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Paternalism and factitious disorder: medical treatment in illness deception

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Abstract

The primary aims are to consider whether a range of paternalistic medical interventions can be justified in the treatment of factitious disorder (FD) and to show that the particularities of FD and its management make it an ideal phenomenon to highlight the difficulties of balancing respect for self-determination, responsibility and duty of care in psychiatry. FD is usually classified as a mental disorder involving deliberate and hidden feigning or inducement of illness, in order to achieve patient status. Both the nature of the disorder and the approach to treatment are controversial and under-researched. It is argued that FD should be classified as a mental disorder; may well expose the patient to extreme risk; can warrant paternalistic interventions, in order to fulfil duty of care. Moreover, treatment of FD is inherently paternalistic and therefore raises interesting questions about justifications and type of paternalistic interventions in psychiatry both for FD and in general. A brief account of key questions concerning psychiatry and paternalism is followed by some case histories of FD, the clinical dilemmas posed and the question of how this disorder might warrant paternalistic interventions. In order to answer this question, two things are considered: the legitimacy and character of FD as a mental disorder; possible frameworks for and types of paternalistic interventions. To conclude, it is argued that there are no compelling reasons for rejecting the use of paternalistic interventions for FD, but that further investigation of FD and type and frameworks for psychiatric paternalism, in relation to FD and other mental disorders, are urgently needed.

Introduction – background and dilemmas

Psychiatry, paternalism and self-determination

The morality of paternalism within psychiatry remains one of the most controversial areas within medical ethics. Even so, mental health law, both in the UK and elsewhere, reflects the accepted view, based on clinical practice, that there are instances when an individual's insight is affected by their condition to such an extent that they are incapable of acting in their own best interests in relation to treatment. There is a statutory provision for surrogate decision making and, subject to assessment, clinicians may fulfil their duty of care towards an individual with interventions, which do not accord with that individual's current intentions and preferences.

Some call for changes to mental health law, which would consider loss of mental capacity regardless of a psychiatric diagnosis and remove what can be seen as discriminatory disorder-based laws [1]. Debate has intensified recently following the UNCRPD 2006, widely understood as a prohibition of substitute decision making in the care of persons with disabilities. Proposed instead is a model of 'supported decision making' and societal obligation to provide for such support [2].[1] Yet, although the CRPD's championing of self-determination and autonomy is generally welcomed, there are major concerns, particularly within mental health care, that it fails to recognize the difficulties presented by patients with severe mental disorder, whose resistance to treatment often is expressed very clearly, is symptomatic of the illness itself and indicative of loss of insight, brings extremely deleterious consequences for the patient themselves if their will is respected and they remain at liberty and untreated. Even the CRPD's staunchest advocates recognize the possibility that, on occasion, an individual's will and preferences might be so affected by their condition

[1] Even the 'fusion' law idea is rejected on the basis of contravening the principles of autonomy [2].

that the consequences of following these present too great a risk, and the individual's wishes can be overruled, albeit with numerous safeguards [2,3].

At times, a clinician's duty of care appears to conflict with the individual's right to autonomy and self-determination, when prioritizing the latter will most probably result in serious damage for the patient. This dilemma, fraught with difficulties, rages not only within psychiatry [4], but within debates such as those surrounding euthanasia and refusal of treatment. On many occasions, a paternalistic medical intervention, which overrules patient refusal, may well prevent major and even fatal damage. This is especially relevant within psychiatry, and it would be hard to dismiss any ethical justification for intervention. As Richardson puts it, 'should we not recognise a moral obligation to allow welfare to trump self-determination in such extreme circumstances?' [3]. Many argue that one cannot understand the patient's will as a genuine example of self-determination, when insight and capacity are so impaired by illness [5].

We will explore these issues in relation to factitious disorder (FD), a psychiatric condition in which the patient deliberately feigns or induces illness or injury, often causing very serious harm to themselves and employing skilful and elaborate forms of deception to hide their actions. Even after discovery by the clinical team, the patient generally refuses to acknowledge their actions.

Many features of this disorder make it particularly interesting in relation to ethical debate surrounding paternalism within psychiatry – for example, the high level of the patient's conscious planning and deliberation; the way in which treatment concerns surround both the disorder and its consequences, insofar as the disorder itself is understood as chiefly constituted by the compulsion to procure treatment of illness through deceit, although its most serious medical consequences are generally those which result from the self-induced illnesses/injuries themselves; the usual unwillingness of the patient to accept either the diagnosis or treatment of FD. Moreover, FD is itself an enigmatic and under-researched condition [6,7], entrenched in so many conceptual and ethical difficulties that there is no broad agreement about either its nature or suitable interventions, and some go so far as to suggest that it should not be recognized as a mental disorder [8]. Our secondary aim was, in the course of exploring the paternalism dilemma, to make some suggestions about the nature of FD itself and to indicate further research questions relating to FD and its definition.

