

Medicolegal and social implications of practising in pain medicine

Lorraine de Gray

Abstract

Pain is the most common reason for patients to see a doctor. Low social support and unemployment are common in such patients. Pain is the third leading cause for absence from work. Patients frequently seek support from their multidisciplinary pain team for welfare support and staying in or returning to employment or education. Pain physicians perform a range of intervention procedures and need to have a clear grasp of the law of consent. They are also called on to give expert evidence in personal injury and medical negligence claims where claimants have been left with chronic pain. This paper explores the legal and social infrastructure, and knowledge that should be at the fingertips of all practising in the field of pain medicine.

Keywords Consent; expert evidence; infrastructure; legal; pain; social

Royal College of Anaesthetists CPD Matrix: 1D00

Introduction

Practising pain medicine within the context of a multidisciplinary team poses different challenges to that of a general anaesthetist. Adult patients often struggle to stay in work or are not employed. Paediatric patients similarly struggle to remain in education. There is frequent reliance on the welfare system and social services. A grasp of the legal infrastructure with regards to disability, employment, mental capacity and safeguarding is essential. Pain physicians can be called on to give expert evidence in personal injury or medical negligence claims.

The welfare system

There are an estimated 14 million people living with chronic pain in the UK,¹ of which 3.5 million report that pain keeps them away from their usual activities including work for at least 14 days in the previous 3 months. Moreover, around a quarter of patients with chronic pain end up losing their jobs and around 13% report that they have to reduce their working hours. Back pain alone ranks as the highest contributor to the global burden of disease. Migraine and arthritis rank among the top five. The societal impact of chronic pain is massive. Patients who cannot

Lorraine de Gray MD LLM FRCA FFPMRCA is a Consultant in Anaesthesia and Pain Medicine at The Queen Elizabeth Hospital NHS Foundation Trust, Norfolk, UK. Conflicts of interest: Dr de Gray has given expert evidence in personal injury claims over the past ten years.

Learning objectives

After reading this article, you should be able to understand:

- the current infrastructure of the welfare system
- salient points pertaining to the Equality Act 2010, the Mental Capacity Act 2005 and the Care Act 2014
- safeguarding
- consent, the law and implications on clinical practice
- expert evidence in relation to pain medicine

work frequently rely entirely on the welfare system for financial support. By not working they cannot pay tax, and therefore this has a double impact. The economic cost of chronic pain is 10% of the gross domestic product.²

As a pain physician, you are frequently asked by patients to write letters of support in relation to either their remaining in employment, or in supporting them in claiming or continuing to receive welfare payments. An understanding of employment law, the Equality Act and the constantly changing welfare benefits can be very useful.

The Equality Act

The Equality Act³ passed through Parliament in the UK in 2010 with the primary purpose of bringing together all the previous acts and regulations pertaining to preventing discrimination. These included the Disability Act.

The Equality Act can also provide protection for certain illnesses when they are established as a disability. Under the Equality Act, a person is disabled if they have 'a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities'.

The Government's Legal Department website³ defines 'substantial' as something that is more than minor or trivial and the example given is 'it takes much longer than it usually would to complete a daily task like getting dressed'. Long term is defined as being more than 12 months. However note that certain conditions such as cancer, HIV infection and multiple sclerosis count from day one of being diagnosed. There are specific rules for fluctuating conditions which can be very pertinent to patients with chronic pain.

For example, a person with Crohn's disease may experience substantial adverse effects for a few weeks after the first occurrence and then have a period of remission. If the substantial adverse effects are likely to recur, they are to be treated as if they were continuing. If the effects are likely to recur beyond 12 months after the first occurrence, they are to be treated as long-term.

The Equality Act³ also refers to 'Indirect Effects' wherein an impairment may not directly prevent someone from carrying out normal day-to-day activities, but it may still have a substantial adverse effect on how the person carries out those activities. The Act specifically uses pain and fatigue as examples: 'where an impairment causes pain or fatigue, the person may have the ability to carry out a normal day-to-day activity, but may be restricted in the way that it is carried out because of experiencing

pain in doing so. Or the impairment might make the activity more than usually fatiguing so that the person might not be able to repeat the task over a sustained period of time'.

