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**FIRST, DO NO HARM: THE USE OF COVERT VIDEO SURVEILLANCE TO DETECT MUNCHAUSEN SYNDROME BY PROXY—AN UNETHICAL MEANS OF “PREVENTING” CHILD ABUSE**

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Michael T. Flannery\*

*Since it was first identified in 1977, Munchausen Syndrome by Proxy has uniquely affected the way in which the medical and legal communities deal with the issue of child abuse. Inherent in the medical response to the disease are issues of suspicion, investigation, identification, confrontation, and, of course, the health of an innocent child. Given the deceptive dynamics of the disease, however, denial and disbelief naturally overshadow every action taken by medical professionals in pursuing these issues. Fortunately, as medical knowledge about the dynamics of the disease continues to develop, medical professionals become more willing and better able to identify the disease and focus their responses on the safety of the child. The greatest problem in prosecuting Munchausen Syndrome by Proxy is that judges and juries remain unwilling to accept the reality of the disease. Consequently, in an effort to confirm medical suspicions and quell legal doubts, the medical community has resorted to covert video surveillance of the abuse while it is being perpetrated in the hospital. In this Article, Flannery argues that this response is an unnecessary and unethical, means of preventing Munchausen Syndrome by Proxy and protecting the child.*

*Flannery supports the approach taken by the Family Court of New York in addressing Munchausen Syndrome by Proxy cases. The Family Court of New York recognizes the unique dynamics of this bizarre disorder, and, therefore, considers all cumulative circumstantial evidence in a Munchausen Syndrome by Proxy case, comparing the facts of the subject case to the commonly accepted features of confirmed cases. Part of the circumstantial evidence that should be considered, Flannery argues, is the dissipation of the child's condition upon temporary separation from the alleged perpetrating parent. As is done by the Family Court of New York, a *res ipsa loquitur* standard should then be applied, and an appropriate disposition for the child should be determined. By employing this standard, the court may confirm suspicions of Munchausen Syndrome by Proxy while avoiding the unnecessary harm to the child inherent in the covert video surveillance of Munchausen Syndrome by Proxy.*

“A good End cannot Sanctifie evil Means; nor must we ever do Evil, that Good may come of it.”<sup>1</sup>

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1. William Penn, *Some Fruits of Solitude*, in REFLECTIONS & MAXIMS RELATING TO THE CONDUCT OF HUMAN LIFE 129 (2d ed., London, printed for Thomas Northcott, 1693).

You may burn my body to ashes, and scatter them to the winds of heaven; you may drag my soul down to the regions of darkness and despair to be tormented forever; but you will never get me to support a measure which I believe to be wrong, although by doing so I may accomplish that which I believe to be right.<sup>2</sup>

## INTRODUCTION

As you read the Introduction to this Article, try this test: take a deep breath and hold it. Hold your breath as you continue reading these initial paragraphs. Now, imagine that someone has covered your face with his or her hands, or, perhaps, with a plastic bag. For how long can you hold your breath? How long before you need air? Is it now? It has only been ten seconds. How much longer before you are forced to take a breath?

By now, you may be breathing freely again. But what if you could not get air? How long before you would begin to panic, flail your arms or kick your feet? Imagine that there is still a plastic bag over your head and you still cannot breathe. Now, imagine that you are only six weeks old, and that the hands holding the plastic bag over your head are the hands of your mother. Consider how long it has been since you took a gasp of air, yet imagine that you still cannot breathe, and will not breathe for another thirty seconds.

Now, imagine something even more surreal. Imagine that, as you continue to be unable to breathe, an entire hospital staff is sitting in the next room, watching you struggle for air as the life is choked out of you. It has been sixty seconds since your last breath, yet the only action taken by the hospital staff is to record your struggle on video. Finally now, after more than a minute, a nurse enters the room as the bag around your head is released.

Shockingly, the surreal scenario you have just imagined actually occurs in dozens of hospitals throughout the United States.<sup>3</sup> These

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2. IDA M. TARBELL, *THE LIFE OF ABRAHAM LINCOLN* 139 (McClure, Phillips & Co. 1900) (quoting T.H. Henderson's version of a Lincoln legislative address).

