TRANSCRIPT OF PROCEEDINGS

THE MEDICO-LEGAL SOCIETY OF VICTORIA

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A DANCE OF INVISIBLE IMPAIRMENTS:
EPIDEMIC DISABILITY SYNDROMES

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DR STEVENSON. When I first joined the Society I thought in fact we would probably be spending more of our time in discussion of the various conflicts between medicine and the law because one of the commonest most conflict between medicine and the law is in the area of personal injury trauma and disability. Tonight we are going to look at the social area where medicine and law conflict together most commonly.

I became a medico-legal examiner late in my career by a rather unusual path. I'm a consultant physician by trade. I was undecided as to what to be when I was a youth. I spent some time doing psychiatry and about 15years of intensive care. Like many ageing intensivists of my generation I decided to go back to clinical medicine and talk to people. I was offered as part of the things I was doing then some medico-legal work. I said I knew about infection, poisoning, trauma, yes, I've seen gold standard of that sort of thing, so I could do it. I found myself then talking to some of the most extraordinary disabled people I'd met in my life but disabled by no pathology that I could define. I could not understand what I was missing. I thought I'll have to go back and repeat a year. Gradually, reading around the subject, I began to make my way through it and this is the result.

When I passed the examination a consultant physician the pass mark was about 80 to 90 per cent and 80 to 90 percent of the candidates would fail, so when you were given your glass of sherry by the examiners you felt you had joined a diagnostic elite. But then that purported diagnostic accuracy has to be measured in the real world, and it turns out to be curiously disappointing.

This slide is a study from three years of hospital out-patients, so there is none of the potential shenanigans of the medico-legal process. The red marks are organic diagnoses and the white lines are no organic diagnoses. So in this great range of symptoms and from cardiology to neurology to back pain, the rate of objective organic diagnosis is a miserable 10 to 20%. So, having introduced myself as from a specialty trained to 80 to 90 per cent diagnostic accuracy we reveal real world diagnostic accuracy as the opposite. So, what's gone wrong?

I'm not here to preach Christian Science. If you suffer a medical catastrophe tonight it is the best time in the history of the world. You will be taken to a hospital where we again we are

working at an 80 to 90 per cent accuracy rate. This slide however shows what happens with the working wounded.

The sociologists of medicine give us the explanation. We're actually specialists in disease. Disease is a definable biological process characterised by objective changes. These are scientific discoveries and technical issues and medicine is good at that.

But disease isn't why our patients come to us. Patients come to us because of illness. Illness is not a biological process but is human distress and behaviour. It is shaped by culture and environment.

It is a seductive temptation as a doctor to think patients experience illness early or largely because they are diseased. But as I hope to persuade you tonight, illness is much more to do about personal suffering and social stresses than about biological disease, so there's a difference.

Illness is why patients come to doctors and disease is how the doctor is trained to interpret their coming. So, the doctor is a professional in disease and an amateur in illness; and our patients are the other way round. A significant proportion of our patients are heavily invested in illness to which preferably the doctor is a peripheral oddity.

Doctor and patient are to a degree collusive. The patient is trying to put his illness and distress in terms, which the doctor finds acceptable. The doctor is trying to interpret the distress in terms of the disease in which he has been trained. Therefore doctor and patient are mutually self-sustaining; they hold each other up like two drunks at a ball.

The way in which people express their illness very is by time and culture. But we tend to be ill in ways that we share with others in the same way as our politics, fashions and religions are shared. The ways of being ill I shall talk about tonight are those which are socially important in contemporary society. This is a list which include insurers' major nightmares common in our society: these are occupational back pain; the various occupational pain syndromes that bedevil industrial medicine. These syndromes all have common features.

They are syndromes predominantly of symptoms without objective physical signs. They are syndromes of disability without pathology. There is pathology in some of these

syndromes. Somewhere between 1 and 10 per cent of back pain presentations you find identifiable pathology. But there is vastly more disability than there is pathology in these syndromes. In many there is no pathology at all.

There are strong cultural and regional variations in these syndromes. For example, in Australia in the 1980's there was an epidemic of RSI where one-third of the Commonwealth clerical workforce were disabled by a condition not found in the rest of the world. There is a worldwide infective illness called Q fever. In the rest of the world people either die or recover from it without long-term disability; in the Australian abattoir trade 30 to 40 per cent of workers claim long-term and permanent impairment by a disease without objective marking whatsoever. When you discuss this with infectious disease physicians in the rest of the world their jaws drop.

We have recently had our house painted by a 50 year old painter. That doesn't happen in Scandinavia. Scandinavian painters retire in their 40s and 50s with a form of chronic fatigue syndrome with strong neurological failure which is called Painters' Syndrome. It's a disability syndrome blamed on paint but not caused by it. People of the same biology in the rest of the world using the same chemicals do not suffer. This is a Scandinavian oddity as RSI and Q fever debility are Australian.

