

A Cautionary Lesson from Simulated Patients

Gerald M. Rosen, PhD, and William R. Phillips, MD, MPH

J Am Acad Psychiatry Law 32:132–3, 2004

Ekman and O'Sullivan¹ once asked, "Who can catch a liar?"—and they demonstrated that it was not mental health clinicians. As observed by Slovenko, "A good poker player probably knows better than a mental health professional whether or not a person is lying. A psychiatrist is a doctor, not a lie-detector" (Ref. 2, p 122). Six actors recently provided a dramatic demonstration of these concerns when they feigned the symptoms of Posttraumatic Stress Disorder (PTSD) at a clinic specializing in the assessment and treatment of that disorder; all were accepted as genuine.³

An extensive body of literature, heretofore ignored by mental health and medicolegal experts, further documents the inability of health professionals to identify individuals who feign disorders. These studies test physicians with "simulated patients"—normal persons trained to mimic the typical signs and symptoms of common disorders. This use of pseudopatients has its origins in the 1960s, when standardized clinical vignettes were developed to teach and test clinical skills in medical trainees.⁴ Over time, the method was extended to assess physicians in community practice and health organizations.⁵

In a search of the medical literature, we identified 12 studies in which (1) normal persons presented significant clinical complaints as simulated patients (SPs), and (2) physicians were provided with a mechanism to report patients suspected to be simulators.^{6–17} In all 12 studies, doctors detected simulators at low rates, ranging from 0 percent to 25 percent. Most studies simply reported the percentage of simulators whom physicians correctly identified,

but Gordon *et al.*⁸ provided additional and important data. These authors recruited 54 interns and trained six SPs to feign one of three clinical problems (urinary frequency, cough, and headache). A total of 233 SP cases resulted, of which only 22 (9.4%) were correctly identified by physicians as "definitely" not genuine. When the standard of judgment or level of confidence was reduced from "definite" to "probable," the number of correctly identified simulators increased to 56 (24.0%). Physicians also had 477 consultations with genuine patients and incorrectly labeled 10 (2.3%) as simulators when making "definite" judgments. When the standard of confidence was lowered to "probable," the rate of false positives increased; 45 (9.4%) genuine patients were misidentified as simulators.

It might be argued that studies using SPs overestimate the likelihood that physicians can be fooled, since clinicians are denied the additional information that may result from repeated visits and an ongoing relationship. However, no studies demonstrate that these factors improve physicians' detection of feigned disorders. Further, malingerers can be consistent when misreporting,¹⁸ and lie detection is not necessarily more accurate in ongoing relationships.¹⁹

Findings on simulated patients and the general literature on lie detection demonstrate that clinicians are not skilled in judging the credibility of their patients. In the context of a physician-patient relationship, in which a working alliance must be developed, there are good reasons to accept subjective complaints at face value. In the context of legal proceedings, however, physicians should be more circumspect. Testimony should be based on objective findings and the awareness that we all can be fooled. Treating physicians bear special responsibility, since their testimony can create "echo attributions,"

Dr. Rosen is Clinical Professor, Department of Psychology, and Dr. Phillips is Clinical Professor, Department of Family Medicine, University of Washington, Seattle, WA. Address correspondence to: Gerald M. Rosen, PhD, 2825 Eastlake Center, Suite 205, Seattle, WA 98102. E-mail: grosen@u.washington.edu

wherein a false perception of validity attaches to a message delivered by a prestigious source.²⁰ The problem can be illustrated by the patient who reports a subjective symptom like “nightmares,” after which the doctor testifies in court that “the patient suffers from nightmares.” Such a declaration, untempered by the evidence from SP studies, creates a false sense of certainty. Clinicians who rely on their patient’s reports are advised to state the subjective and objective findings and offer their professional assessment. When questioned about the actual occurrence of subjective symptoms, or the truthfulness of a patient’s report, the wise clinician would do well to be less than certain.

References

- Ekman P, O’Sullivan M: Who can catch a liar? *Am Psychol* 46: 913–20, 1991
- Slovenko R: *Psychiatry in Law/Law in Psychiatry*. New York: Brunner-Routledge, 2002
- Hickling EJ, Blanchard EB, Mundy E, *et al*: Detection of malingering MVA related posttraumatic stress disorder: an investigation of the ability to detect professional actors by experienced clinicians, psychological tests, and psychophysiological assessment. *J Forensic Psychol Pract* 2:33–54, 2002
- Barrows HS: *Simulated Patients: The Development and Use of a New Tool in Medical Education*. Springfield, IL: Charles C Thomas, 1971
- Beullens J, Rethans JJ, Goedhuys J, *et al*: The use of standardized patients in research in general practice. *Fam Pract* 14:58–62, 1997
- Burri A, McCaughan K, Barrows H: The feasibility of using the simulated patient as a means to evaluate clinical competence of practicing physicians in a community (a pilot project). *Annu Conf Res Med Ed* 15:295–9, 1976
- Carney PA, Eliassen S, Wolford GL, *et al*: How physician communication influences recognition of depression in primary care. *J Fam Pract* 48:958–64, 1999
- Gordon J, Sanson-Fisher R, Saunders NA: Identification of simulated patients by interns in a casualty setting. *Med Educ* 22: 533–8, 1988
- Kopelow ML, Schnabl GK, Hassard TH, *et al*: Assessment of performance in the office setting with standardized patients: assessing practicing physicians in two settings using standardized patients. *Acad Med* 67(suppl):S19–21, 1992
- McLeod PJ, Tamblyn RM, Gayton D, *et al*: Use of standardized patients to assess between-physician variations in resource utilization. *JAMA* 278:1164–8, 1997
- Norman GR, Neufeld VR, Walsh A, *et al*: Measuring physicians’ performances by using simulated patients. *J Med Educ* 60:925–34, 1985
- O’Hagen JJ, Davies LJ, Pears RK: The use of simulated patients in the assessment of actual clinical performance in general practice. *NZ Med J* 99:948–51, 1986
- Owen A, Winkler R: General practitioners and psychosocial problems: an evaluation using pseudopatients. *Med J Aust* 2:393–8, 1974
- Peabody JW, Luck J, Glassman P, *et al*: Comparison of vignettes, standardized patients, and chart abstraction: a prospective validation study of 3 methods for measuring quality. *JAMA* 283:1715–22, 2000
- Rethans J-J, Drop R, Sturmans F, *et al*: A method for introducing standardized (simulated) patients into general practice consultations. *Br J Gen Pract* 41:94–6, 1991
- Rethans J-J, Saebu L: Do general practitioners act consistently in real practice when they meet the same patient twice?: examination of intradoctor variation using standardised (simulated) patients. *BMJ* 314:1170–3, 1997
- Woodward CA, McConvey GA, Neufeld V, *et al*: Measurement of physician performance by standardized patients. *Med Care* 23:1019–27, 1985
- Wetter MW, Deitsch SE: Faking specific disorders and temporal response consistency on the MMPI-2. *Psychol Assess* 8:39–47, 1996
- Swann WB Jr, Silvera DH, Proske CU: On “knowing your partner”: dangerous illusions in the age of AIDS? *Pers Relationships* 2:173–86, 1997
- Rosen GM: Malingering and the PTSD Database, in *Posttraumatic Stress Disorder: Issues and Controversies*. Edited by Rosen GM. Chichester, UK: John Wiley & Sons, in press