3. See *PrimeTime Live* (ABC television broadcast, Nov. 19, 1997), transcript available in 1997 WL 15362147 \*1, \*9 [hereinafter *PrimeTime Live*]. Video surveillance was used at Mary Bridge Children's Hospital, in Tacoma, Washington, to convict 24-year-old Andrea Guzman for attempting to suffocate her 2-month-old daughter Angel. See John Gillie, *Mother Draws 10-Year Term for Assaulting Baby in Hospital: Woman May Be Suffering from Rare Mental Disease, Attorneys Say*, TACOMA NEWS TRIB., Nov. 19, 1997, at B1. A charge of attempted murder was reduced to first-degree assault in exchange for a plea of guilty. See *id.* Reports indicate that Guzman had another 5-month-old child, whose death reportedly was caused by Sudden In-

scenarios are occurring with the knowledge of medical professionals.<sup>4</sup> In fact, doctors and hospital staffs arrange for such incidents of abuse to occur,<sup>5</sup> and as they occur, the abuse is permitted to continue—sometimes for up to a minute.<sup>6</sup> Unbelievably, the justification for this seemingly unimaginable scenario is that it is in the best interest of the very children who are being suffocated and abused. In fact, some doctors adamantly contend that videotaping these occurrences is necessary to save the lives of these children, who are the victims of Munchausen Syndrome by Proxy.<sup>7</sup> Others, opposed to the use of covert video surveillance, cling to the most basic tenet of medical ethics: “First, do no harm.”<sup>8</sup>

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fant Death Syndrome (SIDS) in 1993. *See id.* Part of the plea agreement was that officials would not further pursue that child’s death. *See id.*

At another hospital in Atlanta that conducts video surveillance, Munchausen Syndrome expert Beatrice Crofts Yorker observed a mother smothering a child and one injecting the child with fecal matter. *See* Rob Schneider, *Motives Behind the Nurses: Expert Says Caregivers Kill for Attention: Professor Links Murders by Convicted Nurses with Disorder in which Parents Injure Kids*, INDIANAPOLIS STAR, Feb. 15, 1998, at A1.

It is estimated that since Munchausen Syndrome by Proxy was first identified in 1977, more than 1000 cases have been reported nationally, of which approximately 120 have resulted in death. *See* Sally Kestin, *Experts Study the Abusive World of Munchausen Syndrome by Proxy*, TAMPA TRIB., June 6, 1997, at 2; Janet Leiser, *Judge Denies Mother Custody*, TAMPA TRIB., Sept. 9, 1997, at 1; James Tobin, *Woman Escapes Years of Silence, Secrets and Pain*, DET. NEWS, Feb. 9, 1998, at A1 (estimating that there have been some 700 cases of Munchausen Syndrome by Proxy documented in medical journals since 1977); *see also In re Dylan C.*, No. L-96-152, 1997 Ohio App. LEXIS 2731, at \*5 (Ohio Ct. App., June 27, 1997) (relating physician testimony that Munchausen Syndrome by Proxy has a “mortality rate between eight and thirty-one percent and a morbidity rate higher than fifty percent” and that the perpetrator becomes more inventive and perpetrates more devastating harm as the syndrome progresses without intervention).

It turns out that Munchausen Syndrome by Proxy . . . is not nearly so rare as we would like to assume.

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The notion of a mother deliberately making her children sick to meet needs of her own so assaults our understanding of the natural order that we have a strong desire for it to be very rare. Yet hundreds of cases have been documented.

Rick Casey, *Prosecutor Hitting Road for Baby Case*, SAN ANTONIO EXPRESS-NEWS, Apr. 24, 1997, at 2A [hereinafter Casey, *Prosecutor Hitting Road for Baby Case*].

4. *See infra* Part II.A.

5. *See id.*

6. *See infra* text accompanying notes 226–27.

7. For a discussion of the question of who is the victim of Munchausen Syndrome by Proxy, *see infra* notes 74–75 and accompanying text.