Clinical encounters with FD – some examples and dilemmas?

FD is a condition surrounded by clinical controversy, and is difficult both to diagnose and to treat. Within this paper, however, we will be focusing on those adults presenting with the more severe and persistent forms of FD, involving long illness histories and increasingly dangerous and elaborate forms of illness procurement, usually involving toxic agents or self-wounding. The best way to illustrate the typical characteristics and difficulties is to give some case history examples. These are based closely on a patients encountered by the first author[2] in clinical or legal settings.

[2] A number of key biographical details have been changed in order to maintain anonymity. However, the medical details have not been significantly altered.

A case of severe and concealed self-bleeding

A nurse, in her early 30s, was admitted to hospital for severe and worsening anaemia, which she attributed to heavy and painful menstruation. Deterioration continued, even after admission. She suggested that bleeding from the womb was the cause and received substantial gynaecological investigation. Yet, no obvious cause was revealed and medical records were requested both from Eastbourne (UK) and Australia, her previous places of residence to try to find out more.

Even before records arrived, the night staff raised concerns about frequent and lengthy visits to the lavatory. The patient would lock herself in the cubicle for long periods. She usually took a small bag, explained in terms of menstruation problems, although these visits continued. Meanwhile, senior clinicians soon became particularly worried about the anaemia, which, already serious on admission, was now reaching levels (haemoglobin 5.5) with imminent risk of heart failure. Moreover, emotionally, she seemed strangely unconcerned about this increasing risk, while demanding that she be more thoroughly investigated.

Given the risk, the team decided to carry out an unsanctioned search of the patient's belongings, without her knowledge, and found four hypodermic needles in the bag. After replacing the needles, the duty doctor later found previously unnoticed puncture marks on the patient's hand. In all likelihood, the patient was inserting the needle into her veins and bleeding herself, a process requiring significant medical expertise, and then flushing the drained blood down the lavatory.

When instructed that future toilet visits must be accompanied by a female nurse, she responded angrily that this breached her right to privacy and was told that, without observation, she would not be permitted to remain in hospital. In the presence of a nurse, a consultant psychiatrist then suggested very tactfully that she, herself, might be contributing in some way to the anaemia. Her response was exaggerated anger, including a subsequently retracted threat to discharge herself. Confronted with the needles as evidence, she vehemently denied self-infliction and again threatened to leave.

Warned about the serious risks of leaving the hospital because of the severe anaemia, her attitude changed. She agreed to stay if given blood transfusions, iron treatment and physical rehabilitation. After transfusion, her condition stabilized and haemoglobin levels normalized [9]. All attempts by hospital staff to offer insight, discuss evidence of self-bleeding or offer psychological treatment were rejected.

Her medical records revealed a complex history of patienthood, with severe medical problems in various locations spanning more than 20 years. Conditions noted included bipolar disorder, depression (both with unusual patterns), skin rash, anaemia, obesity treated with gastric bypass, unexplained findings of blood in her urine, chronic pain, opiate addiction, sudden weight loss and gain, dangerous and unexplained blood loss, reported breast change, 'fits' and headaches, with no physical cause revealed through tests. Many of these were repeated with minor variations at different locations.

A life history emerged, including severe physical and mental abuse by her father, which could not be verified, an inability to accept and trust help, and periods of working as a paramedic and nurse, which is common in FD. It appears that she used any

medical knowledge gained in order to enhance her own skills of self-injury and deception, so that her life as a patient and as a clinician ran in parallel. There was no evidence of any significant material gain from her injuries and she appeared to be a lonely individual, readily compliant with medical treatment for her various conditions and becoming less detached once engaged within a treatment situation. Although the possibility of self-induced or feigned illness and FD had been recognized and raised at a number of points in her life and help offered, even when confronted with evidence she consistently denied this possibility.

When physically ready for discharge, she still denied her actions and the staff were concerned that she would soon revert to self-injury. She refused adamantly attempts to persuade her to accept psychiatric treatment and, after discharge, was lost to follow-up. Given her history, it was extremely likely that she would continue to self-injure and seek medical help in new locations. However, in spite of the immense risks involved, having already come close to death on a number of occasions, the staff were powerless. They had already breached ethical guidelines by searching her belongings without permission. They were left to discharge her in the knowledge that, in all probability, her future would bring not only difficult and resource-intensive situations for clinicians elsewhere, but would constitute a life of pain and illness for her, in which she placed herself in enormous danger.

Similar cases

The above case is striking for the length, variety and severity of her 'career' of self-injury and illness deception. However, several aspects make it typical of severe FD and many other cases have been reported including similar risks and fabrication. In two additional cases encountered by the first author similarities emerge.

