PATIENTS WHO DECEIVE

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PATIENTS WHO DECEIVE

Assessment and Management of Risk in Providing Health Care and Financial Benefits

By

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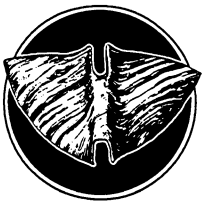

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FOREWORD

Why would people seeking treatment be less than honest about their condition? Not surprisingly, people undergoing examination for courtroom purposes or disability compensation are motivated to malinger or exaggerate their symptoms, but it is counterintuitive that people seeking treatment would not be credible.

It is so commonly assumed that people are credible about their physical or mental condition that the law makes an exception to the hearsay rule allowing evidence of the doctor as to the disclosures made by the individual. As an exception to the hearsay rule, the law admits "statements made for purposes of medical diagnosis or treatment of past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment" (Rule 803(4) of the Federal Rules of Evidence). Indeed, under the rules of evidence, statements about one's then existing (but not past) physical or mental condition made to anyone-neighbor or stranger-is considered so trustworthy that they are admissible as evidence at trial (Rule 803 (3) of Federal Rules of Evidence).

In actual fact, in countless instances, patients withhold, distort, or manufacture information. The styles of deception are as varied as the methods. The extreme to which some patients will go to deceive defies imagination-and often medical knowledge. They will inject themselves with bacteria to induce infections, bleed themselves to produce anemia, eat rat poison-whatever it takes to gain medical attention. They spend their lives going from hospital to hospital, often successfully duping doctors into performing hazardous and expensive diagnostic and surgical procedures. Although some patients produce physical illnesses, others fabricate emotional symptoms, such as extreme depression, or engage in outlandish behavior to feign mental disorder.

Feigned illness absorbs millions of dollars in health care. The problem of patient deception is larger-and more costly-than is generally

acknowledged. Patient deceptions create not only risks for error in diagnosis and treatment, but is also costly in the distribution of benefits as well as hospital care.

In this book, Loren Pankratz, Ph.D., describes the various behaviors associated with such diagnosis as malingering, somatoform disorders, factitious disorder, factitious disorder by proxy, and Munchausen syndrome. He peppers the text with intriguing historical frauds and medical curiosities that serve to remind the reader about the ubiquity of deception in human life. The chapters in the book that deal with assessment include case studies that contain sections of the actual reports that he submitted to primary care physicians, courts, and insurance companies.

Dr. Pankratz's professional career has focused on understanding patients who deceive health-care professionals. He has published papers on malingering, factitious disorder, drug seekers, wandering patients, and pretenders of posttraurnatic stress disorder. He invented his own syndrome, called the Dudley Moore syndrome (after the movie comedian). He has extensively investigated the Munchausen syndrome.

Factitial patients are commonly categorized as the Munchausen syndrome, a term introduced by Dr. Richard Asher in 1951. Actually it is a misnomer. Baron Karl Von Munchausen (1720-1791), for whom it is named, was a famous and colorful war hero. He did not feign illness or dupe people into caring for him, but the extravagant manner in which he told his tales led Asher to associate the Baron with patients who had a syndrome characterized by itinerancy and sensational lies.

The American Psychiatric Association, in its Diagnostic and Statistical Manual list the "Munchausen syndrome" as "Factitious Disorders." The criteria are: Intentional production of feigning of physical or psychological signs or symptoms; the motivation for the behavior is to assume the sick role; external incentives for the behavior (such as economic gain, avoidance of legal responsibility, or improved physical well-being, as in malingering) ar absent; and the behavior is not better accounted for by another mental disorder.

The DSM distinguishes factitious disorders from malingering. The latter is the intentional production of fabrication of an illness to avoid a specific duty or punishment; for example, a claim of illness to avoid jury duty, standing trial, or conscription into the military. In factitious

disorders, by contrast, there are a psychological need to assume the sick role and a lack of external incentives for the feigned illness. some call factitious disorders "unconscious malingering."

