

The Munchausen Syndrome in Civil Forensic Psychiatry

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The diagnosis of Munchausen syndrome requires that a patient intentionally produce or feign physical symptoms with a psychological need to assume the sick role. To differentiate the disorder from malingering one must document the absence of an external incentive for the patient's behavior. Although malingering is a major topic of interest in forensic psychiatry, there has been no literature that looks at the Munchausen syndrome presenting in the civil forensic setting. This paper reports on two cases of the Munchausen syndrome that occurred in the areas of medical malpractice and workers' compensation. The cases highlight how the psychiatrist should approach these cases in the civil forensic setting. The malpractice case also illustrates how the disorder is viewed by an appellate court.

The Munchausen syndrome was first described by Asher in 1951 and was renamed factitious disorder with physical symptoms in the DSM-III.¹ The major characteristic of the disorder is the intentional production or feigning of physical symptoms with a psychological need to assume the sick role. The absence of external incentives for the behavior must be documented as well to differentiate the disorder from malingering. In malingering there is also intentional production of symptoms, but there is a clear external incentive for the behavior

and no evidence of an intrapsychic need to maintain the sick role.

Malingering is clearly a major topic of interest in forensic psychiatry.^{2, 3} The Munchausen syndrome has been of interest in clinical psychiatry for many years as well. However, there are no published cases dealing with Munchausen syndrome in the civil forensic setting. This paper presents two such cases of the Munchausen syndrome in the areas of negligence and workers' compensation law.

Case 1

The patient, a 63-year-old woman, presented to a major Pennsylvania teaching hospital in 1982 complaining of hip pain unresponsive to bed rest and narcotic analgesics. She was noted to be unable to care for herself at home and had required such high doses of Demerol that she became nauseated with vomit-

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ing, which led to dehydration. During the hospitalization Demerol addiction was identified as a major problem, and attempts were made to treat it aggressively. She was noted to be "emotionally distraught, screaming, threatening to sign out against medical advice if her agonizing pain was not relieved." A taper with Methadone was begun but was stopped and high-dose intramuscular Demerol restarted because of fear that the patient's behavior gave her health-care team "no choice." On the day Demerol was restarted, the patient was observed by hospital staff members to be "resting comfortably, relaxed, and conversing with her roommate or visitors when she was unaware of observers. She became dramatic in agonizing pain, tearful (without tears) when the physician walked into the room."

Subsequent multiple attempts either to engage the patient in psychotherapy or to taper her dosage of intramuscular Demerol during the hospitalization failed.

The patient later claimed that during this hospitalization an intramuscular injection of Demerol was administered in her left shoulder, resulting in paralysis. She filed a malpractice suit against the nurse who administered the injection and the hospital where she received care.

After the suit was filed the law firm that represented the hospital began an investigation of the patient's past medical and psychiatric history. Research uncovered that the patient had had more than 50 lengthy inpatient hospitalizations in her lifetime. Several paralegals were assigned full-time duty for several

months to abstract and collate her records, which eventually reached more than 180,000 pages. Her case was evaluated by several defense experts, including a forensic psychiatrist.

Review of the records revealed that the patient had undergone more than 500 invasive procedures and tests in her lifetime in multiple organ systems. She had multiple abdominal surgeries in her twenties and had multiple biopsies and tests for symptoms of vague fatigue and pain, without any definitive results. The first overt evidence of faking of symptoms found in her records occurred when she was 41 years old. She was found by medical staff during an inpatient hospitalization to be manipulating her thermometer to fake a raised temperature and was also found to be manipulating her urethra to place blood in her urine. She was seen by a psychiatrist, but resisted all recommendations for psychotherapy. A proposal was made to "avoid any future harsh diagnostic measures and/or therapy, because of the diagnosis." Despite this warning, the patient continued to be admitted to hospitals and continued to have numerous, painful, disfiguring, and invasive diagnostic tests.

At age 42 she was admitted to another hospital. She did not mention her previous history. During that hospitalization she complained of a 30-pound weight loss, abdominal pain, and bloody urine. A diagnosis of thyrotoxicosis was made. The symptoms remitted spontaneously and no understandable etiology was ever found for the illness. Physicians at the hospital did not consider the di-

Munchausen Syndrome

agnosis of self-administration of thyroid, primarily because they did not have access to an accurate past history.

At age 43 the patient underwent an intensive multi-disciplinary evaluation at an internationally recognized medical center. Unlike her prior treating physicians, the evaluators had access to all of the patient's prior treatment records. They opined that the patient had experienced a fantastic submittal to surgery and other diagnostic procedures. They frankly told the patient that her problem was psychiatric and that she had no organic disease and previous procedures were not justified. All tests were normal except blood and urine. A traumatized urethra was noted and blood found in her urine was thought secondary to self-manipulation. Records were reviewed from previous hospitals showing that the patient voluntarily faked pulmonary function tests to fake abnormal results.