There is strong psychiatric morbidity in these syndromes. These patients are distressed and suffer more psychiatric illness than the rest of the population, even more than the objectively diseased. These present with formal sometimes verbatim narratives of illness. Infectious disease physicians found themselves in the 90s confronted by well-rehearsed patients reciting almost verbatim the Centre for Disease Control narrative of CFS. Around the same time psychiatrics were listening the epidemic narrative of Post-Traumatic Stress Disorder recited by their patients. These are well rehearsed patients who had studied their syndromes.

All of these syndromes are modelled on physical disease or injury. Rheumatologists are haunted by fibromyalgia, infectious disease physicians and immunologists have chronic fatigue syndrome. These syndromes are all over-represented in the legal process, many are almost non-existent outside it; the majority reach their full glory or malignancy only in the legal process.

The nomenclature of these syndromes is a mess. You can classify cancers definitively because cancers stay the same after being classified. Human beings respond adaptively to the

ways they are classified. So you have a wide range of ways of slicing these syndromes up. Because they're predominantly about being ill without medical pathology they fall into the psychiatric textbooks and the psychiatric term for this is somatisation, which is the expression of distress in terms of the soma, using bodily symptoms of to express personal distress or to achieve gain.

But these are the psychiatric illnesses where the patient avoids the psychiatrist. The patient is visits the orthopaedic surgeon, the neurosurgeon, the neurologist, the physician, anyone but the psychiatrist. When sent to the psychiatrist reluctantly, they denied distress, smile cheerfully and say, "I have an emerging disease. Dr Stevenson is trying to find my virus". So while the process is predominantly psychological, the patients avoid psychiatry. Paradoxically, putting emotional distress in physical terms does remarkably cheer people up. Oliver Sachs wrote that functional syndromes are available to the patient as an alternative to despair.

Richard Dawkins' term Meme is useful. Memes are Viruses of the Mind. These memes are cultural illnesses, spread by imitation and social construction. The other term is Idioms of Distress. Traditionally, they have been regarded as hysterias. Hysteria is still a useful term so long as you appreciate it has nothing to do with the wandering of the uterus but has much to do about the History or Story. These are narratives. We all make sense of our lives by telling stories to ourselves, telling stories to each other, or living out stories. These are stories of illness which have run amok.

There's a strong nomogenic flavour to these illnesses. Iatrogenic disease or iatrogenic illness is disease cause caused by doctors and there are two species of it. There are false negatives and false positives. The false negatives are when I don't diagnose your cancer in time, when a diagnosis is missed. This is intensely stigmatised by the doctor, patient, and society; there's immense blame, we try to avoid doing that at all costs, with results that are technically reasonably successful.

But false positives are when doctors diagnose a disease that does not exist. And that is professionally a much safer thing to do. There is much less stigma and frequent kudos. There are lucrative practices based entirely on the diagnosis of non-existent diseases to the suggestible and distressed. Sociologists find that Doctors cause much more harm by epidemic false positive

diagnoses then we do by our occasional dramatic and professionally disgraceful false negatives. RSI was an epidemic of doctors being prepared to diagnose a disease or an injury which didn't exist. If you make a false positive diagnosis you are protecting yourself; the patient goes away with a diagnosis; the social costs and the blame are dispersed. Practices can be built up and the reputation of the medical messiah earned by being prepared to make false positive diagnoses of non-existent diseases.

Nomogenesis is the legal equivalent of iatrogenesis; that is illness caused by lawyers - from the Greek word "nomos", the law; nomogenic illness is almost by necessity false positive. It is the creation or amplification of illness by legislation or by legal action. It is essentially misclassification of human suffering as injury or organic disease, which may then justify the effort because it now has potential cash value. It is a vast industry which rewards its practitioners well, both medical and legal. As the costs are dispersed through the community, they are relatively painless especially compared to the false-positive.

Ian Hacking is a Canadian philosopher who has written extensively on social construction. He wrote a fascinating study on 19th Century psychiatric illnesses that we don't diagnosis any more like fugues, and hysteria. He identified the concept of looping; the classification of the doctor influences the patient behaviour which, in turn, further goes back and then modifies the medical classification and so on. Patients seek to have non-specific symptoms of weariness and discomfort raised to the level of specific diagnoses. That will often say self-respect, and sometimes even enable lucrative compensation.

Now the prize for achieving these syndromes is the sociological phenomenon of the sick role. Societies have always provided care for sick and wounded and relief from responsibility. There is archaeological evidence for this going back to Neanderthal man. It's a social contract of mutual aid and cooperation - what goes around comes around. But illness roles can be desirable because of secondary gains. Being ill is an intrusion on your life if your life is full. It can be a sanctuary if your life is a failure and a disaster. But illness must be put in terms which are culturally acceptable to resolve personal and social problems.

