Message from the Chair

Dear SIG Members,

I trust that you will find this issue of the CLIP SIG newsletter of interest. It contains a comprehensive review of the satellite meeting held during August 2005, prior to the last World Congress on Pain.

Some of you will be unaware of the history of the Special Interest Group on Clinical-Legal Issues in Pain, which was formed at the IASP congress in Paris in 1993 with the following objectives:

- to establish an international forum for the wider discussion of clinical and legal issues in pain;
- to act as a forum for airing views about the difficulties encountered by clinicians and patients in the different legal/health care systems;
- to provide guidelines reflecting the need to produce well-structured and clinically comprehensive reports for legal purposes;
- to ensure that adequate attention is given to pain diagnosis, management and treatment;
- to act as a resource to those who act only on an occasional basis; and
- to produce and maintain an updated bibliography on relevant articles.

Since that time, the SIG held satellites prior to the World Congress on Pain in 1999 (Edinburgh), 2002 (Stanford University) and 2005 (Melbourne). We had planned to also hold a satellite meeting prior to the 2008 Congress, but, as indicated in the Editorial in this issue, the SIG Committee—with regret—decided that such a meeting was unlikely to be financially successful. Therefore, we have stopped planning for a satellite.

We are, however, planning to hold a workshop at the Congress in Glasgow on assessment of litigants with chronic pain and the preparation of medico-legal reports. Contributors will include a lawyer, a consultant in rehabilitation and pain medicine, and a psychiatrist. We also will allow ample time for discussion and contributions from the audience.

The subject of pain and the law is of continuing interest and importance. Many of you are aware of the “Pain and the Law” website (www/painandthelaw.org), jointly developed by the Center for Health Law Studies at Saint Louis University and the American Society of Law, Medicine & Ethics. The website was funded by a grant from the Mayday Fund, and “focuses primarily on the legal issues involving pain management and palliative care.”

A symposium covered in the Winter 2005 issue of Journal of Law, Medicine & Ethics addressed the often-neglected topic of pain management in the emergency department, with articles discussing legal aspects, problems of drug-seeking behavior, opioid abuse, and development of clinical guidelines concerning pain management in the ER.

This issue of the Newsletter also contains a bibliography—admittedly somewhat idiosyncratic—of articles on pain and the law, based on a number of Medline searches using such keywords as law, compensation, litigation and deception combined with pain. If you have any other relevant references, please forward these to the Editor. We expect that future issues of the Newsletter will include updates of the bibliography, containing previously published articles that have been omitted from this publication, as well as those published since October 2007.

I look forward to meeting you all in Glasgow.

George Mendelson
Editorial

The SIG last met in Australia in 2005. Our activities at that time included a very successful satellite meeting in Melbourne entitled “Occupational and Post-Traumatic Pain Syndromes,” organized by George Mendelson and his committee. There was also a workshop at the Sydney IASP meeting and the 3 yearly business meeting.

While the satellite was very well attended, the majority of delegates were non-IAASP members from Australia and New Zealand, with a faculty of core SIG members and some invited international speakers. This has been the pattern of the satellite meetings in Edinburgh and Stanford on previous occasions. It seems, therefore, that those members who subscribe to the SIG have been unable to attend or have an interest in other satellite meetings, of which there are now many!

Following the business meeting, we therefore looked for a suitable venue for a satellite around the Glasgow meeting. Oxford seemed to be the best possibility with inquiries in 2005 defining a limited number of venues even for 2008. We gave much thought to our theme, possible speakers, and especially the likely attendance. Given that few IASP members attend, the UK in August does not attract many delegates to a minor conference at a time when all resources of departments are stretched covering holidays and main meeting delegates. We therefore decided, taking into account the deficit of the Edinburgh satellite, that a further CLIP Satellite in 2008 is probably not viable.

There will be a workshop at the Glasgow meeting focused on providing quality information in report writing and evidence for the courts.

We must also, after 12 years, consider the viability of the SIG in the long run. Given the plethora of other SIGs that have formed since the inception of CLIP, many may have greater relevance in day-to-day clinical activity for some than medicolegal work.