A diagnosis of Munchausen syndrome was made. Despite this finding the patient continued multiple admissions to multiple hospitals and never accurately revealed details of her past history to her health-care providers. During subsequent hospitalizations she was observed again to manipulate her urethra to place blood in her urine. She also began complaining of severe chest pain consistent with a clinical presentation of pulmonary embolism, and took high doses of Coumadin with multiple side effects. Finally, after multiple equivocal perfusion scans, pulmonary angiogram definitely ruled out pulmonary embolism. Despite this finding she was continued on heparin and continued to undergo multiple

perfusion scans, again because she changed health-care facilities and did not tell subsequent providers about her past history.

The patient then began a series of hospitalizations after fracturing a hip and began requiring huge doses of parenteral narcotics. At age 59 a central venous catheter was placed because of poor venous access. The catheters became recurrently infected suggesting that the patient was self-infecting the catheters. It was during one of these hospitalizations that the patient was allegedly injected in her left shoulder, resulting in injury.

The patient filed suit. She continued to have multiple contacts with many different physicians and health providers and also underwent many more surgical procedures. She retained a hand surgeon and a surgical nurse as experts in her malpractice case against the nurse and hospital. Both based their opinion solely on the patient's statements that immediately after the injection in hospital she experienced a "burning pain then resulting in weakness of the left arm and absence of wrist extension and finger and thumb extension." Both opined that the nurse and hospital had been negligent in injecting the Demerol by using an incorrect technique. No such event was documented in the patient's medical record, and the nurse who was on shift at the time of the alleged incident could not recall the patient making a complaint of such symptoms at the time of the injection.

Defense attorneys requested that an independent psychiatric evaluation of

the patient be allowed. This was denied by the trial court judge who ruled it "irrelevant." The evaluating forensic psychiatrist prepared a report based solely on review of the patient's past medical records and opined that the patient suffered from the Munchausen syndrome. The defense psychiatrist further opined in the report that when evaluating such patients physicians should not rely on unverified historical data, but instead only rely on objectively verified data. The defense psychiatrist pointed out that both of the plaintiff's experts relied solely on the patient's unverified statements to establish when the injury occurred and to establish causality. The defense psychiatrist offered no opinion on whether the patient in fact suffered from a wrist drop or other neurologic injuries.

The trial judge, despite defense objections, refused to allow the defense psychiatrist's report into evidence and refused to allow the whole issue of the Munchausen syndrome to be heard by the jury. The trial judge ruled that allowing testimony about the Munchausen syndrome would have "constituted an improper comment on plaintiff's credibility and would, therefore, have usurped the function of the jury." The jury awarded damages to the patient of \$1,300,000.00. The trial court granted a remittitur of \$500,000.00, but denied further post-trial relief. The defense appealed.

The appellate court reversed the trial court and remanded for a new trial. (*Cohen v. Einstein*).⁴ The appellate court found that the trial court's decision that

discussion of the Munchausen syndrome would have usurped the function of the jury was fallacious. The court noted that evidence of a mental illness that impairs a witness's ability to "perceive, remember and narrate perceptions accurately is invariably admissible to impeach credibility, even if not adequate to demonstrate incompetency."

The plaintiff dropped the suit and did not attempt a retrial.

Case 2

The patient was a 36-year-old man, who had been working as a chef in a Pennsylvania restaurant for about four months. One day while trimming meat he injured the extensor side of his left thumb, lacerating his extensor pollicis brevis. He visited a local emergency room. His medical care was covered by his employer's workers' compensation policy. The wound was sutured. It was noted that the patient had an old burn injury on his left hand. He received six sutures and oral antibiotics. Fourteen days later he returned to the emergency room physician. His wound had developed skin necrosis in a 2 × 1.5-cm patch on the extensor portion of his hand. He was referred to a plastic surgeon.

The plastic surgeon was told by the patient that his hand had been previously injured by napalm when he served in Vietnam. New antibiotics were prescribed. The wound did not heal. Necrosis developed again and extended. A chronic ulcerated lesion developed and extended despite intensive outpatient debridement. The patient was admitted to the hospital. In the hospital his wound

Munchausen Syndrome

was noted to be granulating well. The patient was discharged. Several weeks after discharge the wound was noted to be worse. He was readmitted to the hospital. The wound was again debrided, intravenous antibiotics prescribed, and a pigskin graft performed. While in the hospital the patient had extensive medical evaluations for unusual skin and vascular disorders including pyoderma gangrenosum. No unusual medical abnormalities were found. The patient continued to provide history that he had been burned with napalm in Vietnam. He also added that he had been exposed to Agent Orange, and had become infected with malaria when on "back country combat patrol." He was released from the hospital.