So, in a kindly society, emotional illness and personal predicament are given relief but relief is given at a lesser level than for disease or physical injury. There's a hierarchy of entries

to the sick role: wounded in battle or wounded in labour are the most dignified. Illness can convert social dilemma into acceptable disability. So, there becomes a market in illness roles. The tendency for humanity to seek complimentary upgrades is deeply entrenched.

Entries to the illness role can be compensable and this goes back a long way. This slide shows a perfectly ordinary Table of Maims, giving prices for a right arm, a right leg, a left leg. The only odd thing about it is it's paid off in pieces of eight; the date is 1702 and this is from Esquemelin's "History of the Pirates". The pirates of the Spanish Main in the golden age of piracy drew up workplace agreements. The free market of piracy was somewhat ahead of the central state of King George. There was payment for each limb lost so long as it was lost in piratical combat. If you were completely crippled you were given the job of ship's cook, irrespective of culinary ability.

Blackbeard and Captain Kidd are not generally spoken of as being in the forefront of the welfare state but recompense for injury and entitlement to the sick role goes back into human history.

This is a slide which addresses two things. First of all, what's the social impact of these syndromes? This is from Waddell on Back Pain and these are English figures but Australian and American figures are very similar. These are millions of days lost in the United Kingdom per year for back pain going back to the start of the century where workers' compensation and disability support was first initiated. There has been progression throughout until the '80s or '90s and then there's a virtual tripling of disability every 3 years which was when this data was taken out meant that by 2020 every man, woman and new born child in the United Kingdom would be on disability support for back pain.

The social impact of these syndromes is therefore considerable. The dotted line is an abstraction but it is there to remind you that in England, as in Australia, as in America, at the start of the century 90 per cent of the adult population worked in physical labour. At the end of the century this had reversed. Only 10% are in physical labour and the rest of us are elaborating symbols and dealing with abstractions. So the actual burden on the human back has been in long-term decline while purported back pain disability has gone in completely the opposite

direction. There is inexplicable if back pain is was true physical injury

There are principles for working out causation in medicine. People who over a lifetime smoke a million cigarettes have a higher risk of lung cancer that those who smoke none, so the two lines go up in correlation. In here it's the opposite. Disability syndromes or hysterias are cultural effervescences, irrational exuberances. They are the fantasy or the metaphor of disease or injury, not the objective pathology. They do not follow the basic principles of causation; they go off on a frolic of their own.

A similar graph and a similar Inverse Ratio Law are helpful in sorting out the other forms of disability syndrome. It is not major trauma that leads to post-traumatic fibromyalgia; it is minor trauma in the context of litigation and social distress. It is not people who are poisoned and need intensive care who claim multiple chemical sensitivity; it is people troubled by the whiff of perfumes in the workplace.

A similar graph was found for RSI. We are Australia, we're the sunburnt country but we are also a world capital of hysteria. If you look up the textbooks of Mass Hysteria you'll find they start with the dancing mania in the Middle Ages, they go through the Devils of Loudoun, then after spectacular 19th Century epidemics they end up in Canberra in 1980's when Australia was in the grip of what is in the textbooks now describe as the benchmark example of socially constructed mass hysteria mixed with malingering. It was originally interpreted as an epidemic of neurological or musculoskeletal injury where up to one-third of the Commonwealth workplace was classed as disabled. The anomaly was, it didn't happen anywhere else in the world and when actually the studies were done on a repetition in injury they were the wrong way around. Those who did the least complained the most

RSI and Keystroke Rate

Keystrokes / hr	***RSI Claims***
17,000	3.4%
4000	28.4%
400	34.3%

This slide shows a study from Bruce Hocking published in the MJA (Med J Aust 150:724, 1989) when the epidemic was four years old; it shows people doing work for Telecom. At the top of it are stenotypists taking dictation, high skilled, high repetition work, they're doing 17,000 key strokes an hour. At the peak of the epidemic they had a very low incidence (3%) of RSI claim. People doing ordinary clerical work did 4,000 keystrokes an hour and the rate of RSI claim was more (10%). People working at call centres which was boring work, usually part-time, did 400 keystrokes an hour – in this group at the peak of the epidemic **one-third** of the workforce was claiming RSI. So it was the complete opposite of what is associated with causal relation. It was a frolic on its own.

The classic textbook on psychosomatic epidemics is by a Canadian historian, Edmund Shorter "From Paralysis to Fatigue". The model for creating one of these syndromes is this. These imaginative or mimetic illnesses do not imitate non-existent diseases; they imitate genuine organic disease taken as a template. The template is then broadcast and embraced by the suggestible and distressed.

