MANAGING MEDICAL MALINGERING

By Dr Tor Phern Chern

IN A typical doctor-patient relationship, the clinical history provided by the patient is often key for both diagnosis and management. What happens if he is deliberately feigning symptoms? And why should the average clinician worry about malingering patients?

The main reason is that such behaviour is both more common than most clinicians imagine and the potential ramifications can be adverse for both the patient and clinician. Mistakenly diagnosing and treating a patient will expose him to all the potential risks of the treatment with essentially no potential benefits. The clinician is then left with the possibility of being sued for defamation of character and malpractice. Extreme cases of successful litigation include patients who claimed to have cancer and managed to obtain repeat prescriptions of oncological drugs (and then suffered the predictable negative effects) from physicians who did not confirm the diagnoses. In a paediatric population, overlooking malingering-by-proxy in children by parents can be potentially disastrous.

Understanding malingering

Deliberately feigning symptoms is often medicalised either as malingering or a factitious disorder. Malingering is defined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution or obtaining drugs". The difference between malingering and factitious disorders is the motivation for the symptom production. In malingering, the motivation is defined as an external incentive; for factitious disorders, the external incentives are absent.

Most practising doctors in Singapore would have considered these two diagnoses when seeing patients with potential secondary gains (external motivation for seeking help rather than positive internal motivations). Such patients often elicit strong negative countertransferences from the doctors treating them. Nevertheless, it is useful for medical practitioners to be aware of some common myths regarding malingering.

Malingering is often thought of as rare and seen mostly in forensic settings. However, research shows that malingering is not unusual in clinical settings where the outcome of an evaluation has important consequences (eg, insurance claims) and some degree of symptom exaggeration may be present in up to 60% of the patient population. Similarly, malingering is not evidence of deeper psychiatric issues (eg, antisocial personality disorder) and is often an adaptive response to the situation. Malingering is also not a static rigid response pattern (once a malingerer, always a malingerer), but is often behaviour governed by a cost-benefit analysis.

Deception is often associated with malingering, but deception is a universal and normal social human behaviour, and is thus not a telltale sign

of malingering. Lastly, clinical interviews are often not sufficient to determine malingering. A highly respected senior colleague once shared the experience of being entirely fooled by a patient presenting consistently with classic symptoms of schizophrenia. This patient was only exposed after a private investigator showed the clinician videographic evidence of the patient performing acts in her daily life that were entirely inconsistent with her provided history. As it turned out, the patient's behaviour was due to a secondary gain that was not made known to the clinician.

Detection of malingering

Why do some patients malinger? As with much human behaviour, the reasons are complex and multifactorial, but one significant factor is the potential benefits of the sick role in a society that accepts the ill more easily than emotional disorders or problems of living. An unemployed person in debt with a headache is a patient who requires treatment and support, while an unemployed person in debt may be seen as merely needing to get a job. Why a particular person malingers also depends on his previous experiences of being ill, family influences, developmental factors, and mental model of his life situation and resources.

So how can the practising clinician detect malingering? The first step is to recognise the possibility of malingering in scenarios where there is potential for secondary gain (eg, insurance claims or military duty). Other situations to be more sensitive in include patients who present inconsistent histories and have sought medical care from many treatment centres with atypical courses of their conditions. Patients with large number of investigations or predict worsening of their conditions are also at higher risk of malingering. In addition, patients with diagnosis of post-traumatic stress disorder, brain injury and pain conditions are more likely to display malingering behaviour.

If a clinician suspects malingering, what should he do? The first thing is to acknowledge that a routine clinical assessment is inadequate to detect malingering and the cornerstone of detection is a well-prepared clinical assessment with all available documents reviewed and apparent inconsistencies marked out for clarification. Notes from other healthcare providers should be obtained and reviewed in advance, and firm evidence of fabrication sourced. Consultation with a psychiatric colleague should be arranged if possible and the actual assessment should be conducted in a non-judgemental and non-punitive fashion, with continued support included. Future management of the patient should be based on a shared understanding of the diagnosis. It is important not to jump to the conclusion that the patient is malingering despite minor inconsistency or deception, as even patients who malinger can still have entirely genuine treatment needs. The prognosis of such cases is variable, and many patients will drop out of treatment when confronted by evidence of malingering by the treatment team.

Managing malingering

A memorable case I encountered was of a young man in his 20s who had been admitted for several months in an acute ward at a restructured hospital, and had done more blood tests and radiographic investigations than most patients with cancer. The young man had been admitted 46 times before, while his family was well known to be highly vocal about his treatment needs and routinely showed newspaper cuttings of their previous encounters with healthcare staff who failed to take his complaints seriously. He also routinely cited his GP whom he claimed supported his complaints.

By that time, the general management strategy was to simply accede to the patient's requests for more investigations and tests. It did not help that the patient had so many investigations that some were mildly abnormal (eg, possible mild kinking of ureter or that his urine production was so large as to defy belief). Eventually the management team reviewed all his previous 46 admissions, his extensive investigations and spoke to his private GP. It was apparent that his complaints over the 46 admissions were not consistent with any known medical condition and seemed to evolve in tandem with whatever abnormal investigation was available at the time. The GP also did not recall giving the kind of support the patient reported. Lastly, the reported symptom severity was inconsistent with his otherwise healthy clinical appearance.

The team then held a family session where they confronted the patient and family with the entire chronological history and evidence, and strongly suggested the need for appropriate outpatient care. Predictably the patient and family became upset but instead of complaining, they simply discharged him that same day. The team felt that the reason the patient left was because they were trying to put all the pieces of the story together rather than just taking his word for it, so he and his family decided to go to a new treatment setting where they would not face such challenges. Unfortunately he was admitted to another hospital the same night. He was later sent to a psychiatric unit in that hospital which diagnosed malingering and I was told his condition improved eventually.

Conclusion

The lesson here is to keep malingering as a possible scenario when the circumstances suggest it, and manage it actively via a well-prepared assessment with a view towards appropriate sympathetic management of the patient's needs. ■

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