Four months after the injury, the patient developed serious blistering at the graft site and lost the entire graft. The wound extended. The patient's underlying muscle began to necrose as well. More medical consultations were obtained to evaluate vasculitic processes to account for the extensive deep ulcers of the left upper extremity, spiking fevers, abdominal pain, headache, and arthralgias. Despite extensive workups no medical cause for the patient's problem could be determined. His treatment team opined that because of the patient's exposure to napalm and Agent Orange an autoimmune necrolytic process had been initiated, which explained his failure to heal.

The patient's wound now involved his entire left forearm. Full-thickness skin grafts were attempted and failed. The patient then moved to Alabama to visit

friends and was lost to follow-up by his Pennsylvania treatment team.

In Alabama the patient began treatment at a major teaching hospital. He underwent several inpatient attempts at debridement and skin grafting that failed. After five months he suddenly moved to Florida, where he had no family or relatives.

In Florida the patient began receiving care from another major teaching hospital. Because his wound had extended, an abdominal pedicle flap was attempted. It was noted during this hospitalization that the patient was frequently allowed, at his own request, to perform his own dressing changes unsupervised by nursing staff. The flap appeared to heal initially but subsequently failed. The patient was referred for more medical and surgical consultations. He consistently gave his past history of Vietnam combat experience and exposure to napalm and Agent Orange. He underwent ever more heroic surgical and medical evaluations and treatment attempts, including treatment in a hyperbaric oxygen chamber.

During one hospitalization three years after the initial injury, the Munchausen syndrome was first suspected and a psychiatric consultation was requested. The patient was confronted, and he denied factitious production of symptoms. His mental status examination was unremarkable.

Three subsequent attempts at surgical correction by flap placement were attempted. An indwelling Hickman catheter was placed to administer antibiotics. All surgical attempts at correction failed,

and the Hickman catheter became repeatedly infected. The patient also began requiring extremely large quantities of parenteral narcotic analgesic drugs. Finally the patient was referred to a nationally renowned specialist on limb salvage in another state, who noted that the wound had progressed to ischemic atrophic ulceration overlying both bones of the patient's forearm. The surgeon requested that the patient be reevaluated psychiatrically.

The psychiatrist reviewed available records and collected appropriate social and occupational history. The patient told the evaluating psychiatrist that he had served in the special forces in Vietnam, had been exposed to napalm and Agent Orange, and had also experienced a phosphorous burn to his arm when he was injured by a flamethrower. The psychiatrist opined that the patient's presentation was consistent with the Munchausen syndrome and recommended that outside sources be contacted to verify the patient's social history. The patient refused to sign appropriate releases.

The surgeon performed another flap procedure. The patient was warned by the surgeon that if the new procedure failed the patient was risking amputation. The patient was returned to his Florida treatment team for follow-up care.

At this point the patient's former employer's workers' compensation carrier referred the case for a forensic psychiatric evaluation. The evaluating psychiatrist reviewed the patient's extensive medical records and then requested an interview with the patient. The patient

was not represented by counsel, but he consented to the interview.

During the first day of the interview, the evaluating psychiatrist concentrated on the patient's family, educational, occupational, and military history. The patient refused to give the name or phone number of his parents or relatives so as "not to worry them." The patient stated he had received extensive liberal arts and culinary education and had gone to a university on a full scholarship. He reiterated his military combat career and gave extensive details of his special forces training. He noted that he had served as executive chef for several national chains prior to his restaurant employment where he had been injured. He explained that he had taken his new job as chef because he had "burned out" in his prior employment.

Immediately after the first interview several of the schools that the patient stated he had attended were called. They had no record of his attendance. The corporate offices of several of the employers the patient had named were contacted. They had no record of his prior employment.

The next day's interview concentrated on the patient's prior injuries. The patient adamantly denied doing anything to produce his injuries. He again stated that his wounds did not heal because of his prior Vietnam injuries. The forensic psychiatrist confronted the patient with his Vietnam medical and service records (those records had been obtained prior to the interview). The records showed that whereas the patient had served in Vietnam, he had served as a cook and

Munchausen Syndrome

had never seen combat. They further revealed that he had never been burned either by phosphorus or napalm, and he had not been exposed to Agent Orange. In fact, his discharge physical report from the military noted that the patient had received no service-connected injuries. The patient requested a break at this point and a 10-minute recess was granted. The patient never returned to complete his interview.

Further investigation by the forensic psychiatrist revealed that the patient had falsified virtually his entire family, social, educational, and occupational history. The names and addresses he had provided as next of kin for his inpatient stays were false. All of the employment and educational data he provided, both to the evaluating psychiatrist and treating medical professionals, were false as well. It was never possible to obtain an accurate past history. The forensic psychiatrist opined that the patient's presentation was consistent with the Munchausen syndrome.