A number of researchers believe that because the motivational basis in these cases is often unknown or uncertain, its diagnostic legitimacy is compromised. The propose that the diagnosis of factitious disorder with psychological symptoms are intentional. They contend that patients who are diagnosed with factitious psychosis (pseudopsychosis) tend to have family histories of mental illness and often seem over time to develop true, undeniable psychoses such as schizophrenia. The researchers suggest that what is diagnosed as factitious disorder with psychological symptoms is actually the initial warming sign of what is going to emerge as an authentic psychosis, and that patients are done a disservice by giving them a factitious disorder label. Others, however, argue that it is a valid diagnosis. They consider factitious disorder with psychological symptoms to have the same psychodynamic origins as factitious disorder with physical symptoms.

There are situations where mothers with Munchausen Syndrome by Proxy (MSBP) deliberately induce illnesses in their children in order to elicit sympathy or to play the role of heroic caregiver. Dr. Roy Meadow, chairman of pediatrics at the University of Leeds in England, observed parents simulating and producing dramatic illness in their children, and in an article he described the syndrome as "Munchausen Syndrome by Proxy." The term "by proxy" means that instead of inducing illness in oneself, the person with the disorder creates illness in another person, almost exclusively a child. It has also been called Meadow's syndrome.

A number of MSBP cases have made it into the courts. One of the cases, People v. Phillips, a decision by the California Court of Appeals, appears in a casebook widely adopted in law schools. MSBP became recognized in the legal profession as an "insidious variation" of child abuse. In Phillips, the defendant was convicted by a jury of murdering one of her two adopted children and of willfully endangering the life or health of the other by adding a sodium compound to their food. In order to suggest a motive for the defendant's conduct, the prosecution, over objection, presented evidence by a psychiatrist of MSBP. The California Court of Appeals held that because the conduct ascribed to the defendant was incongruous and apparently inexplicable, the psy-

chiatric evidence was relevant to show a possible motive. The court further held that the psychiatric evidence was not rendered inadmissible by the defendant's failure to make her mental state an issue.

The significant aspects of the case include: (1) the appellate court allowed the use of psychiatric expert testimony to describe the phenomenon of MSBP and to give an opinion that the defendant mother fit the profile of a perpetrator; (2) the mother was convicted of murdering one adopted child and willfully endangering the life of the other; (3) the medical facilities had "smoking gun" evidence that the mother had been adding a laxative salt to her adopted infant's formula; and(4) the defendant did not use the insanity defense.

In *Commonwealth v. Robinson,* a case decided by the Massachusetts Court of Appeals, the defendant, a 19-year-old mother, brought her 11-month-old son to the hospital. He was admitted and diagnosed as suffering from "failure to thrive" because of his below average growth and poor weight gain. It was his third hospital admission. The mother remained at the hospital, constantly at his side. She slept on a cot on the floor of the room and assisted the nurses with his care and feeding. Surreptitiously, she put massive doses of salt in his IV. solution, which resulted in his death. There was evidence that she wanted to "get the child fattened up so she could get him out of the hospital and take him home." She told a friend, "He's not supposed to be dead. He is just supposed to be sick." She was convicted of involuntary manslaughter. The defense counsel prevailed upon the judge to prohibit the prosecutor from introducing any evidence concerning a "failure to thrive" or "Munchausen by proxy," but throughout the trial the judge permitted testimony that the child's failure to thrive did not result from organic causes. Character evidence is admissible only at the option of the accused.

One obstacle confronting protective legal intervention on behalf of the child in cases of MSBP is the reluctance of health care professionals to identify the abuse. Usually lacking signs of apparent psychological illness, the perpetrator is rarely suspected. In fact, the MSBP perpetrator is often viewed as an exceptionally devoted parent, always ready to help in the "recovery" of the child.

The various states require professionals who have a responsibility for the care of children to report situations in which they suspect or believe that a child is the victim of abuse. The requirement overrides

confidentiality. But how to detect these "forgers"? Some hospitals have installed covert video surveillance protocols, equipping a patient's room with a hidden video camera that is monitored by the staff. Although evidence obtained by covert surveillance by a private party (not acting under the direction of a law enforcement agency) does not violate the Fourth Amendment's stricture on illegal search and seizure, it nonetheless raises ethical concerns. MSBP perpetrators almost always react angrily to an accusation and deny any wrongdoing.