A middle-aged man attended casualty with a leg wound to the upper thigh, allegedly sustained from a fall while painting a green house. The injury was treated, an X-ray conducted to ensure no more glass was within the leg, and the patient discharged. Three weeks later, the patient returned with torn sutures, and infection. Glass was found in the wound, the patient accused the staff of negligence. After admission, he complained of abdominal pains, and an X-ray revealed the glass in the intestine. When questioned, the patient asserted that glass must have travelled from the leg wound into the abdomen, an anatomically impossible phenomenon. The glass in the intestine could only be explained by swallowing of glass and suggested a likely diagnosis of FD. This patient had a history of multiple injuries and illness, often unexplained, together with emotional abuse from his ex-wife and a complicated childhood history of physical abuse. Despite psychiatric consultations, self-harm was denied, no progress was made and he discharged himself, as soon as physically recovered and contrary to medical advice.

In another example, a female patient, once again with a very difficult childhood history, had a long medical history of joint pains and unexplained injuries. She came to hospital with knee injury and possible nerve damage, claiming to have fallen down a metal staircase, although there was no reasonable account of why she fell and no witness. After treatment with strapping, problems continued, with reports of further loss of function, restricted blood flow and nerve damage. Despite suspicions and evidence that the patient was re-strapping her knee too tightly, she denied this and blamed the team. Eventually, severe damage to the nerves and evidence of gangrene made a below knee amputation essential.

There are extensive examples in the literature, remarkable for their similarities, including the way in which illness is procured, the early histories of deprivation, the loneliness and isolation of the perpetrators and their frequent links to health care work. For example, there is Asher's seminal 1955 case history of a man with prolific haemorrhagica histrionica (FD with self-induced bleeding), who travelled to numerous hospitals, both in the UK and Europe, always reporting that he had been on his way to a monastery when he collapsed from blood loss [10]. Zahner and Muehlenburg give details of a 71-year-old medical technician, who was treated for instable angina pectoris in 29 different hospitals 38 times over 9 years, with dramatic presentation, but with no eventual evidence of coronary heart disease [11]. Savino and Fordtran discuss the difficulties presented by potentially lethal cases of FD, such as a woman with self-induced bacteraemia, an extremely dangerous condition, caused here by self-injection of bacteria grown by the patient in a carefully hidden Petri dish [7].

Savino and Fordtran also make the very important point that, 'in many cases damage to the patients from doctors' treatment exceeds the harm resulting from the patients' self-induced illness'. The risks of iatrogenic damage are a major consideration in the discovery and treatment of FD and increase the need for speedy and accurate diagnosis.

Given the FD patients' typical skills of deception and resistance to the notion of FD, one of the major ethical dilemmas facing clinicians is not just paternalistic action in the treatment and containment of the condition and its consequences, but the breach of patient privacy and accusations of dishonesty which may well be necessary in order to do so.

As these cases suggest, FD presents numerous difficulties for the clinician. Once difficulties of discovery, diagnosis and confrontation have been dealt with, there are then the clinician's concerns about the current treatment and prognosis of their patient. Doctors may well find themselves torn between the ethical principles of respect for patient autonomy or privacy, a professional duty of care to protect their patient from further harm, and a more general sense of humanity and sympathy for the patient's continuing and, apparently, unnecessary suffering.

Yet, despite the general classification of FD as a psychiatric disorder and the immense risk it may pose to the patient, current mental health law and clinical practice allows little provision for detention or compulsory treatment to safeguard FD patients. A level of lucidity and planning is held by many to indicate the absence or lack of severity of a mental disorder and the right to self-determination, meaning that the doctor has no formal right to overrule the FD patient's usual refusal to acknowledge the condition.

It appears undeniable that FD can present both extreme dangers and suffering to the affected individual, as well as major burden on medical resources. While the combination of all these factors may suggest a possibility of justified paternalistic intervention, current scope for such interventions is extremely limited, and traditionally, they are deemed far less acceptable than in the context of other psychiatric disorders, even where these involve far less severe or probable risks.

Illness deception for material gains – a further complication

FD is similar to a number of behaviours involving illness deception, most important is 'malingering' (fabricated illness for material gain) but also to somatoform disorders – in particular conversion disorder. These distinctions discussed in more detail below, are, in practice, often unclear [7]. Not only does this causes difficulties for diagnosis, but, particularly in cases of 'malingering', even if an illness is procured through self-harm for material gain, treatment may be required.

All this is becoming increasingly significant, as society moves further towards a culture of litigiousness and compensation seeking. It is now well recognized that financial incentives generally in the form of compensation dramatically alter presentations of particular conditions. A good example is whiplash after motor injuries, the incidence of which has increased dramatically, notably in those countries that offer insurance compensation for this condition, as have other accident-related conditions despite a decrease in road accidents [12]. Even here though, the correlation between compensation, injury and deception is far from straightforward [9]. When it comes to FD and associated behaviours and disorders, the risks from claims for compensation or material support are a very serious consideration, given the potential severity of the illnesses and injuries and the risk of iatrogenic damage. In one example, compensation was even sought for failure to diagnose FD and the resultant iatrogenic damage for medical treatment for the fabricated condition [7]. Such concerns add a further dimension to considerations of paternalistic interventions.