8. The tenet, “First, do no harm,” is generally attributed to Hippocrates, who wrote: “As to diseases, make a habit of two things—to help, or at least to do no harm.” HIPPOCRATES, *EPIDEMICS*, bk. I, § XI, at 625 (W.H.S. Jones trans., Harvard Univ. Press 1948). *But see* William D. Weitzel, *A Later Addition to Hippocratic Oath*, WALL ST. J., Nov. 25, 1996, at A19 (attributing the phrase “Primum Non Nocere” or “First, do no harm,” to the physician

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Galen). The phrase is probably most commonly derived from the Hippocratic Oath, which provides:

I swear by Apollo the physician, by Aesculapius, Hygeia, and Panacea, and I take to witness all the gods, and all the goddesses, to keep according to my ability and my judgment the following Oath: To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction. I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art). In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.

MARGARET R. O'LEARY ET AL., JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS. (JCAHO), LEXIKON DICTIONARY OF HEALTH CARE TERMS, ORGANIZATIONS, AND ACRONYMS FOR THE ERA OF REFORM 361 (1994).

The British Medical Association (BMA) published a proposed revision of the Hippocratic Oath, equally applicable to the issue of the propriety of using covert video surveillance to detect Munchausen Syndrome by Proxy. The proposed revision provides:

The practice of medicine is a privilege which carries important responsibilities. All doctors should observe the core values of the profession which centre on the duty to help sick people and to avoid harm. I promise that my medical knowledge will be used to benefit people's health. They are my first concern. I will listen to them and provide the best care I can. I will be honest, respectful and compassionate towards patients. In emergencies, I will do my best to help anyone in medical need.

I will make every effort to ensure that the rights of all patients are respected, including vulnerable groups who lack means of making their needs known, be it through immaturity, mental incapacity, imprisonment or detention or other circumstance.

My professional judgment will be exercised as independently as possible and not be influenced by political pressures nor by factors such as the social standing of the patient. I will not put personal profit or advancement above my duty to patients.

I recognise the special value of human life but I also know that the prolongation of human life is not the only aim of healthcare. Where abortion is permitted, I agree that it should take place only within an ethical and legal framework. I will not provide treatments which are pointless or harmful or which an informed and competent patient refuses.

I will ensure patients receive the information and support they want to make decisions about disease prevention and improvement of their health. I will answer as

In the past twenty years, Munchausen Syndrome by Proxy as a form of child abuse has slowly worked its way into the standard vocabulary of the medical and legal professions.<sup>9</sup> Most people outside of those professions have never heard of it, and very few of those who have heard of it understand it.<sup>10</sup> Munchausen Syndrome by Proxy is a form of child abuse wherein the perpetrating parent (almost always a mother)<sup>11</sup> “factitiously induces illnesses or symptoms in a child by fabricating evidence. The fabricated evidence usually results in numerous and extensive diagnostic procedures that in themselves can often harm the child.”<sup>12</sup> Unfortunately, even when the Syndrome is explained to judges and juries, it is rarely

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truthfully as I can and respect patients' decisions unless that puts others at risk of harm. If I cannot agree with their requests, I will explain why.

If my patients have limited mental awareness, I will still encourage them to participate in decisions as much as they feel able and willing to do so.

I will do my best to maintain confidentiality about all patients. If there are overriding reasons which prevent my keeping a patient's confidentiality I will explain them.

I will recognise the limits of my knowledge and seek advice from colleagues when necessary. I will acknowledge my mistakes. I will do my best to keep myself and colleagues informed of new developments and ensure that poor standards or bad practices are exposed to those who can improve them.

I will show respect for all those with whom I work and be ready to share my knowledge by teaching others what I know.

I will use my training and professional standing to improve the community in which I work. I will treat patients equitably and support a fair and humane distribution of health resources. I will try to influence positively authorities whose policies harm public health. I will oppose policies which breach internationally accepted standards of human rights. I will strive to change laws which are contrary to patients' interests or to my professional ethics.

