

Revelation or confirmation?

The ‘fake probe’ in global health

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Abstract

Fakes have become a matter of concern across global health. Commissioning inquiry into presumed fake practices in global health requires both a pre-existing sense of what would constitute real provision *and* a suspicion that it is not being offered. In this Position Piece, we analyse the research methods being used to identify and reveal other—presumed—fakes in global health provision. We put forward the concept of the ‘second-order fake’—the fake that is used to reveal a fake—to draw attention to the methodological politics at stake in the use of the fake. By reviewing historical cases of the creation of methods of deception, we analyse the assumptions they bring into global health from other disciplines. We foreground the promises of revelation that are embedded in probes that rely on fakes to uncover fakes. We suggest that despite the growing prevalence of methods which themselves deploy fakes to find fakes, these techniques bring us no closer to understanding the lived ambiguities of everyday practices of fakery.

Keywords

Deception, Fake, Method, Probes, Global health

Introduction

Over the last few decades, global health initiatives have been beset by mounting concerns regarding the authenticity of numerous goods and services (WHO 2017; Petersen 2014). The global accountancy firm PricewaterhouseCoopers put it this way: talk of fakes should not take our minds to fake Rolexes or Gucci bags since ‘the real money is in plagiarizing pills, not purses’ (PwC 2017, 5). However, fakes, especially good fakes, are hard to identify with certainty. It has proven difficult to move beyond broad estimates, suggestions, and approximations to gain robust figures into the scale and impact of fakes, from pharmaceuticals, to qualifications, to research data itself. The World Health Organization (WHO) estimates that 42 percent of all substandard and falsified medicines reported to them between 2013 and 2017 were from Africa (WHO 2017), with some Southeast Asian countries reporting in the range of 70 percent of their medicines (PwC 2017). The evident problems that fakes pose to global health initiatives, and to health itself, are compounded by the fact that the data about fakes is, at best, shaky. Where does the data for the metrics come from—and what are the ethics and politics embedded in these forms of measurement (Adams 2016; Collins et al. 2020)?

In this Position Piece, we explore techniques designed to probe for the presence of fakery *through fakery itself*. We are particularly interested in the revelatory promise that such methods seem to carry. From daily healthcare provision to medicines being dispensed from pharmacies, techniques dependent on deception are being used to show ‘how things really are’ in global health, often with limited ethical scrutiny. The sections of the essay unpick the politics and epistemic work in methods that rely on fakery, exploring *what* they seek to know, and *how* they seek to know it. We first historicise the revelatory fake. We then examine the range of assumptions embedded in it before exploring examples of its practice in global health. Following the method on its travels, we interrogate its claims to revelation.

Here is an example of the kind of revelatory enquiry that interests us. Between February 2002 and February 2003, buyers consisting of expatriate and local healthcare workers purchased antimalarial drugs from drug-sellers, shops, and pharmacies across Southeast Asia. We are told they were asked to act like ‘normal’ customers. After their purchase, they recorded the type of vendor, the stated manufacturer, the product source or supplier, its cost, and their opinion of its authenticity (Dondrop et al. 2004, 1241). For many in global health, frustrated with the potential risks caused by an industry that presents inert substances as life-saving medicines, asking or employing people to *pose* as buyers is justified because of the ‘urgent action needed to find, prosecute, and close down’ factories and shops, warn publics, and ensure quality-assured drugs are readily available (Newton et al. 2003). But much more is contained in this method. Buyers were asked to *act like ‘normal’ customers*, yet we quickly learnt that they were

collecting *data* and subsequently offering researchers their assessment of whether the drug purchased was ‘authentic’.

Our analysis does not focus on the objects of this story—the fake drugs—but rather on the role of fakery in identifying fakes—the fake probe. Motivated both by explicit and inchoate worries about inauthentic provision (are these drugs real? Is that test genuine? Do fieldworkers fabricate data?), we suggest that methods relying on fakery have been adopted almost without comment in global health, spreading research that uses exploratory deception with revelatory intent to some of the world’s poorest contexts.

