



The therapeutic discharge: An approach to dealing with deceptive patients



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ABSTRACT

Objective: Patients with factitious disorder or malingering behaviors pose particular problems in acute care settings. We sought to describe a manner to effectively discharge these patients and keep further harm, iatrogenic or otherwise, from being inflicted.

Method: Once an indication has been identified, the therapeutic discharge can be carried out in a stepwise fashion, resulting in a safe discharge. We outlined how to prepare for, and execute, the therapeutic discharge, along with preemptive consideration of complications that may arise.

Results: Consequences for the patient, physicians, and larger healthcare system are considered.

Conclusion: The therapeutic discharge is a safe and effective procedure for patients with deception syndromes in acute care settings. Carrying it out is a necessary element of psychiatric residency and psychosomatic medicine fellowship training.

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1. Introduction

Deceptive patients—those with factitious disorder or malingering behaviors—pose a particular challenge when admitted to a general or psychiatric hospital. Deception can include feigning, exaggeration, or actual production with false imputation of medical or psychiatric symptoms and signs. These conditions are both challenging to detect and intimidating to declare. It is thus difficult to accomplish both of these tasks before iatrogenic harm is done through invasive testing, unwarranted treatment, and reinforcement of maladaptive illness behaviors. Such harm follows on the heels of whatever harm that deceptive patients have done to themselves. These harms range from the morbidity of self-induced sepsis to the perpetuation of life problems caused by repeated, medicalized lying. We find the latter to most often involve suicidal ideation in the psychiatric domain and chest (or other) pain in the somatic domain.

Psychiatry is typically consulted either when deception is explicitly suspected or when the patient's behaviors and providers' associated feelings surrounding the deception are assumed to indicate the presence of psychopathology. Treating hospitalized patients with deception syndromes is especially challenging because feigned symptoms only subside if the patient achieves his desired goal, or if persistent—sometimes escalated—deception proves futile, leading the patient to abandon his efforts [1]. Given what has to be

ruled out (i.e., psychopathology aside from factitious disorder), ruled in (i.e., a deception syndrome), and intervened upon (i.e., discerning and addressing the patient's motives), decisions about “what to do with” these patients often fall to the consulting psychiatrist.

There is a small body of literature describing how to handle deceptive patients. In it can be found recommendations both for [2–4] and against [3–5] confrontation. Suggested reasons to avoid confrontation include maintaining the patient's sense of safety, creating an opportunity for treatment by illustrating the bind the patient has created and allowing him some degree of choice, and allowing the patient to save face and avoid narcissistic injury [5]. Kontos et al. [6] proposed a framework based on reciprocal rights and duties in the physician-patient relationship to determine whether confrontation of maladaptively behaving patients is worthwhile. While Kontos et al.'s framework was suggested with the goal of allying with the patient, the same questions it poses—whether the patient prioritizes health, whether the confrontation is ethically permissible, and whether the confrontation is too emotionally gratifying—can precipitate the termination of the physician (or institution)-patient relationship.

Though avoidance of confrontation may be indicated in many cases, some hospitalized patients with deception syndromes warrant confrontation and, potentially, removal from the hospital in order to best minimize further harm to themselves and to the medical system. Because the process can result in a positive outcome for both the patient and the hospital if executed optimally, we consider it to be a “therapeutic discharge.” Here, we outline key issues for psychiatrists tasked with discharging deceptive patients from medical and psychiatric units. These issues include justification of therapeutic discharge in the abstract, when it is indicated, how to carry it out,

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what to anticipate in dealing with the aftermath, and how to educate trainees about this process.

2. Justification

On its face, discharging a patient against his will, or in the face of a threat from the patient, may seem unkind or even sadistic. The deceptive behavior, while misdirected and maladaptive, undoubtedly signals distress after all. To fully appreciate why discharge is justified, we must first examine the consequences of keeping the patient. Beauchamp and Childress's [7] framework provides guidance for this decision using the ethical principles of justice and nonmaleficence. Admission to a hospital bed is, in many hospitals, a zero sum game; a hospital bed taken unnecessarily is another patient's treatment deferred. In this situation, a fairness interpretation of justice dictates that the patient genuinely in need of treatment should be in position to receive it [8]. Continuing to hospitalize a patient with feigned illness (beyond the care necessitated by the manufactured yet truly present disease states [e.g., self-induced sepsis] of severe factitious disorder presentations) implicates the physician as an unwitting collaborator with the patient against justice. Some may object to this formulation and characterize it as the extension of the physician-patient relationship into consideration of population-level concerns. Aside from this being a debatable point, we suggest first that there is a proper place for some of the latter concerns in clinical medicine [9], and second that a deceptive patient places the physician-patient relationship into an ethical context unlike that usually upheld in the ideals of "Hippocratic" medicine.