Therefore the majority if not all of patients seen in a pain clinic are likely to be protected by the Equality Act. This is of particular relevance in patients who remain in employment and for pain clinicians who manage paediatric patients.

Part 6 of the Equality Act³ provides protection for disabled students by preventing discrimination against them at school, college or university. The schools have to make reasonable adjustments for disabled children and teenagers, and this goes hand in hand with the Special Educational Needs framework. Hence as part of multidisciplinary working paediatric pain physicians frequently liaise with Special Educational Needs Co-ordinators. (SENCO).

For patients who fall under the Equality Act and continue to work, their employer is duty bound to make reasonable adjustments to allow them to remain in employment.³ This applies whether they are applying for a new job or if they want to remain in their current role and require adjustments. This could include being allowed to work flexible hours, to have bespoke seating arrangements, ergonomic assessments of work stations amongst others.

Occupational therapists working within multidisciplinary pain teams frequently offer advice and support based on the protection provided by the Equality Act.

Universal Credit and Personal Independence Payment

The welfare system and the type of payments provided change frequently and it can sometimes be quite challenging to keep up with these changes. In 2019, Universal Credit is being rolled out. This will incorporate into a single payment what is currently being paid as Child Tax Credit, Housing Benefit, Income Support, Income-based Jobseeker's Allowance, Income-related Employment and Support Allowance, and Working Tax Credit.

Personal Independence Payment (PIP) is a separate benefit for people who may need help with daily activities or getting around because of a long-term illness or disability. PIP has two parts – a daily living component and a mobility component. PIP has replaced Disability Living Allowance and can be paid even to patients who are in work. For instance, it can help towards paying for a specially adapted car, or towards funding a carer for patients who require assistance with self-care.

Volunteering and assisting in return to work

One of the roles of a pain clinician is to help patients return to work. Frequently volunteering can be used as a way of helping patients to experience again what it is like to be in a working environment. This can also help to open opportunities in the workforce market. Pain services frequently liaise with the National Careers Service⁴ and charities that support patients with disabilities, such as Equal Lives.⁵

Safeguarding: The Care Act 2014 states⁶ that '*People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved*'.

The General Medical Council⁷ requires all doctors to be aware of safeguarding issues and indeed most NHS Trusts provide mandatory training in safeguarding adults, children and specifically vulnerable patient groups such as those with learning disability. There is no doubt that in the context of a multidisciplinary pain team, health professionals come across a higher than average incidence of situations where safeguarding issues arise. Hence awareness, and knowledge of how to interact with other health professionals, social services and at times the legal framework can be crucial to ensure that such patients are managed well and kept safe.

Consent: The General Medical Council states the following principles underpin the process of consent:⁸

1. Listen to patients and respect their views about their health.
2. Discuss with patients what their diagnosis, prognosis, treatment and care involve.
3. Share with patients the information they want or need in order to make decisions.
4. Maximize patients' opportunities, and their ability, to make decisions for themselves.
5. Respect patients' decisions.

These principles very much echo the ethos of multidisciplinary pain management, where listening to patients, educating patients and helping them to manage their symptoms is what we do on a daily basis. One aspect of pain management can involve provision of pain intervention techniques. As such therefore anaesthetists practising in the field of pain medicine can initially find this aspect of practice more challenging. Traditionally, surgeons have acquired written consent for a surgical procedure which is taken implicitly to include the anaesthetic procedure required to perform surgery. There has been a move in recent years with changing case law for Anaesthetists to also have specific consent forms for the anaesthetic itself.

Following the Montgomery⁹ ruling, the law on consent has progressed from doctor focused to patient focused. The practice of medicine has moved significantly away from the idea of the paternalistic doctor who knows best and tells a patient what to do, even if this was thought to be in the patient's best interests. Moreover, it is no longer acceptable for a doctor not to discuss a risk with a patient no matter how small the risk. If that particular patient deems the risk to be important for them, this should be discussed. This is a move away from previous case law¹⁰ where the decision as to whether a particular risk was discussed was based on whether a body of health professionals would choose to do so.

