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Why CRPS Cases Fail in Court (and How to Avoid It)

A practical guide outlining the most common medical and evidentiary pitfalls that undermine CRPS claims — and how rigorous analysis strengthens them.

Introduction

Complex Regional Pain Syndrome (CRPS) is a well-recognized chronic pain condition within clinical medicine, yet it remains one of the most frequently challenged diagnoses in personal injury, medical malpractice, and disability litigation. Importantly, CRPS cases rarely fail because courts deny the existence of the condition itself. Rather, these cases fail because the **legal proof offered does not satisfy forensic standards of reliability, causation, and functional impact.**

This article examines the recurring reasons CRPS cases fail in court and outlines evidence-based strategies to avoid these pitfalls. The discussion is intended for both plaintiff and defense counsel navigating CRPS claims under federal and state evidentiary frameworks.

I. Diagnostic Labeling Is Not Legal Proof

A foundational error in CRPS litigation is the assumption that a treating physician's diagnosis equates to legally sufficient proof. Courts do not evaluate whether a clinician diagnosed CRPS in good faith; instead, they assess **how the diagnosis was reached**, whether it was **methodologically sound**, and whether it can be **reliably applied to legal questions** such as causation, permanency, and disability.

Diagnoses based on incomplete examinations, inconsistent findings, or uncritical reliance on patient-reported symptoms are particularly vulnerable to challenge. Courts increasingly

expect experts to articulate the specific diagnostic criteria applied, explain how alternative diagnoses were excluded, and acknowledge the inherent limitations of CRPS diagnosis.

II. Failure to Establish Medical Causation

Causation is the most common point of failure in CRPS cases. Temporal proximity—symptoms appearing after an injury—is insufficient to establish medical causation. Courts require a reasoned medical explanation linking the alleged inciting event to the development of CRPS.

Common weaknesses include:

- Minor or ambiguous inciting injuries without biological explanation
- Failure to address pre-existing pain syndromes or psychiatric conditions
- Absence of discussion regarding spontaneous or idiopathic CRPS
- Conflation of aggravation with causation

Experts must demonstrate **medical reasoning**, not advocacy, by addressing alternative etiologies and explaining why the alleged cause is more probable than competing explanations.

III. Overreliance on Subjective Complaints

Although CRPS is primarily a clinical diagnosis, courts consistently favor cases supported by **objective or semi-objective corroboration**. CRPS cases often fail when they rely almost exclusively on subjective pain reports without consistent physical findings.

Corroborative findings that strengthen credibility include:

- Persistent autonomic asymmetry
- Documented trophic changes
- Consistent temperature or color differences
- Reproducible physical examination abnormalities
- Longitudinal consistency across providers

Conversely, fluctuating findings, internal inconsistencies, or selective documentation erode judicial confidence.

IV. Overstatement of Severity and Permanence

Another frequent cause of failure is the overstatement of functional impairment or permanence. Not all CRPS cases are progressive or permanently disabling. Courts are skeptical of experts who portray CRPS as universally catastrophic without addressing variability in disease course, treatment response, or documented improvement.

Experts who fail to acknowledge uncertainty or improvement risk appearing outcome-driven. Credible testimony distinguishes **what is known**, **what is uncertain**, and **what cannot be reliably concluded** from the available evidence.

V. Weak or Unprepared Expert Testimony

Expert testimony often determines whether a CRPS case survives dispositive motions or Daubert challenges. Experts who lack forensic training may struggle to articulate their reasoning in a legally meaningful way, even if their clinical knowledge is sound.

Common expert failures include:

- Inability to explain methodology
- Failure to distinguish diagnosis from legal causation
- Absolutist opinions unsupported by literature
- Lack of familiarity with evidentiary standards

Courts expect experts to **bridge medical reasoning and legal proof**, not merely restate clinical impressions.

VI. How CRPS Cases Can Be Strengthened

CRPS cases succeed when they are presented with forensic discipline. Key strategies include:

- Clear articulation of diagnostic methodology
- Structured causation analysis addressing alternatives
- Objective corroboration where available
- Longitudinal record consistency

- Measured opinions acknowledging limitations

A restrained, transparent expert opinion is often more persuasive than an overconfident one.

Conclusion

CRPS cases fail in court not because the condition lacks medical legitimacy, but because the evidentiary presentation often fails to meet legal standards. When medical opinions are carefully reasoned, scientifically grounded, and appropriately limited, CRPS claims can withstand rigorous judicial scrutiny. Effective CRPS litigation depends less on passion and more on precision.

References

1. Harden RN, et al. *Proposed new diagnostic criteria for complex regional pain syndrome*. Pain. 2007.
2. Bruehl S. *Complex regional pain syndrome*. BMJ. 2015.
3. Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993).
4. AMA Guides to the Evaluation of Permanent Impairment, 6th ed.
5. Goebel A, et al. *Complex regional pain syndrome in adults*. Lancet. 2019.

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