Independent Medical Opinion: Pain and Feigning

An Interactive Seminar

Thursday 13th March 2014 (Melbourne)
Wednesday 27th February 2014 (Sydney)
Facilitator: Steven Tipper

• Steven Tipper  
  BAppSc(BiomedSc), MHA, FCHSM  
  Executive Director Clinical Services  
  IMO Pty Ltd  

• Role & objective: Facilitate discussion of the issues for medico-legal cases involving pain and explore the role of an IME in detecting feigning……and their inter-relationship, to improve case management.
## Simple indicator: #words

Random 20 cases review for word count & case hx.

<table>
<thead>
<tr>
<th>IMO Ref</th>
<th># pain</th>
<th># treatment</th>
<th># surgery</th>
<th># medication</th>
<th># feign</th>
<th># malinger</th>
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<tr>
<td>TOTAL</td>
<td>152</td>
<td>132</td>
<td>39</td>
<td>33</td>
<td>0</td>
<td>1</td>
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DEFINITION OF PAIN

INTERNATIONAL ASSOCIATION FOR THE STUDY OF PAIN 1994 & 2011

AN UNPLEASANT SENSORY AND EMOTIONAL EXPERIENCE

ASSOCIATED WITH ACTUAL OR POTENTIAL TISSUE DAMAGE, OR DESCRIBED IN TERMS OF SUCH DAMAGE

IASP PRESS: ED H MERSKEY & N BOGDUK
Next time, If you expect me to believe you are in 10/10 pain, you better be on fire or have a stick potruding from your eye.

your ecards
someecards.com
PERSISTENT PAIN EXPERIENCE

BIOPSYCHOSOCIAL MODEL

Biological

Social

Psychological

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Bio * Psycho * Social

Central Processes

- Biological
- Cognitive
- Somatic
- Affective

Peripheral Processes

- Autonomic
- Endocrine
- Immune Systems
- Genetic Predispositions

Activities of Daily Living
- Environmental Stressors
- Interpersonal Relationships
- Family Environment
- Social Support / Isolation
- Social Expectations
- Cultural Factors
- Medicolegal / Insurance Issues
- Previous Treatment Experience
- Work History
PAIN & Practice Implications

- Pain is subjective.
- Stimuli or illnesses that cause pain are likely to damage tissue.
- Pain is always unpleasant and therefore an emotional experience.
- There is no imaging, physiological, or laboratory test that can identify or measure pain.
- Pain is what the patient says it is.
- The clinician must accept the patient's report of pain.
Basic Definitions & Clinical Implications

- [http://projects.hsl.wisc.edu/GME/Pain Management/session2.1.html](http://projects.hsl.wisc.edu/GME/Pain Management/session2.1.html)

- In this (online course) session, you will learn basic pain-related definitions and review pain physiology. This information is critical to understanding the complex nature of the pain experience and the rationale behind various treatment strategies.
Pain classification

based on pain physiology, intensity, temporal characteristics, type of tissue affected, syndrome:

- Pain physiology (nociceptive, neuropathic, inflammatory)
- Intensity (mild-moderate-severe; 0-10 numeric pain rating scale)
- Time course (acute, chronic)
- Type of tissue involved (skin, muscles, viscera, joints, tendons, bones)
- Syndromes (cancer, fibromyalgia, migraine,...)
THERE ARE SOME NEURONES IN OUR TISSUES THAT RESPOND TO ALL MANNER OF STIMULI

IF THOSE STIMULI ARE SUFFICIENT TO BE DANGEROUS TO THE TISSUE

ACTIVATION OF SPECIAL SENSORS EMBEDDED IN THE SURFACE MEMBRANE OF NEURONES => SENDS AN ALARM SIGNAL TO YOUR SPINAL CORD WHICH MAY BE SENT ON TOWARDS OUR BRAIN
NOCICEPTION \textsubscript{2}
• ACTIVITY IN THESE NERVES IS CALLED “NOCICEPTION” WHICH LITERALLY MEANS “DANGER RECEPTION”

• DANGER RECEPTION IS NEITHER SUFFICIENT NOR NECESSARY FOR PAIN.

PAIN EXPERIENCE DEPENDS ON MANY FACTORS AND IT IS THE BRAIN WHICH DECIDES WHETHER SOMETHING HURTS OR NOT
The Three Components in the experience of Nociceptive pain

**Brain**: The Signal Receiver + Descending controls

The Signal Generator

NOCICEPTOR

**Spinal Cord** = Amplifier

*Prof P Siddall*
Pathophysiology

• Under normal circumstances the nociceptive sensory system **returns to a normal functional state** as soon as healing takes place.