The most effective templates are the most authoritative. So three of the most socially successful ones are RSI, Chronic Fatigue Syndrome and Fibromyalgia - each was constructed accidentally and with benign intent by a committee of a major medical authority, the National Health & Medical Research Council, the Centre for Disease Control, the American College of Rheumatology who round a committee table drew up the paradigm of an illness for the purposes of epidemiology and research.

In each case the paradigm escaped investigative science and went feral. In each case the

model was based on incorrect but plausible. The tentative model for epidemiology and research of RSI was on the basis that repetition caused physical injury. They had it the wrong way round. Chronic fatigue syndrome was posited on the working hypothesis that Epstein Barr virus caused a chronic viral infection and immunopathy. Within four years the idea had been withdrawn, 90% of the planet's population has the virus not the fatigue, but by the idea had escaped; as a testable falsifiable hypothesis Chronic fatigue syndrome was a failed disease. As an untestable unfalsifiable hypothesis, it was a social success as an illness epidemic.

Fibromyalgia is fascinating. The chairman of the committee of the American College of Rheumatology who created it, Frederic Wolfe was for ten years its main advocate, by 2000 he apologised for his creation saying that he had created a monster. This was done with the most altruistic motives but the idea of fibromyalgia had created illness where they had hoped to moderate it –in a moving statement is stated that the aim of the construction was to understand and believe human distress, but in effect they had magnified. It was the emperor's new clothes. The ingredients needed for creating these epidemics is a triad - patients who were vulnerable, physician enthusiasts and supportive cultural environments.

There is a historical tangle of disability syndromes prior to the last ten to 20 years old which will offend no one here and which no one now believe in. The ones I've listed are still have life. Hysterical epidemics are always modern.

It is socially acceptable if you get into your taxi tonight and I get into my taxi and I drive into you or you drive into me that we may be litigating for chronic neck pain two years later. With modern methods of therapy and investigation there are published series of chronic pain after whiplash about 50 per cent at two years staying stable then. This is with best modern treatment. What if you don't treat it at all? There are studies outside Western Europe, this is a Norwegian study from Lithuania, 500 people, whiplash collisions and in many the car was destroyed. The neck pain lasted three days on average and the longest was three weeks. At one year there was no significant residual pain. What treatment had been done? None. The car was taken to a panel

beater, and injured driver worried about getting spare parts.

Crash engineers have been driving cars into each other for 50 years at impact speeds of up to 100 kilometres an hour, they've readily reproduced pain in the neck for three days. Peter Landy, a Queensland neurologist, a few years ago estimated that one-third to one quarter of the legal effort in Queensland was sorting out the long-term impact of motor vehicle accidents: patients with fractured skulls and fractured legs were not complaining of chronic pain. I once examined 25 people who had their necks broken and avoided paraplegia. At six to ten months, none complained of pain, all of them had perfectly normal range of movement, all were glad to be alive. One of followed into my surgery by a lady who walked like a model with her neck held stiffer than advanced rigor mortis. She was a perfectly charming lady who had been in a minor fender bender three years before. She had a pile of reports with her by the usual suspects diagnosing central sensitisation nociception. People whose necks are broken move their necks freely.

So minor collision in Australia is a culturally acceptable entry to the sick role of chronic neck pain. Koro, penis shrinking is culturally acceptable in Asia and Africa, but they are outside the whiplash zone.
Koro is not culturally acceptable in Australia. These are all culture bound syndromes.

This is a famous picture by Brouillet of the greatest neurologist of the 19th Century, Charcot, in La Salpétrière demonstrating a case of grand hysteria. The phenomenon is still full of lessons for today. This is Dora Witman the queen of the hysterics and Charcot, is demonstrating her in one of the clinical pathological demonstrations he did every week.

Charcot defined diseases and triads that we still teach medical students today but for a central ten years of his life he was fascinated by the phenomenon of hysteria which he saw as a genuine neurological disease. Sigmund Freud frequently sat in the audience and thought there was something very fascinating going on with this ladies' subconscious minds. Can we guess at what was happening from what we've looked at from the illness role?

The original hysterics were poor ladies from the streets. Many had had quite desperate lives. Many had to walk the streets and like street-walking people many lobbed into the hospital in search for a feed and a bed. They were put in the acute ward with genuine paralytics and epileptics.

After a little while some of these girls thought "This is nothing, we can do better than that" and they did. They began to throw fits that were more dramatic and more interesting than those they had seen. Charcot's eyes by this stage must have been starved for novelty. He examined them. He began to classify them. He began to demonstrate them. The more imaginative of them presented Charcot's classification with elegant variations. They manifested as a phenomenon of looping. On the wall there you can see dimly a painting of the full arc-en-ciel, standing on the head and the heels and arching with the back in the middle, just as in tetanus. Though it was not intended as a visual prompting, it undoubtedly has the capacity to act as such. It is similar to the way the way medical enthusiasts now hand out lists of symptoms required to syndrome or diagnosis. This man was the greatest neurologist of the 19th Century and for ten years he was unable to distinguish genuine neurological disease from complex adaptive human behaviour got up to please him.