Dr. Dick Atkinson, UK

Melbourne – August 2005

This edition of the Newsletter provides reviews of a number of the presentations from the Satellite Conference entitled “Occupational and Post Traumatic Pain Syndromes,” which was held over two days at the Victoria University Conference Centre. The planning group, headed by Professor George Mendelson, included Danuta Mendelson, who is a lawyer, along with Dr. Carolyn Arnold of the Caulfield Pain Management and Research Centre in Melbourne. The group also included Dr. Dick Atkinson from Sheffield, UK, in his capacity as CLIP Chairman.

Attendees heard presentations by members of CLIP, a number of invited speakers from both IASP and Australasia, as well as a guest legal view from Canada. Delegates were mainly from Australasia, and few of the 150 or so present were IASP members. We have seen similar attendance patterns at previous CLIP meetings, with IASP members preferring to attend other satellites.

Left to right: Dr. Jim Robinson, Dr. Bruce Hocking, Dr. Dick Atkinson, Professor George Mendelson, Professor Bengt Sjolund
In the first session, we were able to hear views of senior members of the legal profession on how pain and pain syndromes are regarded in Canada and Australia. Initially The Hon. Justice Nathan gave his perhaps slightly cynical overview of how the pain of injury is regarded and how compensation may be staged or not used to best results.

1. Workplace injuries produce a faultless flow of compensation. Most times monetary, more often family sympathy, and occasionally community support.

2. Transport injuries sometimes do all of the above, particularly if they are work-related. Not so often do they result in a flow of monetary compensation.

3. A workplace injury, particularly if a poorly educated or disgruntled worker sustains it, commonly results in intractable, often psychiatric injuries.

4. The worker connects the injury with self-esteem, and so the injury becomes the focal point for all the dissatisfaction with the work, and the dislocation caused by uncongenial work.

5. The injury is not the worker's fault, so therefore it must be the employer's, or the system's, or the country's.

6. The worker should be compensated, because health, contentment and manhood have been sacrificed for the job. The worker has become a HERO.

7. Like all heros, the family, the employer and the nation should recognize the worker's hero status, and there is no prospect of recovery until that is done, or the social circumstances change to make hero states no longer suitable.

8. COMMON ABATING INJURIES. Claims of back injury are becoming increasingly unfashionable. Functional overlay, a term concocted by attorneys and quickly adopted by the psychs, is becoming passé. The lump sums have all but disappeared, and so too have the injuries. Wrist and RSI have joined the list with "dropsy" as ancient complaints, so too has the monetary compensation.

9. NEW FASHIONABLE INJURIES. Psychological injuries arising out of sexual molestation. With the availability of compensation from specialist tribunals of money for sexual misconduct, there has been a pandemic of that behavior. Employees can now obtain sums for sexual discrimination, and so too can the victims of criminal conduct. In both cases, the greater the injury, the greater the compensation.

10. In these types of cases, the victim can also become the hero, with the same compromised prospects of long-term recovery.

None of this is to say that the legal balm of monetary compensation should not be applied, and liberally to those injured whether faultlessly or otherwise, but the balm should not irritate the injury rather than soothe it. There are various ways this can be and is being done. Drip-infused compensation, in some situations, only prolongs the hero status. Lump sums can be exhausted, and the hero soon returns to public support. Compensation based on reward for tasks accomplished may be part of the answer. This may involve staged money payouts depending on results from rehabilitation programs. No swimming, no money. Not swimming well enough, no money. Various carrots and don't be afraid of the sticks.

After this, Shelley Miller QC from Edmonton, Canada, explained how she approaches these difficult cases:

Chronic pain cases create significant problems for legal and medical professionals concerned with treatment and compensation. This paper examines some of the difficulties that have emerged in the case law in Alberta, Canada, where an inclusive rule of causation in tort exists beside an uncertain threshold principle for new medical science. The author submits a rigorous approach to evidence of pre-accident history as well as the evolving scientific basis for the diagnosis of pain syndromes will promote more predictable legal and medical outcomes.

