Existential Air Hunger: How Limited Resources and Systemic Bias affected the Treatment of a Vulnerable Patient with Factitious Disorder

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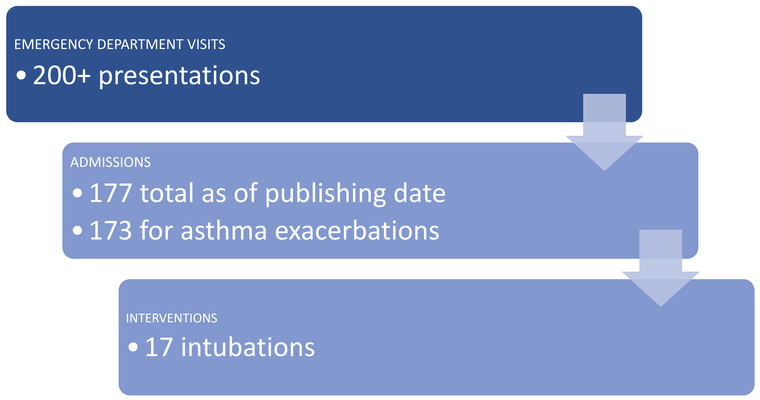
UCONN HEALTH

ABSTRACT

Introduction:
While factitious disorder is a challenging diagnosis even under optimal conditions, this case demonstrates how systemic issues and bias negatively impact a patient's care belonging to multiple marginalized populations. It highlights the need to consider intersectionality in assessing a patient. In addition, factitious disorder, by definition, implies constant exposure to a healthcare environment and increased risk of self-harm by undergoing many unnecessary procedures that can lead to medical complications. In this case, we would like to spotlight a patient that had repetitive exposure to the healthcare system with physical side effects that extended her hospital stays due to defensive medicine.

Case History
C.J is a 50-year-old African American female with a past medical history of asthma, substance use disorder inclusive of cocaine and alcohol, and PTSD, presenting to the emergency department with shortness of breath.



BACKGROUND

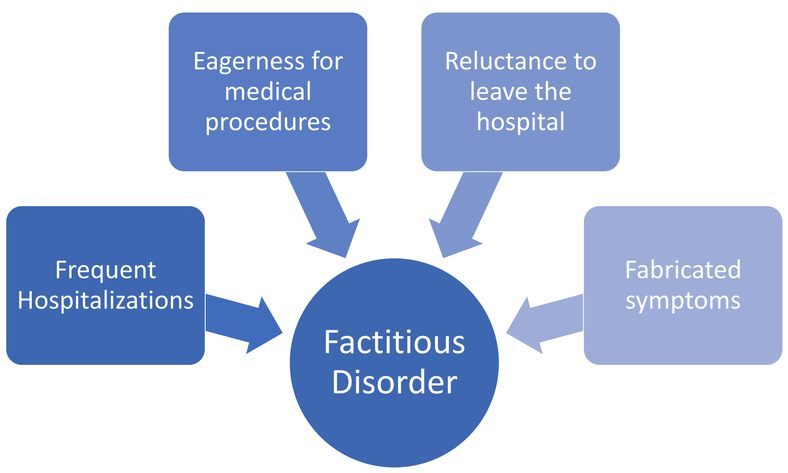
Factitious disorder, also known as Munchausen syndrome, is a mental health condition characterized by a person intentionally feigning physical or psychological symptoms, or even self-inflicting harm, in order to assume the sick role and receive medical attention. Racial disparities in healthcare refer to the differences in health outcomes and access to quality care experienced by different racial and ethnic groups. These disparities can arise due to various factors, including socioeconomic status, education, geographic location, and systemic racism. In the context of factitious disorder, racial disparities may manifest in how healthcare providers perceive and respond to patients exhibiting symptoms, potentially leading to delayed or inadequate care for individuals from marginalized racial or ethnic backgrounds. It is important to address these disparities to ensure equitable and inclusive healthcare for all individuals, regardless of their race or ethnicity.

CASE REPORT

C.J is a 50 year old African American female with a past medical history of asthma, substance use disorder inclusive of cocaine and alcohol, and PTSD, presenting to the emergency department with shortness of breath. At the time of presentation, the patient had 177 admissions documented on the electronic medical record, of which 173 were for asthma exacerbation, with 17 intubations.