The 19th Century was a hard time if you were poor. Medically inexplicable pain and fatigue work a privilege only for the very rich. It could be enjoyed at the spas of Marienbad and Baden-Baden; but if you were poor you had to so something fairly desperate. We live in a

kinder, gentler society; the welfare state and disability support have brought medically inexplicable pain and fatigue even to the poor.

Hysterias are always modern so Charcot photographed everything and there's a fascinating book on the photography of La Salpêtrière. There are many cases of advanced neurological disease and amongst them all there are these startling ladies. Charcot saw this as advanced neurological disease. Looking at it from a century later we see a clever imaginative girl who was having a hoot and who was enjoying the sensation of - that even very clever, very powerful men can be pulled around by the nose or the leg or some other appendage.

Charcot was no fool so why did he get it so wrong? He got it so wrong because he had a disease-orientated approach, he classified as disease what was actually illness. He underestimated these girls' imaginativeness, he ignored their suffering, he didn't appreciate their adaptiveness. Freud was also no fool, but perhaps looking into the subconscious debts was an unnecessary excursus.

Now let us look at a slide which I've shown as a clinical quiz to various medical audiences and it causes trouble and confusion generally even to professors of medicine. Let's look at it in a more relaxed approach tonight from a different perspective. This is a range of people, 200 people with an enormous tangle of symptoms: headache, back pain, fatigue, neck pain - 70 to 80 per cent.

___What Disease is This?

Headache	88%
Backache	80%
Fatigue	79%
Concentration problems	78%
Neck pain	74%
Arm pain	74%
Memory problems	53%
Dizziness	44%
Sexual problems	41%
Numbness	39%

Lees-Haley and Brown: Arch. Clin. Neuropsychology 8:203 1993

Let us look at it from different professional perspectives. Look at it from the point of view of the lawyers first. It will depend on what's happened in these people's lives lately - their backs are hurting, their necks are hurting, their arms are hurting; depending on the history given and recent life challenges they could be represented for industrial back pain, for chronic whiplash, for RSI, for fibromyalgia or you could, if you were of a different group, you could defend claims for these problems.

If you were a diagnostician, well the head would need to be scanned, the neck would need to be scanned, the back would need to be scanned, the temptation to try steroids is considerable. If God has given you a scalpel and you had learned the gift of surgery -- well it will depend on what is shown on the x-rays but if there are bulges in the neck or bulges in the back these can be cut out and fused. So, from different professional perspectives there's a great deal of good we can do the sufferers and at the end of that we can take our very reasonable fee.

So, who are they? This comes from a study in the neuropsychological literature by Lees, Haley and Brown and this was a study looking at people who were litigating for chemical injury. They'd been exposed to various toxins, in fact in fact at an extremely low level. So, is

this toxicology? Well, close but no cigar. This is a different sort of poisoning.

Lees, Haley and Brown did two control groups. They did one control group which was community-based and another control group which were people litigating for **non-medical** issues: divorce, discrimination, harassment, issues like that. And these are the symptoms of the persons who were **litigating for non-medical issues**. These are the control groups. These are litigating in a context where there is no money on the table for physical symptoms at all. Lees, Haley and Brown are actually interested in the neuropsychology; they put the pain questions in just as distracters. And look at all the pain that they found. So, what is going on here?

There's a great deal of humanity in this. First of all, I can get the medical half of the audience on my side by saying simply, "This is compensation neurosis". Compensation neurosis has always been a controversial issue. It has been defined as a cluster of symptoms begotten out of fear, consolidated in anger and greed, and cured by a verdict. This is obviously an evidence-based demonstration of symptoms of compensation neurosis. But it would be shallow simply to leave it at compensation, and one would miss insight into a great deal of human suffering. These people have all been in a situation of personal distress and the distress is then perpetuated by ongoing conflict about distress and the result has been that anxiety, depression, pain, a vast range of symptoms has been tripled. It's nothing to do with pathology; this plethora of physical symptomatology reflects distress and illness.

And these symptoms present in extraordinarily medical patterns and look extraordinarily like physical disease. So, consider what lucrative practices, medical and legal, one can maintain by taking the ubiquitous physical symptoms of distress and misinterpreting them as either emergent disease or as compensable injury.

In the medical literature there's been a long tangled debate about hysterical pain or psychogenic pain, it's thought to be generally very rare and something which affects very weird people.

