

CONCEALING AND REVEALING: MUNCHAUSEN-BY-PROXY SYNDROME IN THE MEDICAL SYSTEM

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The rare form of child abuse known as Munchausen by Proxy Syndrome (MBPS) illustrates some of the problematic features of the technological practice of modern western technological medicine. In perpetrating MBPS, a caregiver (usually the mother) fabricates or induces illness in a dependent child, and the doctor mistakes the symptoms for some illness. The mother's with the apparent goal is of facilitating her own interaction with doctors. There has been extensive literature on MBPS, but little has been published that comments on what MBPS and similar scenarios can teach us about medical practice. We will discuss how doctors and others might be unwittingly complicit in the cruel mistreatment of children and what this may reveal and conceal about the hospital medical system as an institution with socially defensible capabilities. In this paper we will hold in mind three hypotheses which might bear further exploration:

that while personal factors predispose people to illness or particular symptoms, organisational dynamics play a role in the maintenance or escalation of a "medical" condition.
that the particular health problem or syndrome may have or acquire meaning which both conceals and reveals the underlying personal and organisational dynamic and the connection between the two.
that this meaning may be related to the primary task of hospital medical practice and associated anxieties emanating from it. The definition of the primary task bears consideration as it may be affected by subjective interpretation, organisational pressures, corruption or distortion. The "primary task" of hospital medical practice - the core reason for which it exists - would appear to be "to cure illness". Whether this constitutes the true primary task as hospital medicine is practiced is moot. Indeed it may be quite different when defined by different sub-systems within a hospital or across the domain. Or it may be distorted, corrupted or differently interpreted.

CASE VIGNETTE

An infant who was in hospital for six months during which time she required resuscitation more than 100 times for episodes thought to be caused by a unique disease. Subsequently it was found that the episodes of collapse were caused by poisoning by the mother. The usual response to such a case is to ask, "How could the mother do such a thing?". Rather we ask, and this paper attempts to consider, "How could the medical system allow it to happen?". It is helpful to look at what was happening between the mother and the medical system during that six months.

She was intensely involved in planning and implementing medical care. She was carrying out a full range of nursing procedures on her child which would be considered unusual even for someone who claimed (as it turned out, falsely) to be a Registered Nurse. It was common for the mother and one or more of the doctors to spend an hour or more in intense discussion about what had happened over the last 24 hours; what new treatments were planned; likely implications, and outcomes. The mother would actively be involved in the resuscitation process and it would not be unusual to see mother, doctors and nurses all engrossed in the task of bringing the child "back to life" after an episode of shock and to witness the *esprit de corps* of a group of clinicians who had successfully carried out a delicately life-saving operation, an *esprit de corps* that incorporated the mother.

This mother had been out to dinner with medical staff and yet had hostile interactions with some nursing staff. There was open disagreement with some members of the team with some medical and nursing staff full of admiration for the mother, whilst some nursing staff had been suggesting from the first month of the admission that the mother was poisoning the child.

The doctors were fascinated by the case and had begun to draft a scientific paper for submission, describing what they thought to be a previously undescribed disorder.

So what are the characteristics of the medical system that allow this to happen?

THE PRACTICE OF MEDICINE AS A SOCIAL DEFENCE

Obholzer (1994) explored the role of social institutions like the National Health Service in the UK as social defence, which functioned to act as a container for the anxieties about illness and death in the community. Obholzer described the dynamic processes whereby anxieties were projected into the NHS and role holders caught up in perpetuating a socially defensive system. That social institutions play a very important role in managing primitive unconsciously held communal anxieties has been well described (Menzies 1990_). But how these defensive processes occur and the manner in which they act dysfunctionally or as unhealthy defences remains a fruitful area of investigation. Dartington_ (1994) defines pathological defences as "those which are mobilized in order to deny reality, to allow a really mad or unbearable situation to continue as if it were perfectly acceptable, when in fact it needs to be challenged..." (p107). In this paper the hospital medical system is considered in terms of its possible unconscious collaborative role in perpetrating and/or perpetuating an unhealthy defence: indeed one which may result in harm. The MBPS scenario is played out publicly in the interaction between parents, infants, doctors and nurses, and therefore functions as a living critique of modern medical practice,

illuminating but also concealing problematic characteristics of that medical system.

