

THE LEGACY OF BARON MUNCHAUSEN

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Hieronymus Karl Friedrich Freiherr Von Munchausen was a real person and a real Baron and a real traveler. The one thing that was unreal about him was the truthfulness of the tales that he told.

The Baron lived in Hanover, Germany where he was born in 1720 and died in 1797. He served in the Army and fought in the Turkish wars retiring to his estate in 1760. According to published reports after his retirement he became bored with the inactive life that he was forced to lead and in order to compensate for it he developed a habit of inviting his friends and neighbors to his home where he related extraordinary instances of his prowess as a soldier and sportsman. Among his acquaintances was one Rudolph Erich Raspe who was a writer and in 1785, when in need of funds while living in London, Raspe published a small pamphlet entitled "Baron Munchausen's Narrative of His Marvelous Travels and Campaigns in Russia". The following year a book seller secured the right to this pamphlet and published an enlarged edition under the rather formidable title "Gulliver Revived: The Singular Travels, Campaigns, Voyages and Sporting Adventures of Baron Munhikhausen, Commonly Pronounced Munchausen: As He Relates Them Over a Bottle of Wine When Surrounded by His Friends".

Over the next few years a number of sequels were published with additional tales added by various writers and taken from other mendacious tales such as James Bruce's incredible "Travels to Discover the Nile". (1790)

All of the publications had the common theme of the Baron being a widely traveled adventurer who performed amazing and extraordinary deeds such as

conquering Armies singlehandedly and escaping from wild beasts by impossible leaps and feats of strength.

In time the term Munchausen came to be used to describe any extravagantly remarkable fiction and also to describe a person who tells, as his own, adventures as unbelievable as those supposed to have been done by the Baron.

Although Munchausen has been around for nearly two centuries, it is only within the last three decades that the term has been applied medically. Physicians and hospital personnel have long known about a class of patients who make it a full time job to reside in hospitals. These people go from one hospital to another presenting with bizarre complaints related convincingly enough to gain hospital admission and staying for extensive studies for weeks or months until when their basic motive is discovered leave angrily - only to appear at another hospital the same or the next day to start the charade all over again.

These patients have been classified with a number of descriptive terms such as hospital hobos, the syndrome of hospital addiction, peregrinating problem patients, factitious illness, pathological malingering, peripatetic pseudoillness, and metabolic malingerers, just to name a few. It is of interest to note that the very prestigious and usually staid New England Journal of Medicine, a few years ago, published an article about these patients entitled The Hateful Patient which gives some indication as to the feeling that they generate among medical personnel.

In 1951 Richard Asher writing in the British medical publication "Lancet" reported on three such cases and in his introduction he wrote as follows: "Here is described a common syndrome which most doctors have seen, but about which little has been written. Like the famous Baron von Munchausen, the

persons affected have always traveled widely; and their stories, like those attributed to him, are both dramatic and untruthful. Accordingly the syndrome is respectfully dedicated to the baron, and named after him.

The patient showing the syndrome is admitted to a hospital with 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; and he nearly always discharges himself against advice, after quarrelling violently with both doctors and nurses. A large number of abdominal scars is particularly characteristic of this condition. That is a general outline; and few doctors can boast that they have never been hoodwinked by the condition."

The title of Dr. Asher's paper was "Munchausen's Syndrome" and the name stuck - with many articles having been written on this subject in the ensuing years.

There are many things about this condition which are different from most medical problems. Perhaps the two most striking have to do with the numbers of patients and the numbers of case reports which they generate.

In terms of numbers alone this is a relatively rare condition. Perhaps there are no more than several hundred of these people in the United States which would classify it as an exotic medical curiosity. But because of its very nature it is likely that most physicians have, at one time or another, come in contact with one of them. As Asher says "few doctors can boast that they have never been hoodwinked by the condition." The reason for this is simple. Since these people may spend a life time in hospitals and can rarely return to the same one a second time (except many years later) they may visit hundreds of institutions and be seen by thousands of physicians during their career. Some diagrams will be shown later which underscore this aspect.

