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Patients' right to confidentiality and sharing information with colleagues: The dilemma in managing a patient with Munchausen syndrome – A case report

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Abstract

We report the case of a young woman with a "pyrexia of unknown origin" in the background of a history involving SLE, ocular toxoplasmosis and Ig A nephropathy. The history was narrated by her with precise details but there was no documentary proof of any previous admissions. She had a prolonged hospital stay and repeated hospital admissions for the same illness with extensive investigations including a PET scan. Once evidence for "factitious fever" was overwhelming she got herself discharged from hospital refusing psychiatric help. Close scrutiny revealed that she had got herself admitted to several hospitals in the Western Province subsequently, with the same complaint, with all clinicians investigating her extensively, sometimes including invasive procedures. The ethical dilemma faced by us relating to sharing her clinical details with a wider clinical group is discussed.

Key words: Munchausen syndrome, pyrexia of unknown origin, confidentiality, stigmatization

Introduction

Munchausen syndrome is defined as a "disorder characterized by intentional production of symptoms or disabilities" to assume the sick role in the absence of external incentives.[1] Management of these patients is a challenge to the treating physicians due to the complexity in identifying the disorder, timely interventions as well as the ethical considerations in relation to diagnosis and management.[2,3] If not identified early, these patients can pose a serious threat to the health-care system as well as to the patients themselves.[4] It's common to see patients with this disorder seeking treatment at multiple institutions, leaving the institutions as soon as a diagnosis is made with poor adherence to psychiatric therapies which leads to a vicious cycle.[5] This highlights the importance of shared knowledge within the medical community to recognize these patients early, to prevent repeated investigations as well as for early initiation of treatment. However, this knowledge can lead to stigmatization and a negative impact on the patient. Therefore, clinicians must be extremely cautious when managing a patient with this disorder.

We present the case of a young female with a complex medical history who was repeatedly investigated for a pyrexia of unknown origin (PUO) at different health care institutions who was ultimately diagnosed with a factitious disorder. We wish to highlight the clinical and ethical dilemmas we faced in managing this patient and the timely need in raising awareness among the medical community to make sure this patient receives the necessary psychiatric interventions at the earliest.

Case presentation

A 32-year-old woman with a complicated medical history including a diagnosis of systemic lupus erythematosus (SLE) with lupus nephritis, IgA nephropathy, meningitis with ocular toxoplasmosis and provoked deep vein thrombosis following cholecys-

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tectomy, presented to us with an acute febrile illness. She was initially managed as for dengue fever. As she continued to have fever spikes beyond day seven, even after the recovery of platelet counts, without a clinically evident focus of infection, more investigations were done with a view of identifying the cause. Blood cultures became positive for coagulase negative *Staphylococcus aureus* and a mildly elevated procalcitonin level was noted, which supported commencement of antibiotics. Microbiology opinion was sought, and antibiotics were changed, yet the fever continued. Her fever continued beyond a cumulative period of nearly 90 days. Investigations for PUO including serial echocardiograms, autoimmune panels, a bone marrow biopsy, and serial repeat cultures were all normal. More advanced radiological investigations, including contrast enhanced computed tomography (CECT) and a positron emission tomography (PET) scan too were not helpful in identifying a cause for the ongoing fever.

Despite the prolonged hospital stay and multiple procedures carried out, she appeared to be in very good spirits, which became a point of fascination and suspicion! Some members of the clinical team suspected that this might be a factitious fever whilst others believed it's wrong to do so "in the backdrop of illnesses like SLE". Careful observations by the clinical team and initiation of directly observed temperature measurements led to fever free intervals while she continued to have fever during unobserved temperature measurements.

Her knowledge about diseases and diagnosis was astonishing despite a lack of a formal medical training. Apart from clear evidence of previous ocular toxoplasmosis, all the "medical history" was what she recounted and there were no medical records to support it. During an effort to trace her past records, we were able to contact her father, which was surprising as she claimed to be an orphan. Her father supported our suspicion that she keeps moving from one hospital to the another without a proper diagnosis.