From our mutual interest in the making of global health data, we term this technique the ‘revelatory fake’—a method seeking to identify, target, and expose presumed fakes *through fakery itself*: a revelatory, second-order fake. As we will show, the self-evidence of this revelatory capacity is not given. We suggest that to commission inquiry through such techniques requires both a pre-existing sense of a real and a suspicion that it is not being offered. In the spirit of ‘peopling’ (Biehl 2016) global health, we are interested in how second-order fakes emerge. Where does power lie in commissioning inquiry? What assumptions accompany the revelatory fake as a method? Who determines what counts as adequate evidence for what is really going on? We invite readers to think with us about these timely and important questions as we explore revelatory fakes.

Historicising the revelatory fake

Deception, or covert research, is a longstanding technique in qualitative research (Calvey 2017) with an ambiguous ethical status (Roulet et al. 2017; McKenzie 2017; van Niekerk 2014; Bernard 2011). Disciplines such as anthropology, sociology, and psychology have employed deceptive methods, often for purposes of access (Pels 2000). Historicising these techniques makes visible their rationales and social contexts.

When researchers obscure their identity to gain access, they often seek a first-hand experience, such as those of discrimination. In the United States, during and following the civil rights movement, fake identities were used to make visible societal discrimination based on class, gender, or sexual orientation. For example, John Howard Griffin’s autobiographical account *Black Like Me* details how, in 1959, Griffin, a white journalist, decided to undergo medical treatment and cosmetic procedures to temporarily change his skin colour. For six weeks he travelled through racially segregated American states as a ‘fake black man’ (Griffin 1960). Griffin, who was deeply suspicious of dismissive narratives about African-Americans’ experiences, used faking to ‘study up’ (Nader 1972) and to reveal evidence confirming his

suspicious about the detrimental effects of racism. Hence, the politics of the method were explicit; it revealed the experiences of the misrepresented (Becker 1982; Bok 1978).

In 1969, 39-year-old David Lurie complained to a psychiatrist at Haverford State Hospital, Pennsylvania, of hearing ‘hollow’, ‘empty’, and ‘thud’ voices (Cahalan 2020). After an in-depth interview exploring his family life, Lurie was diagnosed with schizophrenia and hospitalised. However, David Lurie was an alias for psychologist David Rosenhan, of Stanford University, California. Rosenhan and seven other ‘patients’ adopted fake symptoms to test whether psychiatrists could distinguish sanity from insanity. In so doing, Rosenhan revealed the often harmful nature of psychiatric hospitals and the artificial and arbitrary process of psychiatric diagnoses. His findings were famously portrayed in the 1975 film *One Flew Over the Cuckoo’s Nest* starring Jack Nicholson, and Rosenhan’s work has been described as ‘one of the most influential pieces of social science published in the 20th century’ (Cahalan 2020). Rosenhan’s findings were so powerful that they catalysed a movement to close and replace large psychiatric hospitals with smaller, community-based mental health centres.

In another example from the early 1990s, this time from the UK, researcher Teresa Hinton aimed to reveal the experiences of those likely to face discrimination in everyday medical practice (Hinton 1994; see also Small and Hinton 1997). Working in London, Hinton addressed her suspicions that medical professionals were discriminating against patients from marginalised backgrounds. She employed three actors to present as homeless to targeted General Practitioner (GP) services in East London. Her study confirmed that the more extreme the person’s housing situation, the harder it was to access a GP. For Hinton, these ‘fake patients’ exposed discrimination by National Health Service (NHS) frontline staff and the revelatory fake highlighted the inauthentic claims of equality of access.

A foundational revelatory fake example from the Global South is ‘The Fake Patient’ (van der Geest and Sarkodie 1998), an ethnography of patient care and ward life in a Ghanaian hospital by Dutch medical anthropologist Sjaak van der Geest and his colleague Samuel Sarkodie, an MA sociology student at the University of Ghana. They sought access to the ‘patient experience’ in light of Ghanaian press reports that hospital wards under government administration were poorly run. Van der Geest approached a local rural hospital, stating Sarkodie’s position as a student from Legon, and got permission for Sarkodie to be admitted as a ‘patient’ to ‘observe and understand what the patients are doing and experiencing’ (1998, 1376). Sarkodie’s observations revealed practices that, the authors argued, would have been otherwise inaccessible to research.

