Malingering?

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Malingering is often a difficult diagnosis to make. Like all neurologists, I see a significant percentage of patients with “functional” or non-physiological disorders. All clinicians do. In most cases it is clear that the patient is suffering and will often reject the notion that the problem is “all in my head,” and thus any hope of improvement, as doctor after doctor is consulted. Malingering is, of course, a different thing entirely. Malingers are consciously trying to fool the doctor, the health care system, the insurers, and whoever else needs to be fooled. The secondary gain for the conversion disorder patients, those who are unaware that their problem has an emotional basis, is often not identifiable, whereas the malingeringer always knows why he does what he does.

Many years ago a patient of mine was arrested for a robbery. Being not too bright, he had taken the purse off the arm of an old lady who knew him. On the day before he was to appear in court, he came to the office and had a convulsive fit, rolling on the floor for many minutes in the hope that I would diagnose epilepsy and get his appearance postponed for as long as possible. That did not happen.

Recently I saw a young man who claimed to be several years into a terrible, rare, inherited neurodegenerative disorder. I have some expertise in this disorder and it was very clear that he did not have it. The patient reported that he had seen several neurologists, and that a gene test confirmed the diagnosis. Unfortunately he could recall no doctors’ names or provide the gene test results. Unfortunately for him, there was only a single laboratory that did that gene test and it had no record that it was ever performed. Since this disease is a really terrible disorder, and the patient had a small child, who would have a 50% chance of having inherited the abnormal gene, and therefore a 50% chance of getting the disease, one might think the notion of raising hope that this all had been a bad dream, would be met with happy surprise. I could certainly understand a large degree of skepticism, if, in fact, several neurologists had confirmed the diagnosis. Why should I be correct and the others wrong? I could certainly understand that reaction, but, imagine, if you had an abnormal MRI and a doctor, or a few doctors, told you that you had a brain tumor and would die soon, and a presumed expert, who specialized in this problem, told you they were all wrong and that the problem was quite different and not life threatening, and possibly curable. One would think that this is a lot better than grasping at straws.

That was not the reception this information met. Anger, accusations of poor acumen and misplaced emphasis on psychiatric problems was how it was received. This later transformed into accusations of stated threats of removing disability, which had not, in fact, been discussed, although thought of immediately on my encountering the hostility of what should have been welcome news.

In diagnosing psychogenic disorders I generally don't spend much time on figuring out secondary gain. In my experience, it is rarely a helpful pursuit. In older editions of the Diagnostic and Statistical Manual (DSM), the psychiatric manual for all diagnoses, a conversion disorder could only be diagnosed if the underlying psychiatric cause could be identified. That has been altered, as it was not helpful to non-psychiatrists and not always true. I have always shied away from making a diagnosis of malingering, as I thought that it usually reflected the doctor's perception of the patient and not the actual clinical syndrome. If the doctor liked the patient it was a conversion disorder, and if the doctor did not like the patient, it was malingering.

In this case, as in many others with non-physiological neurological syndromes, the likelihood that this was a functional disorder was apparent as soon as I saw the patient stand up in
the waiting room. His odd manner of holding one arm, the ease of getting out of the chair and the idiosyncratic and irregular gait, suggested that things were not what they were billed as. The inconsistency of the movements as I took a history and then performed the neurological examination cemented the initial impression. In such cases, the history isn’t usually very important, although histories of unexplained memory lapses, peculiar spells and unexplained improvements add confirmatory support to the hypothesis. In this case, there were none of these, but the laboratory result that never existed was clearly a lie. It was not an exaggeration, a non-physiological occurrence. It was a knowingly told lie. Had he stated that he had been diagnosed based on clinical grounds, I would have easily accepted this as a mistake made by a well-intentioned but not very informed doctor, carried on by later doctors, to whom the clinical syndrome, quite rare, probably never seen by any of them before, made sense.

Diagnosing non-physiological disorders is often difficult, and studies have shown that experts often come to differing opinions about the same case. One must therefore be more humble than usual in making such a diagnosis. A diagnosis of malingering, however, is more than a diagnosis. It is an accusation. The “patient” is abusing the system for personal gain. It is, in fact, a crime. 

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Providing non-emergency healthcare for undocumented immigrants raises issues

HERBERT RAKATANSKY, MD

There are at least 11.5 million undocumented immigrants (UI) currently in the US (about the same number as the total population of RI, CT, and MA). Their health care is marginal, at best.

With three exceptions, these persons are barred from health coverage that utilizes federal funds. Medicaid will pay for true emergencies (criteria set by each state). But: “The potentially fatal consequence of discontinuing Medicaid coverage care even if such care is medically necessary, does not transform the condition into an emergency condition.” For example, chronic hemodialysis may not be covered, so some patients are treated for recurrent emergency crises every 7–10 days, a dangerous approach and expensive to boot.

Emergency care of UIs in RI is reimbursed by Medicaid only when it occurs in an in-patient setting or hospital emergency department. Active labor is deemed a medical emergency.