Secondly, in terms of case reports, the medical literature in England and the

United States abounds with them. Again, the reason, the nature of the illness. Whereas an unusual or informative case is usually reported once in the literature, individual Munchausen patients have been reported many times by many articles in medical journals. Many times articles will appear almost simultaneously with one author not being aware that the other is writing about the same case. At least one of these patients has been reported seven times in medical journals as well as several times in lay publications.

My only known exposure to Munchausen came in 1950, just about a year before Asher named the syndrome. (I say only known exposure because, again by nature, a physician can easily be in contact with such a patient for a considerable period of time before recognizing it)

In 1950 I was resident physician in internal medicine at the Medical College of Virginia in Richmond completing my training prior to coming into practice here in Lynchburg. I have been unable to find any notes or records in respect to this case but I have fullest confidence in my ability to remember important details, even after thirty years, because once the physician has met one of these people he has a difficult time forgetting.

Some time in 1950 there was admitted to the ward medical service at the Medical College of Virginia a white male of approximately thirty-five years of age who told the most remarkable tale. He stated that he had served in the Navy during World War II and was an underwater demolition expert. He further stated that following discharge from the service, having learned about underwater work, he became a professional deep sea diver. He stated that most recently he had been employed as a civilian diver at the Norfolk Navy yard and was involved in salvage operations on several ships sunk off the Virginia capes by German submarines during the war.

His medical problem, he stated, started when he got the bends during a too

rapid ascent from a dive. He had allegedly been treated at a Norfolk hospital for the affects of the bends presumably manifest by severe chest pains. He had been discharged from the hospital and started to the Roanoke to visit relatives when the chest pains had recurred with great severity while passing through Richmond.

To understand something of the way we physicians could be taken in by this story it is necessary to discuss briefly the condition known as the bends. The medical term for this illness is decompression sickness also called Cassion Disease. It results from a rapid change of the body from a high environmental pressure such as underwater to a lesser pressure such as that at one atmosphere at sea level. The changing pressure converts nitrogen in the blood from a liquid to a gas which collects as bubbles in the blood and go to various organs causing headache, muscular cramps, abdominal pain and chest pain. In fact, quite bizarre symptoms. Most physicians never see decompression sickness and know little about it but some skepticism was entertained about our patient when it was pointed out that most articles on the disease indicate that once the acute phase is over patients remain well unless they again return to the same pressure-related conditions.

Our skepticism, however, changed to interest by another finding. On physical examination this man had a cardiac sound which none of us had ever heard before and could not find described in the literature. From time to time on listening to the heart we detected a peculiar and at times very loud clicking noise which was synchronous with the heart beat. This was heard by many observers and no one knew what it meant. But since the exotic diagnosis of the bends along with the very unusual physical finding we were well taken in.

I believe that I know now what the click was. Today we recognize a condition known as mitral valve prolapse which may have serious potential but many times is a quite benign condition. It is a mechanical defect in one of the heart

valves and one of the physical findings is a clicking sound heard when listening to the heart and at times related to voluntary activities of the patient such as holding the breath and assuming certain positions but in 1950 we did not know what it meant and spent about six weeks with this patient trying to find out.

We finally concluded after exhaustive studies that whatever this man had it was not serious. Our professor of medicine came very close to the mark when he ventured the opinion that whatever this click was it was something over which the patient had voluntary control and that he was using it to prolong his hospitalization. The patient was, therefore, discharged much against his will and after much unpleasantness.

A few years later, after coming to Lynchburg, I read an article in the Journal of The American Medical Association by a physician from Philadelphia who reported on a 38 year old deep sea diver with the symptoms of the bends and a clicking sound in his chest who had been admitted to Philadelphia General Hospital. He had remained there for approximately three months after finally being diagnosed as a Munchausen Syndrome. In the next five years at least six additional articles on this patient appeared and finally in March of 1958 Time magazine had a piece entitled "Medical Munchausen" in which our deep sea diver was described. This time he had picked on a Veterans Administration Hospital and had been admitted as a veteran. As it turned out he had never been in the service and was charged with fraudently obtaining VA hospitalization and was sentenced to a Federal reformatory. I have seen nothing of him since that time.