The time of the revelatory fake

As time has passed, the acceptability of methods resting on fakery has waned, especially in the Global North. Almost 20 years after Hinton's London-based study, a 2011 attempt to use 'fake patients' to assess medical care in the US ended in failure (Rhodes and Miller 2012). When the study was announced, the *New York Times* reported that it 'triggered strong public criticism by some doctors and members of Congress' (Pear 2011). One doctor remarked, 'I don't like the idea of the government snooping. It's a pernicious practice' (Rhodes and Miller 2012, 707; see also Vogel 2006).

This 'pernicious' practice had nonetheless moved into US-based healthcare evaluation as early as 1986, with mystery shoppers 'borrowed' from consumer research to offer an 'unbiased report on the day-to-day functioning of hospital activities' (Steiner 1986, 9). As the 1990s progressed, fake patients and 'mystery shoppers' became an increasingly professionalised and standardised industry, integrated through audit culture into the monitoring and evaluation of (mostly US) customer service. Efforts to maximise consumer satisfaction, evaluate customer service, and gather market research data formalised the method during the 1990s. Work began appearing on creating convincing shoppers, training mystery shoppers (Wilson 2001), the 'cognitive aspects' and motivations of mystery shoppers (Morrison et al. 1997), and, inevitably, the purchase of competitor mystery shoppers (Dawson and Hillier 1995). We will return to the idea of 'borrowing' between sectors and examine some of these assumptions later in this piece. In this section, we would like to draw attention to the movement of the fake probe across different domains and geographical locations.

By the early 2000s, institutional review boards (IRBs) at many major universities in North America and Europe had begun attending more closely to social science methods and their ethics. The main ethical objection was that those being observed as part of research needed to give their consent. As the revelatory fake required deception and omitting information from those being observed (participants), informed consent could not be provided and, therefore, such research raised ethical concerns. Hence, the scope of social scientists in the Global North to use fakery 'at home' became increasingly constrained; ethics committees began to refuse approval (Adler and Adler 2002). In 1998, van der Geest and Sarkodie reported candidly that, had they applied to do their 'Fake Patient' study in the Netherlands, they would probably have been refused access. Furthermore, they wrote, 'The European who submitted the request to the Ghanaian hospital would have had a very hard time obtaining the same permission from a hospital at home' (1998, 1379). This shift in geography of the revelatory fake was accompanied by an uncoupling from motivations to 'study up', but with asymmetrical power relationships in its move into global health.

Relocating to global health

Into the late 2010s, while decreasing in public health facilities in the Global North, mystery shoppers grew in popularity in global health, where they were used to measure the quality of clinical care and address concerns about the substandard and fake healthcare and diagnostic products discussed earlier. Just as versions of ethnographic methods and other techniques from the social sciences were being adopted by global health, they were increasingly becoming tied to a field which was growing more attached to machineries of monitoring, evaluation, and assessment.

Sabot et al.'s (2009) study of comparative pricing for antimalarial drugs in Tanzania employed mystery shoppers to buy malaria treatment, a technique generally accepted by the WHO Guidelines on Medical Quality surveys (WHO, 2016). Such cases of 'fake people' usually involve employing actors to play patients or trained healthcare professionals to play 'normal customers'; in both cases, the goal is to acquire products suspected of being substandard or falsified. The results focus on comparative costings of antimalarials, but we learn little about the actual methodology. This omission is important. In *Black Like Me*, Griffin's identity is known to the reader, as was his process of fakery. This information allows the opportunity to assess claims and scrutinise motivations and plausibility of any potential deception. Hence, the fake person's actual identity is relied upon to establish credibility. This credibility is crucial, especially when claims made by revelatory fakes in global health carry such weight—such as when purchases by mystery shoppers become an indicator of the effectiveness and capacity of entire government regulatory structures to identify fakes and their prevalence (Kaur et al. 2010, 50; Risha et al. 2008).