THE MOTHER-CHILD-MEDICAL SETTING RELATIONSHIP

There are internal dynamics in the mother and mother-child dynamics that play a crucial role in the development of MBPS. This has been explored in other clinical papers (See footnote 3). In this context, it may suffice that it has been recognised that the mother would be capable of limited intimacy outside of the medical setting, but enthralled by playing with things that it is ordinarily forbidden to play with, such as her own body, her babies, sickness, death and pain in herself and others, and doctors as figures of authority and as caregivers. Through her pretence and deception, she would thereby create a scenario in which she could be the heroine. She would feel entitled to subjugate her baby's needs to her own on the basis of her disappointment that the baby had failed to offer her the meaning or nurture that she had (unrealistically) expected from it, thus making the baby a focus of resentment.

MBPS AND ITS DYNAMIC RELATION TO THE ILLNESS SETTING:

The MBPS narrative shares and gets many of its features from the ordinary illness narrative. For example: the fluctuating intensity of interaction between mother and doctor that seems to characterise MBPS is also characteristic of the relationship between doctor and patient in the course of ordinary illness, as episodes come and go and investigative zeal waxes and wanes according to the stage and state of the illness. Just as any kind of starvation creates many of the dynamics that might otherwise be thought to be specific to anorexia nervosa, it may be that at least some features of the MBPS narrative come from the broader illness experience.

THE TECHNOLOGY OF MODERN MEDICINE AND ITS DYNAMIC/SYSTEMIC FEATURES:

Prototypically MBPS takes place in the hospital setting, with enthralled, busy, committed doctors, and its nurses divided, some idealising and some denigrating the mother. It is a highly emotionally charged system, dramatically representing the presence of primitive anxieties around illness, death and childhood. Elements of the MBPS narrative are specific to modern technological medical practice._

Features which contribute to the relatively recent evolution of MBPS include:

increased medical specialisation, with more extensive 'routines' for the investigation of particular symptom presentations: a further systemic consequence is the failure to recognise the bigger picture since specialisation focuses by its very nature - and with its status-driven and solution-focused orientation - on the narrower rather than the wider perspective
a fear of neglect leading to a hunt for the cause and a reluctance to see multicausality: Again the pressures on medical specialists and the projection of omnipotent phantasies into them perpetuates this focus.

expectations of medicine to cure all ills, and the subsequent hostility towards the profession for its inevitable failings. freer visiting arrangements and increased consultation with parents, providing a forum where parents can advocate for additional channels of investigation or treatment to be followed.

Despite the valuable democratising aspects of parental involvement, the role of the parent becomes not only more substantial, but in some ways also problematic, in a system where there may be some use for a degree of dependency. The consequent over-distribution of authority and a failure to take proper professional authority can cause problems. These may include avoidance of responsibility for decision-making; inappropriate locus of decision-making; decision-making under turbulent and irrational emotional conditions.

Whilst an analysis of consumerism is clearly beyond the scope of this paper, whatever their other benefits, self help and patient advocacy groups offer further opportunities for engagement around illness. The medical system and its management of pain and responsibility: the interaction of doctors and patients/parents as containers of anxiety. It is worth examining how doctors manage information, and the doubts that arise about what level of openness and truthfulness is most helpful. We are unconvinced that absolute honesty is what is expected or desirable from a doctor. For example, does the patient want to know about every diagnostic possibility that is going through the doctor's mind, no matter how nasty and unlikely? Doctors have traditionally had a licence, and in some cases a culturally determined expectation, to distort the truth. The doctor has thereby been asked to contain anxiety that might be uncontrollable for the patient and family. In our current medical system, at least partly as a product of litigation and consumer advocacy, there is more of a tendency to pass on everything.

