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Ethics, Malingering, and a Lie-Detector at the Bedside*

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ABSTRACT: A psychiatric consultation is presented in which the physician uses a cardiac monitor in the manner of a lie-detector. Ethical analysis of a clinician's duties in cases of suspected malingering addresses both the standard of informed consent necessary for such assessments and the potential forensic consequences of unanticipated clinical findings.

KEYWORDS: forensic science, forensic psychiatry, ethics, malingering, lie detector

The Case

Ms. Smith was a young woman in serious legal trouble. As she recuperated in her hospital bed from the bumps and bruises of a car chase with police, she was accused of fleeing the scene of a felony and running down two police officers with the getaway car. The medical team had completed its overnight observation and the officers guarding her door were eager for her to be returned to their custody. As Ms. Smith's discharge approached, however, she lapsed into brief periods of unresponsiveness, apparently unaware of her surroundings and appearing almost as if she were asleep. These periods occurred without warning, lasted indeterminate amounts of time, and left her with no apparent memory for what had happened. In fact, her memory began to dull as the episodes multiplied until she became uncertain of all events surrounding her arrest.

The medical team's response was comprehensive. Cardiac and oxygenation monitors were put in place, scans and tests were run, and specialty consultations obtained. Ms. Smith was observed by cardiologists and neurologists during her unresponsiveness and kept under close observation throughout the day. Despite the medical onslaught, however, no clues could be found to the mysterious condition of this otherwise healthy young patient. The suspicion that Ms. Smith's symptoms were fabricated began to gain momentum and psychiatric consultation was requested to rule out malingering.

The psychiatric consultant on duty took the call with interest. Malingering is rarely seen in large medical centers and even more rarely proven. The diagnosis of malingering requires identifying the ''intentional production of grossly exaggerated symptoms motivated by external incentives (1)'' and essentially requires making the patient out to be a liar. The need for evidence and detective work often outside a physician's reach or training makes malingering difficult to substantiate. Furthermore, even the suspicion of malingering deforms the clinical relationship. The collaborative nature of the clinical interaction is put in jeopardy since the patient cannot be relied upon in the usual manner for a truthful description of symptoms. At some level, Ms. Smith and the psychiatric consultant would be at odds within the medical consultation.

When the consultant arrived on the ward, Ms. Smith was again unresponsive. ''She's faking, doc,'' an orderly offered helpfully. As the psychiatrist reviewed the medical record he noted two contact persons identified by Ms. Smith who could provide historical information to flesh out her story, now limited by her unresponsive episodes and amnesia. Both her father and psychiatrist were available to describe her past. Ms. Smith, it became clear, had led a turbulent life, seeking psychiatric treatment for help with relationships, adjustment to new working conditions, and other problems of living. But there had been no psychotic elements, prior amnestic episodes, or medical problems such as seizure disorder that might predispose her to her current condition. With this information the consultant was ready to interview the patient.

Ms. Smith was now awake, lying in bed, and reading with apparent disbelief the news stories of her alleged offenses. She described her failed memory with feeling, and complained of a persistent voice in her head that caused her considerable distress. The voice was new, she said; it told her to do bad things. As the interview progressed the consultant became aware of a soft, intermittent beeping that corresponded with Ms. Smith's cardiac alarm. The alarm, intended to monitor her heart rate and rhythm, had been triggered by her rising heart rate. The consultant paid little attention at first, but eventually noticed an emerging pattern. With responses that were clearly at odds with the history and symptoms described by her father and psychiatrist, the cardiac alarm would sound. With description of her new memory deficits and the voice in her head (a symptom previously unknown to her psychiatrist) her heart rate soared. It was conceivable the alarm was detecting her distress at developing new symptoms or the concern over returning to jail, but in further discussion of the implications for treatment or of the charges against her, the alarm was silent. Ms. Smith had apparently been attached to a make-shift lie-detector. The term ''lie-detector'' is used broadly here to describe an instrument assessing changes in physiologic variables often associated with lying. Whether this particular instrument can or should be used to detect lying will be addressed in the forthcoming analysis.

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The cardiac alarm responded similarly in another interview with a second psychiatrist: only uncorroborated statements of symptoms that might be considered exculpatory elicited a jump in heart rate. Neither his colleague nor the consultant mentioned their observations to Ms. Smith at the time. Over all, the clinical findings consisted of an otherwise intact mental state and symptoms inconsistent with known amnestic and psychotic disorders. Moreover, gaze aversion, response latency, vagueness, and other signs often indicative of prevarication attended the discussion of her new symptoms. The seriousness of her legal situation and her pending return to police custody provided the recognizable ''external incentives'' for her behavior. As a result malingering became the primary diagnosis and likely etiology of Ms. Smith's condition.