In the ensuing years much has appeared in the literature about this interesting syndrome. I will now pass out several photocopies taken from the literature which illustrate the extent of the problem.

#1 is a table listing several cases of the syndrome and demonstrating the number of hospitalizations that each one had.

#2 is a detail of one case showing the number of hospitalizations over

a twenty year period.

#3 is another case entitled Willie Morgan's Hospitalizations and Arrests.

#4 are discharge diagnosis and some remarks on thirty two such patients.

One important characteristic of the syndrome and an impediment to scientific study is the basic fact that these people never tell the truth. A medical history, therefore, of worthless and important and interesting past hospitalizations are very difficult to document.

One notable exception to this is a case reported in the July, 1980 issue of the Annals of Internal Medicine entitled "Probing the Dynamics of Munchausen Syndrome." This article attracted my attention while looking up another subject in the cumulative medical index resulting in my decision to write this paper rather than the one on another subject which I had been considering.

This paper was written by a group of physicians at the University of Florida school of medicine in Gainesville, Florida and described a forty eight year old male with many years of typical Munchausen behavior. The unique thing about this one, however, was that he became organically ill when he developed leukemia and although he refused to admit the diagnosis for a long time, when he was admitted to the Florida hospital he finally became convinced that he had a fatal illness and realizing that he had only a short survival time he became anxious to "come clean" and described his entire life style. So for two and a half months of hospitalization, while receiving chemotherapy for his leukemia, he talked at length about his past and also provided resource material and gave permission for his physicians to obtain records from other hospitals throughout the country. With this information they were able to put together a most interesting story which I shall now relate in some detail.

CASE REPORT AND ANAMNESIS

This patient was born in 1932 in Brooklyn, New York. He was described by relatives as "an active, intelligent child." However, his early years were marred by parent neglect. His chronically depressed, barbiturate-addicted mother was of little guidance or support. His father, limited by lack of education and having a language barrier was forced to work at nonskilled jobs at night and was described as being extremely harsh in his limited interactions with his son. When the patient was 7 years old, his deprived home situation was recognized by the juvenile authorities after he was caught setting fire to a neighborhood building. He was then sent to a state school.

At age 8 he needed a tonsillectomy, which provided his first hospital encounter. Enthusiastically using glowing terms, he recounted the environment of the operating room: "surrounded by shining lights" and the "smiling surgeon," who carefully explained the anesthesia apparatus and sensations of induction. This patient also recalled the warmth and tenderness of the nurses during his post-operative period.

At age 12, while still in the state school, he accidentally contacted poison ivy, which necessitated a stay in the school infirmary. There he became reacquainted with the positive aspects of hospital care. A short time later he purposefully rolled in poison ivy to gain readmission to the infirmary. When we asked him why he risked the physical discomfort for such a goal, he replied "pain can't be remembered but pleasure can."

He denied further such behavior during this stage of his life. According to his family, he was a good student who behaved himself and was "quite frightened of discipline."

On reaching adolescence, he was returned to the care of his parents. Soon thereafter his mother died of a barbiturate overdose. She was replaced in the

family by an overbearing, often irrational, maternal grandmother who reinforced the prevailing family atmosphere of emotional neglect and harsh discipline through support of the patient's father. Throughout this period of his life, the patient nurtured feelings of love for his deceased mother and of resentment toward his father, whom he suspected was either directly or indirectly responsible for his mother's death.

He developed an interest in flying and books, particularly the works of the popular medical fiction writer Frank Slaughter. He avoided alcohol and relations with women. He cited to us a lifelong disdain for drinking and casual sexual encounters.

