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Commentary

"Stop the fraud!": What is the effect of social deception priming on health professionals?

Organisations and systems that compensate others for disability due to musculoskeletal injury are attempting to guard against fraudulent claims. Health professionals working within these systems are frequently asked to conduct examinations to determine if a claimant's symptoms are genuine and whether these symptoms reflect a true disability. Moreover, compensation/insurance organisations often make it clear that they expect vigilance on the part of all health professionals to help fight fraud which is a form of social deception. These types of messages concerning vigilance about the possibility of malingering and related social deception represent a form of priming. Priming, in this context, can be defined as exposure to a message or other stimulus that can influence responses to subsequent situations (e.g., interactions with patients).

Priming relating to the existence of social deception (e.g., malingering) is the focus of an article by De Ruderre and colleagues [3] in this issue of PAIN. Their research illustrated that observers, who read a text about the possibility of misuse and social deception within the health care system, provided less positive ratings about target patients than did observers who read a more neutral text. The less positive ratings about the patients, in turn, were predictive of lower ratings of pain and sympathy as well as of larger discrepancies between patient and observer pain reports. It is noteworthy that the Ruderre and colleagues' [3] study was based on an analogue of the clinical setting using vignettes (as well as patient photographs and videos), rather than actual patients, and non-health professional observers. If the findings generalize to health care contexts, however, priming concerning risks of deception could yield broad negative biases and reduced sympathy toward injury claimants. Such biases would negatively impact the health professionals' ability to work with their patients.

If highly valid and reliable tools for the detection of malingering in musculoskeletal pain existed, then the consequences of priming health professionals about the possibility of malingering might have been less problematic. With ideal detection tools, fraudulent claims could be identified with confidence. This would facilitate increased empathy and concern for all other claims. Malingering detection tools, however, are far from perfect and the rates of false positives and false negatives are unacceptably high [1,7]. The absence of diagnostic certainty can create suspicion and priming about social deception can facilitate such suspicion. Perhaps partly due to such priming (and despite the serious limitations of detection tools), many clinicians become overconfident in their ability to detect malingering. Such overconfidence can be problematic; research illustrates that increased diagnostic confidence is not associated with increased diagnostic accuracy [8]. Could the demands for vigilance about the possibility of malingering within our insurance/compensation systems cause health professionals to view patients more negatively? What would the effect of such more negative perceptions be on patient care and effective assessment?

The effects of compensation/insurance organisation messages concerning vigilance about possible fraud or symptom exaggeration on malingering detection have not been studied adequately. Nonetheless, one may ask whether these same messages have the direct or indirect effect of reducing health professional sympathy toward all claimants. If this were the case, would such messages then also affect health professional empathy, concern and appreciation of the claimants' symptomatology? What are the ethical and practice implications of the messages for vigilance to detect malingering and deception? This is an important research question.

Inherently, it is very difficult to conduct naturalistic research investigating malingering or health professionals' likeability of actual patients. Analogue investigations (i.e., research aimed to simulate, under controlled conditions, a real life situation), such as the work of De Ruderre et al. [3] as well as of others [6,9] represents a valuable methodology to investigate such issues. On the other hand, real world research is still needed to evaluate the generalizability of these analogue studies.

Although the study of malingering by patients who report musculoskeletal pain has received research attention for many years, the armamentarium of tools to detect malingering remains quite primitive. To what extent are we serving our patients (or cost-saving for the system) given compensation/insurance system demands for constant vigilance about the possibility of malingering? In fact, some evidence suggests that, in compensation systems where the claimants' complaints are consistently assumed to be genuine and the focus is strictly on successful rehabilitation, there are cost savings [2,5]. Given the serious limitations of malingering detection procedures in musculoskeletal pain, this would support the position of aiming to achieve cost savings through an increased focus on rehabilitation for all claimants. It is also important for clinicians to reflect on the potential impact of a frequent focus on the possibility of malingering on interactions with patients and the probability of successful rehabilitation. This would be especially critical in the case of conditions such as non-specific low back pain, where findings of "organic pathology" may not be available, and also because evidence of histopathological changes, often associated with pain, sometimes cannot be seen in imaging due to device limitations [4].

Conflict of interest statement

The author has no conflict of interest relating to the preparation of this article.

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