letters

TO THE EDITOR

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Munchausen's syndrome

Editor – Like Dr Crawford (*Clin Med* July/August 2005 pp 400–401), I too have maintained an interest in Munchausen's syndrome since I first encountered McIlroy, a notorious sufferer of the syndrome.[1] Indeed, in continuing his follow-up, Dr Pallis and I were responsible for the only re-opening of a closed correspondence in the *BMJ*[2] – which clearly underlines the fascination of the syndrome to the medical profession and to the lay press, which hounded both us and McIlroy himself following our first publication.

However, it is disappointing to see that acute hospital staff continue to be angry or disappointed by their encounters with such sufferers.[3] While this is an understandable reaction – we expect our patients to tell us the truth – it means that the underlying cause of the problem may fail to be addressed: 'Inappropriate confrontation of these patients rarely results in any alteration in their behaviour, and it is precisely because we do not, as doctors, comprehend the more masochistic manifestations of their behaviour that we are so unsuccessful at helping them'.[4] Most sufferers who have been fully researched, usually by psychiatrists, show early signs of disturbance with a history of parental neglect or abuse, and/or a history of petty criminal behaviour.[5,6] If some attempt could be made to investigate these aspects, it might be possible to provide treatment.[7] This may not be easy; as Wade stated, 'The psychiatrist, however, can treat the patient only on the findings and the history. Where the history is a fabrication, then the findings and treatment are based on false premises'.[8] That said, there have been successful attempts to understand the problem, most notably by Brian O'Shea and colleagues who not only managed McIlroy[9] but cared for him at his end.

And this underlines another issue – one we met more than once in McIlroy's history – sometimes these patients can have genuine illnesses. Thus we must ask first what drives these people to deceive, and second be sure that they have not cried wolf once too often. It was not unusual for 'abdominal' Munchausen patients to obstruct from the adhesions following multiple surgery, while heart attacks, strokes and broken hips are not confined to the psychologically sound.

Finally, it is seems appropriate to remind College Fellows that the fictional Baron Munchhausen himself had dealings with them; while Fellows were carousing at the College, he hoisted the College into the air using a balloon, and it was airborne for three days without anyone inside noticing. During this time the death rate in London went down.

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3 Crawford SM, Jeyasanger G, Wright M. A visitor with Munchausen's syndrome. *Clin Med* 2005;**5**:400–1.
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In response

We are grateful to Dr Bamji for his comments on our article. Our intention was not to discuss the optimum management of this phenomenon but to document the reactions of personnel to such patients.

The nature of Munchausen's syndrome is such that patients are admitted to the ward appropriate to the illness they claim to have, not to a psychiatric ward. The nature of their deceit is different from that, say, of the person who is repeatedly admitted with chronic obstructive lung disease who assures everyone he has cut down to three cigarettes a day. It is a deceit that preys on the professionalism of doctors and nurses who consequently feel very let down. That this is not in the patient's best interest is clear.

However, the patient is on an inappro-

priate ward with staff who feel they have been duped. Their skills are not appropriate to his needs; the more so as clinical areas become more specialised. The patient's increasing demands were, in this case, increasingly more aggressively expressed. Our subsequent enquiries revealed that he had been specifically threatening to a female doctor at one of the other hospitals. It is clearly necessary to remove such patients from these wards.

On the other hand, the liaison psychiatry service to which he might have been referred has been compromised by lack of resources and by policies that require it to distance itself geographically and professionally from the district general hospital. It was in no position to respond to a referral. Also, the patient had travelled some distance from his true home base. After he was presented with the evidence of his behaviour, he told us that he had a general practitioner and a psychiatrist in a particular part of the country. He undertook to consult them for the help he acknowledged he needed. Telephone calls confirmed that a man who displayed the *modus operandi* that we had witnessed was known to that practice so a full discharge summary was sent, with a copy to the psychiatrist.

We leave it to others to judge how well we discharged our duty of care to this man.

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Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

A survey of Continuing Professional Development (CPD) in palliative medicine

All doctors are required to undertake Continuing Professional Development (CPD).[1] The medical workforce in palliative medicine is diverse, with many doctors working on a part-time basis but with the same CPD requirements as those working full time.[2–4] A survey was undertaken to establish whether doctors had fulfilled their CPD requirements and to identify problems or difficulties experienced by doctors in undertaking CPD.

A questionnaire was sent to all doctors working in non-training posts requesting information on CPD undertaken in the previous year. Questions were also asked regarding knowledge and understanding of appraisal and revalidation.

The response rate was 53% (381/721). Palliative medicine was the main post for 276 (72%) respondents and 169 (44%) were on the Specialist Register; 214 (56%) held contracts with a hospice or charity; 159 (42%) with the NHS; four with a university (1%). The subgroup most likely to have fulfilled CPD requirements were those on the Specialist Register (64%), and those least likely were those holding a contract with a charitable organisation (33%) (Table 1). A higher proportion of those registered with the Royal College of Physicians (RCP) than in the overall group keep a record of CPD (94%), although only 74% understood College CPD requirements. Only 58% of those registered with the RCP met the criteria for external CPD and 62% for internal CPD. This was, however, higher than for the overall group. For those on a part-time contract (62%), CPD was being undertaken both in work and in their own time – 98% were performing 50% or more of their CPD in their own time.

Fifty-five per cent of respondents stated that their contract was held by the charitable sector, of whom 27% were on the Specialist Register. This subgroup had the lowest percentage for keeping CPD records (81%) and were least likely to understand College CPD requirements (49%) with only one-third achieving requirements for CPD points.

Qualitative comments from this group included:

> 'Does this apply to me? I am only part time at the hospice.' (NCCG 4)

> 'I have never been told how to register for CPD … everything is geared up

Table 1. CPD points gained by doctors working in palliative medicine.

Doctors		Percentage meeting minimum CPD point requirements
Overall	External	43
	Internal	43
RCP registered	External	58
	Internal	62
On voluntary contract	External	33
	Internal	31
On NHS contract	External	55
	Internal	58
Palliative medicine as main job	External	50
	Internal	53
On Specialist Register	External	64
	Internal	69