Overstating the Prevalence of Symptom Exaggeration in Workers’ Compensation Cases

To the Editor:

In the December 2007 issue of the *Journal of Hand Surgery*, Ghori and Chung\(^1\) stated that “it is estimated that 30% to 40% of federal workers’ compensation (WC) claims are exaggerated.” We are not aware of any literature on which such a sweeping and provocative statement could reasonably be based (and to the contrary, there is a large body of literature supporting the reluctance of workers to report injuries and file WC claims\(^2\)–\(^5\)). There is little if any credible research addressing rates of feigned or exaggerated symptoms in the WC population that is generalizable to the universe of WC claims or to the federal subset. The authors support this statement with a single reference to a study of traumatic brain injury patients that suggested that exaggeration was more prevalent in federal than in state systems.\(^6\) That study in turn cited yet another study as estimating a 30% to 40% base rate of malingering in traumatic brain injury patients.\(^7\) That “base rate” study was a survey of 131 of the 388 members of the American Board of Clinical Neuropsychology and reports a 30% to 33% prevalence rate of symptom exaggeration and malingering among disability and WC cases for all injury types. However, it is highly unlikely that patients referred to neuropsychologists are representative of WC claimants in general. In addition, the survey requested neuropsychologists’ own estimates of the percentage of their cases involving “probable symptom exaggeration or malingering” and required no standardized chart review, identified patient sample, or gold standard.

It appears that Ghori and Chung are referring to patients with accepted work-related injuries but who are experiencing slow rehabilitation (and we would hope it is not being suggested that workers are commonly incurring traumatic injuries in order to collect partial and often inadequate wage replacement\(^8\)–\(^9\)). In that context, the statement by Ghori and Chung that “true patients” must be distinguished from “malingers” (p. 1641) should give us pause. Any patient they evaluate and for whom they are willing to bill the WC system is a “true patient,” and one to whom they owe a clinical duty. It has been noted repeatedly that the adversarial nature of the WC system provides an environment in which patients must continually prove they are not well (in contrast with what we would expect of effective health care), which is likely to contribute to extended delays in return to work for a variety of reasons.\(^10\)\(^,\)\(^11\) Focusing on the detection of exaggerated symptoms will not eliminate the costs of delayed return to work or reduce costs due to litigation and conflict. This is not to say that the tests described by Ghori and Chung have no utility, but effectively decreasing WC system costs will depend on comprehensive initiatives to assist workers in returning to work (2 such programs piloted in Quebec and Washington State have shown encouraging early results).\(^12\)\(^,\)\(^13\)

It is critically important to avoid making unsubstantiated and misleading statements that may serve to perpetuate and reinforce adversarial provider-patient relationships and biased views toward certain patients.\(^14\)

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REFERENCES

In Reply:

We would like to thank Sears et al. for their comments regarding our study “A Decision-Analysis Model to Diagnose Feigned Hand Weakness.” Their comments will help us clarify the intent of our study and in doing so we will demonstrate that our fundamental goals are similar. First, we will address 3 important points that were brought up regarding our article, and then we will discuss how our study may serve as an important component within the type of reform suggested by Sears et al.

1. “There is little if any credible research addressing rates of feigned or exaggerated symptoms in the WC [workers’ compensation] population that is generalizable to the universe of WC claims or to the federal subset.”

We agree that it may be challenging to precisely estimate the true prevalence of malingering within the WC system. However, there is a large body of literature that unequivocally shows compensation status is correlated with poorer clinical outcome. In fact, a meta-analysis published in the Journal of the American Medical Association states that “compensation status is associated with poor outcome after surgery. This effect is significant, clinically important, and consistent.” Specifically, data from 129 studies covering 20,498 patients found the odds ratio of an unsatisfactory outcome in compensated patients to be 3.79 (95% confidence interval, 3.28-4.37). There is another body of literature demonstrating that compensation status is correlated with higher costs of providing medical care and longer periods of recovery. Furthermore, there is evidence that shows higher WC benefit results in more benefit claims. For example, after a “rigorous synthesis of the best available theory and empirical evidence on the effect of wage-replacement benefits on the incidence and duration of claims under WC programs,” John D. Loeser, MD, of the University of Washington (Seattle, WA), concludes that “the extant economic studies imply a positive relationship between the level of wage replacement and both the incidence and the duration of WC disability claims.” Specifically, this study estimates that increasing claim benefits by 10% correlates with a 1% to 11% increase in the frequency of WC claims and a 2% to 11% increase in duration per claim. Based on this extensive body of literature, our statement that feigned hand weakness is an important problem can hardly be characterized as “unsubstantiated and misleading.”

Regardless, the intent of our study was not to perform the monumental task of quantifying the exact statistics of malingering within the WC system or to make “unsubstantiated and misleading” claims. Instead, the specific purpose of our article was to “review the current literature on diagnosing feigned hand weakness and propose an efficient diagnostic scheme,” which may be useful to physicians when clinical judgment suggests malingering.

In stating that physicians have a responsibility to detect malingering so that our limited resources can be allocated to patients who truly need them, we certainly were not trying to “reinforce adversarial provider-patient relationships and biased views toward certain patients.” In contrast, we want to ensure that physicians do not jump to the conclusion of feigned hand weakness based on subjective clinical suspicion alone. Our proposed comprehensive diagnostic scheme will help physicians when there is subjective clinical suspicion to follow up with objective tests. It seems quite obvious to us that introducing objectivity to a diagnosis that is largely subjective should undo any existing biases that individual physicians may hold toward “certain patients.”