Ethical Analysis

Among the questions raised by this case is whether it was ethical to use a clinical instrument as a lie-detector. The heart monitor was initially in place for entirely clinical reasons: had its use by a psychiatric consultant crossed a certain line into forensic practice that was potentially problematic? Was the clinical relationship sufficiently altered by the criminal situation as to require higher standards of informed consent? Should the patient have been warned once it became clear there was a correlation between her responses and the heart monitor? Should the monitor even have been considered to possess the capabilities of a lie-detector?

Common approaches to such questions take either a duty-based perspective or a consequentialist one (2–4). The duty-based (or deontologic) approach asks ''to whom is the duty owed?'' and analyzes the ethical problem in light of the response. Deontologists hold that relationships between individuals can determine right conduct. They also argue that properties inherent to certain actions determine their ethical nature. Both elements of a deontologic approach will be useful in explicating this case. The consequentialist (or utilitarian) approach analyzes dilemmas by assessing the potential outcomes. The greatest balance of good over ill (i.e., the principle of utility) is considered the driving force behind utilitarian analyses. Deontologic and consequentialist approaches will be taken in turn to tease apart the ethical requirements of Ms. Smith's case. The argumentation is offered as one ethically permissible approach to a case that permits analysis by other constructs that may weigh relevant principles differently.

Deontologic Concerns—The Duty to the Patient and to the Treatment Team

The primacy of physicians' duty toward their patients is the benchmark of modern medical ethics. The collaborative nature of ideal medical care is grounded in the principle of respect for persons—a principle that honors the patient's value system in coming to treatment decisions (5–6). Based in theories of autonomy, specifically that right action requires actors capable of self-determination, respect for persons requires that the patient's weighing of risks and benefits drive physicians' actions and advocacy for the patient's choice. The doctrine that puts respect for persons into action is consequently informed consent. Consent to medical treatment, including even the simplest tests, must generally be given under conditions permitting voluntary action, choice among alternatives, and information about those choices, thus honoring patient autonomy. In usual clinical circumstances, respect for patients requires treating them as competent, informed, and autonomous decision-makers. Does this evident and strong duty not apply in Ms. Smith's case? Perhaps not completely. There are two elements of the case that may weaken the physician's duty and alter a primarily patient-centered approach.

First is the specter of malingering. Rather than participating in a collaborative exploration of symptoms, physicians are thrust into an investigative role that casts a skeptical eye on the patient's self-report. The doctors must look for ulterior motives and restrain the advocacy usually shown to patients in their care. The duty to the patient, therefore, depends to some degree on the context of the interaction—usually an implicit contract for care between patient and care-giver. When the patient malingers, however, the contract is violated and the context changes. In cases such as Ms. Smith's, where the motivation to malinger can range from avoiding time in the lock-up to testing out a potential legal defense, the physician takes a somewhat different approach.

The clinical interview to assess malingering provides an illustration of how the altered clinical relationship may work. Instead of asking specifically whether a patient hears voices in her head, for example, one may ask about ''unusual experiences'' without offering clues as to what usually constitutes a recognized symptom. Open-ended questions that do not offer the patient classic descriptors of a particular illness or easy answers to choose from become useful. The physician may even ask unrelated or nonsensical questions to assess whether symptoms are truly part of a recognized syndrome. Furthermore, information from collateral sources is critical. Collateral information can be part of a reserve against which to compare the patient's responses. This is not so much in the nature of a set-up—the patient is given an opportunity to rebut the other sources—as it is an attempt to assure the accuracy of patient-physician communications. Indeed, clinicians in various clinical contexts use such techniques to pinpoint diagnoses and assess patients' descriptive capacities or insight. But with malingering in the picture these techniques are motivated by concerns that alter the interaction and distance the physician from the patient.

A second factor influencing the physician's duty is the nature of the consultant's role. Although the physician is still obliged to offer good care in a responsible, ethical fashion, care is offered indirectly. Recommendations are made to the primary treaters who apply them in the manner most befitting their care of the patient. The consultant, therefore, is again one step removed from the patient. In fact, it can be argued in this case that the consultant's primary duty is to assist the medical team in its diagnosis and treatment of Ms. Smith. If she is attempting to pull the wool over their eyes, the consultant's techniques and findings cannot be tempered by a misplaced concern for her hidden agenda.