As we will discuss further below, the relationship between FD and material gains cannot be reduced to a straightforward distinction, a phenomenon that has even led some prominent researchers to doubt the very status of FD as a mental disorder [8]. For an FD patient, however, benefit and compensation processes can, apart from material gain, offer opportunities for medical and legal attention and validation, all of which may be appealing without indicating that an underlying mental disorder diagnosis is now incorrect.

What is paternalism and what issues are relevant to justifying paternalism in the treatment of FD?

Paternalism 'is the interference of a state or an individual with another person, against their will, and defended or motivated by a claim that the person interfered with will be better off or protected from harm'. The term 'paternalism' is often understood as carrying negative associations of perceived excessive or unjust interference with an individual or group's legitimate choices. However, there are also approved actions within society, which would be classified as paternalistic and it is important to understand the inherent normative neutrality of the concept itself when debating whether a particular instance of paternalism is justified [13].

FD involves the production of self-induced illness concealed by skilled deliberate deception. Thus, any attempts to discover, contain or treat the FD itself (i.e. the intent to create illness and hide the act of creating), as opposed to simply the feigned or induced illness will, in some way, be contrary to the wishes of the patient, insofar as they wish to be treated purely on the basis of this procured or feigned illness. We might say that 'the clinical diagnosis and treatment of FD is intrinsically paternalistic in a way inapplicable to other medical conditions'. For the very act of seeking diagnosis contravenes the patient's will. Consequently, clinicians are grappling with the ethics of paternalistic interventions, as soon as they consider the possibility of FD, even if these ethical complexities are not considered directly in their struggle to give the patient the best treatment.

In general, paternalistic interventions within psychiatry would be justified as examples of 'soft' rather than 'hard' paternalism, insofar as the subject's capacity for autonomous decision making is judged to be impaired by their disorder, so that any harmful actions resulting from this disorder are not classified as examples of voluntary agency. In order to justify paternalism within FD, it will therefore be necessary to explain why the self-harming actions of the FD patient can be viewed as non-voluntary or lacking control in some important respects.

Justifications for paternalistic interventions in FD

Justifications for intervening in FD, contrary to the immediate wishes of the patient, can be divided into two categories:

1 Cost to the patient. As we have seen, there is substantial risk to the individual, both from self-induced illness and from any treatments of this illness. FD may dominate an individual's life and put them in life-threatening danger.

2 Cost to others. These include costs to insurers, employers and to the state resulting from provision of medical [14], social and economic support, along with risks to health care professionals, who may face disciplinary action if FD is missed.

Strictly speaking, it is only the first category of justification, which can be seen as medical paternalism, insofar as it is based on concern for patient best interests. Nevertheless, it seems safe to assume that, if one accepts FD as a medical disorder which causes suffering to the patient, any action taken to minimize the second group of external costs will go hand-in-hand with protection of the patient themselves.[3]

Interventions for FD should only be considered as true paternalism if FD itself is recognized as a medical disorder, and patient health and well-being are the primary motivation. Any consideration of whether paternalism is justified, therefore, must first be supported by arguments to show the validity of maintaining FD's classification as a recognized mental disorder. We shall offer arguments to support upholding this classification. We can then consider more fully whether the extensive risks to the patient in severe cases of FD are a legitimate justification for paternalistic interventions, as well as the type of legal, ethical and clinical framework, which would support such interventions and the form such interventions might take.

[3] If, however, FD is classified not as a mental disorder, but as a deliberate, controlled and non-pathological pattern of behaviour, motivated by the potential material gains of illness deception, justifications for medical interventions could be considered as stemming more from the protection of others and the culpability of the FD individual themselves, an idea that has gained some currency [8,15].

Thus, FD is a fascinating context within which to explore issues pertaining to paternalism, not only because, unusually, its treatment could be considered to be intrinsically paternalistic, but also because, given the element of deception necessarily involved, the types and justificatory frameworks for paternalistic interventions, which might be considered useful, are unusually varied and complex.

FD as a mental disorder – key characteristics?

As we have stated above, the case for considering paternalistic medical interventions for FD depends on whether we classify FD itself as a medical disorder, with patient health and well-being as the primary aims of intervention. The multiple difficulties surrounding the condition especially planning, agency and deception have led many to question this classification. Before discussing the case for paternalism, therefore, it will be important to establish more clearly the dominant characteristics of FD, in order to support our claim that it merits classification as a legitimate and often serious mental disorder.

The condition is rarely diagnosed and controversial. Rather than any definitive analysis, we aim to give a sufficient account of FD on which to base an investigation of justifications for paternalism; to point out some interesting questions, which might merit further research; and, in doing so, to challenge some of the reasons given as to why FD should not be classified as a form of mental disorder [8,15].