To complete this session, Paul Mulvany of Workforce Legal in Melbourne outlined the way Australian courts are "preoccupied with pain."

"Pain" in conjunction with "suffering" and the "loss of enjoyment of life" is the basis upon which monetary damages are awarded for "non-pecuniary losses." The availability of pecuniary damages for "non pecuniary loss" provokes alarm in legislators and their actuaries. All Australian jurisdictions have prohibitions or restrictions on access to, or limits on, pain and suffering damages. Similarly, when pseudo-scientific tools, such as the AMA Guides, are mandated for the assessment
of impairment, the chapters relating to pain are legislatively excised.

When courts purport to assess the extent of pain, as they regularly do, the process is relatively crude. Stoicism is admired. Proportionate pain is acceptable, but pain that appears disproportionate arouses suspicion. A universal law of proportionality is assumed. In the adversarial arena, the recent advances in neurobiology are rarely explored. Where they are explored, it is often superficial, with evidence called by either party from medical witnesses, who though dogmatic, have limited experience in the field. Syndromes abound, each of which appears to delineate the right to treat rather than classify the malady. The courts apply a knowledge garnered solely in a compensation environment with little experience of equivalent non-compensable conditions. Reliance on rhetoric such as “pain behavior” or “functional overlay” is all too easy.

Could it be that greater education of courts and tribunals, their demand for more sophisticated evidence from leading clinicians, and the use of qualitative assessment methods may lead to a fairer result? Or could it be that the courts merely reflect a pain aversion that much of the medical profession displays?

**SIG Financial Statement:**
The balance in the CLIP SIG account at the end of the third quarter, September 30, 2007 was US$22,551.

**SIG Membership:**
The SIG has 110 current members in 18 countries with 28 specialties.

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**Vehicle Accidents, Trauma and Pain**

**Prof. Harold Merskey from Ontario considered the issues around “Pain and the Insurance Industry”**

Compensation payments to travelers for injuries related to accidents on railways, and to workers in various settings, date back to the first half of the 19th century. For almost as long as there have been laws providing for compensation, there have been arguments about “compensation neurosis,” pain alleged to be disproportionate to injuries and the veracity of plaintiffs. While the need to test the truthfulness of the injured person is frequently considered in the literature, discussion of the behavior of insurance companies is quite sparse. Unlike pharmaceutical companies, whose efforts to promote and maintain their products are often subject to attack in the media, insurance companies rarely receive the same scrutiny.

Doctors who work as defense witnesses and those who work as plaintiff witnesses often receive substantial rewards for their participation in trials and for their opinions and advice outside trials. To what extent does favorable treatment of either party extend into the literature?

This presentation reviewed three articles that have been promoted as demonstrating the benign nature of whiplash injuries, and a further consensus statement by doctors on post-traumatic fibromyalgia. The role played by insurance companies in these matters is considered, and it is concluded that the rules similar to those for the pharmaceutical industry with respect to its involvement in medical research are desirable with respect to the insurance industry also.

As always, Dr. Nikolai Bogduk from Newcastle, Australia, was both thought-provoking and definitive in his presentation. He draws on a lifetime of careful research into the “evidence and myths” of whiplash.

There is a major and serious dissonance between evidence and assertions concerning whiplash and the patients who suffer it. It is commonplace for so-called experts to denounce patients on the basis of widely held opinions that are established but without foundation.

**Myth: There is no mechanism by which the neck can be injured.** This is not true. Those who hold this self-serving view choose not to consult the extensive engineering literature. From volunteer studies, it is evident that whiplash is not a flexion-extension injury; it is a compression injury. Not all subjects, however, who are exposed to the whiplash commotio are injured. Most escape injury. The biomechanical mechanisms of injury are relevant only to those who suffer chronic pain.
Myth: Motor vehicle accidents are the risk factor for chronic neck pain. This is not true. Simply being involved in a motor vehicle accident does not condemn subjects to pain. Indeed, in the long term they have the same prevalence of neck pain as individuals who have never been in a motor vehicle accident. However, those patients who develop symptoms immediately after an accident have a three-fold greater risk of developing chronic neck pain than does the general population.