How might these two factors, the suspicion of malingering and the consultant's role, affect the application of respect for persons and informed consent in Ms. Smith's case? The right of patients to decide what is to be done with their bodies (i.e., their autonomy) and their vulnerability in the patient role still requires strict attention to informed consent. Patients are protected from coercion and misrepresentation by these ethics so that even if they do not maintain their part of the bargain, they are not abandoned to an all-out search for answers and concomitant abuses of their autonomy. The physician remains in a medical role, despite the antagonistic flavor. In the medical role, therefore, the usual ethical principles apply. But do they apply with the same force? How and when should the patient have been warned about the cardiac alarm?

It can be argued that the suspicion of malingering justifies a somewhat lower standard of information disclosure. The physician need not adhere to standards ruling a collaboration when it becomes clear the patient is not there to collaborate. The usual standards

of informed consent exist for those involved in the collaborative contract, not for those taking advantage of its ideals. If the patient has violated the contract by deliberately misleading the physician (or is suspected of doing so) the physician need not inform the patient of the specific purpose of questions or tests designed to diagnose the deception. This is not to nullify requirements for informed consent under these circumstances, but to suggest that the consent standard may reasonably be adjusted when simple clinical techniques yield information the patient might otherwise wish to conceal. Even under normal circumstances clinicians do not warn patients that their techniques may subtly elicit information useful in a variety of ways—it should not be necessary here. Furthermore, the information was not being used against the patient in a punitive fashion or as part of a criminal investigation. Such formal forensic investigations would certainly require altered standards (i.e., protection from self-incrimination, availability of an attorney) to protect the subject from abuses of state power, but with the intent being to overcome a dissembling patient in a clinical context, wholesale changes in informed consent are not required.

The primacy of the duty to the medical team may also support a lower standard of information disclosure in this case. Since the alarm was providing information to answer the team's clinical questions, the information to the patient might justifiably be delayed. Warning Ms. Smith early on may have put her on guard and vitiated a great deal of related clinical data. To satisfy the need for an accurate diagnosis of malingering as well as the requirements of informed consent, Ms. Smith may be offered an opportunity to respond to the clinical observations, but only after the hypothesis of malingering has been formed and tested. Moreover, she was certainly aware that her symptoms would be investigated clinically to the fullest extent possible. In that sense an implied consent already existed.

Deontologic Concerns—The Nature of the Act

Are there certain properties inherent to the act of using a cardiac monitor as a lie-detector that affect its ethics? It might be said that relying on the monitor to provide such information stretches its capabilities. Although cardiovascular activity is a seminal element of polygraphy, cardiac monitors alone are not intended or validated for such use, rendering this application scientifically problematic (7–8). Nor are there reports in the general clinical literature applying cardiac monitors to suspected malingerers. The monitor, however, was not used in a vacuum, nor was it used as a formal crime-solving instrument. It was one of numerous data addressing a clinical dilemma and available from the clinical interview, clinical observations, and historical information. It could even be tested with questions asked in a controlled fashion and with a second interviewer. That the monitor responded in a manner consistent with the clinical hypothesis and with other clinical findings supports its use as an investigative clinical tool.

Might using the monitor as a lie-detector inject an inquisitorial flavor out of keeping with the clinical interaction? Certainly the emotional valence of the relationship changes as the consultant begins to use a clinical instrument in the manner of a police investigator. Its use conjures the image of physician as agent of the state, but as noted previously this concern can be mitigated by focusing on the needs of the medical team and assuring that the information is used for medical purposes. Moreover, the forensic flavor arising from the police presence, the pendency of criminal charges, and the suspicion of malingering was introduced well before the consultant noticed the monitor's relationship to the patient's responses. As long as the bounds of the clinical focus are maintained, the act retains its ethical standing.

