

Hospital hoppers — jumping to conclusions?

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In 1951 Asher applied the term 'Munchausen's syndrome' to a group of patients admitted with an apparent acute illness supported by a plausible and dramatic history which was found subsequently to be made up largely of falsehoods. The patients were found to have attended and deceived an astounding number of hospitals and discharged themselves against advice, often after quarrelling with nursing and medical staff. One illustrative case history documented 18 different hospital admissions. Asher commented at the time that 'the patients gained nothing but the discomfort of the investigations and often operations. The patients appeared to have an intense desire to deceive everybody as much as possible'. However Asher did suggest in the same article that the patient's motive for the deception may be a desire to be the centre of interest and attention (Walter Mitty syndrome) — if not being the surgeon they could still gain from the equally dramatic role of being the patient!

Munchausen's syndrome is used synonymously with chronic factitious illness (American Psychiatric Association, 1987). It is suggested (Pankratz, 1981; Ford, 1986) that besides factitious illness the patient should fulfil the two other main characteristics in Asher's description — peregrination and pseudologica fantastica, to be diagnosed as Munchausen's syndrome.

The very name has been criticized (Patterson, 1985) and others have been suggested: 'Hospital Hoboes', 'Hospital Vagrants', 'the desire to be ill' (Parker & Barrett, 1991). In the West Midlands these patients are termed 'Hospital Hoppers'. The syndrome has been extended to take in a particular form of child abuse — Munchausen's syndrome by proxy (Meadow, 1977). Patients continue to deceive and doctors continue to write about it. It has been suggested (Markantonakis & Lee, 1988) that a central register of known sufferers be established by the Royal College of Psychiatrists.

Many of these patients present to accident and emergency (A&E) departments in an attempt to gain admission to hospital. Many are identified by experienced staff, often it seems, without reference to any file. Within the West Midlands Health Authority an informal system of notification of other hospitals has become established. A&E departments receive occasional letters giving some patient details and history relating to previous attendance(s) but there is not, it would seem, an organized system of identification or notification of these cases.

A study was conducted recently by the author in 24 hospitals in the West Midlands in order to determine current practice. This has shown that most A&E departments receive between six and ten notifications of 'Hospital Hoppers' from other hospitals and most (23) retain the information. Only two departments kept data on computer. Most (21) would retain it indefinitely. However, whilst 16 departments had identified a total of 39 'Hoppers' in the previous year, 21 cases had gained admission before being discovered. Total attendances at the A&E departments in the year exceeded 900 000 patients. Despite this, 22 departments wanted the notification to continue.

In the same hospitals only two had a formal committee to decide whether a patient was a 'Hospital Hopper' and only three followed some form of criteria for making the diagnosis.

These made reference to previous attendance, the present history or reference to the notification file — but not a combination of these. Thirteen hospitals notified others and one hospital notified Social Services.

'Hospital Hoppers' make up a very small proportion of the overall workload of an A&E department, but they engender feelings of anger and frustration when they are discovered because, it would seem, of the deception that they practice. No-one wants to be seen to be wrong in their diagnostic assessment of a patient. This probably accounts for the almost universal support for the continuation of a notification procedure for A&E departments expressed by A&E staff in this survey.

Despite the small numbers of patients, there remains support for a notification process. Is it not then essential to ensure that the process is both reproducible and as accurate as is possible? Also that the system identify as many 'Hospital Hoppers' that attend as possible. At present the decision that a patient is a 'Hospital Hopper' is made as a result of a variety of considerations by a variable number of individuals with a varying experience who appear to not be using defined protocols to reach the conclusion that a patient is a 'Hospital Hopper'. There is no universal process that is followed that could be identified in this survey. The obvious danger of this is labelling the unfortunate patient who may be disreputable, drunk, confused, ill and genuine!

If it is accepted that despite the small number of patients a system of notification is required, then the time has now come to organize a proper system. Standardization of criteria used to establish a 'Hospital Hopper' diagnosis must become accepted. Why not start by using Asher's original definition of the 'Munchausen syndrome'? Namely, presenting with an apparent acute illness which is simulated or self-induced, having a dramatic and plausible medical history largely made up of falsehoods, attendance at a number of hospitals and deceiving medical staff and self-discharging (often against advice) usually after quarrelling with staff.

Each hospital or health district should develop a group structure or committee which can consider each case — rather like the well established 'case conferences' organized by social services in child-protection cases. These committees could include senior staff from A&E, management, an independent consultant, the general practitioner and a social worker. Once a decision has been made that a patient is indeed a 'Hopper' then the details should be entered onto a regional, or national database. This could then be controlled, re-assessed and distributed properly. This information should be retained on the ever increasing computerized A&E record

systems (ref. the Child Protection Register) to enable immediate and automatic identification of the patient who (re-)attends using the same name. Aliases could also be entered.

The problem of a 'suspicious' patient attending an A&E department out of hours could still be managed better if each A&E department identified a senior contact point which immediately surrounding A&E departments knew about. Then one department could telephone a warning to the A&E departments of surrounding hospitals if their patient left under suspicious circumstances, without necessarily labelling the patient irretrievably forever before the full facts are considered by the case conference. These calls would naturally be confidential.

The final consideration should be that of addressing the fact that the patient has attempted to deceive or defraud the hospital. If a person impersonates a doctor he is prosecuted. Should people who impersonate patients be charged with fraudulent behaviour, or is this an illness, and is therefore the subsequent behaviour (with possible violence) part of that illness and excusable?

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