The medical literature fails to show even one case of successful psychiatric treatment of the MSBP mother. Some suggest that the goal of treatment is not to "cure" these individuals, but to help them act out their "illnesses" to a lesser extent. They say, "If a patient has an emotional disorder for which we have a specific treatment and the factitious disorder is only secondary, we can treat the primary disorder while simultaneously dealing with the issue of feigned illness."

There are few Cinderella stories. For 99 percent of factitial patients, it is always midnight, the pumpkin is just a pumpkin, and no shining heroic figure ever arrives to snatch them from the twisted fantasy which they have created. But there is the promise that more and more of these patients can be identified.

Patients with somatoform disorders are of another type. They are not generally considered deceptive, but their symptoms do not have the expected underlying organic pathology. In a way not easy to distinguish, they are different from malingerers and patients with factitious disorder. According to the DSX the symptoms of somatoform disorders axe not intentional. They do not surreptitiously create symptoms. Patients with factitious disorder falsify in order to stay in the sick role; patients with somatoform disorder believe they are doomed to it. Hypochondriasis is a form of somatoform disorder.

The term "psychosomatic" is often taken to refer to illegitimate forms of illness generated by immature persons who imagine or otherwise psychologically generate physical symptoms. The DSM contains a subcategorization format that allows clinicians to specify the type of psychological or behavioral factor that affects the patient's medical condition the factors-so designated include the broad range of psychological and behavioral phenomena that appear to affect physical health.

In the academic world, Dr. Pankratz was for years a professor of medical psychology at the Oregon Health Sciences University in

Portland, Oregon, and a consulting psychologist at the VA Medical Center in Portland. He recently retired early and is now a consultation psychologist and clinical professor in the Department of Psychiatry in the Oregon Health Sciences University. He devotes much of his time now to independent consulting, speaking and writing. His interest in deception by patients led to an invitation to join the Scientific Advisory Board of the False Memory Syndrome Foundation founded in 1992 by Pamela Freyd out of concern of the "delayed memories" of sexual abuse leading to accusations against parents or others.

Given the trust that inheres in the physician-patient relationship, the physician tends not to question what the patients reports, but as this book shows, a dose of skepticism is in order in many cases. This exceptional book is written for physicians, mental health professions, emergency-room staff, claims examiners, safety experts, risk managers, attorneys, and indeed, anyone interested in the human psyche. It's stranger than fiction.

Ralph Slovenko
Editor, *American Series on Behavioral Science and Law*

PREFACE

To know the things that are not, and cannot be, but have been imagined and believed, is the most curious chapter in the annals of man.

Godwin, *Lives of the Necromancers*, 1834

Over the past 25 years I have attended to the possibility of deception in the context of medical settings, legal disputes, and insurance claims. Many people, I have discovered, fail to provide important information and distort the truth. Some distortions are harmless, but others have serious consequences. Some deceptions are understandable, but others seem senseless, self-destructive, and pathological.

Inside the insurance industry, the incentives for patient fraud are obvious, and the costs are understood. However, patient deception is usually not expected in medical settings. Most of the information on patient duplicity is found in single case studies or letters to the editor, leaving the impression that the problem is uncommon or trivial. However, my clinical experience has convinced me that the problem of patient deception is bigger–and more costly–than is generally acknowledged. Deceptions, like pathogens, can create serious problems.

My hunch was confirmed in the early 1990s when I discovered a way to obtain comprehensive medical histories of all the patients in the Department of Veterans Affairs, the largest health-care system in the United States. From the personal computer on my desk I was able to document that hundreds of wandering patients were accumulating thousands of hospital admissions, and consuming millions of health-care dollars (Pankratz & Jackson, 1994). Not all of these admissions were based on deception, and not all patients who deceive are wanderers. Nevertheless, those who do wander provide a rich context for illustrating what happens when the patient knows something that the clinician does not know. As I came to see, their fractured care resulted in diagnostic confusion, unnecessary treatment, and inconsequential outcome.

The problem of patient deception is not restricted to wandering veterans but also exists in civilian hospitals and clinics (Pankratz & Jackson, 1995). Some wandering patients prefer rural settings, where

care is more personal, but modern specialty-focused hospitals that emphasize investigation are actually more vulnerable (Southall et al., 1977; Sapira, 1981), which should become evident to readers of this book.