The mystery shopper method is also increasingly being used as a research tool in large field studies to assess assumed poor-quality medicinal drugs, devices, and care across African, South Asian, and Southeast Asian contexts (Madden et al. 1997; Kohler et al. 2017; Christian et al. 2018) in the Global South. The growth of this method and the varying quality of its implementation prompted King et al. (2019) to evaluate and outline what they considered its pros and cons in global health. They argue that mystery shoppers 'provide uniquely rich data [...] of great value to both researchers and policymakers' (King et al. 2019, 625), save labour, and allow for the observation of care without the provider's knowledge. The ignorance of providers is framed as an absence of 'interference', which, they argue, identifies 'deficit in care' and treatment (2019, 626). Furthermore, individuals not consenting is considered crucial for reasons such as the Hawthorne or 'observer' effects (when an observed individual alters their actions to more positive or 'productive' behaviour when they become aware of being observed). Hence, it is argued that 'real' behaviour occurs when the observer is unaware of being observed, and what is faked is their 'performance' in response to being monitored. King

et al. state that there are ethical issues with this method, including risks of harm to those faking if detected, but that the potential gains justify not applying the same ethical procedures globally. While numerous scholars have highlighted the relocation of clinical trials to exploit weaker ethical regulation in the Global South (Petryna 2009), the fake that probes for how things are ‘really’ done, with its revelatory promise, continues to be routinely deployed without sustained reflection on broader ethical concerns, power inequalities, social value, and its methodological implications (Taberner et al. 2016). There is scarce attention given to its examination by social scientists.

Revelatory intent

Revelatory or second-order fakes are deployed to address numerous types of suspicions. The promise of revelation stems, in part, from the origins of the suite of methods that use fakes to find fakes. While we have glossed over the differences between the *kinds* of revelatory interventions to which global health researchers turn, it is worth pausing to reflect on their origins. When techniques are transposed into investigating suspect practices or products in global health, their differing origins (and motivations) are often forgotten. For example, ‘the sting’ as a technique originates in crime. With its long history in North American law enforcement, it differs from an audit which originates in accounting. Stings are also different from mystery shoppers. While a full account of how these techniques are borrowed from law enforcement to healthcare, and from healthcare to global health evaluation, is beyond the scope of our essay, we contend that tracing implicit assumptions and changing power dynamics across settings is vital. A sting operation has neither similar objectives nor a similar degree of suspicion as a mystery shopper. Are we investigating suspected criminal activity or poor employee performance? By borrowing such techniques, global health researchers are implementing what anthropologist Bob Simpson (2013, 56) has called ‘templating’ between domains, often without appreciating the history and epistemic underpinnings accompanying them.

One case illustrates the importance of attending to how domain borrowing can happen in practice, and makes evident how revelatory practices travel. In 2009, the US Government Accountability Office (GAO) conducted a ‘sting’ operation on research ethics committees (IRBs) (Douglas-Jones 2019). Amid concerns about for-profit IRBs in the US, the GAO created a fake trial for a post-operative gel and sent it to three committees. It had a made-up protocol, a non-existent principal investigator with a ‘transparently suspicious resume’, and included a ‘verifiably false’ company. The trial was tailored by the GOA to be ‘sufficiently plausible to undergo review’ (Barton, cited in CEC 2009, no pagination). Two committees rejected it outright, but one, ‘Coast IRB’, approved it. In the ensuing hearing, the director of Coast, Dan Dueber, was asked to testify. He argued that the GAO ‘acted illegally’ in its

‘elaborate, expensive fraud’ (CEC 2009). The hearing considered Dueber’s indignation to be outrageous, reminding him, ‘Your board unanimously approved this fake company to turn fake tests using a witches’ brew recipe for a gel that doesn’t exist’ (Barton, cited in CEC 2009, no pagination). He had been duped, they said, and should own up to the inadequacy of his committee’s review process.

Coast’s demise is a story of a ‘sting’—a method designed to act on strong suspicion of criminal activity—moving into the for-profit ethics review sector. It is also thrilling: the outcome—a committee caught, a suspicion confirmed—was widely reported in the USA. Later that year, a US Food and Drug Administration (FDA) representative travelled and recounted it to an audience of IRB members and capacity-builders in Chiang Mai, Thailand. Attendees responded less to Coast’s poor review, and more to the resources invested in a ‘system’ of suspicion, to test and examine reviews in a manner adopted by law enforcement.

The discussion at the subsequent trial makes the many baseline assumptions of this method visible. First, by using a fake as a lure, a test or ‘sting’ rests on the assumption that the fake is not detectable to those being deceived. It takes skill to create a trial sufficiently plausible to undergo review. Yet, often in accounts of data produced through fakery, there is little or no information about the identity or characteristics of the people who produced the knowledge. Such omissions raise many questions: Who is employed to be the fake person who exposes a fake? What is their (assumed and actual) skill and expertise? How are they paid, and for what? How are they instructed, and by whom? What degree of specificity are they asked to generate? What is ‘enough data’? Who makes up their backstory? The fake, it is presumed, does not trouble its surroundings, nor is it involved in constructing that which it seeks to find.

