Jon Garvey chews the cud and digest the essence of wisdom

He's out there somewhere

Little can be more rewarding than to read right the way through a really thick, juicy set of patient notes.

There is, of course, a pure historical fascination in perusing the faded pontificadons of bygone specialists about treatments we no longer believe to work for conditions we no longer believe to exist. There is an equal fascination in reading the more recent letters, which are equally dogmatic but less faded.

More important, though, is the insight the complete record can give about a patient we have hitherto seen through the blinkers imposed by the consulting room. Unfortunately, when a new patient's records finally arrive, not many of us have time or courage to wade through volumes of illegible longhand and chronologically jumbled correspondence. But if we do, we may distil the essence of wisdom. In my practice, we may also avoid the need to build an extra room for our expanding files.

I have just finished editing the notes of a man I have believed, even from my days as a local medical SHO, to suffer from recurrent pulmonary embolism and chronic bronchitis. For these he is on permanent anti-coagulation, steroids, oxygen, and a veritable wind band of inhalers. And yet, if one traces his story across the years and many different doctors, the only evidence for either of these conditions has been the patient's reporting of his symptoms. Xrays, lung scans, venograms, lung function tests: all have shown uniformly negative results, but so widely scattered across the notes that probably nobody has ever noticed, except to remark that the patient tends to exaggerate his symptoms. And when one sees that these diagnoses have led to major surgery and numerous hospital admissions, where anticoagulation proved difficult and it was suspected that the patient was not taking his tablets properly, the whole business begins to acquire the features of… Von Munchausen syndrome.

When Richard Asher described this condition—which captures the imagination of every medical student even more than the other florid eponyms which are the mainstay of finals—it was, of course, from the point of view of a hospital physician. In general, those he encountered were unmasked, discharged, and disappeared into the night air until they cropped up several hundred miles away. But the above case is the second I have seen in general practice, and there are striking similarities between this and the following case history.

This example is, if anything, more classical than the first. We acquired him from a refuge for the homeless, whither he had come from some coastal town, though the account he gave of his movements before that was somewhat confusing. It appeared his wife had died a few years earlier, and he had never really got over it. He had given up his job on the trawlers to stay with his children, but had fallen out with them, and had since been to various places trying his hand at this and that.

His poor health was a handicap. He had angina, for which he had needed coronary artery bypass surgery (unsuccessful), and asthma, for which he needed inhalers and oxygen. The former still troubled him, and we were often called out to give injections of Fortral (he said he was allergic to morphine and pethidine). A couple of times he collapsed near the hospital and was admitted, cardiographed and injected. He discharged himself against advice next morning, and told us the staff had insulted him.

Later on, we began to receive discharge summaries from neighbouring, and not-so-neighbouring, hospitals, where the same story was told. Meanwhile, at his request, we had org-anised referrals to chest physicians, surgeons for minor ops, the dietician for obesity, a work rehabilitation centre, and even a trip to a psychiatrist for an unmen-tionable problem he thought to be at the root of his troubles. He defaulted on them all.

The long and short of it was that when his notes finally caught him up, they contained discharge letters for no less than 120 hospital admissions, this itself being only a fraction of the total ("This old customer turned up on the ward again..."). Have you ever worked in a British hospital? He's been there, had his Fortral injections for angina, stayed a few days if it suited him, and discharged himself again. He was not an addict as such—on average, he would only have one or two shots in a month—and when we saw him, he never complained when we substituted oral analgesics.

Apart from the fake, or semi-fake, diseases and the hospital admissions, there are other parallels between my two patients. Both seem to have come from unhappy homes (though neither actually has medical records which prove it). Both tell numerous versions of their life-story; indeed the most consistent thing about their biographical details is that there doesn't seem to be a word of truth in them. Wives are said to have died of cancer, in air raids, or simply to have run off. My patient's trawler fleet, from the old address on his records, appears to have sailed from north Hampshire. Even his psychological problem, confided, it emerged, quite frequently to persistent psychiatrists or understanding GPs across the country, varies in nature from year to year, and appears to have been used simply as a holiday from angina.

But what motivates such bizarre behaviour? Not simply a desire to sponge on the attentions of others, I am sure. Neither would it appear to be simply masochism, in the sense of gratification from pain. While I admit I've not been able to pin one of these patients down for long enough to prove it, my impression is that their whole life is an attempt to cover their tracks. They deeply dislike themselves, and go to enormous lengths to build a smokescreen of false events and even false diseases to hide their real identity from the world—and from themselves. I don't know what they've got to hide, but it would be interesting to find out.

Jon Garvey: "One of you lot is looking after him."

There is a temptation, once one gets hold of the real facts, to confront the villain with them, and see what happens. I wonder if it wouldn't be more instructive, and possibly more therapeutic, to keep one's knowledge from him, and try to use it to draw some of the truth out. Perhaps I shall try it with my pulmonary embolism patient.

In the case of my angina patient, I never got the chance, for the week we received the notes, he disappeared from his lodgings and was never seen by us again (Munchausens must be telepathic!). But he's out there somewhere, which means that one of you lot is looking after him. Let us know how you get on, will you?▪