In Jon's capacity as a psychiatrist working in a paediatric medical setting, he has seen cases in which he has believed that unreasonable choice has been offered to the parents of patients. There must be some doubt that the parents of a dying boy with a one in a thousand chance of cure from a painful, dangerous and disfiguring procedure should be asked to make a choice about whether the procedure should go ahead. In his view, even if we accept that there is no discretion about informing parents, good medicine in this situation consists in providing necessary information about the procedure and its risks, and then to clearly advise against it. But doctors' interpretation of informed consent sometimes means that too much responsibility, and with it unmanageable levels of anxiety, is forced back onto patients and family who have too little knowledge, and experience and emotional turbulence to discharge that responsibility. It may be that the pressure to tell the parent 'everything' and the over-inclusiveness of the mother in medical "intimacies" with their exciting and anxiety-producing associations contributes to the genesis of Munchausen by Proxy Syndrome.

THE ROLE OF RISK MANAGEMENT AGENTS

A two year-old girl with leukemia had relapsed and death was inevitable. However, the parents had maintained hope of cure, believing that the mother's pregnancy would result in a child who could be used as a source of bone marrow transplantation. The unanimous clinical opinion in the hospital was that the child should

be allowed to die. The parents insisted that they wish to have the child undergo full cardio-pulmonary resuscitation. The Hospital Clinical Ethics Group supported the view that resuscitation should not go ahead, but the hospital's lawyer overruled this recommendation and the child was resuscitated on 10 occasions over 24 hours with breakage of ribs and other traumatic sequelae before finally the parents decided that they would accept the child's death. It is apparent from this vignette how systemic or organisational decisions which relate to issues of insurance and litigation may override the real primary task and contribute to the systemic maintenance of a pathogenic process.

PROJECTIVE IDENTIFICATION AND ITS MOBILISATION IN THE MEDICAL SYSTEM:

The capacity of the MBPS perpetrator to get the kind of responses from others that she needs for her subterfuge has sometimes been attributed to subtle manipulative skills. However, we think it is more likely that, far from a special sensitivity to other people, the perpetrator fails to read or attend to the way other people actually behave in her interaction with them, responding instead as if they were playing the part she had allocated to them. This is not a conscious process, but one occurring outside of awareness. This may, however, occur via the psychological mechanism known as a "projective identification". Projective identification that can have a powerful coercive effect on people. This is especially so where the role unconsciously allocated by the perpetrator resonates with the actual personality of the respondent and is supported by systemic needs to mobilise the staff into particular roles, such as expert, or saviour, as described earlier..

If the respondent does not play the allocated part, then they can be replaced, consistent with the observation that many MBPS perpetrators have serially consulted many doctors, usually falling out with them and dismissing them until they find one who that is tractable, whose valencies are such that an unwitting collusion can take place. This important dynamic is writ large in MBPS, but presumably applies in other settings as well, and might be helpful in understanding ways in which the medical system may be mobilised by patients with all kinds of presentations.

As Greenacre (1958) notes, successful imposture probably requires that those who are deceived are not only victims but also unconscious conspirators. (See also Shafer, 1999). Whilst spouse and family are the most obvious candidates for the role of conspirator, might the medical system unconsciously unintentionally collude with the perpetrator in the MBPS scenario, and what could the motivation be? Kets de Vries (1978) describes a very powerful collusive mechanism between superior and subordinate in a management setting. He identifies the process of "folie a deux" as moderating a fixed belief system which becomes systemically entrenched. In this symbiotic relationship two (at least) participants in a superior-subordinate relationship are caught up in a closed system of projective identifications (usually initiated by the more powerful and narcissistic) which sustains a pathological and usually paranoid stance. The clinical manifestation of this condition is described in ICD-10 Classification of Mental and Behavioural Disorders World Health Organization, (1992)

Originally a clinical term - meaning "madness of two" - the term refers to a condition in which two people are caught up in shared fantasy or delusion in a fixed belief system. The ICD-10

Classification of Mental and Behavioural Disorders_ (1992) defines it as an_ Induced Delusional Disorder:

"A rare delusional disorder shared by two or occasionally more people with close emotional links. Only one person suffers from a genuine psychotic disorder; the delusions are induced in the other(s) and usually disappear when the people are separated. Both the original delusions in the dominant person and the induced delusions are usually chronic and either persecutory or grandiose in nature. Delusional beliefs are transmitted this way only in uncommon circumstances. Almost invariably, the people concerned have an unusually close relationship and are isolated from others by language, culture, or geography. The individual in whom the delusions are induced is usually dependent on or subservient to the person with the genuine psychosis."