Second, the sting, as with many other interventions based on fakes, presumes and depends upon an unawareness of those being investigated. Indeed, this unawareness is not only considered necessary, but is presumed to provide researchers access to ‘operating as usual’ (King et al. 2019). The common inference is that *only* through the investigator’s fakery can what is ‘really happening’ be revealed, especially if that ‘real’ is considered fake. In other words, what is ‘objectively happening’ can only be ascertained through such artificial constructs as fake customers, fake CVs, and fake questions. This assumption often acts to justify the deception integral to using fakes.

Returning to the example of Coast, we might agree that, while Dueber’s indignation at his trial was self-serving, he nonetheless had the opportunity to publicly confront those who (as he saw it) had defrauded him. He could testify in court in an ill-fated attempt to save his company—an opportunity that reminds us that, in most cases where a fake is deployed, the results of findings are published in paywalled journals, written without the prior knowledge of

those accused of faking (or of being ineffectual in detecting fakes). The second-order fake is presented as providing conclusive evidence, foreclosing opportunity for alternative explanations and giving the subjects of the account little recourse to reply. In this way, the second-order fake exposes the imbalance of power between the accuser and the accused to determine what is fake and then reveal its presence.

Confirming the real?

As ethnographers are well aware, there are numerous examples in global health where the real is uncertain and elusive (Kingori and Gerrets 2019). For instance, in Kenya, a country which, according to recent figures, has 0.2 physicians per 1,000 people (World Bank 2014), 31-year-old Ronald Melly worked for many years at the Kapsabet County Referral Hospital as a ‘fake doctor’ (Chaguza 2018). He had no formal training but, through observation and being self-taught, performed eight complex operations. It was only his promotion, due to his success, which prompted a background check revealing his lack of qualifications.

Melly’s case highlights the difficulty of establishing the so-called ‘real’ in contexts where the real might rarely be encountered, or when substandard is *the* standard (Gryseels et al. 2019). While at the hospital, Melly and colleagues operated on a woman who died giving birth, though her child was saved. His colleagues argued that this death did not arouse suspicions because maternal deaths were common and it was difficult to disentangle any lack of skills held by Melly from their usual practice of operating with scarce resources. How, then, would a fake patient or health professional discern and isolate the fake doctor, Melly, from his qualified colleagues, when minimal equipment and resources means that standard operating procedures are regularly circumvented during complex operations? Which everyday acts would signal fakery in this context? What would a ‘real’ doctor look like without the resources to act to a prescribed standard? What does ‘real’ training look like? This example also raises questions of morality: is the fake always wrong?

As Clare Wendland (2010) argues, doctors’ training needs to be functional in real-world conditions and, therefore, training based on expensive instruments designed for resource-rich contexts is an artifice for those operating within resource-constrained settings. Suspecting doctors in weak healthcare systems of falling short of standards designed for resource-rich contexts, and then designing probes reliant on fakery which then ‘reveal’ these doctors to be substandard, misses opportunities to capture alternative accounts of what is real.

Used as a type of qualitative research into global health projects, researchers and those faking are stripped of obligations to consider positionality, undertake reflexivity, or even act with transparency. Anonymity and protecting those faking from harm is often used to justify the

profound lack of methodological detail. Revelatory fakes transfer considerable power to those faking, positioning the method as an impartial, morally neutral object capable of accessing and extracting reality, while having no role in its construction. Yet there are many reasons, including those drawn from historical examples, why this should be questioned

Fifty years after Rosenhan's study of psychiatrists, Susannah Cahalan (2020) tried to trace the other 'fake patients'. She gained access to documents Rosenhan left after his death, including years of correspondence, diary entries, and his draft manuscript on the study. She also interviewed his colleagues, family, and friends, and hired a private investigator. Cahalan discovered no evidence that the 'fake patients' ever existed. What has transpired is that Rosenhan shared the concerns of many of his contemporaries regarding the neglectful and harmful practices in psychiatric hospitals, which supported his suspicion that patients received poor diagnoses and care. He pretended to expose the real goings-on in psychiatric hospitals but, in fact, his probe and the findings it produced were themselves fake. Callahan argues that due to the power of Rosenhan's work, years of chronic underfunding of psychiatric hospitals ensued, the effects of which are still being felt today. Callahan suggests that Rosenhan's deception contributed to a culture that has continued to cause considerable harm to those in greatest need.