Myth: There is no basis for the symptoms. This is not true. Tinnitus is the only symptom for which no one has been able to provide an explanation, short of invoking inner-ear damage; but tinnitus is not a common feature of whiplash. The major symptoms can all be related to pain or its treatment.

Myth: X-rays are normal; therefore there is no injury. This is heresy. Studies have shown that nearly all injuries evident at post mortem are invisible to plain radiography.

Myth: Failure to respond to treatment is a sign of malingering. This, too, is a self-serving aphorism. It should not be surprising that patients do not respond to treatment, for it has been shown that commonly used treatments simply do not work.

If patients are submitted to precision diagnostic techniques under double-blind, controlled conditions, the source of pain can be found in over 60% of cases. Once the source of pain has been determined, precision treatment can be implemented. However, if such techniques are not used, the patients languish, feeling abandoned and accused.

Dr. Ken Craig of the University of British Columbia presented the delegates with an up-to-date understanding of PTSD and chronic pain:

‘Chronic pain and post-traumatic stress disorder (PTSD) frequently are co-morbid, with either condition predicting an atypical likelihood and exacerbated symptoms, distress, functional impairment and disability of the other. While estimates of the prevalence of PTSD in the general population range between 7% and 12%, co-morbidity rates of 20% to 75% have been reported, with the range partly reflecting different patient populations. Co-morbidity is elevated in MVAs. Cognitive, affective, behavioral, and physiological features common to both conditions, particularly when chronic pain is characterized by substantial emotional dysfunction, suggest shared vulnerability factors and mutual maintenance of the two conditions. Proposed mechanisms have included 1) attentional and reason-

ing biases (e.g., hypervigilance, catastrophizing, angry rumination), 2) anxiety sensitivity (e.g., elevated somatic focus and fear of interceptive feedback), 3) reminders of the trauma (e.g., pain, intrusive thoughts, muscle tension), 4) avoidance (failure to desensitize, deconditioning), 5) depression (fatigue, reduced activity), 6) anxiety and pain perception (hyperarousal, reduced tolerance), and 7) cognitive demand from symptoms that limits use of adaptive strategies (numbing, preoccupation with harm). These logically lead to exploration of psychological interventions, with specificity of the interventions to features of the two conditions supporting this approach. Current evidence suggests cognitive-behavioral therapy as a treatment of choice, in addition to pharmacotherapy. Thus, there is an emerging understanding of substantial prevalence of concurrent chronic pain and PTSD, a rich appreciation of important underlying mechanisms, and assessment and intervention approaches for addressing the issues.

The foregoing suggests a rational, scientific, albeit incomplete, progression to understanding and resolving the intricate complexities of PTSD compounding persistent pain. But, our understanding of PTSD and chronic pain needs to be understood in terms of broader medical, public health, and legal issues. The realities are more complex, in part because questions frequently are raised about the credibility of patients presenting with either of the two conditions, let alone both. Both chronic pain and PTSD are often met with skepticism and questionable treatment. Both can be characterized as medically unexplained conditions, rendering them particularly problematic for those incapable of conceptualizing symptoms without a pathophysiological basis as important. In both chronic pain and PTSD, diagnosis is dependent upon subjective report. Unfortunately, the term subjective refers not only to personal experience, but it also connotes unreliable, transitory, and readily distorted events. This seemingly inevitable questioning of credibility has powerful personal, social, organizational and legal implications. Evidence from the literature on litigation relating to both chronic pain and PTSD is mixed, but certainly does not convince that prospects of substantial settlements sustain the conditions. Credibility judgments affect decision-making—for example, the outcome of litigation. Presenting evidence of misrepresentation alone can have an impact on the outcome of litigation. Presentation of surveillance video evidence needs to be questioned because of its impact. It is worthwhile questioning whether cost savings engendered by efforts to contain fraud are justified when costs to vulnerable patients of false positives are considered.”
Professor George Mendelson in his presentation looked at the difficult problem of ‘Nomogenic Pain and Learned Illness Behavior’ and how these may present and how they may be interpreted in terms of possible gain. It is a commonplace observation that many personal injury litigants and workers’ compensation claimants complain of pain that appears to be disproportionate to the extent of objectively demonstrable organic abnormalities. While it is recognized that pain can be a feature of psychiatric illness (for example, depression), very often the pain complained of is attributed to a physical injury—in the absence of an objectively demonstrable organic lesion—and there is no evidence of clinically significant mental disorder.