Folie a deux usually involves a paranoid and powerful person in a superior role and a subordinate . The emotionally charged, enthralling, grandiose and anxiety-laden setting of hospital medical practice can be understood as a fertile setting for its development.

Could it be that the MBPS perpetrator is playing the same game that medical role-holders are, working the kinds of narratives that attract medical role-holders' interest?_ Whilst their collusion is clearly not conscious, the motivation for collusion might be and may be well understood as a systemic manifestation of a folie a deux delusional system. For example, a doctor might be quite aware of a desire to publish a paper in relation to a previously undescribed medical illness. It is possible that he or she might unwittingly coach patients to come up with more and more elaborate symptoms and signs. Indeed, one of the most engaging aspects of work for many doctors and nurses is the enthralling excitement of life and death activities and decisions. The heroic, last minute, lifesaving intervention is the standard of the medical genre. Doctors sometimes get into trouble in their personal and professional lives because of their inability to put aside the excitement of their work in favour of other important parental, marital and clinical responsibilities, effectively giving priority to living and participating in exciting narratives at personal cost.

Doctors have been known to be the treating physician in more than one case of MBPS, and we can speculate about certain characteristics that might typify the 'MBPS doctor'. It will be seen that I am not describing a stereotype of a 'bad doctor'. Indeed, he or she might be a competent and well respected paediatrician, but would be one who tends to see things in black and white terms, for example, wanting to understand problems as either all medical or all psychosocial. He/she would work in an area of paediatrics where certainty is rare and many presentations have multi-factorial causes, and be an enthusiastic user of medical investigations. This investigatory zeal might partly come from being anxious about missing something, but also from an attraction to the possibility of finding the rare cause that colleagues have missed. For example, if a colleague is presenting a case where the illness presentation seems to have a primarily psychosocial explanation, our doctor would be the one who raises a rare alternative physical explanation that might account for some of the symptoms, but is implausible in light of the overall presentation. His/her manner with parents would be quite intense and collegial, offering detailed explanations, and being responsive to their requests, if somewhat less assiduous in taking a history of their social and emotional circumstances. It seems to me that there is a case for cautiously designating such an individual as an 'MBPS doctor', as a step towards thinking about the role of doctors in

MBPS, just as labelling the mother as an 'MBPS perpetrator' helps to focus on her contribution.

Sometimes the response of doctors to a challenging patient, who is critical of the care received from other doctors, is to accept the challenge alone, rather than seeking help and consultation from colleagues. The apparent rationale for this self-imposed isolation is something like 'Only I can manage this case', an attitude that the perpetrator - and probably the medical system - tends to reinforce with her/its idealisation of the current doctor, and denigration of others with whom the treating doctor might ordinarily consult. This may also be a fertile setting for a folie-a-deux relationship. The resultant intimate partnership between perpetrator and doctor might see them conferring together at the bedside of a critically ill baby, narrowly and urgently focussed and insufficiently aware of salient details of the rest of the environment.

A small, mainly old literature on the career choice and some of the personal characteristics of surgeons includes suggestions that the sadism of surgeons is mostly sublimated to higher purpose, but sometimes manifests in inability to empathise with the suffering or fear of their patients. I have also been informed that unpublished research with practicing anaesthetists suggests that they gain overt satisfaction from what some of them described as 'killing patients and bringing them back to life again', but there is nothing convincing published on anything but superficial and perhaps rationalised understandings of the gratification of medical practice. Of course, this lack of literature may reflect an absence of the deeper motivations that we are looking for. But experience and discussion with medical colleagues convinces us that excitement from sensual aspects of medicine, from the possibility of death, or from outsmarting illness and/or our colleagues, are acceptable, if not necessarily socially popular, gratifications from the practice of medicine. It is not, however, legitimate for the mother of a sick child to seek similar gratification at the expense of her baby, which makes the perpetration of MBPS pathological (as well as dangerous). In our opinion, our understanding of MBPS and of other perverse behaviours that are enacted within the medical system (for example, repeated self mutilation), will be incomplete until we have a better understanding of what motivations, including the socially unpalatable ones, drive doctors and nurses.

