"Munchausen by proxy syndrome": not only pathological parenting but also problematic doctoring?

Jon N Jureidini, Allan T Shafer and Terence G Donald

ABSTRACT

- Certain social expectations of medicine combine with characteristics of subspecialised technological paediatrics to facilitate the form of child abuse labelled "Munchausen by proxy syndrome".
- Examining this form of child abuse highlights possible shortcomings of medical practice.
- The primary medical tasks of diagnosing and curing illness and of preventing suffering are sometimes overridden by other motivations of which doctors may not be fully aware.
- More open discussion of what motivates health professionals in their work may improve medical practice and lead to a reduced incidence of Munchausen by proxy syndrome.

MJA 2003; 178: 130–132

THE LABEL "Munchausen by proxy syndrome" is best applied to cases of child abuse in which a caregiver, usually the child's mother, fabricates symptoms or induces illness in a dependent child, and the doctor mistakenly believes that a naturally occurring illness is present.[1] Thus, an active interaction between the caregiver-perpetrator and medical professional is required for the syndrome to occur.

There is an increasing expectation that medicine will cure all ills and end all suffering, and an ensuing societal hostility towards the profession for its consequently inevitable shortcomings in diagnosis and management. We believe that social expectations of and the nature of modern medical practice lead vulnerable doctors, when exposed to Munchausen by proxy syndrome (MBPS) perpetrators, to become unwittingly complicit in the cruel mistreatment of children. We suggest that MBPS may arise when doctors are unable to accept, on behalf of our society, our limitations in dealing with undiagnosable illness or abusive mother–child relationships.

Psychological theories of organisational dynamics have been used to examine society's reliance on medical systems to help manage and avoid anxieties about illness and death.[2] In keeping with this tradition, we propose that MBPS demonstrates that doctors' primary tasks might not conform to the role allocated by society, but might be distorted or corrupted by organisational and other pressures.

Case vignette: baby Jane

Baby Jane was hospitalised for six months, during which time she required resuscitation over 100 times for haemodynamic collapse. Her doctors attributed these episodes to some unique disease, but it was subsequently found that the mother had induced each episode by poisoning Jane.

The usual response to such a case is to ask, "How could the mother do such a thing?". What is not asked is the equally important question, "How has the medical system been complicit?".

See also page 133

Department of Psychological Medicine, Women's and Children's Hospital, Adelaide, SA.
Jon N Jureidini, PhD, FRANZCP, Head.
Perth, WA.
Allan T Shafer, MA (Clin Psych), D Litt et Phil, Socioanalyst and clinical psychologist.
Child Protection Service, Women's and Children's Hospital, Adelaide, SA.
Terence G Donald, MBBS FRACP, Head.
Reprints will not be available from the authors. Correspondence: Dr Jon Jureidini, Department of Psychological Medicine, Women's and Children's Hospital, 72 King William Road, North Adelaide, Adelaide, SA 5006.
jureidini@healthyskepticism.org

It is helpful to explore what was happening between the mother and the medical system during the six months that the child was being poisoned in hospital.

Jane's mother was intensely involved in planning and implementing medical care. She carried out nursing procedures on her child, regularly conferring with doctors, and actively contributing to each resuscitation. She was part of the *esprit de corps* of a group of clinicians that successfully carried out the life-saving procedures. She was friendly with medical staff, but interacted angrily with some nurses, one of whom had suggested, from the first month of admission, that the mother was poisoning Jane. The treating doctors were fascinated by the case and had drafted a scientific paper reporting a previously undescribed metabolic disorder.

Clinical practice: contributing characteristics

What characteristics of the medical system allow situations of misdiagnosis and unnecessary investigation of MBPS to develop? Some, such as increased consumer involvement, subspecialisation and risk management, are relatively new; others, such as professional standing and rivalries with colleagues, are longstanding.