As explained above, FD is widely recognized as a type of mental disorder within psychiatry, although it is rarely diagnosed and controversial. Its central feature is deception, known by many as 'illness deception' and it is also defined by its assumed motivations. For example, DSM-V applies a diagnosis of FD when a person 'intentionally produces, feigns or exaggerates the symptoms of a disease, illness or psychological condition', motivated by a desire to assume the 'sick role' [16]. 'Production' in this definition implies, most usually secret self-injury through mutilation or poisoning. Probably, the most serious subtype of FD, in terms of risk, is known as Munchhausen syndrome, when patients deliberately induces physical injury or illness, for example, by swallowing glass, injecting bacteria, taking powerful drugs, self-wounding or applying toxic agents to the skin or eye. This subtype is often chronic, with a 'career' that takes the protagonist to a variety of hospitals all over the country, accompanied by dramatic and false histories of misfortune [11,17].

Kozlowska categorizes FD as 'inherently social and interpersonal' because of its dependence on reaction from others and adoption of a socially recognized role. Although DSM-V suggests that there is an absence of other motivations, such as material gain, it is difficult to maintain any absolute distinction, given that illness in developed nations is so often accompanied by some type of material compensation, and this is becoming a point of increasing controversy. We would suggest, therefore, that the assumption of the sick role be seen not as exclusive, but as both primary and necessary motivation, even if other motivations may be present [7,16–18]. We argue that the combined presence of deception, illness deception and material benefit does not, as suggested by Bass and Halligan, present a reason in itself to question the overall diagnosis of FD [8,15], but simply a reason to be more vigilant about using medical records and other tools to establish patterns of behaviour and other evidence.

Diagnosis and treatment

Diagnosis of FD can present enormous difficulties to clinicians [18]. FD patients are often extremely skilled at hiding their deceit and frequently have extensive medical knowledge or training [18,19]. Suggesting and attempting to verify patient deceit is an uncomfortable process for both clinician and patient, making FD a difficult diagnosis even to consider. Such worries are also coupled with concerns that an incorrect diagnosis of FD or associated disorders may lead clinicians to overlook legitimate health conditions. In one example cited, abdominal angina was mistakenly diagnosed as psychogenic pain, resulting in the death of the patient [7].

Furthermore, diagnosis is confused by overlap of symptoms with other psychiatric and non-psychiatric health disorders or with certain non-pathological behaviour patterns, as well as the possibility of co-morbidity with conditions including personality disorders, eating and mood disorders [18,20–23]. FD is also differentiated from somatoform disorders on the basis of intent, insofar as the latter is held not to involve conscious feigning or production of illness. Nevertheless, this can be a very problematic distinction to make in practice.

Such difficulties are, however, common to psychiatric diagnosis, and the mental health professional is trained to use their clinical knowledge and experience to establish which disorder, if any, the current symptoms are primarily indicative. Bass and Halligan argue that the inability of clinicians to manage such difficulties of diagnosis constitutes one reason for rejecting the usual medical definitions of FD: 'it seems unlikely that most clinicians can reliably and consistently extricate the contributory role of deception and hence distinguish factitious disorder and malingering' [15]. However, FD is certainly not the only psychiatric condition where skilled deception plays a key role or where patients attempt to hide their true beliefs or motivations; negotiating these problems is part of the mental health professional's expertise. The above difficulties do not therefore seem a sufficient reason to dispute the validity of the condition itself, but should be seen instead as further incentives for trying to establish an enhanced understanding.

There are no definitive studies to establish successful treatments for FD. However, there are indications that, if accepted, treatment with a combination of antidepressant SSRI medication and CBT can be helpful [24], while psychotherapy alone may also have some success [25].

Extensive histories and multiple locations

Most cases of FD include lengthy histories of illness deception, often starting in childhood. Patients frequently enter employment with the medical profession. A wide variety of health problems may be reported and patients may move around frequently, in order to avoid raising suspicion about the frequency of illness or to escape from clinician situations after their behaviour has been identified and challenged. When possible, investigation often reveals childhood trauma or abuse, during which time illness,

often accompanied by deception and lying may have become a means of escape from abuse, danger or distress. Sometimes, it also appears to be triggered by trauma during adult life or, repeatedly, by a series of difficult or traumatic events [7,15,18,26].

Prevalence

Some estimates suggest that FD has a prevalence of between 0.5% and 2%, some as high as 5% although it is generally agreed that it may be likely that the number is underestimated because of the difficulties of diagnosis [7,15,18,19].

Type of illness, severity and risk

As we have seen from the case examples in the first section, FD can carry great risks for the patients and the cost of non-intervention may be high. Patients with severe FD often engage in extremely dangerous behaviour, wounding, blinding, infecting and injuring themselves, requiring risky medical treatment. FD is 'associated with substantial morbidity and mortality' [15] and there are numerous case reports of substantial damage and life-threatening injury/illness. Consequently, FD may well dominate the individual's life, confining them to a solitary and often peripatetic existence. It is important that this potential risk is fully recognized. Sadler's arguments against paternalistic interventions within FD, for example, are based on the principle that 'most of the time, factitiously ill patients represent no immediate, emergent danger to themselves or others' [27], and are called into question if these most severe cases of FD are considered.