Indeed, the problem of patient deception is so extensive that readers will certainly notice many topics missing in this book. However, my desire to be encyclopedic was tempered by acknowledging the reader's limited tolerance for endless examples. For variance, I included examples from the older medical literature, which additionally illustrates the enduring nature of these problems, and I have liberally included arcane sources in the field of fraud to remind the reader about the ubiquity of deception in human life.

Additionally, I separated the styles and methods of deceivers from the assessment process. In this way, I hoped to avoid mixing tedious examples with the ground rules for making diagnostic decisions. This was also convenient because deceptive styles are not signs of specific diagnostic categories but are generic. A knowledge of deception will, therefore, help the clinician on topics that I have not reviewed.

The case examples (all disguised) focus mostly on legal work, in which my decision-making processes were usually part of my report. In presenting these, I have tried to bring the reader into the process of my analysis, providing examples of my final work product.

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My thanks to the many colleagues who provided invaluable suggestions on drafts of this manuscript, especially Laurence Binder, Raymond Templin, and Keith Campbell. Chairmen of Departments and Chiefs of Services who provided generous support include Joseph Bloom, Joseph Maratazzo, Roland Atkinson, and Steven Starker. Shirley Toth, R.N., sleuth of the Portland VA Medical Center, and hundreds of physicians referred me the world's most interesting patients. Insurance companies and third–party payers, especially David Smith at SAIF Corporation, were particularly helpful in providing follow-up information on patients. Librarians are indispensable for research, and I thank those at the Portland VA Medical Center who were always willing to find the unusual things that I sought. Charlotte Stewart and Gwen Huntsman-Porter provided invaluable assistance in the preparation of this manuscript. My wife, Ethelyn, and my family have endured years of my preoccupation with deception, tolerating my collection of books on the topic cluttering every room of our house.

Finally, I thank the most important people of all–the patients who shared their stories and dreams that were, for them, more tolerable than reality. I owe special gratitude to the many patients who maintained contact with me over the years, helping me better understand their disorders.

CONTENTS

PATIENTS WHO DECEIVE

Part I
SETTING THE STAGE

Chapter 1

THE ACTOR

Patient is a previously well, white male who was assaulted late at night.
Resident's admit note on patient called "the Actor"

The personal, social, and domestic complications are so voluminous that no further attempt will be made to summarize the inadequacies.
Resident's discharge summary of "the Actor"

Because of their richness and variety, the wanderings of a single patient are reviewed to give the reader a vivid introduction to the magnitude and spectrum of clinical deceptions. This particular patient's illness illusions, illness enhancement, and surreptitious self-injury were often missed because clinicians failed to view his symptoms in their historical context. However, even clinicians familiar with this man's extensive history might describe and diagnose his behavior in numerous different ways. Faced with such complexity, the most judicious path for the clinician is to avoid speculation about patient motives and to view the many forms of deceptive behavior principally as inappropriate or maladaptive ways of interacting with the medical-care system.

In the early 1980s a cardiologist asked me to see a patient who repeatedly sought admission to our hospital following his coronary artery bypass surgery the year before. Was this 42-year-old man struggling with depression?

On the ward, the patient was commonly known as "the Actor" because he claimed to have recently been in several motion pictures. However, he told me that he left his work in the film industry and was now working on a master's degree in fine arts. Despite attempts to impress me with his accomplishments on screen and stage, he described many psychosocial problems that revealed a very different version of his life: nightmares, agitation/anxiety/restlessness, and eco-

nomic stress. Because of these two strikingly variant portraits, I agreed to see him as an outpatient. He signed release-of-information forms so that I could learn more about him.

To locate his earlier medical records, I started with the small pieces of information that he provided me. The medical records I received revealed more complex problems, so I then made some guesses about which additional hospitals he might have used. The results were more fascinating than I expected. With the help of a student assistant, I eventually documented 53 emergency room visits and 106 hospitalizations. The charts we collected weighed 9.8 kg. These represented only a small part of his invasion of the medical system; nevertheless, they provided a dramatic outline of his bizarre odyssey.

We discovered that this man was not working on a master's degree; he had never even graduated from high school. He was not an actor but had served only as an extra in a local film. Any acting he did was in service to his role as a professional patient, an abuser of the health-care system. All across the United States, and especially on the West Coast, he had produced his symptoms in emergency rooms and hospital wards. He was a Munchausen syndrome patient, so named after a teller of tall tales.