When a patient's deception is uncovered, the physician is immediately placed in the position of choosing whether to reinforce the patient's behavior. Continued hospitalization reinforces the patient's maladaptive illness behaviors and thereby encourages successive instances of feigned illness. The patient is harmed because primitive, unproductive coping strategies are promoted over adaptive, productive approaches to dealing with perceived stress. Continued hospitalization also places the patient in a position to worsen their condition, through their own efforts or via iatrogenic action. Patients, unaware that providers recognize their deception, but perhaps aware that something is amiss, may escalate their expressions and/or manifestations of illness in order to continue presenting a compelling case for hospitalization. Despite recognizing an element of feigning behavior, physicians may also feel compelled to continue the medical workup in order to justify keeping the patient in the hospital, and to put off the anxiety-producing alternative. Thus, multiple subtle forms of harm are enacted but superficially masked by the fact that the patient remains unperturbed. Nonmaleficence is violated by a false equating of conflict with harm.

Importantly, having a formal policy and procedure for dealing with deceptive patients reduces the possibility of the overall hospital reinforcing the behavior through variable ratio reinforcement (e.g., a slot machine), in which some physicians choose to discharge the patient when deception is detected and others continue hospitalization. This does not, unfortunately, eliminate the reinforcement that comes from a patient going to different healthcare facilities (peregrination) [10] that lack access to records indicating a history of deception.

3. Indications

The therapeutic discharge is, like any medical intervention, predicated on an accurate diagnosis. In this case, one must be confident that the patient has factitious disorder or malingering behaviors, as these entities remain diagnoses of exclusion. Clues to deception include a pattern of maladaptive coping strategies, overfamiliarity with hospital staff, multiple allergies listed (with allergy lists often constructed in such a way to require the administration of specific desired agents for a given indication), and, most importantly, a history of deceptive illness [11]. Of course, the last clue is predicated upon providers' willingness to act

upon their deception concerns. Deception may be uncovered via noting of inconsistencies or implausibilities in single or across multiple interactions. Direct observation of the patient engaging in efforts to worsen his condition is obviously desirable, but may be too high a threshold to meet in routine patient care as too few of these observations are obtainable, unbiased, and uncontested.

The main contraindication to a therapeutic discharge is the necessity of inpatient medical care despite evidence of deception. Such is usually the case in induced disease states in factitious disorder. In these cases, patients should receive necessary medical care under strict supervision to limit any further patient manipulation of the situation. It should be noted that the level of suspicion that warrants added supervision (e.g., a 1:1 observer) is lower than that needed to make a definitive diagnosis of deception and/or enact a therapeutic discharge. Patients unknown to the hospital or larger umbrella system require adequate workup for medical or psychiatric causes of their symptoms, and rarely warrant therapeutic discharge on their initial admission.

4. Preparation

To proceed with a therapeutic discharge, the physician must be relatively sure that the patient is engaging in deception. A thorough review of the longitudinal medical record may demonstrate repeated instances of deceptive behavior; because patients will often present to multiple institutions with the same complaint, retrieving medical records from other institutions will bolster the argument. Suspicion of deception should lead to a thorough review of the patient's presentation and labs with other physicians to confirm or refute the implausibility of the medical illness. If the patient is feigning psychological symptoms, discrepancies between the patient's description of his internal state and outward appearance should be noted, as should the sudden development of new psychological symptoms or suicidal ideation, especially around the time of discharge. Review should also occur with nurses, who are the most likely providers to notice odd behavior, e.g., the patient spending prolonged amounts of time in the bathroom or having excessive numbers of visitors. Physicians should attempt to obtain the same information using different questions at different times to reveal inconsistencies. Of course, since patients under this kind of suspicion are more likely to be disliked to start with, one must be careful not to overly scrutinize their behavior or to too easily cast it in a nefarious light. Better to be a good doctor than a bad detective.

Until a definitive decision is made to discharge the patient, all physicians and staff should maintain their usual interactions. If the physicians show their hand prior to the discharge, the patient may "up the ante" by making threats or accusations, generating new medical complaints, or by actually harming himself, requiring further medical evaluation and care. A safety assessment should be done prior to the time of discharge, as statements the patient makes (e.g., indicating future orientation) may reveal a lack of danger that will neutralize provocative statements the patient makes at the time of the discharge. As in all interviews up to this point, the interviewer would be well advised to leave direct questioning about the hospitalization-requiring complaint for the end of the interview, and leave room (via open-ended questions, indirectly associated conversation, etc.) for contradictory statements to emerge in earlier stages. Above all, the feigned illness should be treated seriously throughout the hospitalization.

5. Discharge [see Fig. 1]

Once a final decision for therapeutic discharge is made, medical and nursing staff must prepare for the discharge. The patient's belongings should be packed in advance, to the extent that is possible; otherwise, the patient should pack his own belongings under the supervision of security once the discharge conversation is finished. Prescriptions and any orders required for discharge should be written in advance and all discharge paperwork should be printed and ready with the nurse.

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