With this evidence, we referred her back to the psychiatry team, whose junior members had initially reported that she had no psychiatric abnormality. This time however the senior psychiatrists concurred that she had a strong psychological (psychotic) component which was suggestive of a factitious disorder which could explain her clinical condition. The diagnosis was explained to her, and she was counselled by the psychiatric team. It was suggested to mention this in her clinical records for future references. She was discharged with a plan to review if the fever recurs. Over the next few months, we came to know that she had been admitted to 4 hospitals in the region with a history of "fever" and each occasion she had been commenced on extensive investigations for pyrexia of unknown etiology. It's very likely as we write this today, she is being investigated in some hospital for an illness with sophisticated investigations and the results will be baffling to the clinicians.

Discussion

Patients with suspected PUO warrant extensive investigations, especially when they also have a complex medical problem like SLE in the past.[6] The treatment, the cost of investigations often pending the final confirmation as well as the prolonged hospital stay, is a burden to the already overburdened hospital system.[7] When such a system is being tested by a patient with Munchausen syndrome who has an almost "real" illness, the system will be stretched to the extreme.

This patient presented to us with a background of many complex medical illnesses without any confirmative evidence to support them, apart from her ocular pathology. Her medical history was too significant to be ignored. Prolonged fever in an immunosuppressed patient cannot to be taken lightly and we evaluated the patient extensively. Although with time we felt that the patient might have a factitious illness it was difficult to ignore the persistently positive blood cultures along with a slightly positive procalcitonin level and daily fever spikes on the fever chart. This was confounded by the assurance given to us by the psychiatrists that the patient was of a sound mind.

The evaluation for PUO in this patient over a period of 90 days cost the system a minimum of 745,000 SLR (2300 USD). This value was for the investigations alone. The total healthcare cost would be much higher. The patient always maintained that her illness was real and was highly resistant to follow psychiatric treatment. Upon leaving our hospital during her subsequent admissions to different medical institutions she had undergone lumbar punctures and bone marrow biopsies for which she consented without any reluctance. We realized much to our dismay that she had not shown any of the previous diagnosis cards and her "behaviour issue" had not been identified by the other medical teams. At this point we faced the dilemma about the issues pertaining to "confidentiality" and disclosing our findings with our medical colleagues in sister institutions.

There are a few situations in which sharing patient information without expressed consent is not considered as a breach in confidentiality. This would include, when obtaining his/her consent is impractical, when it's done in the best interest of the public or when such an act is done in the best interest of the patient.[8] These situations are exceptions where, we may be doing more harm to the patient and the society, by not disclosing this information.[9]

Patients like ours are not common but clearly not unique. Failure to share information among colleagues and between specialties and not seeking appropriate mental health support has led to multiple surgical procedures and subsequently even death by suicide.[10]

Ethicists deliberating on disclosing and sharing information of patients with factitious disorders and Munchausen syndrome with medical colleagues of other institutes should consider the conflicting issues of the holy grail of not violating patient confidentiality. The potential benefit will provide for the patient (for example by preventing unnecessary procedures) and the greater benefit for the society (e.g. by cost saving). Even if disclosure is deemed necessary without the patient's approval, the patient should be informed that the information will be passed to relevant parties. ie: the disclosure should never be deceitful.[3]

Treating her underlying behavioral problem would be the ideal solution for this scenario. In this specific instance we failed to do so, as early diagnosis was delayed and when the diagnosis was finally reached, she refused to accept the diagnosis and left the medical institute.

Conclusion

The case highlights complexity of diagnosing patients with Munchausen syndrome as well as the complex issues relating to ethical dilemmas faced by the medical teams managing these vulnerable patients.

Author declaration

Disclosure of interest

Authors report no competing interests to declare.

Criteria for authorship

CW was the registrar in medicine who was responsible for the patient. AP supervised the management. The manuscript was prepared by all authors involved, collectively. All authors participated in manuscript revision, agreed to submit the manuscript and approved the final version of the manuscript. All authors had full access to clinical data.

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