British Med. Ass'n, *BMA Updates Hippocratic Oath* (visited Jan. 25, 1999) <<http://www.bma.org.uk/pressrel/archive/970327b.htm>>.

9. In one study involving 86 professionals from various hospitals, community service programs, the Ohio children's service agency, and law enforcement agencies, professionals employed in hospitals or medical settings were three times more likely to have heard of Munchausen Syndrome by Proxy than those employed by community service agencies. See Keith L. Kaufman & Daniel Coury, *Munchausen Syndrome by Proxy: A Survey of Professionals' Knowledge*, 13 CHILD ABUSE & NEGLECT 141, 141 (1989). For a discussion of the nature of Munchausen Syndrome by Proxy, see Michael T. Flannery, *Munchausen Syndrome by Proxy: Broadening the Scope of Child Abuse*, 28 U. RICH. L. REV. 1175, 1224-32 (1994) (arguing that, in order for it to be appropriately addressed, conceptually it must be integrated into the common understandings of both the medical and legal communities).

10. See generally Flannery, *supra* note 9.

11. See Flannery, *supra* note 9, at 1182.

12. *Id.* (citation omitted).

understood, and sometimes, not even believed.<sup>13</sup> In many cases, expert testimony regarding the disorder is disallowed.<sup>14</sup> Thus, the very deceptive nature of the Syndrome perpetuates itself within the medical and legal systems<sup>15</sup>—the two

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13. See *In re Aaron S.*, 625 N.Y.S.2d 786, 787 (N.Y. Fam. Ct. 1993) (describing the accusations of Munchausen Syndrome by Proxy as “so counter-intuitive to our concept of being a parent that it seems unbelievable”).

14. See *State v. Lumbrera*, 845 P.2d 609, 620 (Kan. 1992) (instructing the jury to disregard all evidence concerning Munchausen Syndrome by Proxy); *Commonwealth v. Robinson*, 565 N.E.2d 1229, 1237–38 (Mass. App. Ct. 1991) (barring all evidence regarding Munchausen Syndrome by Proxy); cf. *People v. Phillips*, 175 Cal. Rptr. 703, 715 (Cal. Ct. App. 1981) (allowing evidence of Munchausen Syndrome by Proxy for purpose of showing motive); *Reid v. State*, 964 S.W.2d 723, 730 (Tex. App. 1998) (allowing evidence of Munchausen Syndrome by Proxy for purposes of explaining mother’s conduct and motive).

In July 1996, Yvonne Eldridge was convicted of “abusing two sickly babies,” whose conditions she worsened by tampering with their intravenous lines and misinforming doctors about their symptoms. See *Foster Mom Convicted of Abuse Granted New Trial*, SAN DIEGO UNION-TRIB., Jan. 18, 1998, at A7 [hereinafter *Foster Mom Convicted*]. She was “sentenced to more than three years in prison.” *Id.* However, a California Superior Court judge subsequently granted her a new trial, ruling that her trial attorney failed to call relevant witnesses and did not present evidence that would have supported her defense. See *id.*; Charlie Goodyear, *Retrial Set For Foster Mother: S.F. Lawyer Serra May Represent Her in Abuse Case*, S.F. CHRON., Jan. 21, 1998, at A14 [hereinafter Goodyear, *Retrial*]. The judge did not allow the jury to hear evidence about the syndrome, finding that the testimony would be too prejudicial against Eldridge. See Goodyear, *Retrial*, *supra*. Ironically, in 1988, Eldridge was honored by First Lady Nancy Reagan as part of the Great American Families program for her dedication in caring for dozens of needy foster children. See *Foster Mom Convicted*, *supra*. In 1992, however, when investigations revealed that three children had died in Eldridge’s care and eight other children were allegedly mistreated, her foster care license was revoked. See Charlie Goodyear, *New Trial for Foster Mother Convicted of Abuse: Supporting Witnesses Weren’t Called*, S.F. CHRON., Jan. 17, 1998, at A13.

