Original Article

YOUNG DOCTORS' PERSPECTIVES ON MALINGERING AMONG CORPS MEMBERS IN A RESOURCE–LIMITED ORIENTATION CAMP CLINIC: A MIXED METHOD STUDY.

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Abstract

Introduction: Malingering among National Youth Service Corps (NYSC) members is common yet poorly documented. Failing to detect and declare cases of malingering may impose economic burden on a resource restrained camp clinic. False attribution of malingering could hurt genuine patients. This study explored the young doctor's perspectives on malingering in the orientation camp clinic of Bayelsa State.

Objective: To determine young doctors' perspectives on malingering among corps members in a resource–limited orientation camp clinic.

Materials and Methods: A descriptive cross-sectional study was conducted. Following the Diagnostic Statistical Manual (DSM) IV criteria for diagnosing Malingering, quantitative and qualitative data were collected from the study population by administering a self-developed semi-structured online questionnaire and by conducting a focused group discussion (FGD) respectively.

Results: Mean age of respondents was 28.35 (SD=2.925) years with 80% males and 20% females. Close to half (45%) of the doctors were sometimes exact at detecting malingering and 45% of them had only two years' practice experience. Military parades and quest for redeployment are most identified reasons for malingering among corps members. Deciding not to report detected cases was due to lack of investigations to rule out initial diagnosis. Wastage of limited clinic resources and fatigue of limited human resources were the most identified consequences of malingering. Exposing and dealing with culprits, reducing camp strenuous activities and a high index of suspicion by corps medical team were some of the suggested ways to curb the menace.

Conclusion: Malingering is common among Corps Members posted to Bayelsa State and it may be detected without the use of any special psychological assessments. To curb it, identified cases should be documented, exposed and dealt with. Camp strenuous activities and other precursors should be reduced.

Key words: Malingering, corps members, young doctors.

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INTRODUCTION

Malingering, which is defined as the intentional production of false or grossly exaggerated physical or psychological symptoms for the purpose of an external benefit such as escaping duty, mitigating punishment or receiving an unwarranted favour is not a new condition among military and para-military personnel and young persons[1, 2]. It can be

further differentiated into "pure malingering" (for a disorder that does not exist at all), "partial malingering" (for exaggeration of existing symptoms), or "false imputation" (when symptoms are attributed to a totally unrelated aetiology)[3].

Malingerers are motivated by the benefits they seek and they may be hard to detect especially when there is inadequate experience by the attending physician. Globally, malingering has been well documented among Military personnel. A study between 2006 – 2011 which accessed electronic database used by the department of Defence in the United States of America to monitor and manage military health care activities worldwide revealed 1,074 diagnosis of malingering and factitious cases out of 28,065,568 health care visits. These cases of malingering were mostly among unmarried enlisted males into the army[4].

Sadly, malingering seems to be an undocumented trend among corps members in Nigeria deployed to undertake the compulsory one-year National Youth Service Corps (NYSC) scheme which is always preceded by a three-week orientation course. This course is undertaken in a somewhat para-military training camp where rigorous activities like parades and 'Man-o-War' activities interlaced with a tight schedule of protracted lectures and skill acquisition exposures are experienced. Just as it is obtainable in military settings, the camp is usually much regimented.

Doctors are usually reluctant to report cases of malingering for varying reasons[5]. In Nigeria for example, the most recent documentation of malingering was in a 5-year-old boy in Ilesa in 2016[6]. There are no published studies on malingering among corps members but anecdotal evidence suggests it exists across various orientation camps in the country. Consequently, we do not know the specific rate of malingering among corps members in Nigeria, but there is likelihood that it is significantly under diagnosed among this group of young adults.

Even though it is easy to define, clinicians still find making the diagnosis very challenging as they are most likely reluctant to diagnose it for fear of being wrong, being seen as too strict, or so as not to stigmatize the patient[5]. Understandably, the gap between suspicion and confirmation is still an issue necessitating the emergence of several psychological testing to unmask fake presentation. Unfortunately, these tests cannot determine the subject's motivation as observed in a particular study[4].

Although malingering was removed from the index in the Diagnostic Statistical Manual - 5 (DSM-5), the criteria for when to consider malingering remains unchanged[7]. However, according to the DSM-IV criteria, malingering should be strongly suspected if any combination of the following exists: when there is a medico-legal context of presentation; when there are marked discrepancies between claims and objective findings, when there is lack of cooperation with evaluations or treatment, or when there is the presence of antisocial personality disorder[1].