Recent trends

Subspecialisation

Increased medical subspecialisation can lead to the loss of a wider perspective. Increasingly, even relatively minor symptoms are assessed by a subspecialist into whose domain these symptoms seem to fall — for example, the gastroenter-

ologist as first port of call in managing childhood encopresis (faecal incontinence).

Now, serial subspecialist consultation may replace collaborative second opinions. Further, medical fragmentation into subspecialties coincides with the disappearance of the "wise old doctor", who could lessen the anxiety of both the primary care doctor and the patient and his or her family about an "unmade" diagnosis.

Risk management

The increasing influence of risk management practices leads clinicians to ensure that all possible explanations in their "territory" are considered. This approach to decision-making leads to more extensive investigation of particular symptom presentations. Further, diagnosis is reached mainly by investigation rather than through discussion and clinical opinion.

In paediatrics, this investigatory zeal is further compounded by the perception of children as precious and vulnerable.

Consumer consultation

When a patient presents with diagnostically ambiguous symptoms, the doctor and patient must reach a consensus as to how these symptoms should be understood and managed. This process is always already potentially more complicated and more susceptible to error in the triadic — doctor/parent/patient — relationship characteristic of paediatric practice. Today, the rise of consumerism means that there can be recurrent consultation with parents rather than with colleagues, providing a forum where parents can advocate for, and sometimes even insist on, additional channels of investigation or treatment.[1,3]

Information overload

At least partly as a product of litigation and consumer advocacy, doctors' current obligations regarding "informed consent" may lead to too much information as well as responsibility being loaded onto patients and family.

In informing a patient (and family) about a proposed surgical procedure, there is a clear requirement to inform about all risks, including rare but dangerous complications. However, such a comprehensive approach may not be desirable for patients with minor unexplained symptoms, where resultant anxiety may contribute to hostility, conflict and the seeking of further opinions.

Perhaps, the perceived loss of discretion to withhold information and the resultant overexposure of caregivers to exciting and anxiety-producing medical "intimacies", such as the possibility of rare but serious diagnoses, can contribute to the genesis of MBPS.

Old vulnerabilities

Personal status

Doctors may associate more personal status with finding *the* diagnosis than with clarifying that a problem has multiple ill-defined causes. Also, they may avoid saying "I don't know what is going on here", perhaps because they fear revealing their ignorance.

Professional rivalries

Doctors may investigate further than is logically warranted out of fear that, if they admit to not knowing what is going on, other consulted colleagues might do more tests or jump to their own, alternative diagnostic conclusions.

Doctors can enjoy triumphing over colleagues. When a parent is critical of previous care, another doctor will sometimes accept the challenge of managing the patient without seeking help and consultation from colleagues. The rationale for this self-imposed isolation might be something like "only I can manage this case", an attitude that the perpetrator of MBPS abuse tends to reinforce through idealisation of the current doctor, and denigration of those with whom the treating doctor might ordinarily consult.

The resultant intimate partnership between MBPS perpetrator and doctor might see them — as in the case of baby Jane — conferring together at the bedside of a critically ill baby, with the doctor narrowly focused on the current crisis, and insufficiently aware of other salient details.

Doctor: innocent bystander or guilty party?

Essential to the drama

In cases of MBPS, the doctor may not be an innocent bystander in the deceptive process: MBPS abuse doesn't properly start until a doctor becomes actively engaged in the process;[4] and MBPS perpetrators create dramas of medical interest. The enthralling excitement of life-and-death activities and decisions is an aspect of work that engages many doctors. The heroic, last minute, life-saving intervention, as exemplified in Jane's case, is too commonly the standard of the medical genre. Doctors' personal and professional lives may be compromised by their inability to put aside such excitement in favour of their own parental, marital and clinical responsibilities.