MOVE TO CALIFORNIA

His family moved to California when he was 16 years old. He quit high school and left home to work at odd jobs. Within a year he met a young woman and entered a common-law marriage. Within a few months, while pregnant, she died of acute leukemia. After a suicide gesture, he enlisted in the Coast Guard. He spent his first year of service, 1950, as a medic in an isolated lighthouse on the coast of Washington. He was severely depressed and bored. To escape, he feigned an attack of acute appendicitis. He described to us with some pride how he skillfully used bogus complaints of nausea and vomiting and even demonstrated rebound tenderness in the correct anatomical location, which prompted local physicians to perform an appendectomy. He recalled the surgeon postoperatively describing an inflamed appendix. During the remainder of his Coast Guard tour, he fought depression with intermittent use of meperidine (Demerol; Breon Laboratories, Inc., New York, New York), which was available to him through his position as a medic. A Coast Guard Medical Board found him to be unfit for duty "by reason of psychopathic personality without psychosis," manifested by "childish pranks" and antisocial behavior. This available Medical Board report is totally consistent with our observations.

on this patient 28 years later.

He returned to California and rediscovered a woman who had jilted him a year previously. Another man had abandoned her when she became pregnant. Our patient gallantly married her and spent the next 5 years, 1952 to 1957, trying to establish a career and a semblance of normal family life. During this time he neither used illicit drugs nor feigned illnesses. He began working part-time as an emergency room orderly and the first-aid man for a construction firm. Through connections with construction projects and his experience in paramedical matters, he developed an interest in the then newly developing specialty of safety engineering. He described to us with pride his role in various lifesaving procedures. Through on-the-job training and self-education, he advanced to another set of construction projects, which necessitated his moving to Alaska and leaving his growing family in the northwest United States. After a few successful months, he became lonely, quit that job, and took another one in Oregon with less prestige and less potential for professional reward.

PERIOD IN PRISON

He soon discovered that his wife had become romantically involved with another man. Although he nobly handed his wife over to her lover, even paying some of their expenses, he again became acutely depressed. Shortly thereafter he attempted suicide by an intravenous overdose of narcotics, which he had obtained from a construction project dispensary. Although this attempt was unsuccessful, the police discovered narcotics in his possession. He offered virtually no sort of legal defense and was sentenced to several years in prison for this felony. He now admits that prison appeared a better alternative to life on the outside. The first few months he was imprisoned in a state mental hospital. During his confinement he swallowed a spoon so that he could escape to the "soft" environment of a city hospital ward. Subsequently he was transferred

to prison. He kept to himself and used his free time to study medicine (for example, The Merck Manual of Diagnosis and Therapy. Merck, Sharp & Dohme Research Laboratories, Rahway, New Jersey:) and law, eventually becoming well-versed in the terminology of both fields.

In 1961 he was paroled, but within a few weeks anxiety and depression again set in. He wrote a prescription for meperidine, succeeded in having it filled, and then, inexplicably, turned himself in to his parole officer. Not surprisingly he was returned to prison. He was again offered parole 4 years later but refused on the grounds that he was "not fully rehabilitated."

In 1968 he was assigned to the prison plumbing shop. He was threatened by inmates after resisting their pressure to steal materials useful in an escape. Sensing an impasse, he injected small amounts of saliva subcutaneously in his popliteal area. Several days later an abscess developed, and he became slightly febrile. He incised the skin of his abdominal wall with a sharp tool and claimed he had accidentally become impaled on the tool. He was taken to the infirmary. Fever and leukocytosis induced by the unnoticed abscess and the expertly feigned signs of peritoneal inflammation (excluding, of course, absent bowel sounds, which he regretted that he could not produce) won him a laparotomy, which revealed no disease but resulted in the secondary gain of a secure environment.

Another ploy he developed at that time was complaining of severe toothache. He professed allergy to local anesthetics and obtained extractions under general anesthesia. Anesthesia had become a pleasurable, erotic experience in that he would often acquire penile erection during induction.

INTERNATIONAL TRAVEL

A short time later he was again paroled. He was employed by the cargo division of a large international airline, giving him contact with his adolescent

love of flying and travel. He traveled privileged weekend flights solely for the excitement of the flight itself, which he relished for the sense of danger it engendered and the "cozy, cocoon-like" atmosphere of the plane itself. Within a few months the airlines learned that he was an ex-convict. Fearing embarrassment, he left, and with the aid of airline connections traveled throughout Europe and the Near East for 2 years. During this time, his routine use of meperidine markedly increased. His drug-seeking behavior caused him to leave one country after the other. To obtain the drug, he visited local physicians complaining of migraine headaches, chronic dislocating shoulder, renal colic, tic douloureux, or abscessed teeth. After passing through India and Hawaii, he arrived in Australia where he was caught in possession of meperidine. He was in a drug rehabilitation program briefly, became homesick, refused further therapy, and was deported persona non grata to the United States in 1971. On his return he was jailed a short time for parole violation.