Rogers and Shuman found that the use of DSM criteria results in the accurate identification of only 13.6% – 20.1% of actual malingerers (true positives)[8]. However, 79.9% – 86.4% of individuals are misclassified as malingerers (false positives) using same criteria. Accurate detection of malingering is a pressing societal issue[8].

Though it is not considered a form of mental illness or psychopathology, malingering can occur in the context of other mental illnesses and can be the beginning of a latent mental illness waiting to manifest. Adequate diagnosis and appropriate sanctions are needed to curb this trend.

A study done in the US that reviewed 1,074 confirmed diagnoses of malingering observed that 21.9% cases of malingering were diagnosed by social workers, 14.8% by clinical psychologists and only 5.2% by general practitioners[4]. Orientation camp clinics have corps members as doctors with very limited experience at detecting and diagnosing malingering.

The orientation camp clinics in most states are under-funded obviating the need to have proper management of scarce resources rather than spending it up on malingering cases. Identifying a malingerer will help focus resources toward patients with genuine symptoms.

Findings from this study will guide the administrative authorities on steps to take to address malingering in orientation camp in Bayelsa state and may be useful in other NYSC camps in Nigeria.

Among the 773 camp clinic illness visits recorded during the 2019 Batch B, Stream 2 orientation exercise, only three cases of malingering were documented in the case notes. Ironically, doctors were reported to have attributed exhaustion of medical supplies to malingering. This study was carried out to explore the young Corps Medical doctor's reasons for deciding not to document the over 200 suspected cases of malingering and their perspectives on the motives, consequences, and deterrents for detected cases of malingering in the orientation camp clinic in Bayelsa State.

MATERIALS AND METHODS

The study setting was NYSC temporary orientation camp at Kaiama in Kolokuma/ Opokuma LGA of Bayelsa State. The camp is headed administratively by the State Coordinator of the NYSC. The administrative head of the camp clinic is a staff of NYSC and the technical head is a Corps doctor who oversees the activities of all corps medical personnel in the camp. Each camp has a pair of senior doctors from the Department of Community medicine, Federal Medical Centre Yenagoa attached to the camp clinic to supervise the activities of corps medical personnel.

The target population was the Batch B stream 2 of 2019 Corps members and the study population were the 20 fully licensed Corps medical doctors. Eligibility criterion was a fair knowledge of the definition of malingering based on components of the DSM IV criteria by the doctors who were directly involved in the care of patients at the camp clinic of that batch.

It is a descriptive cross-sectional study that employed a mixed method approach of data collection. For the quantitative data, a short online survey questionnaire having several questions was designed and sent via WhatsApp to all eligible respondents. Non-response was prevented using compelling asterisks for answering all questions before submission. Participation was voluntary.

The sections included demographics, structured questions on number of years of practice, rating scale for effectiveness in detecting malingering, experience with malingering within the last one year and within the camp, and open-ended questions on perceived motives and deterrents for malingering. The survey was carried out during the last week of the camp. Response was 100%. Quantitative data was analysed using the Statistical Package for Social Sciences (SPSS) version 23.0 (SPSS Inc., Chicago, Illinois, USA) and the data was summarized and presented using charts and descriptive statistics of mean, frequencies and percentages for socio-demographic characteristics.

The day after the online survey, a focused group discussion (FGD) involving eight consenting corps doctors comprising three females and five males and lasting about 87 minutes was carried out to further explore the reasons and suggest detecting methods and deterrents for malingering among corps members. The discussion was transcribed manually and was analysed using themes and codes.

Approval to carry out the study was obtained from the administrative head of the camp clinic and each participant consented to participating in the research by ticking a consent slot.

RESULTS

Quantitative data:

Mean age of respondents was 28.35 (SD=2.925) years with 16 males (80%) and 4 females (20%). About the years of experience of practice since

qualifying as a medical doctor, 45% of respondents had two years' experience and 20% had one-year experience. The rest had variable number of years of experience as shown in figure 1.