Susceptible to patient coercion

The capacity of the MBPS perpetrator to elicit from others the responses required for her or his subterfuge has been attributed to subtle manipulative skills. However, we believe it more likely that, far from being especially sensitive to other people, the perpetrator *fails* to attend to and "read" others at all. Rather, he/she automatically responds as if the doctor is already playing the part that the perpetrator has allocated to them. The resultant coercive effect can be powerful where the role allocated by the perpetrator resonates with the personality of the respondent. We have speculated elsewhere about characteristics that might typify the doctor at risk of being involved in an MBPS scenario.[3]

Doctors who do not play the part allocated to them by the perpetrator can be replaced. This course is consistent with the observation that Jane's mother, like many MBPS perpetrators, serially consulted many doctors, falling out with and dismissing several before finding one with whom she could collude.

Two-way process

On the other hand, a doctor's excitement at life-and-death scenarios, or fascination with apparently rare and publishable cases, might cause him or her to *unwittingly* coach patients to come up with more elaborate symptoms and signs.

This important bidirectional dynamic — patient influencing the doctor and *vice versa* — is writ large in MBPS, but presumably applies in other settings as well. This dynamic might be helpful in understanding ways in which patients may "mobilise" different parts of the medical system with different kinds of presentations and the corresponding ways in which doctors may respond. In the case of MBPS this leads to a vicious circle rather than a positive feedback loop.

Unacknowledged professional rewards

Unfortunately, little is written about the deeper psychology of doctors' career choice. Experience and discussion with medical colleagues suggests that access to intimate stories, and the excitement that comes from the possibility of death and from outsmarting illness and/or our colleagues, are acknowledged sources of gratification for doctors. Further, unpublished research with practising anaesthetists suggests that they gain overt satisfaction from what was described as "killing patients and bringing them back to life again" (Eric Miller, consultant, Tavistock Institute of Human Relations, London, personal communication, 1993). The MBPS perpetrator might unconsciously tap into some of the vulnerabilities that arise out these poorly understood motivations.

In our case vignette — in which the mother and the doctor are both excited by the task of resuscitating a baby — it is obvious that the mother's excitement at the expense of her baby is illegitimate. Whether this is so in the doctor's case is less clear.

Some suggestions

We propose that the personal and organisational dynamics of MBPS illustrate that, in hospital medical practice, the doctor's goal of easing suffering can be distorted by a need to protect oneself from the anxiety inherent in life-and-death decisions, and/or by organisational pressures. We suggest that in MBPS, serial consultation divides specialists so that the drive to uncover the mystery of the presenting problems becomes primary, and that ongoing narrow investigation of the presenting symptoms interferes with gaining the "big picture" perspective needed to reveal the pathological parenting inherent in child abuse. Thus, doctors who perceive themselves as being passionately invested in the task of curing illness might be induced by a parent to collude in a preoccupation with solving medical puzzles at the expense of a child's wellbeing.

Medical mistakes such as MBPS are less likely to occur in an environment in which empathic physicians take thorough histories, and the diagnostic process involves collaborative referral and continual reflection on the consultation process. We suggest that clinicians should approach both history-taking and case-discussion with an attitude of respectful scepticism. Further, each individual doctor's needs and desires within the medical system must be better understood to create an environment in which the potential effects of medicolegal risk, competitiveness and defensiveness can be appreciated and allowed for.

Acknowledgements

JJ's contribution is supported by an Australian Research Council grant.

Competing interests

None identified.

References

1. Donald T, Jureidini J. Munchausen by proxy syndrome: child abuse in the medical system. *Arch Pediatr Adolesc Med* 1996; 150: 753-758.
2. Obholzer A. Authority, power and leadership: contributions from group relations training. In: Obholzer A, Roberts VZ, editors. The unconscious at work: individual and organizational stress in the human services. London: Routledge, 1994: p39-47.
3. Jureidini J, Donald T. Child abuse specific to the medical system. In: Adshead G, Brooke D, editors. Munchausen syndrome by proxy. Current issues in assessment, treatment and research. London: Imperial Press, 2001: 39-47.
4. Greenacre P. The imposter. *Psychoanal Q* 1958; 27: 359-382.

(Received 4 Jun 2002, accepted 26 Sep 2002) ❑