There is very little literature on what it is that doctors seek from medicine. There is material about overt gratification such as status, money, altruism, etc, but surprisingly little about some of the "deeper" motivations. Medicine is a sensual profession that involves touching and manipulating bodies. It is a profession where success is judged by triumph over illness and death. Success also sometimes involves triumph over colleagues. There is a fascination with the rare and a vulnerability to becoming enthralled by fascinating material. When we see, as we did in this case, the mother and the doctor excited by the task of resuscitating a baby, we can clearly see that the mother's excitement is illegitimate. The question arises as to whether the doctor's excitement is legitimate. We would want to argue that it is, provided it falls within (yet to be specified) boundaries.

In the psychiatric setting, disagreement amongst staff is known to be a potent determinant of excited behaviour amongst patients. Main's famous description of working with 'difficult patients' in a therapeutic community shows many commonalities to the interaction of MBPS perpetrators with the medical system.

Common experiences with these difficult patients included: the view amongst the nurses caring for the patient that the patient had been mishandled in a prior setting; disagreement, sometimes hostile, between previously involved therapists; and insatiable and often imperious patients who convinced individual nurses, often through telling them secrets, that each of the nurses was the only one who could help. Furthermore, Main reported the painful discovery by his staff that they had become part of an enactment of sadistic and masochistic roles that they concluded were a product of the interaction between staff and patients, rather than arising from either group. Main's psychologically sophisticated staff were caught up in a scenario that arose both from them and their patients, just as we are suggesting is the case in MBPS.

Conclusion

At the start of this paper we suggested that three hypotheses bore some further consideration. In the light of the above observations, we suggest:

that while personal factors predispose people to illness or particular symptoms, organisational dynamics play a role in the maintenance or escalation of a "medical" condition.

It seems probable that the interaction between the mother's pathological narcissistic investment in the MBPS dynamic interacts with various pressures from the medical system ie: the idealisation of the grandiosely omnipotent position of the medical specialist and splits within the nursing system which polarise views towards the mother/child dyad in a setting highly charged with anxiety and intimacy may result in the maintenance of a "folie-a-deux" closed system dynamic which is widely supported through the often unquestioned authority given to doctors.

That the particular health problem or syndrome may have or acquire meaning which both conceals and reveals the underlying personal and organisational dynamic and the connection between the two:

Serial consultation deepens the splits between different specialists such that the drive to discover and uncover the mystery of the presenting problems becomes primary, aided by the excitement and thrall of the medical puzzle that this meaning may be related to the primary task of medical practice - one which through its life-and-death quality is intrinsically infused with anxiety - and associated anxieties emanating from it. The definition of the primary task bears consideration as it may be affected by subjective interpretation, organisational pressures, corruption or distortion.

If the primary task of medical practice is to cure illness, then in collusion with the passionate investment in this task against the background of projections, ongoing narrow investigation of the presenting symptoms may assume a significance which interferes with gaining the sort of bigger picture perspective which would reveal the pathology. In so doing the pathological narcissistic elements of hospital medical practice may be concealed and sustained.

Indeed we suspect that MBPS both conceals and reveals the pathological elements of the mother in the mother-child dyad, and the child's unwitting participation in this. Simultaneously, (we are suggesting) in the wider hospital system MBPS conceals and reveals the investment on this system in avoiding some painful aspects of its primary task: essentially the need to maintain omnipotent fantasies about doctors, and to conceal painful similar realisations of maternal failure.

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1 See page 3 for a description of the concept "social defence