The concept of “nomogenic disorder” (that is, a putative disorder that has its basis in litigation) has been expanded by some writers to include the symptom of pain that cannot be explained on the basis of a physical or psychiatric disorder and complained of in the setting of legal proceedings.

There has been a tendency to use the concept of “nomogenic pain” as a synonym for malingering, and in those jurisdictions where this argument has been advanced, the courts have not accepted the clinical validity of this formulation.

On the other hand, the concept of “learned pain behavior” does have some utility in describing situations where pain complaints and pain behavior are perpetuated by environmental factors. Not infrequently, when pain persists beyond the expected healing time of a physical injury, such environmental influences can be shown to reinforce pain complaints and pain behavior. These factors may be related to interpersonal dynamics, societal expectations, and/or potential or actual “gains” of the patient role—described in the literature as both “secondary” and “tertiary” gains.

Trauma and Pain

Dr. James Robinson of the Multidisciplinary Pain Center in Seattle considered the effect of trauma and its relationship to the workers compensation system. There is a similarity with repetitive strain type injuries, and he looked at the mechanisms involved.

‘For purposes of administrative efficiency, workers’ compensation carriers typically make simplifying assumptions about the onset and course of musculoskeletal conditions among workers. Carriers are best equipped to manage musculoskeletal injuries with following characteristics: (1) they occur as a result of overwhelming mechanical forces (e.g., falling from a roof); (2) the injury stimulus causes a measurable biological abnormality (e.g., a fracture of the thoracic spine along with damage to the spinal cord); (3) the symptoms of which the injured person complains are closely related to the biological abnormality (e.g., inability to walk in the context of a definable thoracic spinal cord injury); (4) the injury follows a predictable course of recovery, eventually reaching a point of maximal medical improvement; and (5) the ability of the injured person to work after the injury can be reliably inferred on the basis of objective evidence of impairment of the injured body part.

Unfortunately, the musculoskeletal complaints of many workers do not fit the model outlined above. In particular, some workers present with upper-extremity conditions that appear to have developed in response to repetitive activities at work, rather in response to a single overwhelming mechanical load. A variety of terms have been used to describe these conditions, including repetitive strain injury (RSI), cumulative trauma disorder (CTD), disorder associated with repetitive trauma, occupational overuse syndrome, and work-related musculoskeletal disorder. There are small differences in meaning among these terms—e.g., the RSI construct developed in Australia did not include carpal tunnel syndrome, whereas the CTD construct developed in the United States did. But the similarities among the terms are much more prominent than the differences.
The disorders described as RSI or CTD are contentious, because they often violate all 5 of the simplifying assumptions listed above.

1. Since there is no specific injury stimulus, it is difficult to be sure whether the exposures or activities that produce a CTD occurred in the workplace, as opposed to the individual’s extra-work activities.

2. In practical settings, a CTD is identified when a worker reports the onset of upper-extremity symptoms, and the examining physician postulates that the symptoms were caused by repeated exposures to forces in the workplace. Given this logic, it is inevitable that “CTD” acts as an umbrella term with respect to pathophysiology. For example, rotator cuff conditions, lateral epicondylitis, deQuervain’s syndrome, carpal tunnel syndrome, and many other conditions can all be construed as CTDs. To make matters even more ambiguous, no definite pathophysiologic mechanism can be identified to explain the symptoms of many workers who appear to have CTDs.

3. Since the pathophysiology of CTDs is often unknown, it is impossible for a physician to interpret a worker’s symptoms in terms of the abnormal biologic process thought to be causing the symptoms.