In Florida, 20-year-old Kelly Dunsford injected her healthy 11-month-old son with insulin to make others believe that the child had diabetes. See *Mother Accused of Injecting Healthy Infant with Insulin*, ST. PETERSBURG TIMES, Mar. 12, 1997, at 5B. In a Washington, D.C. hospital, Tracey McPherson held a plastic bag over her two-year-old son Tre’s head in an effort to suffocate him. See Nancy Lewis, *Medical Expert Questions Deaths of Woman’s Other Children*, WASH. POST, Mar. 13, 1997, at D3. The child was in the hospital because McPherson had pushed him out of a third-floor window. See *id.* McPherson’s ten-month-old daughter, Ebony, died in 1984 under mysterious conditions. See *id.* Her four-month-old son, Antwain, died similarly in 1988. See *id.* Prior to the incident with Tre, McPherson had made fifteen trips to the emergency room with the boy. See *id.* The case includes the telltale signs of Munchausen Syndrome by Proxy; however, when the prosecuting attorney attempted to question McPherson at trial about the Syndrome, the judge disallowed the questioning, concluding that it was too late in the proceeding to introduce evidence of the disease. See *id.*

15. The perpetuation of Munchausen Syndrome is ironically demonstrated in one case where a letter to the *New England Journal of Medicine* claimed that the disease that the patient feigned having was Munchausen Syndrome itself. See Marc Gurwith & Clare Langston, *Factitious Munchausen’s Syndrome*, 302 NEW ENG. J. MED. 1483, 1483–84 (1980). As Chris Amirault notes: “Paradoxically, by choosing to fake Munchausen Syndrome the patient proves that he or she suffers from it. As a result, the term *factitious*, which initially signifies that the patient does not really suffer from Munchausen Syndrome, now signifies that the patient really does.” Chris Amirault, *Pseudologica Fantastica and Other Tall Tales: The Contagious Literature of Munchausen Syndrome*, 14 LITERATURE & MED. 169, 184–85 (1995). The case took on an added twist of irony when it was revealed that the case itself was fictitiously contrived as a humorous

systems that must attempt to prevent the disease, or at least deal with its consequences.

Although Munchausen Syndrome by Proxy is still far from a household term, medical<sup>16</sup> and

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con, "prompted by the frustration of frequent encounters with the self-destructive behavior of patients with factitious disease." *Id.* at 186. In still a third twist of irony, Amirault suggests that the original fictitious letter serves as "an exemplary piece of medical literature . . . 'an exploration of the paradoxes' of this disorder." *Id.* Amirault further points out that the fact that the original piece contained the identity of the patient—Norman U. Senechbau—which ran contrary to the cardinal rule of contemporary medical ethics, indicates that the letter was meant as fiction. *See id.* at 186–87. Indeed, the level of irony runs deeper: "Norman U. Senechbau" is, in fact, an anagram of "Baron Munchausen." *Id.* at 187.