After release he met a 25 year old woman, the fiancee of a young man he had met in jail. The patient fell in love with her, and she became dependent on him but never gave up her affection for her jailed lover. The patient, again displaying gallantry, supported her financially and at the same time helped get the young man's sentence reduced. While the latter was serving his sentence, our patient married the woman and they spent the next year traveling in the United States and abroad at the expense of his former airline employer. This stage of the relationship ended with the former boyfriend's release from prison. The patient then returned to heavy meperidine use and traveling in foreign countries.

After returning to the United States, he tried to establish himself near his wife and her lover, both of whom had become addicted to heroin. He had difficulty holding jobs because the meperidine use became more widely

recognized by those around him. In spite of this and the lack of love his wife demonstrated for him, he preferred to remain close and render whatever support he could. In discussing this period, he moralized about the evils of heroin use, although concurrently he himself was treated on several occasions by local, state, and Veterans Administration (VA) hospitals for drug addiction and depression.

A HEMATOLOGIC PROBLEM

in 1973 he was found to have leukocytosis and anemia. After wrangling a bone marrow biopsy under general anesthesia, he was told he had chronic myelogenous leukemia. However, until recently, he consistently refused to accept this because he would ultimately lose control of his strange lifestyle to this malignancy. Referring to his first wife's death, he stated that leukemia was a "particularly bitter pill to swallow, as it killed the only person I have ever truly loved." He preferred to believe his leukocytosis was caused by an occult infection, but repeated attempts to find common infections were fruitless. He therefore developed an obsession that the leukocytosis was due to filariasis (15) he had acquired from intravenously injected water from areas of the world where filariasis is endemic.

Innumerable hospitalizations have documented his quest to support the diagnosis of filariasis or other "worm infestations." Nearly all these hospitalizations documented chronic myelogenous leukemia with persistently positive Philadelphia chromosome analyses, increased serum vitamin B 12 values and vitamin B 12 binding capacities, and low leukocyte alkaline phosphatase activities. Between 1973 and 1978 he traveled from city to city in the United States. Using ingenious ploys, he obtained medical care from numerous hospitals and clinics largely under false pretense.

Although the geography varied, a few distinct patterns arose. The drug seeking motive was behind most of his outpatient visits. Complaints were those he had

used before and two new ones---"bone pain" secondary to chronic myelogenous leukemia and occult infection made plausible by his leukocyte count. He discovered that by allowing slight withdrawal symptoms to develop, he could increase his leukocyte count to 100,000 to 200,000 cells/mm and promptly gain admission to nearly any hospital he chose. After readministration of meperidine the leukocyte count would promptly fall to the range of 20,000 to 40,000 cells/mm. These modes of operation necessitated his moving often enough that trusting physicians would not become overly suspicious. He claimed that it was much easier to get significant amounts of meperidine as an outpatient; therefore, his drug habit was never the sole motive for seeking inpatient care. The pleasure of obtaining meperidine was greatly enhanced by hospitalization itself and by the procedures because of the excitement and "sense of danger." He obtained most of the drug through outpatient visits to private offices and emergency rooms because of the enormous quantities he used (700 to 1000 mg. in a single intravenous injection), the privacy he needed to administer such a dose, and freedom needed to secure the next day's dose.

