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'FUNCTIONAL OVERLAY', AND ILLNESS BEHAVIOUR IN CHRONIC PAIN: DISTRESS OR MALINGERING? CONCEPTUAL DIFFICULTIES IN MEDICO-LEGAL ASSESSMENT OF PERSONAL INJURY CLAIMS

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INTRODUCTION

In personal injury (PI) litigation involving musculoskeletal incapacity, the terms 'functional overlay' and 'illness behaviour' are frequently adduced to explain the persistence of pain (and associated incapacity) following injury, particularly where the physical findings are inconclusive. They are often diagnosed 'by exclusion' based on the *absence* of conclusive physical findings rather than the *presence* of alternative explanations, such as psychological reactions to injury and incapacity. As such they are frequently employed as 'pseudopsychological diagnoses'.

The purposes of this article are to highlight the difference between clinical and medico-legal assessment, to examine specifically the task confronting the psychologist or psychiatrist as an expert witness in cases of PI involving musculoskeletal incapacity, and to clarify some of the ambiguities inherent in the use of terms such as 'functional overlay' and 'illness behaviour'.

THE CONTEXT OF MEDICO-LEGAL ASSESSMENT

General purpose

The primary role of the medico-legal assessor is to provide a professional opinion on the origin, nature and prognosis of a client's complaints, in response to a letter of instruction from a solicitor (whether that of the plaintiff or that of the defendant). It should be noted immediately that the request comes from the solicitor, acting on behalf of the client by whom he/she has been instructed and not directly from the client. The client can, and often does, express a view concerning the content of the assessment, but the solicitor is acting essentially on behalf of the court to prepare evidence for consideration by legal counsel in the light of possible submission to court. The role of the expert witness is, therefore, to respond to the needs of the legal process and only indirectly to the needs of the client, which are not properly

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a matter of direct concern to the expert witness. The relationship between the client and the medico-legal assessor is, therefore, radically different from that between patient and doctor. This fact is seldom appreciated by the client, and sometimes not by the expert witness. However, it may be appropriate to suggest the need to consider treatment and to offer to write to the client's general practitioner.

The nature of the legal process

The expert's report is presented as part of a body of evidence adduced by the teams of solicitors to prosecute a complaint or defend it. In the UK, the legal system is essentially an adversarial one, and assessment needs to be understood in that context. Although a high proportion of cases are settled as a result of negotiation between the two teams of lawyers, the expert witness needs to be mindful that this is not always so. In the case of PI, both the plaintiff and the defendant have a right to an adjudication, by a disinterested third party. Frequently this will be a judge who interprets the evidence presented to him in light of the principles of justice laid down and interpreted where appropriate in the light of legal precedence. The primary role of the expert witness, therefore, is to present an opinion not on the 'rights or wrongs' of the case, which is properly a matter for adjudication, but on the origin, nature and likely prognosis of the complaint. The opinion is based on the nature of the specific professional expertise for which the expert has been instructed. Clearly the witness will be expected to have a sound and respected knowledge of the condition in question. The opinion, as represented in the report, may be subject to cross-examination in court, and in that context both the substance of the report and the authority of the expert as evident in the defence of his/her report will have a bearing on the adjudication.

The standing of the expert

As an expert, the witness will be expected to bear credentials to support the legitimacy of his/her claims to expertise. The standing of the expert certainly will be appraised in terms of clinical familiarity with the injury or incapacity concerned, but must appear credible as well as knowledgeable. Credibility will be a function of the expert's professional reputation, current professional standing and demeanour in the witness box. An important issue is that of the expert's impartiality, which is sometimes difficult to sustain in the adversarial medico-legal process.

According to Lord Wilberforce in *Whitehouse v. Jordan* (1981)

"Expert evidence presented to the court should be, and should be seen to be, the independent production of the expert, uninfluenced as to form or content by the exigencies of litigation. To the extent that it is not, the evidence is likely to be not only incorrect, but self-defeating" [1].

The task confronting the expert witness therefore, is a complex and highly technical one, yet the basis of the opinion is, of course, clinical. Advances in clinical research in matters of chronic pain and disability, particularly in the last two decades, have illustrated, however, that the nature of chronic incapacity is more complex than previously believed. It will be argued that some of the current difficulties facing the plaintiff in personal injury cases involving pain and incapacity are a consequence of a general failure to understand the nature of chronic incapacity by medical assessors.

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