Each patient should therefore be seen as an individual and each consent should be tailored to that individual to support them make decisions about their own health and to understand and accept that procedures are not always successful and complications can occur despite the best treatment.

A two-stage consent process is advised, where in consent is first obtained during the clinic visit followed by confirmation of consent on the day of the procedure. Careful documentation is essential. Patients should be provided with procedure specific information leaflets – these are available from nationally recognized bodies. Most NHS Trusts also now provide procedure specific consent forms which provide significant detail with regard to risks and benefits associated with the procedure. It is

crucial that patients are given enough time to ask questions, understand and reflect on the options discussed.

There may be instances where patients specifically ask not to be provided with risks inherent in a procedure. In these instances, documentation of this fact is very important. If a patient does not accept information provided or treatment options offered, then a second opinion should be offered.

Mental capacity: The Mental Capacity Act 2005¹¹ is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. Assessing a patient's mental capacity goes very much hand in hand with managing consent and safeguarding.

In the context of a managing a patient with chronic pain, assessing a patient's mental capacity may be required when discussing pain management and consenting to treatments. Typical situations could arise when managing patients with dementia, severe learning disability, post head injury, certain neurological disorders and mental health illnesses. In these situations, one may also come across advanced decision (or directive), independent and personal advocates.

An **advanced decision** is (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) a legally binding decision that allows someone aged 18 or over, while still capable, to refuse specified medical treatment for a time in the future when they may lack capacity to consent to or refuse that treatment.

The Care Act 2014:¹² If a person has care and support needs, but has a *substantial difficulty* in making decisions, the local authority has a duty to support them and assist them in making decisions. An **independent advocate** is appointed in these cases to support and represent this person. The Care Act defines four areas where people may experience substantial difficulty. These are:

- understanding relevant information
- retaining information
- using or weighing information
- communication of views, wishes and feelings.

Patients can also appoint a personal advocate (a friend or a family member) who can have a **lasting power of attorney** which enables them to make decisions about the patient's health and welfare, or decisions about their property and financial affairs.

Medicolegal reporting and expert evidence: Consultant anaesthetists who practice in pain medicine may choose to give expert evidence in personal injury and medical negligence claims, where claimants have been left with chronic pain. There are Expert Witness Training Courses as well as post graduate Masters courses and diplomas in Medical Law. Expert evidence is used to help the court in its judgement when the case before it involves matters on which it does not have the requisite technical or specialist knowledge. A witness owes no duty of care to anyone in respect of the evidence he gives to the Court. His only duty is to the Court and to tell the truth.

In 2011 the Supreme Court of England and Wales made a historic decision¹³ during the case of Jones v Kaney¹⁴ to divest

expert witnesses of immunity from having legal proceedings taken against them on the basis of the evidence they produced. During this landmark case a clinical psychologist giving evidence for the claimant was criticized by the judge for the way she provided evidence, in particular in relation to a joint report with the defendant's lawyers.

According to this ruling, expert witnesses can now be sued in civil proceedings for wrong-doings relating to the evidence they produced. This case caused a significant ripple in this field. There had been previous cases where expert witnesses had been heavily criticized by the presiding judge and indeed struck off by the General Medical Council, the most well-known being that of the paediatrician Sir Roy Meadows¹⁵ who gave evidence in the case of Sally Clark, a woman who was accused of murdering her two children. Meadow's evidence was deemed to be flawed, as there was no scientific evidence for the statistics he had used to support his testimony for the prosecution.

Loss of immunity for expert witnesses does not apply to Scotland and the concern is that it is likely to have a significant negative impact on the number of doctors who will still practice in this field.

Conclusion

It is impossible to cover this broad field in a single paper. I hope the reader will be stimulated to explore further the legal and social infrastructure and knowledge that should be at the fingertips of all practising in the field of pain medicine. ◆

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