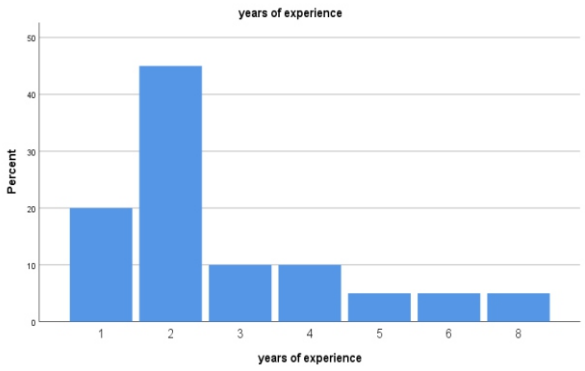

Figure 1: Bar chart showing years of experience of respondents.

Findings on how corps doctors were in diagnosing cases of malingering showed that most of them were sometimes exact and only one was always exact.

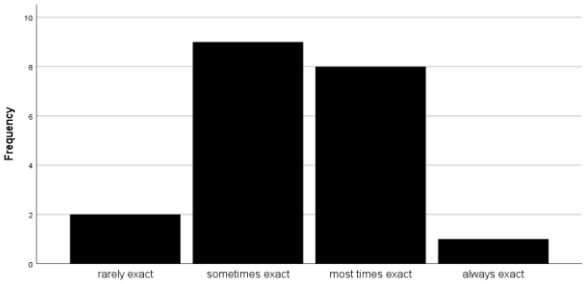

Figure 2: Bar chart showing how exact respondents were in detecting Malingering

Exploring the reasons why the doctors decided not to document even after detecting or perceiving malingering, 70% of respondents wanted to give patients benefit of doubt. 25% of respondents were still unsure of the diagnosis. 35% identified discovery of an undisclosed or another diagnosis, 20% because of existing policies and 15% failed to document because of negative impact it will have on the patient.

Open ended survey responses from Respondents

Table 1: Motives of Malingerers

Responses	Frequency of responses
To avoid parade and rigorous activities	15
Quest for redeployment and relocation	7
Boring Lectures	2
Get favours and attention	2
Genuine fatigue	1
To find a soul mate	1

Table 2: Consequences of Malingering

Responses	Frequency of responses
Wastage of time and resources	6
Overworked healthcare staff	6
Giving potentially dangerous drugs to otherwise well patients	4
Ignoring genuine complaints	3
Overrated number of managed cases	3

Table 3: Detecting Malingering in camp clinic

Responses	**Frequency of responses**
Taking detailed history, examination and thorough questionin g in an atmosphere of empathy	4
Offering Placebo	4
Cajoling tactfully	1
Isolating patient from the crowd	1

Table 4: Ways to curb Malingering in camp clinic

Responses	Frequency
Validated Medical reports thoroughly screened	4
Dealing with culprits promptly	3
By making optional or reducing some strenuous activities are in camp	3
Increasing awa reness among medical personnel on camp	2
NYSC should be made voluntary	1
I doubt that it can truly be curbed.	1

The survey tool had an open-ended section permitting multiple responses from the respondents. They reported that most of the cases of malingering were because corps members wanted to avoid parades and the rigorous activities in camp. Other reasons in decreasing order of magnitude include quest for redeployment, boring lectures, to get favours and genuine fatigue (table1). The consequences and deterrents of Malingering are presented in tables 2 - 4.

Qualitative data from FGD

Theme A: Experience with regards to malingering, common fraudulent presentations and motives for malingering.

Experiences

A total of six respondents already had prior experience with malingering patients before coming to camp hence they were primed to suspect Malingering. Only two were encountering it for the first time

"Prior to NYSC, I didn't really manage any cases of malingering, but I heard about it being managed it by other colleagues. Coming to NYSC and being in this orientation camp, I actually had an encounter …who had a case of malingering. NYSC orientation camp was my first encounter with cases of malingering."

Another doctor revealed:

"Actually, before I came here, I never knew there was something called malingering. I heard it first time here. In the first week of our stay here, there was a girl, Hausa lady. She actually came in with symptoms of Asthma but there were no clinical signs. She talked about cough, difficulty in breathing. In fact, she came with a medical report stating that she had status "asthmatic" not asthmaticus. Then I knew something was fishy and what she wanted was relocation".