His hospital admissions were interesting. A common pretended illness was acute renal colic. He easily induced "hematuria" by placing a drop of his blood in his urine sample. Should hospital personnel act suspicious, a cotton swab soaked in blood and subsequently placed in the urethral meatus produced not only hematuria but also a painful clot that he passed at will before observing, doubtful hospital staff. He not only feigned illnesses but on several occasions arranged and directed parts of his own patient care (13, 14). Consulting the "yellow pages" of a telephone book he would call a group of urologists and learn which of them was out of town; invariably one was. He would then call the emergency room of a hospital in which the urology group had privileges. He would impersonate Dr. "A" and state that he was out of town and that his patient, namely our patient, had called long distance and was in need of admission for recurrent renal colic. As Dr. A, he would then give plausible

admission orders, including reasonable doses of analgesia, blood work, instructions for fluids, and straining all urine, as well as giving instructions that one of his "colleagues, Dr. "B" was to be notified to see the patient after appropriate admission orders were carried out. Our patient would then present himself in the emergency room and produce a urine sample to which he had added some of his own blood. The adventure would end several days later when Dr. B could not find any records of the patient in Dr. A's files. The patient would then leave after an angry confrontation but after several days of room, board and analgesia.

Although able to perform this deception several times in his career, he never ascribed his success to the gullibility of physicians; rather he felt that this sort of thing worked because of the inherent trust between patients and physicians, the desire of physicians to help patients, and the desire of the patients to be helped by physicians.

MANIPULATION OF THE MEDICAL COMMUNITY

Other examples of his ability to manipulate the medical community include the events partially reported by Allegra, Woodward and Chandler (13): While making his exit from a Texas bondsman's office, he jumped from a window and broke his right calcaneus. He then hobbled to a hospital where he complained of pain of unknown origin in the heel. After being at the hospital for about 6 hours, he fell out of favor with the nursing staff because he was ordering meperidine over the telephone, having impersonated one of the emergency room physicians. He made it to a hospital in Colorado and again, while seeking attention for his foot, disrupted the hospital routine. After a confrontation with the authorities, he consulted the telephone book, called a private orthopedic group, and worked the same deception he had used with urology groups in the past. Again, posing as Dr. "C" he arranged to have an ambulance transfer him to another hospital, where he had prearranged laboratory work and roentgenograms and had

even reserved, on his own, 45 min. of operating room time, having made sure that Dr. "D" was free when the operating room was available. That the hospital in which he desired hospitalization was full at the time did not deter him. He arranged transfer of a patient from the orthopedic wing to another hospital to make a bed available for himself. The calcaneus was successfully pinned before the deception was discovered.

We initially encountered the patient at the Shands Teaching Hospital in 1976 when he complained that he had untreated filariasis (15). He explained he was a safety engineer for a major airline and his important work had taken him all over the globe, including such exotic places as Hong Kong, Indonesia and Africa. This part of his story seemed credible because he recalled details of the Far East that were verified by his intern who had lived in the same area of the world. He stated that he had intermittent fever and swelling of his lower extremities and scrotum. He claimed to have recently been in a hospital in Washington, D.C. and that blood smears drawn at 0200 and examined with particular attention to the edges of the cover slips had yielded a diagnosis of filariasis. Because of "business obligations" he said he had left the hospital before adequate treatment could be given. At our hospital, physical examination revealed a temperature of 39°C and a fluctuant, warm, tender mass over the left deltoid muscle. Needle tracks were present on his arms and legs. Abdominal examination showed numerous well-healed scars and splenomegaly. His leukocyte count was 42,000/mm, and a blood smear was compatible with that of chronic myelogenous leukemia. The subsequent work-up ruled out filariasis and documented the presence of chronic myelogenous leukemia, of which the patient claimed no knowledge, although he had known of this illness for approximately 3 years. A call to the hospital in Washington revealed that he presented with the same complaint but that appropriate studies there could not confirm the diagnosis of filariasis. We treated a subcutaneous abscess, but the patient left the hospital against medical advice after a heated dispute

about the detailed specifics of his therapy for leukemia. However, just before leaving, he obtained a prescription for meperidine from the emergency room resident by impersonating his attending physician on the telephone.

A few weeks later he was admitted to a locked psychiatric hospital. He "borrowed" an intern's white coat and stethoscope and walked off the ward, having the locked door opened for him as he escorted another patient's family down the hall discussing detailed medical matters concerning their relative.