No identifiable pattern has been found as to choice of illness, although, for example, Munchausen's and fabricated heart disease appear to be more common among men [7,11], while self-induced infections are more characteristic among women [15].

Insight and control

Despite the extreme risks involved, FD patients seem unable to stop their illness deception. Even when presented with evidence, patients rarely acknowledge that illness is either fabricated or self-induced [7,26] and will often discharge themselves, though still at risk, rather than acknowledge FD or accept help. FD patients exhibit an inability to realize and accept the discovery and evidence of their condition, together with the way in which the illness appears to drive them on continuously as a primary motivation that overrules all other aspects of life and stability and may cause huge or even fatal damage. This strongly suggests both a lack of insight and control over their condition, which does not reasonably suggest self-determination, and which would seem to support the classification of potential interventions as 'soft' paternalism. As with other aspects of FD, this phenomenon needs further research.

Challenges to the notion of FD as psychiatric disorder

Main objections to existing classification and understanding of FD as a mental disorder are based on three concerns: the difficulties of diagnosis; the overlap between FD, non-pathological illness deception and deception as a commonly used 'social skill'; the high level of conscious planning and control associated with FD behaviour [8,15,27].

As we have argued above, the multiple diagnostic difficulties associated with FD should not, in themselves, be taken as a reason to doubt its mental disorder classification. Misdiagnosis and diagnostic uncertainties, for multiple reasons, are problems across the range of psychiatric conditions, as one might expect from a health condition, which lacks testable physiological markers and relies on observed behaviour for diagnosis. Bipolar disorder, one of the most prevalent and debilitating psychiatric conditions, is notoriously difficult to diagnose, with evidence suggesting that the majority of patients will receive multiple misdiagnoses, with correct diagnosis taking 10 or more years in approximately a third of cases [28,29]. Reasons for misdiagnosis include both confusion with other mental disorders and unrecognized pathology caused by problematic overlap of symptoms with non-pathological behaviour. In another example, schizophrenia, it is well documented that even ethnicity may contribute to misdiagnosis [30]. Moreover, the diagnostic difficulties posed by symptom-based disorders are by no means exclusive to mental disorder and are associated with an increasing range of debilitating conditions like chronic pain or chronic fatigue [31,32], with as many as 80% of medico-legal claims are now for conditions that are only defined symptomatically such as back pain, whiplash and PTSD.

Although there is currently widespread debate concerning over-diagnosis of mental disorder and proliferation of new conditions [33–38], especially in cases where pathology seems questionable, difficulties surrounding diagnosis do not constitute, in themselves, a reason to reject the existence of a disorder. Similar arguments can be made concerning FD and the difficulties surrounding overlap and co-morbidity of mental disorders, which are, once again, widespread and controversial phenomena within clinical practice [39–42].

Beyond the diagnostic difficulties, it is the issues of insight, control and motivations, which have led to some of the strongest objections to the classification of FD as a psychiatric disorder, and are often found to engender negative and censorious attitudes among clinical staff. Bass and Halligan, for example, argue that deception and pathological compulsion or loss of capacity are mutually exclusive phenomena, suggesting that the loss of control/voluntariness associated with FD cannot accompany the conscious choice associated with common understanding of the phenomena of deception.

They explain that everyday usage of the term deception describes the attempt to deliberately and wilfully convince someone of events or actions that one knows not to be true. This involves several high cognitive processes. If a subject can be shown to be suffering from a recognized diminished capacity (cognitive or psychiatric) where he/she cannot be reasonably expected to exercise choice over their internal motivation or actions, then it seems both unfair and inconsistent to characterize such a person as engaging in deception as typically understood [8].

Their argument appears to be based on the assumption that severe psychiatric illness or loss of mental capacity rules out the ability to engage in what the authors describe as 'high cognitive processes', intent and the choice to perform an action. Similarly, Sadler suggests that, unless there is psychosis or co-morbidity with another psychiatric condition involving loss of capacity, the FD

patient should be considered autonomous [27], and treatment recommendations may well veer towards harsh and punitive options because of this assumption of full choice and responsibility.