Consequentialist Concerns—Consequences for the Patient

What might be the consequences of incorporating the cardiac alarm observations into the medical record as part of the assessment of malingering? Dangers to the patient may arise if she were testing a potential legal strategy by claiming amnesia or insanity. The voice in Ms. Smith's head may be invoked as evidence of psychosis, the potential foundation of an insanity defense. Amnesia would be relevant to Ms. Smith's competence to stand trial, specifically her ability to assist her attorney in reconstructing events around the time of the alleged crime as well in recollecting an alibi. Confidential information in the record would likely be discoverable if the patient then made an issue of her mental state at trial. The discovery that she may be a good subject for a true polygraph test, or the interpretation that she had actually undergone a true test, could undermine her defense. In fact there were a number of observations that may be as harmful. The observations that her symptoms did not fit any known clinical entities and that she offered new clinical information under the threat of prosecution would certainly not be helpful to her. Consequently, the observations from the cardiac monitor could be just as harmful as other normally reportable findings from the clinical interview. Placing these observations together in the record would appear ethically equivalent as long as the monitor data were described in clinical terms. If the ''lie-detector'' observations were described as supportive of other evidence of malingering and included with the appropriate qualifications, they would be as ethical as any valid clinical data.

Should the dangers of legal discovery consequently concern the medical team? Can the medical team and its consultants behave as if future legal strategies were at issue? Clearly this would take the medical practitioners far afield from their clinical role of diagnosis and treatment. They would be required to consider potential future behaviors unrelated to present health concerns and of uncertain likelihood. Although a forensic flavor has been introduced by the circumstances of the case, the physicians here are not agents of the government endowed with responsibility for solving a crime. Their investigative behaviors are in the service of diagnosing a clinical condition, not participating in the legal process. Should the patient herself make the medical findings relevant to ensuing legal action, the medical team does not bear the responsibility for the potentially damaging effects. Effects on her criminal case would be unintended consequences of a clinical inquiry and require that the patient herself raise the issue of her state of mind. The patient's need to develop a legal defense, therefore, is at a significant logical and ethical distance from the clinical question at hand. By extension, to require the medical team to protect the development of a fraudulent defense, is a stark absurdity.

These arguments would be weakened if the medical team and its consultants overstepped the bounds set to govern their own behavior. Had they placed the monitor with the intent of catching a lie and misrepresented its purpose, the requirements of informed consent would be violated and the action rendered unethical. If the stakes had been higher it is conceivable this might be permissible, but under the circumstances it would be difficult to justify. The findings in this case were serendipitous and motivated by legitimate clinical concerns both at the outset and subsequently.

That the diagnosis of malingering might speed the patient's return to police custody would be ethically relevant only if the

medical team had special exculpatory information exonorating Ms. Smith or if an oppressive political regime were misusing police power. Otherwise, medical practitioners step out of role in interfering with legitimate state interests.

Had the information been shared with police or state investigators, the role-specific duties of the health-care provider would have been similarly violated. The line would have been crossed between medical professional answerable to a clinical process and forensic agent answerable to the legal system. Neither violation occurred here rendering the clinical findings and their use acceptable despite the unique distractions of the case.

Consequentialist Concerns—Consequences for the Treatment Team

What if the case became sensationalized, broke as a major news story, and led the eleven o'clock news? It might become known that physicians used clinical tools to test whether patients lied to them. Might this knowledge generalize in a harmful fashion and undermine trust in medical professionals? The uniqueness of a clinical malingering investigation provides some guidance here. It is hard to imagine that most patients would misunderstand the requirements of such a case; after all, patients in the usual clinical relationship bring real health problems to their doctors, not fabrications. The patient's report is a crucial starting point for making the diagnostic and treatment efforts that characterize the physician's part of the bargain. If there can be no assurances that these efforts are based on truthful information, the integrity of an important process is called into question for all participants. Attempts to malinger consequently cannot be given the same ethical standing lest the consequences be far worse for a far greater number. Physicians could make a strong case to their patients for using a lower standard of informed consent in making such diagnoses. Otherwise, an important social mechanism—the physician-patient relationship—would be undermined.

Epilogue

Ms. Smith ultimately pled guilty to a series of felonies, including assault and battery with a dangerous weapon on police officers, and was sentenced to a minimum prison term of ten years. She did not raise the issues of amnesia or insanity at her court appearances. The consultant ultimately used the observations from the cardiac monitor in support of his diagnosis of malingering, having informed Ms. Smith of his observations and finding that she could offer no clarification for the apparent inconsistencies in her report. Discussion of the duty owed to her and of the potential consequences of the consultant's actions followed the analysis presented here. The medical team and its consultants were satisfied that maintaining a clinical focus, restricting the information to the usual medical archive, and adjusting their application of informed consent to a level compatible with diagnosing malingering was in keeping with their ethics as clinicians.

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