• But many features of sensitization persist and are manifest as chronic pain and hyperalgesia, especially when the nervous system itself is injured leading to chronic neuropathic pain.

• Imaging studies have shown that chronic pain is accompanied by **permanent structural alterations in specific brain areas** that play a crucial role in nociception.

http://projects.hsl.wisc.edu/GME/PainManagement/session2.3.html
Neuropathic Pain

PAIN CAUSED BY AN INJURY OR DISEASE OF THE NERVOUS SYSTEM

**Diseases:**
- Trigeminal neuralgia
- Postherpetic neuralgia

**Injuries**
- Musculoskeletal System
- Sciatica

**Symptoms:**
- Pins & needles
- Burning
- Night pain, hands/feet
Neuropathic pain syndromes

• Neuropathic pain (NP) syndromes are chronic pain disorders that develop after a lesion of the peripheral or central nervous structures that are normally involved in signalling pain.

• It is estimated that about 35% of chronic pain patients suffer from NP, and that up to 5% of the population is affected.

Neuropathic pain assessment?

• Self-employed pain diaries are recommended for tracking the temporal course of neuropathic pain in patients and for documentation of the consumption and effect of analgesic drugs over time.

Neuropathic Pain Assessment – An Overview of Existing Guidelines and Discussion Points for the Future
Nurcan Üçeyler, Claudia Sommer
European Neurological Review,
2011;6(2):128-131
One in four GP patients has chronic pain

- A QUARTER of patients seen in general practice have chronic pain and one third are prescribed opiates, new data shows\(^1\).

- **GP Pain Help app & website** aims to help GPs manage pain in their patients

Resource (download app): http://www.gppainhelp.com/Title.html
Phases of pain treatment

• Initial (injury)
• The treatment of pain generally proceeds through several distinct phases. Following the onset of a painful condition, the treatment of acute painful conditions is driven by medical factors.
• Routine diagnostics, medications, restriction of activity, and physical therapy i.e., the physical, chemical, and electrical aspects of treatment.
Phases of pain treatment

- **subacute phase**, from one to six months post-injury, is the period during which transition from acute to chronic pain is most often observed.
- natural history often involves a “downward spiral,” in which a medical condition becomes progressively more enmeshed with psychosocial complications.
Phases of pain treatment

• In the **chronic pain phase**, the full biopsychosocial spectrum is often seen

• **Psychosocial interventions for chronic pain** revolve around four main components: treating affective distress, cognitive and characterological factors, chemical dependency concerns, and managing the social consequences of chronic pain.

**Illustrative Case for commentary?**
For discussion (Lowy handout)

- After 50 years of Medicine in Sydney, I say without hesitation or qualification, the increase in medical and legal sophistication over the decades has made the help-seeker’s position worse, far worse.

Handout for discussion:
LOWY_The-relevantless-bottom-line
REC2_20092012_00001.pdf
Mendelson_2002: “A critical reading of the literature indicates that there are

- No valid clinical methods of assessment of possible malingering of pain.
- Given that pain is a subjective phenomenon, it is concluded that the concept of “pain malingering” lacks validity.”
QUOTE:
“The ultimate issue of the veracity of the plaintiff is for the Court to determine, and epithets such as “malingrerer” have no place in reports prepared for legal purposes by health care professionals.”

• QUESTION: Has anything changed re: Courts & reports in the last decade?
Psychology: testing for feigning

Changes (10 years)?

• There ARE valid clinical methods of assessment of malingering/feigning

• Appropriate use of ‘neuropsychological testing’ & ‘clinical psychological testing’

**clinical & medico-legal experts are in the audience**

• Symptom validity tests (vs. normal function) ~ neurological tests?
Examples of tests administered

- **SCL-90-R (Symptom Checklist-90-Revised)** – a 90 item self-report symptom inventory which is a measure of current psychological symptom status.

- **Pain Patient Profile (P-3)** – a measure of dimensions of emotional distress associated with primary complaints of pain.
• The **Pain Self Efficacy Questionnaire** - a measure designed to assess the extent to which an individual believes they have the capacity to continue to enjoy and perform previous activities, despite pain.

• The **Pain Disability Index** – a measure of the degree to which various aspects of life are disrupted by pain.