For those who had previous experiences of Malingering patients prior to the camp, they shared the various circumstances in which they encountered such patients, most of whom were detected by senior and more experienced colleagues and they perceived it was common among females who were prone to seeking attention:

"On two encounters I have seen malingering cases in the past. First was in 600 level, a lady was trying to fake migraine headache to trouble her husband who was showering attention on a mistress outside her marriage. It was difficult for us to detect it. However, we detected her symptoms exacerbated whenever she sees her husband. That was what led the consultant to say he wants to have a word with her. It was then she opened up"

Some other doctors had these to say:

"Females malinger more than males. It is also common during the first week of camp. It is also more common among those who do not have much medical knowledge" – Dr EO.

"I have had some few encounters with malingering patients. There was this lady who needed a change of vehicle from her husband who came in with symptoms suggestive of Appendicitis. When you do all the examinations, they don't just tie up. My consultant just called her into his office and asked her, what do you want. That was when she opened up that she doesn't like her car anymore, her birthday is two weeks and she wanted her husband to get a new car. They can't fool a Physician" – Dr NO.

"My third experience with it was in this camp on countless occasions, persons telling me they have PUD with a wrong position of abdominal tenderness, or complaints fever with bizarre fever pattern and currently afebrile, when I tell them I'll give them medications they will have to take in front of me, some of them will frown and when I probe further I discover they were trying to escape parade."

"I think female folks malinger most with presentations like syncopal attack because they know it is seen as near death and think if the doctor is able to resuscitate you, the next thing is to send you home"

"My first encounter was during house job. Where I practiced, the women do it for financial favours and attention. When their husbands travel on long trips, there is poor communication so the only way they think they can get their husband's attention is by presenting ill at a health facility" – Dr IO.

Presentations and Reasons for Malingering

In the Camp clinic, Depression, Peptic Ulcer disease and other pain presenting conditions were the most frequently reported presentations as observed by the respondents. Their experiences on camp were quite revealing:

"She came in as a case of depression, she really went to town telling me about the symptoms, she must have really read about it… telling me about suicidal ideation but at the end of the day, I didn't know it was malingering till someone heard her telling a friend how she said all that with the aim of getting redeployed. Some other malinger prone illnesses include peptic ulcer diseases, symptoms of hypoglycaemia, asthma. The motives behind it is just a get away from the hustle in bustle camp, most of them want an exeat or redeployment, some do it for more attention from home and friends on camp"

"some come to collect free drugs to keep for the future self-medication so that after camp they don't spend money getting those drugs should they fall ill" – Dr AE.

"Malingering cases seen in camp include PUD, asthma, abdominal pain. Reason for malingering in camp was to escape punishment for a lie they told the soldiers, others come to mimic the illness of a friend who cannot come to clinic, so they want to get drugs for their friend, craving for rest"

"Reasons for malingering in camp, parades are stressful and the soldiers do not seem to know how to draw the line, SAED lectures are not as engaging too,… people's questions are hastily brushed aside, at this point of our life people used to freedom coming into a camp with a regimented lifestyle, the camp clinic therefore is regarded as a place of solace and refuge away from the regimented lifestyle where there are no barky sounds but tenderness. With the security situation in the country, people want to relocate to places near their homes hence they present malingering".

Theme B: Perception- diagnosing/ documenting disparity

Absence of diagnostic facilities to rule out Malingering, Sympathy, being unsure of the diagnosis were some reasons respondents gave for deciding not to document such cases even when they were established.

"*When the doctor feels fooled, his initial reaction is irritation, next is subdued anger, his ego is bruised, hence he may not want to document it. For me, once your symptoms don't match the findings, I diagnose it and when they open up to me, I just develop sympathy for them, so I don't bother documenting it*" – Dr IO.

"*Personally, for me, malingering is a diagnosis of exclusion. I am not in a hurry to make the diagnosis when I'm not sure. Secondly, in some cases like here in camp clinic, we don't really have facilities for investigations do rule out malingering, you are really handicapped"* – Dr EC.

"*The shame that your colleague's diagnosis might be different from yours should the patient happen to come across your colleague thereafter*" – Dr AO.

"Clearly you are in an edge not to do be in a hurry to make such diagnosis of malingering because no investigative tools, also if patients had similar previous symptoms though there are no present signs, you would not want to be in a hurry. I think the doctor should document it if it is clear-cut for statistics and to send red-alert. The doctor should discourage those caught else if they sensed they succeeded, they will tell their friends who will also come and malinger" – Dr NO.

"Reasons for delay in documentation for me as a fresh graduate since I have not seen lots of cases as a young doctor, I will always think that there might be other conditions" – Dr C.