This patient's intelligence and resourcefulness were also demonstrated by the following incident: While using a pay telephone in a drug store and impersonating a physician, he observed a pharmacist taking his order for meperidine. The pharmacist acted somewhat suspicious. Two men soon entered the pharmacy and assumed positions behind the counter. When the patient was to pick up the prescription, he was arrested by one of the newly arrived men and charged with "impersonation of a professional person." The patient then confirmed the fact that the two men were narcotics agents. He pointed out that by dispensing the drugs and accepting cash for these medications, the agents were acting as pharmacists. Because neither had ever attended pharmacy school, they were impersonating professional persons. He was immediately released and told to leave town.

The patient's ability to manipulate the medical system was rivaled only by his ability to do the same with public transportation. He is a master of sneaking onto airplanes, trains and buses. He was eventually discovered in the lavatory of an international flight. Because one of the passengers was a reknowned political figure, authorities deduced that this man without a ticket, money or identification had planted a bomb on the airplane. The airplane was landed and fruitlessly searched while he was arrested.

Not long ago his pattern of traveling from hospital to hospital was interrupted by a prison term for passing bad checks. While in prison he managed to swallow

a spoon on two occasions, leading to two different abdominal procedures, his spleen was removed during one of these procedures. The remainder of his teeth have been extracted, one at a time, under general anesthesia from which he obtains an erotic, pleasurable sensation. He has also had several repeat bone marrow biopsies, again each under general anesthesia.

RECENT MEDICAL ASSESSMENT

In 1978 he returned to this medical institution for reevaluation of chronic myelogenous leukemia and for drug rehabilitation. The day before his prearranged admission, he was crossing a street and was struck by an automobile. He sustained bilateral fractured tibias and fibulas. He feigned no illness this time but rather seemed more concerned that he was approaching the end of his life.

Physical examination revealed a cachectic, mildly agitated white man in no acute distress. The skin showed needle tracts in all potential venipuncture sites, including the great vessels of the neck. The lungs were clear, and the cardiac findings were normal. The abdomen had numerous well-healed scars, and the spleen was now surgically absent. Both legs were in casts. Examination of mental status showed that he was oriented to time, person and place.

Memory and intellectual function were intact. The rest of the neurologic examination was normal except for a diffuse hyperreflexia. Results of blood tests were compatible with chronic myelogenous leukemia. He remained in the hospital for 10 weeks. A program of drug withdrawal was begun. During the course of this hospitalization, we tape-recorded more than 30 hours of medical and psychiatric interviews. Elaboration of his history was obtained through available medical records and interviews with family members and physicians conducted in person and by telephone. Midway through his hospitalization when his relationship with us was at its best in terms of personal communication and understanding, he began secretly to obtain meperidine by briefly leaving the hospital and going to private physician's offices. One night his nurse

discovered bottles of labeled meperidine and syringes on his night stand; he had "accidentally" left them out for all to see. A confrontation ensued. He was agitated, hostile, and aggressive and threatened to leave the hospital against medical advice. After a long discussion he elected to remain under our care, and a second narcotics-withdrawal program was initiated. Within a week or so the patient was completely rational, and plans were made to admit him to a local "halfway house." When he was to leave the hospital, he was again found with meperidine and syringes blatantly laid out in the open. A second heated confrontation occurred. This time he angrily left the hospital in a frankly paranoid state.

Since leaving our care he has continued his nomadic lifestyle. However, because his fractured legs never properly healed, he has been using his real orthopedic complaints to gain admission to hospitals. Since he has left us, he or his physicians have contacted us from over 20 states.

REVIEW OF AVAILABLE MATERIAL

We have assembled his available VA records from 1968 to 1979 (14 kg. of material). His travels are documented as well as other events. His histrionics have portrayed him as a free-lance writer, airplane mechanic, safety engineer, commander of the Persian Navy, an American Indian, and sole survivor of a secret helicopter accident behind enemy lines during the Korean War. He has claimed to be the master of seven foreign languages. He has been described as "childish," "antisocial," "crazy, but not psychotic," "smooth," "talks in circles," being able to "sell freezers to eskimos," "suspicious with highly intellectualized behavior," and "brilliant." The records show that only rarely was he admitted to the same hospital more than once. His ability to resurface thousands of miles away in a few hours after discharge was no doubt aided by his ability to obtain free travel. After a discharge against medical

advice, he has nearly always blamed a confrontation on the personnel's inability to understand his problems. In situations like those at our hospital, where all attempts were made to appease, he eventually precipitates a crisis by "accidentally" being caught with contraband material. He has often been caught on a hospital telephone impersonating his attending physicians. On several occasions he has simply left a hospital never to be seen again.

