LETTER TO THE EDITOR

RE: Harth M, Neilson WR. Fibomyalgia and disability adjudication: No simple solutions to a complex problem. Pain Res Manag 2014;19(6):293-299.

To the Editor;

We thank the editorial office of *Pain Research & Management* for the opportunity to reiterate some facts following the commentary in the current issue of the *Journal* (pages 293-299), 'Fibomyalgia and disability adjudication: No simple solutions to a complex problem', written by Drs Manfred Harth and Warren R Nielson in response to our article, 'Adjudication of fibromyalgia syndrome: Challenges in the medicolegal arena' (Pain Res Manag 2014;19[6]:287-292).

1. Criteria

While we can appreciate that fibromyalgia (FM) criteria have been the cause of much debate, intensified in the past few years with the publication of new diagnostic criteria by the American College of Rheumatology (ACR) in 2010, we must correct a misconception put forth by Harth and Nielson. The 2012 Canadian FM guidelines do not propose criteria to diagnose FM. Rather, they simply affirm that both the 1990 and 2010 ACR criteria should not be used to diagnose FM in an individual patient in the clinic setting. Consistent with this concept, we contend that these criteria should not be used to establish (or reject) a FM diagnosis in the medicolegal setting. In that FM is a polysymptomatic condition with variable expression in different patients, as well as variability in the same patient over time, adherence to strict criteria to 'confirm' a diagnosis is a fallacy. We emphasize that adjudicators must appreciate that these criteria rely on subjective patient reporting, which may be less reliable in the medicolegal setting.

2. Family physicians

The physician who is consulted in a timely manner following the traumatic incident alleged to have caused FM is best placed to assess a possible causal relationship. The reason for this is quite simple: preinjury state is vital in the adjudication of FM. The records of the family physician may contain the only reliable information regarding preinjury physical and mental status. Medical records that are most contemporaneous with the alleged causative event are also likely to be more reliable and not contaminated with embellishments or memory lapses over time. While Harth and Nielson express their concern regarding this position on analysis of causation, we ask them a simple question: How can an FM 'expert' physician, who parachutes into the legal adjudication of FM years following the traumatic incident, be in any position to inform the courts on the likelihood of causation, if not having access to medical information preinjury and directly following the event? We do acknowledge that comfort with FM is not optimal for most physicians; however, this is true for specialists and for general practitioners alike. Most FM patients are seen by a plethora of physicians over the years, often amounting to copious medical documentation – a cause of confusion. Our intention was, therefore, to direct adjudicators toward the most reliable documentation.

3. Trauma and FM

Harth and Nielson would have us believe that causation of FM following a traumatic experience is as solid as gold. We contend the contrary. In truth, the medical community has been largely unable to confidently ascertain causation in FM. Areas of interest include a genetic predisposition, influence of individual phenotype and effects of environmental factors. In truth, the premise of FM causation by a traumatic experience is based on a handful of studies (most of which are centred on motor vehicle accidents and whiplash as being linked to FM onset), all of which present important limitations. Governing bodies and tribunals have accepted that this prevalent condition can be disabling for some persons and, therefore, may affect work ability, thus accepting the legal argument of trauma causation in FM for some. We choose to acknowledge these limitations in the published literature and have reminded adjudicators of these limitations, much to the apparent dismay of Harth and Nielson.

4. Assessment of functional impairment in FM

Harth and Nielson appear to confound FM in the research setting and FM-related litigation. We do not question the validity of questionnaires used in FM research, nor do we question the use of diagnostic criteria in the same setting. However, what applies in research does not necessarily translate into hard evidence in the legal arena. The role of an adjudicator is to evaluate the claim from all aspects. Ultimately, the adjudicator will determine whether FM was causally linked to a traumatic event and/or whether impairment is sufficient to merit compensation. Expert testimony reporting on functional impairment is sought by adjudicators to reach a fair decision, based on current medical knowledge and the law. We contend that reliance on study questionnaires based on subjective patient reporting to assess impairment in a medicolegal context is of limited use. Such expert testimony would lack an essential component – expertise. Computing scores assessed by a questionnaire and reporting said scores does not provide the nuance of clinical interpretation and judgment, and is of no assistance to adjudicators. When asked for a medical opinion on functional impairment, the court is asking for an opinion, not a scoring of patient-answered questionnaires. If such were the case, the role of the medical expert would be obsolete and replaced by a computer printout.

5. Expert testimony

In considering the admissibility of expert testimony, we referred to the rulings of the Supreme Court of the United States (*Daubert v. Merrell Dow Pharmaceuticals* [1]) and of the Supreme Court of Canada (*R. v. J.-L.J.* [2]), whereby the evidence presented by an expert should be based on sound scientific methodology. By suggesting that an outdated and poorly referenced text is an acceptable document to help the courts (the Workplace Safety and Insurance Appeals Tribunal, in this case), Harth and Nielson fail the primary test for expert testimony. Merely raising the argument that the alternative "if there were no such papers, members of the panel would be inclined to seek information on Google, or Wikipedia" is a disquieting statement from the medical community. As we stated in our article, any document other than a peer-reviewed publication should conform to standard procedure for citing the literature, should clearly reflect the current state of the art and should be regularly updated to maintain consistency with current science.

6. Tests of symptom exaggeration

When discussing feigning versus exaggeration (two constructs we agree are not synonymous), Harth and Nelson make a case about malingering not been an issue in FM. Malingering, or conscious simulation of disease process, is a concept that touches several chronic pain disorders for which objective evaluation of alleged symptoms is an issue. Exaggeration of symptoms is a much wider concept and does not necessarily imply malingering, but may provide a fallacious advantage in the medicolegal setting. As previously stated, personal and societal factors will affect symptom experience, perception of functional limitation and, therefore,

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outcome. There is no question that increased public awareness of FM is mirrored by a rise in societal perception of disablement, with up to one-third of North American individuals with FM now claiming disability. The concept of disability augmented by psychosocial factors is exemplified by the repetitive strain injury 'rise and fall' in Australia in the 1980s.

In conclusion, our final thoughts regarding the commentary by Harth and Nielson are that they are unfortunately content with concepts of the past. We have chosen to provide advice and highlight shortcomings in the adjudication of FM. We realize that we have touched a few sensitive chords and are delighted that we have sparked a debate on how the courts should 'treat' FM.

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REFERENCES

1. Daubert v. Merrell Dow Pharmaceuticals 509 U.S. 579 [1993].
2. R. v. J.-L.J. [2000] 2 S.C.R.