Such assumptions often feature in discussions of psychiatric conditions and it is beyond the scope of this paper to engage in depth, either with this specific example or more widespread occurrence. The notion of agency, choice and cognitive abilities within psychiatric disorder are complex. While particular related issues have been extensively debated in law, the nuances of capacity loss within psychiatry remain under-researched. Nevertheless, in order to question a dismissal of FD based on the presence of intent, cognition and choice, it is sufficient to point out how prevalent related phenomena are throughout psychiatry and in law, where the establishment of *mens rea* or 'guilty mind' is a key matter at the trial of those who may be mentally ill. Recent work on decision-making capacity is giving empirical backing to the common observation that, in many instances of severe mental disorder, cognitive processing is not significantly impaired [43]. High-profile legal cases, such as that of SB, are a good example of how dramatic and controversial this mix of advanced cognitive capacity, choice and mental disorder can be. Here, the UK Court of Protection ruled that a woman detained under the MHA, and agreed to be lacking in decision-making capacity concerning treatment, nevertheless had full capacity to engage in legal proceedings to prove her capacity to make the decision to terminate her pregnancy. It was SB's apparent agency, intellectual abilities and capacity both to instigate and understand legal proceedings which led the judge to his ruling [44].

The ability to continue normal functioning in multiple dimensions is often found within even severe mental disorder. More importantly here, perhaps, is also the ability of the individual to engage in conscious deliberation and to choose a course of action, even if the insight, which underlies this process, has been impacted. A good example here is suicide. Even if other contexts may occasionally lead individuals to take their lives, the association of suicide and attempted suicide with severe mental illness, often incorporating elements of psychosis, is widely acknowledged, and it is commonly estimated that over 90% of suicides can be linked to a psychiatric disorder [45]. However, such behaviour often involves intent, complex deliberation and planning, surrounding, for example, research to find an effective method and obtain necessary tools and opportunities, minimization of damage to others and leaving explanatory information.

Perhaps the clearest reason to question the view that the presence of deception should invalidate the FD classification is not simply the general assumptions about cognitive processing and choice, but the occurrence of what would be termed conscious deception within a range of other recognized mental disorder. To name a few instances, suicide attempts will often involve deception concerning frame of mind and intentions; substance abuse and eating disorders can often involve very elaborate and skilful deception surrounding harmful behaviours; anxiety disorders or OCD may well involve deceptive strategies to avoid exposure to situations perceived as threatening. Issues of deception, cognitive ability, co-morbidity and diagnostic uncertainty lead to many difficulties within the clinical practice of psychiatry. However, such difficulties are by no means restricted to FD and it would seem unreasonable to use them as the basis for rejecting its classification as a mental disorder.

Finally, there is the possible overlap of motivations. As we have argued above, there may be room to confuse FD with 'malingering' – causing or feigning of illness/injury for the purpose of material gain. Nonetheless, identifying the legitimate presence of FD, even if material gains are involved, is simply one of the many diagnostic challenges facing clinicians.

There are cases where the gap between the 'patient role' and 'material gain' motivation seems doubtful and there is good evidence for questioning an absolute distinction. Eisendrath and McNeil, for example, detail a number of cases where FD patients have entered into civil litigation, but also died from their FD-induced injuries. Even if the distinction is 'permeable', they argue, this should not distract attention from seeing FD as a legitimate and potentially fatal disorder [46]. Indeed, in many cases of FD and especially those involving severe illness and risk, it would be extremely hard to identify any type of substantial material gain that could give some kind of ordinarily understandable justification for the procurement of illness and treatment entailing this level of risk and damage. The self-bleeding nurse, for example, had endured a life of isolation, constant moves, suspicion, while putting herself at major and often fatal risk, with no identifiable major material gain or motivation. Her case is typical, rather than exceptional, among those with the most severe variants of this condition, suggesting that, as a broad guideline at least, the 'patient role motivation' criterion is not invalid.

Paternalism in the treatment of FD – justifications, frameworks and type

We have argued that, despite lack of research and the many uncertainties surrounding FD, there are insufficient reasons to doubt its 'mental disorder' classification. If we accept this classification, particularly in cases where FD involves major risk to the patient, it seems that there may well be justifications for paternalistic interventions in the face of patient resistance to FD diagnosis and treatment. Such justifications would accord both with the general ethical principles associated with compassion and clinical duty of care, as well as the underlying principles of existing mental health law. Furthermore, paternalism is intrinsic to and present from the outset in the medical treatment of FD, given that FD is defined around the will and intention of the patient to conceal their condition.

Formal or statutory interventions

At present, in the UK and elsewhere, the dominant frameworks for paternalistic interventions within psychiatry are mental health laws such as the UK MHA 2007. These allow a patient to be hospitalized and treated involuntarily, if there is perceived risk to the individual themselves or others resulting from a diagnosed mental disorder. As such, FD appears to satisfy the necessary criteria. Johson and Harrison, for example, argue that, just as for other psychiatric disorders, civil commitment is justifiable if the degree and immediacy of risk to life is sufficient [47].

In practice, instituting such measures would be difficult. Containment of the patient, in order to control current risk, may be possible. However, given that patients will most likely reject diagnosis and that treatment is uncertain and probably involves some type of psychotherapy, the enforcement of treatment beyond containment would be difficult. Nevertheless, although FD needs further research, it may be hoped that, even with the limited

resources currently available, during this containment period, the patient may agree to some type of medical intervention in an attempt to combat the FD or lessen its severity. There have been some successful cases documented [47].