The revelatory fake is being deployed in global health with the explicit intent of shaping policy and practice. However, many accounts offer scarce insight into their methodology and, if we take the historical examples presented in this piece seriously, there is cause for further thought on this method.

Confirmation or revelation?

In this Position Piece, we have looked at fakes that researchers in global health use as a method of revealing other—presumed—fakes. As concern about fakes grows among global health practitioners, these methods matter because they are prioritised in research about fakes in global health; indeed, they are often taken as a constitutive component of methods assemblages that go into producing estimates about the prevalence and magnitude of fakes as a problem. Unsettling the reasoning and histories of these methods allows us to interrogate the tacit equation that what is *really* happening is a *fake*, and only a *fake* will reveal this *real*. This leads us to ask whether the revelatory promise in the second-order fake may operate more in a mode of confirmation than revelation.

As fakes participate in the making of knowledge about fakes, it is clear that their performative and revelatory nature is appealing and their results dramatic. However, the original purposes for which a method was designed, we suggest, shape the assumptions underlying its use. When

fakes are used to reveal, they seldom *only* reveal. They also *create* what they intend to reveal, while obscuring suspicion as the motive that led to their own creation.

What becomes visible through focusing on the uneven distribution of second-order fakes as a method is that they carry considerable histories and politics. While increasingly difficult to commission in the Global North, their use is frequently approved for many locations in the Global South. Might this asymmetry not *produce* rather than *reveal* a narrative about fakes in the South, if the research is neither proposed nor conducted in the North? As it is harder to examine fakes in the North, the research imbalance means it is easier to assume that fakes are more prevalent in the South. In this way, structural and regulatory bodies participate in generating data on fakes in the Global South while omitting equivalent focus on practices in the Global North. Indeed, by focusing on the distribution of the *method*, this asymmetry becomes visible.

We also raise questions of voice: who speaks through the revelatory fake? Years after *Black Like Me*, Griffin commented that it was ‘absurd for a white man to presume to speak for black people when they have superlative voices of their own’ (Watson 2011). Indeed, even at the time, African American academics and civil rights activists such as Kwame Ture (born Stokely Carmichael), while recognising his laudable intent, openly questioned why Griffin had not engaged black people directly and sought out their insights rather than opting to undergo extensive medical and cosmetic procedures to become a ‘fake black man’. This critique of Griffin’s work remains pertinent to the revelatory fake in contemporary global health. Fake probe studies undertaken in resource-poor contexts seldom provide recourse for those whose lives are affected or those under investigation, nor do they recognise their agency to provide their own account.

Considering these practices through the lens of the politics of method makes visible uneven landscapes of regulation and power relations that lie in geographies of knowledge. As a counter to the appeal of rapid assessment, we invite ethnographers to attend to research in global health which depends on revelatory fakes, and to engage in dialogue with practitioners for whom these methods offer an appealing and fast form of knowing. It is a method that returns our gaze to the ‘global’—the histories that are woven into methods, the temporalities that make demands for rapid knowing, and the economics that drive new markers of evidence.

The full task of unpicking the epistemic work of revelatory fakes is greater than this Position Piece. However, we want to question the powerful appeal of the revelatory fake. By interrogating the tacit givens upon which methods that seek the ‘real’ are based, the complexity of fakery within global health can be better understood. Ethnographers have the capacity to ‘document what gets hidden by, or what remains invisible to, other disciplinary practices’ (Adams 2014, 191). Ethnographers with long-term relationships in the field, undertaking slow

research (Adams et al. 2014), are well positioned to ask precisely the political and nuanced questions of how this data is made. Without significant engagement with this method and evaluation of its appropriateness of resource-poor contexts in the Global South, we argue that revelatory fakes do little to bring us closer to understanding the lived ambiguities of everyday practices of real and fake in global health.

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