• **Orebro musculoskeletal pain questionnaire** – soft tissue < 12 weeks
<table>
<thead>
<tr>
<th>SCL-90-R</th>
<th>Adult female non-patient</th>
<th>Female psychiatric in-patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Somatisation</td>
<td>99th percentile</td>
<td>Upper extreme</td>
</tr>
<tr>
<td>• Obsessive-Compulsive</td>
<td>99th percentile</td>
<td>Upper extreme</td>
</tr>
<tr>
<td>• Interpersonal Sensitivity</td>
<td>99th percentile</td>
<td>Upper extreme</td>
</tr>
<tr>
<td>• Depression</td>
<td>99th percentile</td>
<td>Upper extreme</td>
</tr>
<tr>
<td>• Anxiety</td>
<td>99th percentile</td>
<td>Upper extreme</td>
</tr>
<tr>
<td>• Hostility</td>
<td>98th percentile</td>
<td>Upper extreme</td>
</tr>
<tr>
<td>• Phobic Anxiety</td>
<td>99th percentile</td>
<td>Upper extreme</td>
</tr>
</tbody>
</table>
EXAMPLE INTERPRETATION:
“The normative data indicate that it is highly unlikely that an adult female non-patient would produce scores such as those produced by Ms Volunteer. Individuals with scores such as those produced by Ms Volunteer are considered to have “dramatising” response styles, or to be consciously exaggerating their levels of symptomatology.”
Universal Pain Assessment Tool

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

- **Verbal Descriptor Scale**
  - **0**: NO PAIN
  - **1**: Alert Smiling
  - **2**: No humor serious flat
  - **3**: Furrowed brow pursed lips breath holding
  - **4**: Wrinkled nose raised upper lips rapid breathing
  - **5**: Slow blink open mouth
  - **6**: Eyes closed moaning crying
  - **7**: Bedrest required

- **Wong-Baker Facial Grimace Scale**
  - **0**: NO PAIN
  - **1**: MILD PAIN
  - **2**: MODERATE PAIN
  - **3**: MODERATE PAIN
  - **4**: MODERATE PAIN
  - **5**: SEVERE PAIN
  - **6**: WORST PAIN POSSIBLE

• Footnote: Google “pain assessment” = about 21,000,000 results (0.22 seconds)
Psychological testing issue?

• For many patients, the phrase “psychological evaluation” is intimidating.

• Because of this, within the field of health psychology, the phrase “behavioral medicine consultation” is often used instead.

Substituting this phrase may decrease the patient’s resistance to a referral.
Benefits of psychological assessments

• provides an **accurate diagnosis** of the disorder for the patient (& when it is unclear to the psychologist).

• allows **treatment to be based on the exact symptoms** of disorders & how a specific patient may react to different treatments.

• most testing completed in 6 to < 12 hours

• Only by **regularly assessing** & measuring pain, as routinely as the other vital signs, can we hope to ...improve management* (*Brevik et al Br J Anaesth. 2008 Jul;101(1):17-24. Epub 2008 May 16.)
Compensation & Health Outcomes

Research clearly indicates

- the importance of **psychosocial factors in long-term disability** &
- recent evidence suggests that appropriate early medical intervention that takes this into account can significantly reduce chronicity and long-term disability.

Compensation & Health Outcomes

• Such intervention should ideally be a co-ordinated interdisciplinary effort (for example, medical, psychological and physiotherapy) to provide interventions that address as many levels of the case as possible.

• Why not multidisciplinary coordinated IME’s?
Psychological medicolegal assessments

• It is the mental equivalent of physical examination.
• Determine the pre-morbid functional level
• Confirm if there is any impairment
• Is there a causal link between accident and the psychological impairment?
• Treatment review and recommendations
IMO specialist consultants

• Dr Mary WYATT

Occupational Physician

MPH, MBBS, DObst, FRACGP, FAFOM

• Appropriate Referral: Musculoskeletal injuries. Special area of interest is spinal injuries, Complex Regional Pain Syndrome. Parkinson's Disease. Chronic fatigue syndrome

• Level 6, Suite D, 492 St Kilda Road
IMO specialist consultants

• Dr John SILVER

Occupational Physician
MBBS FACOM FAFOM

Appropriate Referral: Bony/soft tissue (orth) trauma neck back chest & abdo.; Underwater and aviation medicine; Transportation & MVA. Spina Bifida. Travel injuries: Dengue Fever, Bites. Xylene toxicity and other chemical toxicities. Life expectancy (cancer, heart disease)
IMO specialist consultants

- Dr Gregory WHITE
  MBBS FRANZCP CIME
  Psychiatrist

Appropriate referral:
- All Psychiatric/stress injuries
- No persons under age 18 for assessments, No gazetted fee examinations (Victorian Work Cover)
- 54-56 Station Street, Fairfield, VIC 3078
IMO specialist consultants

• Dr Paul KORNAN

MBBS; DPM; FRANZCP; MRC PSYCH

Psychiatrist

• Appropriate Referral: Psychiatric assessments including TPD, Disability, claims by relatives for family members, Product liability, Family law, Sexual abuse and stress claims. Will dispute PTSD, car accidents, public liability, personality disorders and medical negligence