4. Rather than following a predictable course of recovery, CTDs often function as chronic disorders that may get worse over time. This makes it difficult for observers to determine when a worker has reached maximal benefit from treatment, or when his/her claim should be closed.

5. The ambiguity surrounding the biological underpinnings of most CTDs make it very difficult for a physician or a claims adjudicator to determine the work capacity of an individual with a CTD.

Regardless of the specific term that is used to describe them, musculoskeletal conditions thought to arise from repetitive exposure are common, and are fraught with ambiguity. Strategies that workers’ compensation carriers might employ to address these conditions more systematically will be discussed.

Professor Bengt Sjolund now works with the rehabilitation of victims of trauma in Copenhagen. He presented a model based assessing disability in terms of function—the International Classification of Functioning—and directing rehabilitation toward this.

A more realistic approach would be to describe the multidimensional nature of human functioning, applying the concepts of the new International Classification of Functioning (ICF; WHO 2001) to provide a basis for interdisciplinary pain rehabilitation. It should be noted that, according to the ICF model and terminology, chronic pain is an impairment (Sjölund, 2003) that in certain contexts may give rise to activity limitations and participation restrictions. The fact that non-motor impairments have to be taken into account in rehabilitation has long been acknowledged in cognitive rehabilitation of persons with traumatic brain injury, but is equally important for persons with sensory impairments, such as chronic pain. It also makes it imperative for the team physician, usually a specialist in physical and rehabilitation medicine, to be familiar with not only rehabilitation principles but also with the neurobiology of pain, with pain assessment including sensory examination (Sjölund, 2004), as well as with pain treatment. Furthermore, ICF focuses on the importance of the context—not only the physical and the social, but also the attitudinal aspects. Moreover, personal factors, such as the cognitive interpretation of the pain condition by the individual and its consequences, can be addressed systematically. Attempts to define core sets of ICF categories, realistic to use both for epidemiological and therapy-related purposes, have recently been published (Cieza et al, 2004).

To perform adequate rehabilitation or to define work disability, it is thus much more realistic to describe the situation in ICF terms than in a simplified disease (ICD-10) perspective or according to the hitherto developed topological Pain Taxonomy of the IASP (Merskey and Bogduk, 1994).
Dr. Geoffrey Littlejohn of Monash University presented the evidence for the relationship between trauma and fibromyalgia. There are both physical and psychological aspects that comprise this relationship.

‘Fibromyalgia syndrome (FMS) occurs commonly in the community with prevalence of about 2-4%. Key features include the presence of widespread pain and widespread abnormal bodily tenderness (allodynia) in many tissues. Characteristic features include emotional distress, sleep disturbance, fatigue and muscular stiffness. Significant disability may occur, often with resultant interaction of the individual with societal safety-net arrangements. FMS associates with a number of other stress-linked somatic syndromes. No cause for this disorder has been found in the painful tissues of sufferers, nor has any unifying biochemical disorder been found. However, significant abnormalities in central functions of the pain system as a whole have been identified with the key biological process being sensitization of pain pathways, which in turn causes the key somatic clinical features. Psychological and social inputs are potent activators of the pain sensitization process.

FMS has long been associated with trauma. However, a causal relationship, particularly where interaction with safety-net legislation is involved, has always been controversial. The biases and polarized opinion in this area of health care are among the most extreme in medicine and often negatively impact on the patient’s outcome, which in turn adds to downstream societal costs.

FMS is associated with acute injuries to spinal areas, often of minor severity but high in emotional impact, with between 10 and 20% of such individuals developing FMS in this context. For instance, the relative risk for developing FMS after a motor vehicle accident with associated neck symptoms may be as high as 11. However, few prospective controlled studies are available to better characterize this association.

FMS occurring after chronic nociceptive input, as may occur in the workplace, is less well characterized, but evidence of psycho-social inputs appears more important than that of any ongoing nociceptive damage. Some studies show over 50% of FMS patients fulfill criteria for post-traumatic stress disorder. In general, emotional distress and other personal factors seem more important in causing FMS than ongoing trauma-associated tissue damage, although that may have initiated the initial pain and subsequent work or life predicament.