An alternative to the MHA framework is capacity-based legislation. This would allow involuntary treatment if the patient was assessed to have lost the capacity to make health care and treatment decisions, and involuntary detention and/or treatment was in their best interests [48]. Capacity-based legislation may be less inherently discriminatory than an MHA-type model. However, unless considerable work is done to enhance understanding of both how FD affects capacity and how an FD-induced loss of capacity can be recognized, assessment would be problematic. Such work is urgently needed if we are to be able to counter the view of FD as a legitimate expression of patient self-determination that should be accepted despite the risks.

Informal interventions

As well as formal interventions, supported by legally sanctioned compulsion following assessment, the practice of what might be referred to as 'informal paternalism' is widespread within psychiatry, but little discussed. For example, despite the frequency of methods of leverage, which do not involve formal compulsion within psychiatric practice, there is little debate, research or guidance surrounding its use [49–52]. Informal paternalism is particularly important in the case of FD, where overruling and confrontation of the patient's wishes, views and statements is an integral part of the treatment process. As we have seen from the cases detailed above, ethical dilemmas concern what may be considered to be unsanctioned breaches of privacy, such as searching possessions, secret observation and aspects of investigating patient history or informing others, as well as treatment. The need to find evidence for FD will very likely involve such processes, all of which may be challenged by the patient, particularly if insufficient evidence is found or the patient denies the validity of the evidence in some respect and/or challenges medical authorities.

Savino and Fordtran, for example, detail a number of cases where searches have been used to find FD, as well as the ethical dilemmas surrounding such a course of action. Rights-based objections to interventions such as room searches have intensified in recent years, raising major ethical difficulties in cases where such an intervention may be the only way to discover the causes of damaging and even life-threatening illnesses [7]. Although such dilemmas have been identified and certain solutions proposed [7,27,48,53–55], there is still no widely acknowledged or detailed guidance available for clinicians.

The difficulties surrounding intervention in FD show that, in relation to both FD itself and also to other psychiatric conditions, there is need for further investigation of how and whether methods of investigation or leverage, which are not formally sanctioned, should become an ethically acceptable form of clinical intervention.

Conclusions

Medical approaches to FD and suspected FD are inherently paternalistic, given that even discovery and diagnosis already involve overruling the patient's wishes to have a fallacious account accepted. Patient resistance to diagnosis and treatment typically persists throughout the clinical engagement. As such, FD raises interesting questions about the role and types of paternalism in medical care, and is a very useful context for exploring current debates surrounding tension between respect for patient self-determination and clinician's duty of care to protect their patient.

We would argue that there are no compelling reasons or arguments to reject FD's classification as a mental disorder, despite difficulties surrounding diagnosis, co-morbidity, motivations and agency. Instead, FD should be recognized as a mental disorder, but one in urgent need of further research and conceptual clarification. FD may well involve severe injury, disregard of consequences and persistence of and failure to acknowledge behaviours even when confronted with evidence. It would appear that such behaviours represent a mental disorder of some severity and that the patient is not exerting self-determination or choice over their actions in the sense that these terms are commonly understood. Nevertheless, we consider that capacity, choice and insight within FD are poorly understood and need further research, if we are to support the widespread view that more successful and consistent diagnosis and treatment of FD should be available.

Given that the more severe cases of FD can entail major damage and even risk of fatality to the patient, and appear to involve an impairment of control and insight, we argue that there is a strong case for suggesting that employment of 'soft' paternalism via mental health law involving enforced containment and treatment can be justified. FD also raises interesting questions about the employment of less restrictive paternalistic interventions, which are not covered by formal statute, and which, in our view, need careful consideration, not only in FD, but in other conditions such as eating disorders, drug abuse and repeated self-harm.

Finally, we would argue that the need for improved understanding and identification of FD is all the more pressing, given the increasing use of illness deception for material gain. This often entails serious damage to the perpetrator and increasing litigation against medical professionals for misjudgements within diagnosis and treatment. Moreover, for FD patients, such litigation offers not only material gain, but additional confirmation of the sick role. Thus, both the need for patienthood and the desire for money are simultaneously gratified, running the risk of bringing external validation to the FD patient's behaviours. In our view, and perhaps contrary to accepted wisdom, these twin desires can and do coexist, and this complication should be acknowledged within our approaches to FD.

The complexities surrounding FD lead to many difficulties and mean that, in current practice, adoption of paternalistic interventions is neither common nor widely accepted. In practice, FD patients are viewed as problematic and may well meet with strong disapproval and censorious attitudes among health care professionals, who see their actions as self-controlled, manipulative and placing illegitimate demands on overstretched health care resources. Such prejudicial views need urgent re-examination. FD can become a compelling and tragic way of life for those who suffer from this condition, and we consider that they are likely to benefit from the new approaches we advocate.

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