Who gets hysterical pain? You saw the numbers - 80 to 90 per cent -we all do. We're all hysterics. Put us into a situation of social distress and keep the squeezes on and we almost all of us develop psychosomatic pain. What if you've got into this tangle because you hurt your neck or you hurt your back or you hurt your arm originally? You don't even have to tell a fib.

You're in a self-perpetuating cycle and then if you are going to a surgeon with that complaint of pain you're a natural target for a scalpel. Conscientious committees of the College of Rheumatologists looking at that morass of symptoms created syndromes, in much the same way that primitive astronomers created constellations out of the chaos of the stars: fibromyalgia, chronic fatigue syndromes are artefacts on the background of human distress.

These were symptoms where there was no cash value on the pain. This was getting behind the usual problem in assessment of compensation neurosis the patient is being paid. Does it make a difference if symptoms are being paid for?

Well there are two ways of looking at that and one is economic and the other is medical. The one I discovered first was from the incidental journalism of Lord Salisbury who was the English prime minister who passed the first Workers' Compensation Act and he worked this when he was foreign secretary. And it was an interesting account. It was about a Victorian governor of Jamaica who was distressed to find that a large number of people in Jamaica were dying of snakebite. As a benevolent social engineer he declared a bounty on snakes: one shilling for each dead viper brought to the police station. The result you will be obvious to any economist in the audience. What happened was the people of Jamaica prospered and the vipers of Jamaica proliferated. It was a win/win situation all around. The governor had become father to a commercial and domestic snake-breeding industry. Jamaicans were confronted with the choice of losing an occasional slow or drunken Jamaican to snakebite or an unending supply of government largesse. They took the second option.

This is actually a principle which is in the economic textbooks used to explain various perverse incentives in various well-intentioned acts of social engineering which turn out not as one intend. It's the Vipers of Abruzzi effect. Giving a cash value to an evil does not cause less of the evil, it causes more of it.

Does this stack up in the medical evidence? Yes, it does. We're in a society which for various benevolent reasons gives a cash value to back pain.

Greenough and Frazer are South Australian orthopaedic surgeons, they've looked at the

average time of disability for non-specific back pain without sciatica, non-compensable was one week, compensable back pain was one year; of the a difference of 5,200 per cent, that's statistically significant.

Doctors by default position are trained to trust. We are used to people coming to us to tell us unpalatable truths about themselves. "I smoked 80 cigarettes a day for years and I'm coughing blood." Or. "I've had a wild holiday on the West Coast of America and I've got this rash". Our default position is absolute trust and the working hypothesis that a symptom is pathology and it is our duty to find it.

So, for us to be appointed the gatekeepers to the medicolegal process of injury was really unfortunate. We are not by nature and instinctive good at it when the thought crosses your mind that could some people be lying to us you actually have to go and do the research. The person who has published most of it is a lady with the unlikely name of Bella de Paulo who is a respectable professor of psychology in the United States: lying serves basic social functions and she's been having people record lying and research into lying for years. Lying is frequent. Most people lie or are lied to about three times a day. In fact the average frequency was that in a 20 minute conversation there's a 20 to 30 per cent chance of a lie. It varies considerably with age. Mature adult to mature adult conversations include lies about 20 to 30 per cent. Adolescents to parents is 50 per cent per 20 minutes. Mating adolescent to mating adolescent is also 50 per cent. As good as it gets is long-term stable marriage where it gets down to less than five per cent a day.

Then there is research on how can you tell whether people are lying? In fact it's almost impossible. Very gross liars may stand out but when looked at critically, the experienced physician, the experienced lawyer trying to judge a lie by the cut of the patient's jib scores about five per cent better than chance. And in fact it gets worse than that because the more information you're given the worse the detection rate. This is demonstrated by a study which looked at various ways of observing was the patient sweating, were they stammering. Well, maybe you can gain five per cent on that. But if you blindfold the person who is trying to detect their ability to tell whether they're being lied to, it goes up 25 per cent.

Again, it gets worse. There was a study that looked at people undergoing various

painful medical procedures filmed and compared with medical students pretending they were undergoing such procedures. These films were shown to a lay audience. The actors were rated higher in genuineness and higher in pain. I assume this information is looked at carefully on the Bench.

Then as you do more of this sort of work, you start to wonder, is it possible that some of these people could even be malingering? Well, malingerers have a very bad reputation so naturally one feels they smell of sulphur). The standard textbook on pain is Bonica. It's about 1500 pages and when I first began to worry about this, I looked it up, I had an electronic edition so I could use control there when I went through it and I found "*malingering is very rare*" three times.

