

A Physician's thoughts on malingering

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ABSTRACT A recent book compilation of papers from an international symposium on malingering and illness deception is reviewed. Now that medical education is moving away from the traditional model it is timely for students and doctors in training to become aware that patients regularly mislead doctors by minimising or exaggerating their symptoms. This book concentrates on the latter. There are helpful insights into common conditions when the history dominates the picture and in which there are seldom findings on examination or reliable tests. Of particular interest are contributions on the epidemiology of sickness absence from work and on the effect compensation processes have on the chronicity of problems. This book is essential reading for doctors writing Reports for the Courts and in general offers insight that will help all doctors with their clinical practice.

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LIST OF ABBREVIATIONS Myalgic Encephalopathy (ME), post-traumatic stress disorder (PTSD)

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In the context of patient care, GPs and hospital doctors recognise that patients tend, on the whole, to downplay their symptoms and cope remarkably well with disability, adjusting in a determined way and being positive. The general reluctance that people still have in suspecting serious or sinister illness manifests through dismissal or misinterpretation of unexplained symptoms – and at times delays diagnosis. There is, of course, a minority of patients who appear to dwell on minor or non-specific symptoms and who succeed in building up bulky case folders without ever really managing to attain serious or clear-cut diagnosis. There are also those, for example with ME, where the objective disablement is often less than the subjective assessment of the situation. But, in general, our interactions with patients are with people who are honest about their complaints and who are anxious to resume normal working, domestic, and leisure activities as soon as possible.

It is timely that there should now be a truly readable book which looks essentially at the way in which patients misrepresent their illnesses. At a time when medical students are encouraged to dwell overly on ethics, and when communication skills venture to become a more important attribute than knowledge or diagnostic ability, there should be some room for the educational concept that the patient may be miscommunicating with the doctor; and there should be awareness of the situations in which this occurs. These days there is less responsibility and clinical continuity in the early postgraduate years, so it is surely the case that most of us find ourselves either Consultants or GP Principals before we begin to get street-wise and understand the patterns.

This 370 page paperback is a compilation of fully referenced papers given by a miscellany of most eminent



FIGURE 1 Halligan P, Bass C, Oakley D (editors). *Malingering and Illness Deception*. Oxford University Press; 2003. £35

contributors from the UK, North America and Australia at a meeting in Woodstock in 2003. It is impossible to do justice in a short review to the extent and quality of the papers in this book. Readers will approach it either as sceptics or 'acceptics' depending on their own readiness to go with the line that the patient has to be believed. I venture to predict that the sceptics will be strengthened by getting more system and understanding into their scepticism and that the more believing will be forced to realise that they must become more questioning.

There is much in this for GPs faced with the modern epidemic of sickness absence and benefit exploitation, and in the background of virtually all compensation cases. A paper from Charles Baron and Jon Poole admirably sets out the epidemiology and sociology of absence from work, and the tendency for those who are not stimulated by their employment to prolong illness and seek preferential early retirement packages due to 'sickness'. Low back pain as a

cause of work absence rose by 500% in the UK from 1985 to 1995 and at a time when harder, tougher, manual work – such as coal mining – was declining. Most specialists will find sections which are relevant to their work, especially those who are used as medico-legal experts in the many compensation settings in modern society. There are most illuminating analyses of the familiar conditions where the history cannot be disproved by an absence of clinical findings – such as whiplash neck, low back pain, and the PTSD complex. Whiplash is a throw away word in A&E Departments and GP Surgeries, but once introduced and worked upon by lawyers and suggestible experts it will last for ever. In many countries the diagnosis of whiplash is dismissed as a sore neck which will recover within days without treatment and, of course, it does. The hugely exaggerated PTSD epidemic is fully explored by Loren Pankratz from Portland, Oregon, and he makes a devastating critique of the post-Vietnam contribution to this. The epidemiology was flawed by the convictions of researchers, and the proliferation of treatments and programmes was based on false epidemiology and sentiment. There is actually no scientific basis for flooding disaster communities with counsellors – psychological debriefing, if anything, does more harm than good. More rigorous research suggests that the professionals are often the problem. Post-traumatic stress disorder, according to Pankratz, is an admixture of people suffering from the traumas of life, impostors, those who have stumbled into it to avoid other labels, and those directed by well-meaning but mistaken professionals. The reviewer knows from those who hear Criminal Injuries Compensation Appeals that the familiar symptomatic constructs of PTSD are sometimes listed by individuals who have had trivial injury with no connotation of fear or threat to life, and it does appear that some psychologists and some psychiatrists do not discern that this may be invention. Chris Main from Salford, admirably dissects out the issue of exaggeration – is it to deceive or to convince, can it be unconscious, and is overreaction mediated by distress? There is no doubt that the litigation process itself has real influence on the manner and content of symptom presentation. Sadly, compensation patients often do less well than ordinary patients with the same diagnosis and who have had the same orthopaedic treatments; compensation does not cure the complaint, rather it underlines its authenticity, and validates its chronicity. George Mendelson from Monash sets out a detailed analysis of the situations in which compensation does not ease the complaint, and in which compensation patients tend to go on doing less well than others – Henry Miller's 1960s view that there is an absolute failure to respond to treatment until the compensation issue is settled is probably wrong in that the failure will persist after compensation.

Doctors in so-called advanced countries with benefits systems, sickness-enhanced superannuation schemes, and legally driven compensation cultures have simply got to get wise to the truths and fictions that are discussed

in this very important book. There is an informal conviction which some young lawyers incautiously voice that it is known where medical evidence can be obtained to support specific situations. If a few doctors naively mislead courts, many are content to allow patients to overestimate the degree and chronicity of disability. There is evidence in many contributions to this book that most of us collude with minor deceptions – sometimes even knowingly when we like or sympathise with the patient – a thought that we should ponder. It goes against what we are taught to be sceptical or to appear unsympathetic, but in contexts where there are financial prizes to be won the evidence is that most of us need to throw away our rose-tinted spectacles.

This book should be read by medical students and might give some substance to ethics teaching dominated by more conventional topics. It will give any medical student an edge in his or her understanding of occupational medicine and public health medicine. Indeed the reviewer has, through this book, somewhat belatedly come to appreciate that these two subjects substantially overlap. It is compulsory reading for any doctor writing a report for a legal purpose, seeing a patient in relation to injury or compensation, or providing certification of benefits. It is indexed well enough for us all to find the areas relevant to our own practice, and each paper is fully referenced. Each paper stands alone and this is a reference volume which does not need to be read throughout. But there is a cohesion and order which rewards a reader with the time and interest to read every paper. It sets out the intellectual disciplines we have to impose on ourselves. The good news is that the conference from which it came was sponsored by the Department of Work & Pensions. It is even possible that politicians may be getting the message that a decent sized chunk of our GNP is being sidelined into unjustifiable benefits, inappropriate compensation, premature retirements, insurance costs, and legal and court costs. However, we as doctors are however best placed to derail this gravy train but we need to inform ourselves to begin to do so. To date we have conspicuously failed and more often than not the medical evidence provided is uncritically supportive of claimants.

Doctors have to be right when they conclude that patients are being untruthful or manipulative. It is obviously catastrophic when malingering is wrongly diagnosed, and that is why so much medical evidence is less than conclusive. Recognising this, Medical Defence Societies, and several Benefit Agencies, are no longer reluctant to obtain video evidence of the capacities of claimants. As doctors we can only notice situations where what our eyes tell us does not resonate with what we are being told and spell out any inconsistency. Doctors who have read this valuable book will be much more use to the Courts and will also help patients who will otherwise by custom and usage come to sacrifice their useful lives to imaginary disability.