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# *The Case*

## *Medically Disabled or Malingering?*

Mr. J. is a 39-year-old skilled construction worker who has been complaining about unrelenting chronic pain, following an on-the-job injury 4 years earlier. Over the course of treatment, he has advanced up the analgesic ladder, been unable to work (while being compensated by company insurance), and used ever-increasing doses of increasingly potent opiates, as well as a host of other adjuvant analgesics and antidepressants. Mr. J. claims that this situation has "messed up his whole life." His pain management physician, Dr. Dolorosa, suggests that Mr. J. might be a viable candidate for transcranial magnetic stimulation (TMS) to treat intractable chronic pain. This treatment would also render Mr. J. medically disabled (and he would receive full medical workers' compensation benefits, as well as potentially being compensated by an out-of-court financial settlement for damages). Per study protocol, Mr. J. undergoes magnetoencephalography (MEG), functional magnetic resonance (fMR), and diffusion tensor and kurtotic imaging (DTI/DKI) to help correlate and identify brain regions putatively involved in his pain, and which could be viable targets for TMS. However, following imaging, the study physicians report that Mr. J. "presents with images of a normal brain, absent patterns of signal intensities in brain regions or networks indicative of centralized pain." Mr. J. is not accepted into the study. Moreover, Dr. Dolorosa is now concerned that Mr. J. may have been, and is, misrepresenting his symptoms and signs, and might be frankly malingering.

**Question:** ***What should Dr. Dolorosa do?***

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### Commentary: Treating the Patient Who Has the Disease

**Eric H. Denys**

The case of Mr. J. presented here exemplifies the problems that arise with chronic disease complicated by chronic pain. Missing is the clinical information, which is paramount when one is making a diagnosis. Therefore, only generalized comments can be provided. In the present example, we find ourselves at the end of a 4-year unending saga and consideration of experimental treatment. When no abnormalities are found on preliminary tests to determine suitability for inclusion in such experimental treatment, a red flag is raised. We must therefore engage in "reverse engineering" to elucidate crucial elements in the story.

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### A Young, Capable Man Is Injured on the Job and Suffers Unrelenting Pain; His Illness Is Covered Under Worker's Compensation Insurance

In the initial months following the injury, there should generally be little reason to doubt the legitimacy of the complaints, and treatment with appropriate pain medication is warranted. As soon as the expected improvement does not materialize, there is a need to explore contributing factors. Because the injury occurred on the job, it is worth inquiring whether there are impediments to returning to the work force. These can include interpersonal conflicts with coworkers or superiors. Did the patient point out a hazardous condition that was neglected by his superiors, which he, a responsible employee, resents? Was his injury related to these conditions? It is not uncommon that such factors surface early in the course of treatment but are often overlooked. Secondary financial gain is less likely in a well-functioning worker at this stage, but emotions affect every patient's way of dealing with adversity.

### Pain Medications Are Administered in an Escalating Fashion

It is surprising, perhaps no longer today with the awareness of overprescription of narcotics, that pain medication was seen as the only way to address the patient's complaints. Lost with the advance in medical technology is the adage "A good physician treats the disease; the great physician treats the patient who has the disease" so eloquently expressed by Sir William Osler and others over the past century. The medication-based approach most certainly complicated the patient's illness. Not only was the focus too narrow, but it very likely led to narcotic dependency, a pattern of chronic illness, and a vicious circle of pain begetting pain and more medication. This brings up the current narcotics epidemic for which physicians are to blame. Although it is true that governmental agencies interceded and mandated 10 hours of Continuing Medical Education (CME) in pain management for license renewal in California, and drug companies had every incentive to follow suit and push for more potent prescriptions, it was the moral and ethical duty of the individual, educated physician, including at academic education centers, to do no harm. Who else was the captain of the ship, notwithstanding threats by opiate-dependent patients to file a complaint if their access to narcotics was denied?

### An Experimental Treatment Is Considered

From the context, I presume that a centralized pain syndrome had become the working diagnosis, and that there was consideration of an experimental treatment protocol with transcranial magnetic stimulation. It was fortunate that the patient failed the inclusion criteria, because otherwise, this saga would have been perpetuated. A centralized pain syndrome is sometimes invoked when no other explanation can readily be found, although it is wise to forego such conclusion for a while and assess the total set of circumstances, as became evident in this patient.

### Long-Term Absence From The Workforce Becomes Habitual

It is well known in worker's compensation circles that a patient out of work for more than 2 years is unlikely to enter the work force again. Think of the Monday morning syndrome or the return to work after a long vacation. By that time, the patient will have adapted to a new lifestyle, very much dependent on others as well as on medication, and will be unable to pull himself

up by the "bootstraps". Mr. J.'s claim that this situation has "messed up his whole life" is certainly true. After years of lack of progress, depression is a likely complication. Depending on the nature of the depression, it could be not only the expression of an unfulfilled desire to get well, but also a side effect of multiple medications. If the psychological makeup of the patient and social circumstances "cooperate," the only next step can well be a request for financial compensation. Even Worker's Compensation may find a settlement, including future treatment, an acceptable option. Such an outcome represents a financial settlement, but does not address the underlying illness and the patient's well being.

### Malingering?

Malingering is not a disease or mental illness. It is the fabrication of symptoms for personal financial or emotional gain. Such attitude may be difficult to diagnose, at least initially, and should not be labeled as malingering lightly. Some physicians are too quick to ascribe symptoms that they cannot explain to malingering. In my opinion, malingering is rare. More common is the perpetuation of symptoms because underlying or concomitant emotional factors remain unattended to. In addition, the majority of patients are unaware or will deny that anything emotional is playing a role in their predicament. Such situations require special skills of the treating physician, which few possess, as education in psychology in the United States has often been given little attention, in the medical curriculum, at least in the past.

### What Should Dr. Dolorosa Do?

From my previous discussion, the reader can already guess my recommendation. At this stage, 4 years after onset, the task is enormous. No single physician can handle the complex issues that have by now contaminated the treatment. One needs to take a fresh approach with a specialized team that includes pain management, psychiatry, rehabilitation, vocational counseling, psychological assistance, social workers, financial assessment, and an insurance willing to pay. The insurer almost always delays such a team approach for financial reasons. If this team approach were instituted early on when complicating emotional factors are discovered, the outcome would be quite different for all involved. Dr. Dolorosa should not be part of this team and should be advised to take additional CME covering such elements as a more holistic approach to patient care for the benefit of all future patients. Unfortunately, the current corporate structure of healthcare delivery with an emphasis on efficiency is unlikely to make it easy for physicians to spend sufficient time to address physical and emotional components in the 10–15 minutes allocated per visit. In the past, physicians could elect to provide comprehensive care and spend more time with patients at the cost of diminished income. It is doubtful that corporate medicine in the United States will embrace such physicians. The one hope might be that patients could gain access to a team of caregivers in a more integrated approach that would end up being less costly, ultimately to the benefit of patients. Hope springs eternal.

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## Commentary: Doing the Most Good with the Least Harm in Cases of Suspected Malingering

**Brian Andrews**

The scenario presented involves a young construction worker years after being