and if not why?
- Are there recommendations for further treatment?
- Is there a referral to a pain specialist or care expert in terms of further treatment and assistance with recovery.
- Have the claimant's solicitors advised further medical evidence is being obtained or they cannot yet disclose medical evidence.
- Is there any evidence of psychological issues.

Dealing with claimant's solicitors

Where there are concerns that a case is or is developing into a 'pain' case develop a strategy in dealing with the claimant's solicitor.

- An early attractive offer may buy off the risk.
- Look at the benefits of buying off the claim with a fighting part 36 offer and / or a Calderbank offer to provide protection on costs.
- Ensure the case proceeds at a reasonable pace through regular chasers to ensure all evidence has or is being disclosed. Poor prognosis is often borne out with the long running of cases.
- Insist on a realistic schedule of loss as soon as possible. "TBC" should be discouraged!
- Look at potential exaggeration and fundamental dishonesty. Symptoms can be easy to feign.
- Be aware of the experience of the claimant's solicitors in dealing with such cases and refine tactics accordingly. We don't always have to progress to a joint settlement meeting.

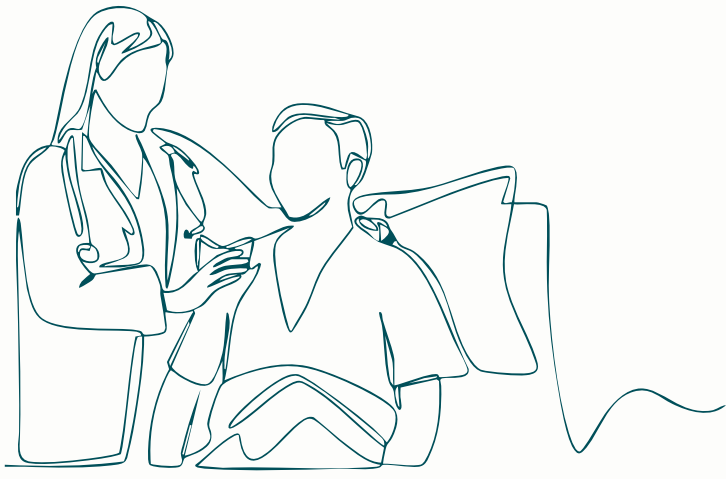
Claimant solicitors' specific tactics and our response

- Failure to allow any early access to GP and hospital records: - Make clear and repeated requests in writing raising points on costs and consider a disclosure application at the appropriate time.
- Check if the records are complete or whether there are gaps. – Chase for full records.
- Medical evidence may be disclosed without any prior court permission and appears as an ambush – try and control the situation with the staging of evidence. Organic reports first!
- Constant requests for interims which delays the conclusion of a case – a difficult one but note the right to an interim isn't automatic!
- Claimant solicitor Insistence on our raising questions on their own evidence (particularly in lower value cases where we have concerns of escalation). These can only clarify an opinion and we should preserve our option to obtain our own evidence where there are key issues on causation.
- Hostility to disclosed surveillance evidence - ensure we follow case law and guidance in disclosing this where possible.

Malingering and exaggeration

All experts should consider if there are any such signs of conscious or unconscious exaggeration.

Establish if the claimant has cooperated during medical examination and any other prognosis which may fit in with a pain condition.



Experts

In most cases we should obtain orthopaedic, psychiatric or neurological evidence as appropriate to look at organic causes before looking to a pain expert.

Key questions depend on the type of expert instructed but appropriate queries include :-

- Is there a definable condition?
- Is the claimant exaggerating the condition?
- Is it possible the claimant's condition will improve upon resolution of the case?
- Did the claimant have a pre-existing vulnerability?
- Are there any unrelated causes or is the accident leading to chronic pain is the key factor. This will include whether the accident was trivial and if any other activities or events could have resulted in the same outcome?

What is your action plan?

- Consider the issues and areas of dispute and keep liability live where possible.
- Put a strategy in place at an early stage.
- Obtain all relevant records.
- Look for other causes or signs of complex regional pain syndrome bearing in mind the nuances of this condition.
- Choose your medical evidence carefully, seek guidance as to who is known in the field.
- Don't agree to a pain management expert in lower value cases where there is a physical cause for the pain.
- Provide detailed instructions to experts particularly in respect of pre-existing conditions.
- Review of schedule of loss and supporting documentation.
- Consider treatment costs and future needs. In these cases, treatment is more likely to succeed once the case is concluded.
- Consider providing some costs of rehabilitation. This may allow you to assess the nature of symptoms at an early stage and it may be prudent to allow for some of the holistic input including a gym membership - possibly supported by a short-term personal trainer. Input from an experienced physiotherapist using CBT, psychology and involving the claimant's family in developing a positive mindset should also be considerations.

Pain checklist – red flags

- Further medical evidence to be obtained with no clear prognosis.
- Refusal to disclose medical records / Partial disclosure.
- Psychiatric / Psychological evidence to be obtained.
- Demographic and sex.
- Ongoing / continuing loss of earnings.
- Ongoing / continuing care and assistance.
- Incomplete or no schedule of loss.
- Disadvantage on open labour market and loss of job opportunity.
- Chronic or unexplained pain.
- Pain 8 out of 10 plus for minor injuries.
- Attendance at pain management clinic.
- Failure to recover as anticipated.
- Deterioration of symptoms.
- Unusual or unexplained symptoms.
- Head injury and / or loss of consciousness.
- Impairment of cognitive function.
- Stress.
- High recoverable benefits.
- Repeated requests for interims.
- Who are the claimant solicitors?

Chronic pain indicators

There are key words, statements or circumstances to be looked out for in medical records, reports and communication from the claimant's solicitors.

- Chronic pain.
- Pain syndrome.
- Complex regional pain syndrome for fibromyalgia.
- Pain management clinic.
- Discolouration of skin.
- Blanching.
- Spasms.
- Pins and needles.
- Pain that is out of proportion to the initial injury.
- Recurring GP and hospital attendances.
- Initial improvement then deterioration of symptoms.
- Recovery not in line with initial diagnosis and failure to recover as anticipated.
- No physical explanation for the claimant's symptoms so no diagnosis can be provided.
- History of injury to the same area.
- History of previous complaints with no identifiable cause.
- Large volumes of referrals to specialists.
- Reference to various treatments without success and / or follow up.
- Background of psychological problems.
- History of repeated absences from work prior to the accident.

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