The Munchausen syndrome, as we shall see, is an unofficial label. According to the diagnostic manual of psychiatric disorders, this man's proper diagnosis would be "factitious disorder," which refers to symptoms arising from self-inflicted or manufactured causes rather than from the natural course of disease or accident.

HIS CREDITS

Most Munchausen syndrome patients use one or two particular ploys to obtain hospitalization. This man, however, had a much more elaborate repertoire. He specialized in neurological emergencies, complaints of depression and drug abuse, genitourinary infections, cardiac problems, and postsurgical complications. I reviewed his records to create a master problem list of the symptoms he presented, the issues explored, and treatments pursued by physicians (Table 1:1). I was astonished by the breadth and complexity of what I found.

Table 1-1 Presenting complaints of the Actor.

GASTROINTESTINAL
Diarrhea, constipation, nausea, vomiting, food poisoning, pancreatitis, proctitis, peritonitis, rectal bleeding

PSYCHIATRIC
Suicide attempts, depression secondary to addiction, situational anxiety, vocational maladjustment, sociopathy, inadequate personality, conversion reaction, malingering

GENITOURINARY
Hematuria, pyuria, dysuria, gonorrhea, urethral calculus

ENDOCRINE
Diabetes mellitus, abnormal thyroid function tests

NEUROLOGICAL
Blurred vision, headaches, blackouts, photophobia, seizure disorder, numbness, diplopia

DRUG ABUSE
Addiction, polypharmacy, substance abuse, "lost" medications, drug withdrawal

DERMATOLOGICAL
Lesions, scales, buccal cellulitis

ORTHOPEDIC
Frozen shoulder syndrome, lumbar pain, sacral pain

DENTAL
Gross pathology in all four quadrants, gingivitis

ACCIDENTS
Falls, muggings, car accidents, nosebleeds, contusions, head injuries, abdominal wounds, cuts

SURGERY
Two abdominal surgeries, left inguinal herniorrhaphy, right inguinal herniorrhaphy, subcutaneous granuloma, verruca, coronary artery bypass graft (triple vessel), hemorrhoidectomy, laparotomies, appendectomy

INCISIONAL COMPLICATIONS
Infections, lumps, rupture, pain at site of graft incisions, drainage from wounds and incisions

CARDIOVASCULAR
Coronary artery disease, chest pain, orthopnea, thrombophlebitis, hypercholesteremia, hyperlipoproteinemia

ALLERGIC REACTIONS
Codeine, iodine, shellfish, paper tape

IATROGENIC
Tardive dyskinesia, adhesions, diastasis

OTHER
Lump in throat, hearing loss, influenza, cough, nasal congestion, "feels bad all over," bronchitis, fever, myopia, exogenous obesity, drainage from ear, tinnitus

Many of this man's symptoms were merely *illness illusions.* He faked the blood in his urine, he lied about nausea and vomiting, and he acted out a seizure disorder.

Some symptoms were produced by *surreptitious self-injury.* The Actor was especially skillful at simulating head injuries and other effects of falls, auto collisions, and physical attacks. To produce blood for the simulation of an emergency, he would open an old wound on his scalp. Appearing with dirt on his knees and wearing rumpled clothes, he became the victim of a "mugging" for whom the emergency room personnel unwittingly played the roles of healers, comforters, and sympathizers. Some of his self-injuries were serious, however, as when he occasionally reopened surgical incisions and self-infected his wounds.

Finally, even when his symptoms were real, he used *illness enhancement* to gain additional advantages. For example, on more than one occasion he manipulated his disease to assure himself a hospital admission. He could easily precipitate an emergency by allowing his diabetes to soar out of control. Thus, he used his legitimate medical problems to extend the privileges of the sick role.

Because of his skill, the Actor's illness illusions and trivial self-injuries were treated as real, and his illness enhancements were treated as unique emergencies. His success in gaining treatment, like applause, merely prompted repeat performances.

His life style, diet, noncompliance with treatment, and habitual personal neglect were usually hidden. They remained behind the scene because of his skillful dissimulation. As a result, services were wasted and his problems remained unsolved.