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Insurance surgery: Growing pains

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David Johnson & Rebecca Blythe examine the ever growing phenomena of chronic pain claims & the challenges that they throw up for insurance litigators

It has always been the case that personal injury claims handlers need a rudimentary understanding of medical conditions and emerging new medical terminology. However, of late, particular challenges have arisen around the emergence of chronic pain claims.

"Chronic pain conditions" involve pain symptoms continuing to be reported more than three months beyond the date of resolution of the injury giving rise to the pain the first place. The range of conditions that may then be cited as an explanation for that single scenario are quite diverse and demand subtly different approaches.

Scope of the problem

The condition most often associated with chronic pain claims is Complex Regional Pain Syndrome (CRPS). Type I involves no demonstrable nerve damage. Type II involves demonstrable nerve damage. It is a physically evident syndrome, diagnosed according to the Budapest criteria.

Where CRPS is not made out, the emphasis often turns towards psycho-social explanations, the premise for which is that while the claimant's pain is genuinely experienced, it is, nevertheless, a product of psychological issues. A plethora of psychological conditions fall into this bracket, the most frequently encountered being somatoform syndromes, conversion disorders, and factitious disorders.

Also within this bracket falls fibromyalgia, a condition involving pain throughout the body, manifesting itself in a physical loss of function.

All of these conditions have the potential to be significantly debilitating. Many of them are associated with poor prognostic outcomes. They will frequently arise out of minor accidents. Yet they can give rise to substantial damages awards, exceeding £1m in extreme cases.

Pain being a subjective phenomena these claims are also open to exploitation by the unscrupulous. At the far end of the spectrum sit the diagnosis of Munchausen syndrome (feigned pain to attract attention/sympathy) and malingering (fabricated pain for the purpose of a secondary gain).

Inherent challenges

Spotting these claims early is challenging, the conditions often being undiagnosed when the claim comes in. An initial reserve entirely commensurate to the severity of the accident will later look woefully inadequate against the claimants' subsequent loss of function.

Dealing with them once they're identified is no less difficult. Causation is often a complicated issue, chronic pain patients often having long medical histories with significant psychiatric elements.

It is often tempting to be sceptical about the genuineness of the condition and occasional instances of fraudulent claims mean that it is entirely legitimate to test the diagnosis of the condition.

That then raises the complicated question of which expert to use. Having often obtained an orthopaedic report to rule out there being an organic explanation for the pain, the claims handler then has to second guess whether to instruct a rheumatologist (best suited to fibromyalgia and CRPS claims), a psychiatrist (more appropriate to the psycho-social conditions) or a pain specialist (general able to comment across the piste but sometimes felt to focus too heavily on treatment, at the cost of causation for example).

Treatments are available but with litigation often felt to be a "maintaining factor" prolonging the condition, it is not always appropriate for treatment to take place before the litigation is complete.

Bespoke solutions

So how do lawyers and claims handlers navigate that minefield? In some instances the answer is badly, with scepticism sometimes acting as a barrier to proactivity, ill considered expert instruction often taking claims down a fruitless path and issues over causation often being missed, all leading to reserves being blown among much recrimination.

Some pointers for those looking for a slightly more favourable outcome:

- Retrospective analysis often throws up red flags that ought to have raised concerns about the possibility of a chronic pain involvement at an early stage. Prudent insurers and firms are deploying training and crib sheets to let handlers know what to look out for.

- Record analysis is key, both in terms of bottoming out causation and gauging an idea of the type of condition that you are actually dealing with.
- Matching the right expert to the right case is key. If scouring the medical records for clues about what you're dealing with leaves you with nothing but a headache, consider asking a prospective expert whether they consider themselves the right expert for the job, before they examine.
- Be considered in your use of surveillance. Psycho-social does not always equate to conscious exaggeration and while a degree of scepticism is healthy, signs such as muscle wastage, for example, should not be ignored.
- Be considered in your deployment of rehab. If the expert advocates deferring treatment until after the case, pressing a judge to assess quantum on the assumption of a positive outcome to post litigation treatment may be less risky than pressing ahead with immediate treatment with a low chance of success.

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