We arbitrarily chose the 12-month period from July 1975 through June 1976 to document the patient's travels. We used only the VA records available to us. Beginning with VA hospitals in Madison, Wisconsin, and ending with Wilkes-Barre, Pennsylvania, he was admitted 39 times for a total of 152 days (average admission 4 days). It is uncertain how many emergency room visits, private hospital visits, and non-VA hospital admissions were made during this time. The records also showed a 10-week gap when he must have avoided all VA hospitals. Of these 39 admissions he was discharged against medical advice 34 times, including three escapes. He estimated that he has been hospitalized a total of nearly 400 times. Indeed, he has called himself "the Duncan Hines of American hospitals."

We learned that as bizarre as his lifestyle was, he apparently adhered to a certain "code of ethics" which includes no smuggling or selling drugs; no using false names; no stealing, breaking and entering, or the like; no use of "street drugs"; no use of alcohol; no use of barbiturates; no leaving labels on vials of prescribed drugs. Explaining the first four rules, he offered that breaking any of these could get one into trouble with either the police or organized crime. Alcohol and barbiturates (an overdose of which killed his mother) he viewed as dangerous. A physician's name on the label of a bottle of drugs could cause the initially entrusting physician embarrassment or trouble if it were discovered.

Well, this is undoubtedly the most in depth study of Munchausen Syndrome that has thusfar been written but it does not give us much insight into the cause of this intriguing condition. For many years these people were considered as pure malingerers who behaved in this manner as a way of life. The hospital was their home, where they lived for years and years. With no job, no income and no insurance they were actually parasites on society. I think that our deep sea diver, at the time we saw him in Richmond, was considered in this category and was classified as an ingenious bum who had found his way of life.

The question has also been raised as to whether or not people with Munchausens may actually be drug addicts and certainly a significant number of those which have been reported have addiction as a part of their problem. But not all. Many of them have not exhibited any drug problem at all and our deep sea diver, as far as I can determine in all of the reports that have been made on him, has not been considered in this category.

Psychiatrists in recent years have become interested in the condition and originally thought it might be some form of hysteria. They also considered that these people are purely psychopathic personalities.

Recently, however, some psychiatric literature has suggested that this may be a true psychosis. One common denominator in all of these cases is the description of an unhappy childhood, usually a broken home and almost invariably with strong maternal attachment and paternal rejection. Some psychiatrists have suggested that the hospital environment is, in effect, a sub-conscious return of the individual to the protective security of the mother's womb.

Of interest to note is the fact that almost all of the people suffering from Munchausens are highly intelligent. I didn't give it in detail but the patient that I just reported from the University of Florida had extensive

psychological testing and his IQ and other psychological tests were of a fairly high order. It is also obvious from the ingenuity which these people use in manipulation of physicians, hospitals and others that they possess fairly keen minds.

In any event, the condition is apparently resistant to treatment. There has been one article which reports a cure but that was an individual who was hospitalized in a psychiatric institution for 3 years and it seems to me that it is sort of futile to treat a condition whose primary symptom is long term hospitalization with long term hospitalization.

Finally, I believe that the name Munchausen is unfortunate. As I indicated earlier in this paper, the syndrome has been called by a number of descriptive terms. Psychiatrists have recently introduced the name "Chronic Factitious Illness" and it seems to me that that is appropriate. It is chronic, it is factitious and it is an illness, but we seem to be stuck with Munchausen and that is a pity.

These patients are very difficult. They use time and money and resources that are needed for other sick people. They are irritable, hateful, and cause untold miseries for many people.

The good Baron, I suspect, was none of these. He probably did no harm and in terms of literary enjoyment perhaps did a great deal of good. He deserves better than the legacy assigned him by Dr. Asher.