Yes, trauma causes FMS, but the link relates in small part to initial tissue damage and nociceptor activation and in large part to emotional damage and the subsequent complex neurophysiological response that initiates the pain sensitization process and the resultant clinical consequences that we label as FMS’.

Professor Chris Main evaluated movement toward recovery and some of the obstacles commonly encountered. Psychological issues are increasingly recognized and addressed, but in the legal context it is often difficult to predict outcome, let alone return to work.

‘There have been energetic attempts to improve the working environment, with ergonomic redesign, to reduce the risk of injury, but this specific focus on primary prevention has perhaps hindered proper analysis of the mechanisms of recovery from injury, many of which seem to be psychosocial rather than biomechanical or ergonomic. The “injury model” is not able to explain the wide variation in resultant disability, but nonetheless, many workers perceive their musculoskeletal symptoms to be work-related, and so it is appropriate to consider psychosocial aspects of work.

A clear focus on the psychological concomitants of pain and disability does appear, however, to have had some success with chronic pain patients. Thus, the logic of trying to prevent some of the “recoverable” disability seems irresistible, and the prevention of disabling back pain would appear to be a much more realistic target than primary prevention. Early intervention, however, requires a system for identification of those potentially at risk of chronicity.

In the field of back pain, the concept of risk has been examined in terms of “flags.”

Signs and symptoms considered indicative of possible spinal pathology, or of the need for an urgent surgical evaluation, became known as red flags. Similarly psychosocial risks factors predictive of chronicity were termed yellow flags, later differentiated into clinical yellow flags (with a primary focus on health) and occupationally focused blue flags (concerned specifically with aspects of work). In the workplace, a further set of risk factors, in terms of potential obstacles to recovery, have been identified. There is an important distinction is between perceptions of work (blue flags), such as high demand/low control, unhelpful management style,
poor social support from colleagues, perceived time pressure and lack of job satisfaction. Black flags are not a matter of perception, and they affect all workers equally.

The second part of the presentation focuses on the implications in terms of medicolegal assessment in incorporating the concepts of obstacle to recovery, in reference to both clinical and occupational settings.

In personal injury assessment, examination of occupational health records is often illuminating in identifying not only the immediate sequelae of a work accident, but also potential occupational obstacles to re-employment. Apparent mismatches between the claimant’s self-report and the occupational records, or between the clinical and occupational records, may raise the possibility of exaggeration or misrepresentation, but there other aspects of assessment that may have to be taken into account. Issues of causation in terms of culpability remain the cornerstone of every cause, since if a negligent act (tort) is not proved, then the issues of compensation and the quantification of damages do not arise. There are, however, issues concerning condition, since the recognition of psychologically-mediated pain syndromes as a pain disorder rather than as a primary mental illness has challenged traditional thinking in terms of the nature of injury.

There is a further major difficulty that merits comment. Experts are often asked to give a view on prognosis, with and without treatment. Furthermore, claimants have a duty to mitigate their losses. In addressing blue flags it may be necessary to move beyond the bounds of traditional clinical rehabilitation to include a specific occupationally focused component, but whether such a recommendation for intervention is likely to be successful will require both a competent clinically and occupationally focused approach, as well as a workplace that facilitates recovery. Giving a fair view on probably “end-state” disability, on which assessment of damages may be based, therefore can represent a considerable challenge to the personal injury assessor.

Professor Chris Main

Timely topics in pain research and treatment have been selected for publication, but the information provided and opinions expressed have not involved any verification of the findings, conclusions and opinions by the IASP or the SIG on Clinical/Legal Issues in Pain. Thus the opinions expressed in this Newsletter do not necessarily reflect those of IASP, the SIG, or of the Officers and Councillors of either IASP or the SIG on Clinical/Legal Issues in Pain. No responsibility is assumed by IASP or the SIG for any injury and/or damage to persons or property as a matter of products liability, negligence or otherwise, or from any use or operation of any methods, products, instruction or ideas contained in the material herein. Because of the rapid advances in the medical sciences, the publisher recommends that independent verification of diagnoses and drug dosages should be made.

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