• 12 Collins Street, Melbourne / Skype also
IMO specialist consultants

- Mr James DRURY
  Clinical Neuropsychologist
  BSc(Hons), MSc(Neuropsych), MAPS

- Assessment of the nature and extent of disability resulting from brain injury;
- Evaluation of capacity to return to work, mental competence, testamentary capacity, cognitive functioning, malingering, Personal injury, General IQ, TAC approved.
Injuries dealt with:
- Primary area of practice: Traumatic brain injury.
- Other areas of practice: Cognitive dysfunction relating to alcohol/drug abuse, cerebrovascular accidents, hypoxia, mental competence.
- Have you ever questioned whether a clinical neuropsychologist may be appropriate for one of your cases?
IMO specialist consultants

- Dr Leslie ROBERTS  
  MBBS FRACGP  
  Neurologist

- VIC Certifications S112 Approved
- Specialist Yes TAC Approved
- Specialist Yes VWA Approved
- Specialist Yes VWA Trained Assessor Permanent Impairment - AMA 4th Ed.
  Monash Course Yes

- NSW; Q’ld & SA: Approved Specialist
IMO specialist consultants

- Dr Anthony LOWY
  Occupational Physician
  MBBS, FRACGP, FRACP (OM), CIME

- Appropriate Referral: Worksite assessments, return-to-work programs
  - Chronic Fatigue, claimant to bring all medication, blood tests and all documentation available.

- Injuries dealt with: spine; upper limb; lower limb
IMO specialist consultants

• Dr Jane Lonie
  Clinical Neuropsychologist
  BA(Hons), MA Clinical NeuroPsych, PhD
• All matters requiring cognitive evaluation of older adults or any matters relating to the assessment of cognitive capacity in the elderly.
IMO specialist consultants

• Dr Kasey Metcalf
  Clinical Neuropsychologist
  BSc(Hons), M Clin Neuropsych, PhD

• Appropriate Referral:
  Neuropsychological assessments for
  those with traumatic or acquired brain
  injuries.
Injuries dealt with:

- Traumatic/acquired brain injury
- Alcohol & substance-related brain impairment
- Diagnostic clarification
- Profiles of cognitive strength & weaknesses
- Assessment of decision-making capacity
- Assessing eligibility for Lifetime Care and Support Scheme.
Dr John DITTON
Pain Medicine
MB BS(Syd), FANZCA, FFPMANZCA

Appropriate Referral: Dr deals with all chronic pain regardless of body area.

Warning Message External: Doctor requires a list of medication the patient is taking, as well as x-rays and MRIs.
IMO specialist consultants

• Dr Katherine DIMARCO
  Psychiatrist
  FRANZCP, MBBS (Hons), BMedSci.

• Will assess people aged 16 and over
• Psychiatric referrals: depression, anxiety, adjustment disorder, stress, mental health, psychiatric injury, psychological injury
• Dr Ian De Saxe

Psychiatrist

BSCC (Hons) (NSW), MBBS(Sydney), FRANZCP


• No physical examinations for psychiatric patients.

• Will assess children & teenagers by case
# IMO National Circuit List

- **Issue date:** 4 March 2014 included

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<th>Location</th>
<th>Name</th>
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<td>Dr Ross Douglas Whittaker</td>
<td>Rheumatologist, Comcare, WPI</td>
<td>17 April</td>
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<td>VIC</td>
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<td>Melbourne</td>
<td>Dr Ian De Saxe</td>
<td>Psychiatrist, Comcare, MAA</td>
<td>24 March</td>
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<tr>
<td></td>
<td>Dr Ross Douglas Whittaker</td>
<td>Rheumatologist, Comcare, WPI</td>
<td>27 March</td>
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<td></td>
<td>Dr Mary Wyatt</td>
<td>Occupational Physician, Comcare</td>
<td>6, 27, 28 March 4, 16 April</td>
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</table>
Ask IMO about SPECIALTY then SPECIALIST?
• Specialists including Occupational Physicians, Neurologists & Psychiatrists dependent on case
• Psychological assessments
  o Causation & diagnosis
  o Capacity for work
  o Treatment (past & future)
• Neuropsychological assessments
  o Brain damage/impairment assessment
  o Treatment following brain injury
  o Capacity for work
  o Feigning/Malingering
IMO Seminars – what’s next?

• Current IMO SEMINARs
  – Sydney 27/02/2014
  – Melbourne 13/03/2014

• Future seminars on ????
  – PTSD
  – Chronic Fatigue Syndrome
  – Chronic Diseases
  – Compensation & poor outcomes
  – What do you suggest ?????
References

An IMO handout is provided for references used in this presentation, sourcing resources and interesting reading.

*Free is good, pain-free is better*

Administration pain point:

Evaluation forms for completion