Theme C: Consequences of unchecked malingering and how it can be checked in an orientation camp

The most recurring response was wastage of resources and the high level of physical activities at the orientation camp, which they suggested should be reduced to check malingering.

"There are a number of consequences. One of them is wastage of resources, overtasking mental capacity, if you give a drug a patient doesn't have indication for, the patient abuses the drug and side effect"

"just like we have said, wastage of resources and time. The energy we should have spent managing a real case is spent stressing the doctors on a fake case. Over-diagnosis results from being stressed as doctors. In this camp, we should have a high suspicion of malingering to check it. I don't know whether it is medically right to use placebo. My suggestion is let the timetable be adjusted a bit. The doctors should not be seen to be panicky else malingering patients tend to remain in the condition"

– Dr NO.

"Malingering among corps members should be checked by reducing the factors earlier mentioned, we are not military personnel and our lives should not be too regimented, after three weeks camp, the military training received may add little or no value to our lives so …this should be tapered down"

"like my colleagues have said, it causes this vicious cycle, at the beginning of camp, so many people that are malingering made us waste so much drugs on them. Now at the end of camp, many people have gone through much intense physical activities, more are stressed that their bodies are now having real issues that we should use those drugs for but we don't have the drugs anymore because we have used them for the ones that faked symptoms and threw away the drugs. It can also make us overlook certain subtle conditions that actually exist. Malingering cases can distract us from the actual patients"

"Because of the stringent rules on camp, people who need rest are not allowed to rest in the hostels, we have limited bed spaces in the clinic, if you have six patients with a fever, you would not want them to go to the hostel, but how about those with headaches, the ones with belly aches, those with muscle cramps, they can't really march, they can't be moving up and down yet the military personnel will not allow them rest in the hostels. --"These are the consequences of unchecked malingering. For the lectures, compulsory for 5 hours, people forced to sit down, funding low. I will say you can't make a spot diagnosis of malingering; you can't even send someone away from the clinic because you think he is malingering since you can't prove. It is not something you can stick out your neck for."

"Get a second or third opinion. The ways out include reducing the stress on the corps members. If the camp will be less stressful, if the accommodation facilities are better, less people will malinger. If we could split the lecture times and have something that is more youth friendly as an interlude, it will be nicer"

"Again I was saying that if the team of doctors makes a diagnosis of malingering and is so certain that this corps member is actually malingering and calls for a second opinion third opinion and a team of doctors come and affirm that diagnosis and the Corps member you know attests to it that actually I was malingering. Just to reduce the inflow of malingering patient I think there are some modalities to be put in place to reduce the inflow of malingerers".

"I think this institution as it is, should have a pseudo disciplinary committee for malingerers. That committee would just come ask them questions and kind of sensitize them, warn them that this happened... just like a threat to them".

"Counselling in the clinic, a pseudo disciplinary committee that is set up by this institution and a medical psychologist."

DISCUSSION

This study explored the reasons for the young doctor's hesitancy in documenting detected cases of malingering and perceived motives, consequences and deterrents for malingering.

Truly, the diagnosis of malingering rests upon the identification of an external or secondary gain being present as the main motivation for the behaviour. Our study participants established the diagnosis of malingering as they detected a number of reasons for malingering as observed in the camp clinic. They also identified the female gender as the most malingerers. This finding contrast other studies where the male folks were culprits. This difference could be as a result of the fact that most literature on malingering were in military settings where males were predominant.

From our study, the most identified motives in the order of frequency included to avoid parades and rigorous activities in the camp. This is comparable to a similar study carried out in University of Washington which identified similar motives as they explored the perception of military medics on malingering within the military health care community[9]. Other motives as discovered in our study included a quest for redeployment and relocation; to get favours and attention; an escape from boring lectures and genuine fatigue.

For healthcare providers in general and behavioural health providers in particular, malingering is a difficult issue especially for the inexperienced. From our study, majority of the respondents had only an average of two years' experience in medical practice. As rightly observed in another study, medical training is designed around the collaborative and paternalistic model of the patient seeking care and the physician providing it. The behavioural health setting takes that one step further, with the understanding that not only is the patient openly seeking help, but also that a therapeutic rapport will be a significant aspect of the treatment. A deceiving patient rejects this model, and unless healthcare providers are forensically trained, their education leaves them unprepared[9].