The patient's workers' compensation carrier ceased paying for medical care. The patient was not heard from again.

Discussion

When patients consciously lie about physical symptoms and signs, there are two diagnostic possibilities: chronic factitious disorder with physical symptoms and malingering. Although the DSM-III equated the Munchausen syndrome with factitious disorder with physical symptoms,⁵ the DSM-III-R correctly points out that the Munchausen syndrome is a chronic severe form of the

disorder associated with multiple hospitalizations.⁶ Asher⁷ named the Munchausen syndrome after Baron Heironymus von Munchausen.*

Forensic psychiatrists are intimately familiar with the diagnosis of malingering. Malingerers fake or exaggerate symptoms in order to achieve a readily understandable goal. In fact in the forensic setting such a readily understandable goal is usually made obvious by the legal context of the evaluation and malingering is high on the differential diagnostic list.

The Munchausen syndrome, however, is infrequently thought of in the forensic or the clinical setting. Asher, in his classic paper naming the disorder, noted that:

...the patient showing the syndrome is admitted to a hospital with an apparent acute illness supported by a plausible and dramatic history. Usually his story is largely made up of falsehoods: he is found to have attended, and deceived, an astounding number of other hospitals . . . a large number of abdominal scars is particularly characteristic of this condition.⁷

Perhaps the best modern general reviews of the Munchausen syndrome are by

* Baron von Munchausen (1720–1797) served the German Army as a cavalry officer and, retiring as a captain, spent the rest of his days on his estate. Like many old soldiers he occasionally exaggerated his involvement in "glorious" campaigns. Rudolf Raspe (1737–1794) led an extravagant lifestyle in German society, which led to large debts. He stole from his employer, and a warrant was issued for his arrest. He evaded capture and fled to London. In 1785 he anonymously published *Baron von Munchausen's Narrative of his Marvelous Travels and Campaigns in Russia*. The book, which described the Baron participating in outlandish feats, proved to be immensely popular and is still in press today. It is unclear whether Raspe ever met the Baron. After publication of Raspe's book, the Baron became an instant celebrity. The Baron attempted legal action, but Raspe's anonymity precluded success. The Baron died at age 77, a bankrupt and embittered recluse.^{8,9}

Hylar and Sussman¹⁰ and by Enoch and Trethowan.¹¹ Hylar and Sussman describe clinical features, epidemiology, predisposing factors, and differential diagnosis for this disorder. Hylar and Sussman note several associated features found in patients with the Munchausen syndrome. These include: (1) receiving treatment at various hospitals miles apart, with the patient distorting past symptoms to maximize the acuteness of the presentation; (2) showing remarkable medical sophistication; (3) having frequent demands for medication; and (4) having an absence of visitors during prolonged hospital stays.

Patients with the Munchausen syndrome are difficult to manage and are not usually responsive to psychotherapeutic or pharmacologic interventions. The primary goal of treatment may be to protect the patient from further surgeries by educating the staff about the Munchausen syndrome.¹²

Although patients who present in the forensic setting with both malingering and the Munchausen syndrome lie about and may fake their symptoms, only patients with the Munchausen syndrome will lie and fake symptoms and historical details unrelated to the goals understandable in their case.

Frequently in the civil setting the forensic psychiatric examiner has the luxury of time and resources that are not available to clinical examiners. Such time and resources are particularly important in the evaluation of Munchausen syndrome patients, because there may be literally thousands of pages of records to review. Verification of family

and historical data can also require a great deal of time. In litigation, the release of records may sometimes be forced over the objections of the plaintiff as well. Finally just waiting for key records may take months (the military service and medical records in Case 2 took five months to receive from initial request). The civil forensic examiner may be the first clinician to be able to verify the plaintiff's past extensive lying behavior.

Other than making the diagnosis, the forensic psychiatrist can best help the fact finder in negligence cases by pointing out that patients with the Munchausen syndrome must have subjective symptoms verified by objective data before attribution of injury or causality are made. The result of civil cases frequently turns on such attributions, and without such an explanation the fact finder is liable to assign damages incorrectly.

In the workers' compensation setting, the forensic expert can evaluate the claimant's prior history of behavior consistent with the Munchausen syndrome and point out that the worker's difficulties are self-generated.

Although probably not highly prevalent in civil cases, the presence of the Munchausen syndrome has the potential for costing defendants enormous amounts of money and for wasting limited resources on patients who deliberately worsen their own conditions. The forensic examiner should have a high level of suspicion for considering the Munchausen syndrome in civil litigants when the litigant presents with a history of multiple unexplained medical prob-

Munchausen Syndrome

lems unrelated to the litigation at hand. The examiner should also be suspicious of the syndrome when attempts to verify personal or historical data are met with resistance.

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