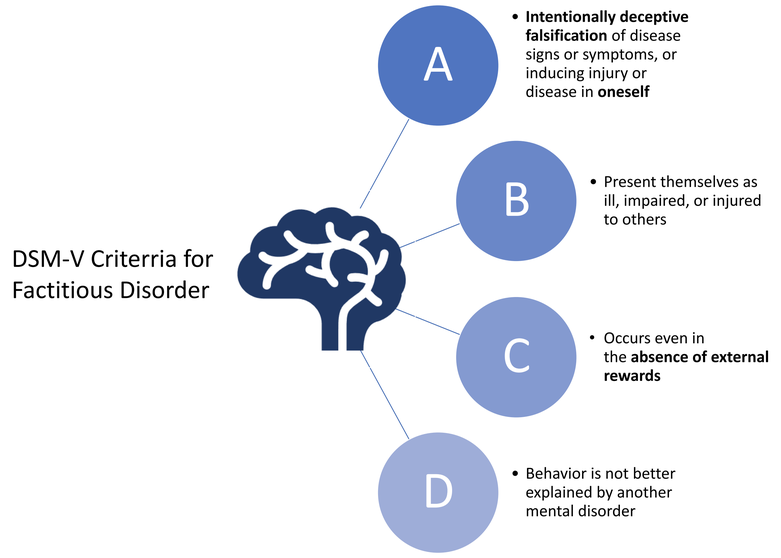
On initial presentation, the patient repeatedly demanded intubation, declining less invasive etiologies of supplemental oxygenation. During the evaluation, patient presentation was incongruent with endorsed symptoms, with patient maintaining oxygen saturations and wheeze being suppressible when engaged in conversation. During this encounter, she reported never having issues with asthma until she had left an abusive relationship, and since then has had a drive specifically to be intubated as she feels that it ameliorates her suffering. She reported exaggerating her wheeze until she felt that she was taken seriously and expressed dismay that she is assumed to be drug seeking despite repeatedly declining medications. Over the course of her hospitalization, she developed a modest improvement in insight and was discharged with outpatient psychiatric follow-up.

Moreover, the stigmatization of patients with factitious disorder can lead to suboptimal care and strained doctor-patient relationships. Healthcare professionals must receive education and training to recognize the signs of factitious disorder, approach these cases with empathy, and collaborate effectively with mental health specialists to provide appropriate care.



CONCLUSION

C.J presents a compelling case on how lack of diagnostic clarity and defensive medical practices present a significant systemic stressor and has demonstrable harm at an individual level. (Feldman, 1994) For instance, C.J. demonstrated findings consistent with tracheal stenosis, a common sequela of recurrent intubation, and one that makes future intubations progressively higher risk. Moreover, this case highlights a need for examination into our own biases towards patients with factitious disorder and the paucity of research that would allow for evidence-based care into their treatment (Yates, 2016).



IMPLICATIONS

It is essential as a profession to examine how the intersectionality of marginalized populations affects care of our most vulnerable patients. We must critically examine how a case like this would be treated if the patient was not a BIPOC woman presenting to an urban safety net hospital. Moreover, we must examine how system-level lack of access to psychiatry, case management and social services places patients like C.J. more susceptible to delays in diagnosis and care.

REFERENCES

Bérar, A., Bouzillé, G., Jego, P., & Allain, J. S. (2021). A descriptive, retrospective case series of patients with factitious disorder imposed on self. *BMC psychiatry*, *21*(1), 588. https://doi.org/10.1186/s12888-021-03582-8

Feldman (1994). The costs of factitious disorders. *Psychosomatics*, *35*(5), S06–507. https://doi.org/10.1016/s0033-3182(94)71750-3

Gill, S., Malnev, D., & Raina, J. S. (2022). Factitious Disorder: An Angioedema Copycat. *Cureus*, *14*(6), e25638. https://doi.org/10.7759/cureus.25638

Khanal, R., Sendil, S., Oli, S., Bhandari, B., & Atrash, A. (2021). Factitious Disorder Masquerading as a Life-Threatening Anaphylaxis. *Journal of investigative medicine high impact case reports*, *9*, 23247096211006248. https://doi.org/10.1177/23247096211006248

Yates, G. P., & Feldman, M. D. (2016). Factitious disorder: a systematic review of 455 cases in the professional literature. *General hospital psychiatry*, *41*, 20–28. https://doi.org/10.1016/j.genhosppsych.2016.05.002