The law specifies that the treating physician must document that the medical condition meets the “definition of an emergency medical condition.” Doctors therefore, may be in a very uncomfortable position. Since the Medicaid coverage, once approved, can last 15 months there may be a conflict between the continuation of essential health care for one’s patient and denying payment for such care if the doctor declares the emergency to be over.

In some states, including RI, a pregnant woman may register her fetus (at any age) for care under the federal Children’s Health Care Program. This qualifies the mother for prenatal care, thus delivering care to the fetus. After birth the child is a citizen, but maternal care ceases 60 days after delivery. There are in excess of 500 such cases yearly in RI.

It is estimated that 8 million (70%) of the UIs have jobs, constituting 5% of the US labor force. These immigrants theoretically could get employer-based coverage but it is likely that most of them are working in the “cash business world.” To enter the standard job market they would need a social security number. It is a paradox that those immigrants who work using false social security numbers are paying taxes into a system from which they cannot benefit. From a strictly economic viewpoint, they are an asset to the health care system.

Does a doctor or any of her staff have a legal obligation to report to authorities the suspicion that a patient is an UI? The answer is a resounding NO. Generally there is no legal obligation to report a crime. Exceptions include crimes committed on the office premises or mandated reporting such as in child abuse. The right to speak freely is also the right not to speak at all.

The doctor is not in a neutral position, however. Information given to a doctor or her staff is considered protected health information (PHI) under HIPAA. PHI may be used only for medical care, billing and office operations and may not be divulged to others without express consent of the patient. Thus a doctor (and staff), even if inclined to report, are constrained from doing so. The Supreme Court has ruled that laws requiring such reporting are unconstitutional.

Patients may use false names because of fear (reality-based or not) of becoming known to “the authorities.” Interestingly, it is not against the law to use a name that is not one’s legal name. It is a crime, however, for the doctor to use a false name when billing a third party. Penalties for not identifying patients properly and not billing honestly can be severe, especially when federal or state funds are involved.

A patient using a false name may be at a medical disadvantage as well. Some medical records, including lab and imaging reports, might be under a different name and therefore not known to the treating doctor.

Doctors may not discriminate based on gender, race, ethnicity, sexual orientation and other factors, including immigrant status. Except for emergencies, however, doctors may choose to treat only those persons who can pay.
Even if doctors are willing to forgo payment for their services, modern diagnostics and therapeutics inevitably involve interventions that generally are not free.

The Supreme Court has affirmed that a state may require that persons stopped for any reason may be required to prove citizenship status. Such a statute (SB 1070) in Arizona has caused illegal immigrants to avoid medical care. They tend to not leave their immediate neighborhoods and they avoid health care facilities for fear that they might be “official.” There is documentation of fewer doctor visits. This happens despite current (this could change) regulations that designate medical care facilities as “safe zones.” Nutrition also suffers; the immigrants are afraid to visit markets outside their immediate neighborhood.

Lack of proficiency in English is widespread in the immigrant community and independently correlates with poor medical outcomes,

Our country has a long history of private philanthropy that includes medical care. Immigrants may utilize federally qualified community health clinics and “free clinics.” The RI Free Clinic (RIFC) provides continuous care to all RI residents who have no medical coverage and insufficient resources to access care. Since the RIFC does not bill anyone, UIs can be seen without legal consequences.

Immigrants in detention are another matter. The Immigration Control Enforcement (ICE) division is mandated to provide or pay for their medical care. In 2015 there were 26,500 persons in detention and 199,107 intake screenings, suggesting that about 13% of those detained are actually in detention at any time. There were 126,486 sick calls, 90,276 mental health interventions, 234,001 prescriptions filled and 19,483 emergency room or off-site referrals. Infectious diseases [HIV, TB, etc.] are treated and follow-up care is facilitated. Detainees are mostly held in “contract prisons” [e.g. Wyatt in Central Falls] where they are treated like convicted felons. The quality of medical care of prisoners is variable at best and there is no independent quality measure of ICE-provided care. Public advocacy groups [ACLU, etc.] and press reports have documented the poor quality of care provided by ICE.

Thus the current emphasis on increased deportation and detention adversely affects the health of those targeted in multiple ways. A small number of UIs are eligible for limited federally financed health care coverage (emergencies, prenatal care and in detention), but most UIs are outside the “system” and lack any care.

My conclusion: doctors, individually and collectively, should advocate for a national health care system in which we can fulfill our moral duty to care for all persons.

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Addendum
Subsequent to writing this article, the Trump administration rescinded federal health care standards for detained immigrants and now allows prisons to set their own standards.
Finally, some good news about insurance for medical professionals

We have partnered with the Rhode Island Medical Society to offer an exclusive Concierge Program designed specifically for medical professionals to save on their personal and business insurance.

Contact Robert A. Anderson, AAI at 401.272.1050 – randerson@rimsibc.com