Now almost everything in that book has about twelve references but this had no references. It took me about one go to found through and I found an impressionistic study when no one had tested. So I started to look through the literature elsewhere. With back pain and neck pain and things like that, well people acting, people in distress, so it's all very fudgy. But there are areas where people can give you solid numbers and the neuropsychologists have produced a tangle of interesting research with an instrument called the TOMM. TOMM stands for "test of malingered memory". And what it is, the patient is shown about 200 different shapes in quick succession. You're shown them once to familiarise yourself and then was shown again and asked if you've seen them before and it's mixed up and it's a very good test. You look at it and it's intellectually daunting but what it is testing something very basic in the brain stem. It's not really "Do I know your face". I mean "Have I seen your face in the last five minutes". If you fail the TOMM on genuine grounds of cerebral injury, you have the most devastating brain damage you have to be institutionalised, you can't find your way back to your table, you can't make it across the street.

So people who've had major skull injuries, brain tumours taken out, penetrating skull injuries do very well on this. I used this for some time myself and when I tested people with, say, major strokes or had major cerebral trauma it really cheered them up remarkably. They'd look at this very daunting test and they'd find they'd do well and they would go out chuffed.

But if you were testing someone who was being, say, more imaginative and had fibro,

brain fog or whiplash and "my brain's gone completely" and been telling you how they couldn't work, well they - it worried them. They would start off and find they were getting everything right and find themselves confronted with this ostensibly very difficult test suddenly embarrassed themselves, finding themselves scoring at a genius level, so they would have to default and start showing negative memory. So, it gives a very clear, very good cut-off point.

There was an enormous study by the American College of Neuropsychologists which examined poorly explicable pain and fatigue which scored about 30 per cent malingering. You look at some areas of fibromyalgia, chronic fatigue and whiplash, claiming disability; it goes up to 60 per cent. Now that's a worry because if one or two per cent of your patients claiming disability are malingering, the doctor and the lawyer can act as a gatekeeper. But if 60 per cent of a very lucrative income stream is malingering this is a strong disincentive to truth and a strong incentive for the doctor and lawyer acting as a gatekeeper to turn their eyes.

It also disabused me of the convention that only nasty people malinger. Amongst the people I've seen make a hash of it, unfortunately not when tested by me, were a very nice doctor and a very nice lawyer, not in this State, both with parallel dilemmas, a personal difficulty, a useless husband or a runaway husband and three children at private schools. They were faced with a dilemma, whether to tell a lie to the likes of me or to their do your best for the children.

This led me to Stevenson's law of malingerers. There are obviously commercial malingerers out there and many. Malingerers, the more interesting ones, come out of a situation of distress. I've met one self-confessed malingerer in my life and he is my rear neighbour. I have to make it perfectly clear it's my rear neighbour because my next door neighbours are here tonight and I must make it perfectly clear it's not them.

But my rear neighbour told me an instructive story about how once he went to the local library and looked up the symptoms of acute appendicitis and went to the local hospital and recited the symptoms and they took out his appendix which was, of course, perfect. My rear neighbour was one of the most charming men I've met in my life and he wasn't odd at all and if you or I had been in his boots and had had the wit to do it would've done the same thing. It's not about subconscious psychopathology, it's about social context. His boots were in Vienna and it was 1937. He was starving. He had never had a job. And if one had an abdominal operation in

those pre-antibiotic days you were sent for convalescence to a convent in the hills where you had three square meals a day for 30 days. 90 square meals for a vermiform appendix. So, it was a no-brainer. And he said "The next year, Peter, Hitler was marching in and I was cheering, I would get a job, it was a mistake because then I saw there were Jewish women in mink coats having to clean the streets with a toothbrush while people spat at them, it was not very good, but the next year I got a job. I was in the Wehrmacht, I was invading Poland".

Now we come to treatment. Treatment, fortunately, is short because it's paradoxical. In normal medicine the aim and effect of treatment is to relieve pathology. Normal medicine is a triumph of human achievement. We live longer than we did before. But in disability syndromes there is no pathology so the effect of e treatment becomes to frustrate the natural process of spontaneous recovery.

So, it is not that disability syndromes aren't treated enough. In fact these syndromes attract treatment like wasps to honey. Any way you slice it, if you look at the psychiatric literature on somatoform these patients have three times the normal incidence of surgery compared with medically ill patients. In the compensation setting claimants with minerals pathology are much more likely to be operated on and much more likely to receive paramedical treatment.

One of the more precisely documented example though is outside the physical disability syndromes which we've discussed. It's the psychiatric category of post-traumatic stress disorder. Post-traumatic stress disorder has many of the qualities of a socially constructed illness. It has a central nucleus of horrific reality and it has a large socially constructed illness penumbra. The socially constructed penumbra has proliferated enormously.