One unique finding about the qualitative aspect of our study was the enumeration of likely malinger prone presentations. They include acute exacerbation of a painful condition and peptic ulcer disease. This was observed in a case report of a 35-year-old African-American male who exaggerated his symptoms in the presence of a pre-existing medical condition[10]. This type of presentation is common since pain is a subjective complaint, the possibility that patients complaining of it may be falsifying or exaggerating it always exists. Detecting malingering will therefore depend on the experience of the doctor or one with a high index of suspicion of malingering. The young doctor attending to corps members in camp is therefore expected to practice as a detective. This may however make him less empathetic or else he/she becomes an accomplice in the crime.

A study in University of Washington highlights the temptation for physicians to "look the other way" and give their patient the benefit of the doubt in all but the most egregious cases[9]. This temptation to ignore deception is worsened because physicians are not equipped with the resources needed to verify a patient's history.

As observed in our study various reasons were advanced for failure to document cases of malingering among Corps members in camp clinic. The most common reason was to give patients benefit of doubt and sympathy. The next reason was being unsure of the diagnosis especially due to absence of essential diagnostic tools. Other reasons identified in our study include discovery of an undisclosed or another diagnosis, negative impact on the patient and existing policies. Some of these policies in the camp clinic include not attending to non-emergency cases during camp parades and lectures and early discharge within 12 hours on admission leaving the doctor with lesser contact time with the patient. Truly as observed in another study, labelling an individual as a malingerer can be stigmatizing, carries negative connotations, and can negatively impact on an individual for the remainder of their

lives[11].
As observed in a similar study, malingerers show poor compliance with treatment and stop complaining about the assumed illness only after gaining the external benefit[12]. This was discovered in our study as respondents' revealed ways they used in detecting malingering. Some identified ways include thorough questioning, using placebos, and tacit cajoling.

Some other studies have reported some documented psychological assessments used to detect malingering such as Structured Interview of Reported Symptoms (SIRS), Structured Inventory of Malingered Symptomatology (SIMS), Minnesota Multiphasic Personality Inventory 2 (MMPI-2) and others[13]. In our study, there were no psychological tests done to detect malingering. A huge majority of the cases were established as malingering after the culprits owned up much later either directly to the doctor after thorough questioning, to other health care workers or to a friend who revealed it after the benefit had been gained. However, resources had been wasted in attending to the malingered cases before the disclosure was made. In a resource poor setting like ours, where medical supplies are hardly adequate for genuine patients, it is imperative that this menace should be curbed.

Our study identified dealing with the culprits if found as a way of tackling the menace. This view was also shared in a similar study in military setting where a person attempting to avoid service by feigning illness or disability or by a self-inflicted injury is subject to court-martial and punishment[14]. This study is not without limitations. Each year up to 5 streams in two or three batches attend the orientation camp. Only one stream was involved in our study and the experience of malingering may vary from stream to stream. We therefore cannot generalize the findings to other streams. Secondly, the lack of definitive diagnosis for the condition may affect a true estimation of the magnitude of the problem.

CONCLUSIONAND RECOMMENDATIONS

Malingering is an identified disorder among Corps Members posted to Bayelsa State. The reasons are multifactorial and cases are specifically presentations which diagnostic facilities in the orientation camp clinic are unavailable to rule out. Malingering may be detected even without the use of psychological tests especially when culprits disclose their intention in an atmosphere of empathy. Unchecked malingering will weary health team and waste limited resources. To curb the trend of malingering, identified cases should be exposed and dealt with. Strenuous activities and other precursors to malingering in the camp should be properly addressed by a comprehensive approach at all levels. The National Youth Service Corps should always raise awareness about malingering among every batch of corps medical staff and malingering should be listed as a punishable offence in the camp bye laws. Culprits should be made to face the camp court. There should also be continuous collaboration with the Nigerian Medical Association to strengthen validation of Medical fitness reports brought to camp.

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CONFLITS OFINTERESTS

There are no confiicts of interest.

AUTHORS' CONTRIBUTION

DKI designed the study, wrote the protocol,

supervised data collection, and wrote the first draft of the manuscript. AA and OAS reviewed the protocol and performed data analysis, EAO and RS reviewed and developed the initial draft of the paper. All authors read and approved the final manuscript.

ETHICALAPPROVAL

The research work was examined and approved by the NYSC State Coordinator.

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