In the last months I've seen the diagnosis made twice and I'm not a psychiatrist. Once was for a woman who bruised her knee on a bus. The other came out of a squabble around a photocopier in the office. Both had certified diagnosis of post-traumatic stress disorder from those mundane events and psychiatric evidence certifying need for years of expensive treatment.

Look at treatment. If something horrible happens to you tonight what could seem more

useful and important than early and intense professional counselling. It seems a no-brainer. Well and do not take my word for it. The evidence has been looked at Cochrane Collaboration level. Cochrane collaboration conclusion was that early preventative counselling increases the incidence of post-traumatic stress disorder threefold, it increases the duration the same.

I once had the role of sitting in on some of the medical and psychiatric aftermaths of people in the Port Arthur massacre and I saw three people who had been on the Peninsula. Two people had been on the Peninsula. One had heard a shot in the distance. One might have heard a shot in the distance. The other wasn't on the Peninsula but had to do the rosters. They were outnumbered four to one by counsellors and were chronically disabled for years. In the afternoon I saw a Cook who was three feet from Martin Bryant when he shot her through one side to the body to other and she was back at work in six weeks. So, the psyche and social context are more important than the trauma. As Peter Landy wrote in his review, the least hurt complained the most.

The treatment of disease is a triumph of medicine but the medicalisation of human misery is a lucrative social disaster. One version of this talk now has about eight slides for references but this is the quick version and I'll give one which is authoritative because it's the American Medical Association Guides to Chronic Impairment. These syndromes are characterised by excessive medicalisation, by iatrogenic factors and by nomogenic. In other words, it is Pogo's law. We have met the enemy and he is us. Thank you very much.

Question: How do you identify chronic pain?

DR STEVENSON: - a chronic pain syndrome is a descriptive term, in other words it means the patient continues to complain of pain for which there's no medical explanation. If there is a medical explanation for the pain there is a medical treatment. In the pattern of disability syndromes or somatoform illness, pain is coming out of distress and it is then modulated or perpetuated by social conflict, so it is not susceptible to medical treatment. In fact medical treatment becomes counter-productive. The literature on somatoform illness and chronic pain syndromes indicates the complaint is a tactical reaction to a social predicament and until the predicament is resolved

medical treatment is useless.

QUESTION: How does modern society deal with chronic pain?

DR STEVENSON: Probably the form of treatment which cuts across sort of the short version would be cognitive behaviour therapy which is trying to alter patterns of thought and patterns of behaviour which is basic Buddhism, in other words right action, right thought, right consideration but it's not a medical treatment, it's a non-medical treatment for personal and social distress.

QUESTION: Don't you think if there are any real physical conditions that can't yet be medically explained that might be in some of these black box type conditions which you talked about.

DR STEVENSON: Yes, it's likely that there are. But if you actually look at the epidemiology it is unlikely that they are large or many. For example, remember the slide on RSI, if for example it was found that people who were doing more work had a higher incidence of pain and a higher incidence of disability then the reasonable explanation would be that this was a subtle overuse injury which our tools as yet do not define. But in fact what you have is the opposite. So, yes, you are correct and there must be undefined occasional undefined diseases which will be found by the standard techniques of scientific medicine. But if you look at the debatable borderland, what we are do more often is missing the patient is formulating distress or having a symptom which is coming out of distress so it's a two-way traffic. Our professional bias is to over-diagnose the physical.

QUESTION: Is chronic pain syndrome similar in Australia to other countries?

DR STEVENSON: Yes, there is. Again, the New Zealand incidence of chronic whiplash is lower than ours. There were studies from Canada where it changed to no fault, dropped the incidence of chronic whiplash claim. People who have had whiplash are often in pain in their neck chronically but they're not in pain because of injury. They're in pain because of emotional distress, argument about their case, the fact that they're having much too much treatment, the fact

they've got a chiropractor who's at their neck three times a week for weeks, whereas my patients who had had their broken neck no one touched would get better. So, yes, no fault injury is taking away pain. The price of the viper does alter the affect.

QUESTION: Just a short question, John, a quick question on sensitisation. How do you explain, Peter, the hard evidence of the organic changes in things like spinal flexor reflexes in patients with whiplash and fibromyalgia compared to controls - I think which aren't actually under conscious control which can't be feigned or manipulated or put on.

DR STEVENSON: In central sensitisation - there's undoubtedly evidence of central sensitisation in objective neurological injury but the claim - but I also see central sensitisation diagnosed in an epidemic manner in the compensation area in blatant absence of any neurological injury. Now if central sensitisation was the common mechanism then you would see it commonly in people who have broken their necks. I would have seen it commonly in the aftermath of major trauma. You would see it in such laboratories of violence as Rugby League. One would see post-traumatic fibromyalgia as common phenomena on the sporting pages. We don't see that. I see it claimed considerably and excessively after minor, trivial or non-existent injury in the medico-legal area.