16. *See, e.g.,* U.O. Aideyan & W.L. Smith, *Radiological Features in a Case of Munchausen Syndrome by Proxy*, 25 *PEDIATRIC RADIOLOGY* 70 (1995); Randell Alexander et al., *Serial Munchausen Syndrome by Proxy*, 86 *PEDIATRICS* 581 (1990); *All in a Day's Work . . .*, *NURSING TIMES*, Oct. 15, 1997, at 16; Laweh Amegavie et al., *Munchausen's Syndrome by Proxy: A Warning for Health Professionals*, 293 *BRIT. MED. J.* 855 (1986); Tanash H. Atoyntan et al., *Munchausen Syndrome by Proxy*, 19 *CHILD PSYCHIATRY & HUM. DEV.* 3 (1988); Mouhab Ayass et al., *Munchausen Syndrome Presenting as Hemophilia: A Convenient and Economical "Steal" of Disease and Treatment*, 10 *PEDIATRIC HEMATOLOGY & ONCOLOGY* 241 (1993); Janiine Babcock et al., *Rodenticide-Induced Coagulopathy in a Young Child: A Case of Munchausen Syndrome by Proxy*, 15 *AM. J. PEDIATRIC HEMATOLOGY/ONCOLOGY* 126 (1993); Marjorie A. Baldwin, *Munchausen Syndrome by Proxy: Neurological Manifestations*, 26 *J. NEUROSCIENCE NURSING* 18 (1994); Lisa Hains Barker & Robert J. Howell, *Munchausen Syndrome by Proxy in False Allegations of Child Sexual Abuse: Legal Implications*, 22 *BULL. AM. ACAD. PSYCHIATRY L.* 499 (1994); A.P. Bath et al., *Munchausen Syndrome by Proxy: Otolaryngologists Beware!*, 107 *J. LARYNGOLOGY & OTOTOLOGY* 151 (1993); Susanne Blix & Gregory Brack, *The Effects of a Suspected Case of Munchausen's Syndrome by Proxy on a Pediatric Nursing Staff*, 10 *GEN. HOSP. PSYCHIATRY* 402 (1988); C.N. Bools et al., *Co-Morbidity Associated with Fabricated Illness (Munchausen Syndrome by Proxy)*, 67 *ARCHIVES OF DISEASE IN CHILDHOOD* 77 (1992); C.N. Bools et al., *Follow Up of Victims of Fabricated Illness (Munchausen Syndrome by Proxy)*, 69 *ARCHIVES OF DISEASE IN CHILDHOOD* 625 (1993); Christopher Bools et al., *Munchausen Syndrome by Proxy: A Study of Psychopathology*, 18 *CHILD ABUSE & NEGLECT* 773 (1994); Joni Jacobsen Bosch, *Munchausen Syndrome by Proxy*, 11 *J. PEDIATRIC HEALTH CARE* 242 (1997); Mary L. Brown, *Dilemmas Facing Nurses Who Care for Munchausen Syndrome by Proxy Patients*, 23 *PEDIATRIC NURSING* 416 (1997); Mary Bryk & Patricia T. Siegel, *My Mother Caused My Illness: The Story of a Survivor of Munchausen by Proxy Syndrome*, 100 *PEDIATRICS* 1 (1997); Brenda Bursch et al., *Nurses' Knowledge of and Experience with Munchausen Syndrome by Proxy*, 19 *ISSUES IN COMPREHENSIVE PEDIATRIC NURSING* 93 (1996); Donald J. Carek, *The Munchausen by Proxy Controversy*, 34 *J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY* 261 (1995) (letter to the editor); Patricia T. Castiglia, *Munchausen Syndrome by Proxy*, 9 *J. PEDIATRIC HEALTH CARE* 79 (1995); Daitow A. Chan et al., *Munchausen Syndrome by Proxy: A Review and Case Study*, 11 *J. PEDIATRIC PSYCHOL.* 71 (1986); Karen A. Crouse, *Munchausen Syndrome by Proxy: Recognizing the Victim*, 18 *PEDIATRIC NURSING* 249 (1992); P. DiBiase et al., *Munchausen Syndrome by Proxy Complicating Ear Surgery*, 122 *ARCHIVES OTOLARYNGOLOGY—HEAD & NECK SURGERY* 1377 (1996); Terence Donald & Jon Jureidini, *Munchausen Syndrome by Proxy*; *Child Abuse in the Medical System*, 150 *ARCHIVES PEDIATRICS & ADOLESCENT MED.* 753 (1996); Andrea J. Eberle, *Munchausen by Proxy*, 36 *J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY* 1491 (1997); Edmond C.O. Edi-Osagie et al., *Munchausen's Syndrome in Obstetrics and Gynecology: A Review*, 53 *OBSTETRICAL & GYNECOLOGICAL SURV.* 45 (1998); John L. Emery, *Child Abuse, Sudden Infant Death Syndrome, and Unexpected Infant Death*, 147 *AM. J. DISEASES CHILDREN* 1097 (1993); D.M. Eminson & R.J. Postlethwaite, *Factitious Illness: Recognition and Management*, 67 *ARCHIVES OF DISEASE IN CHILDHOOD* 1510 (1992); Donald Evans, *The Investigation of Life-Threatening Child Abuse and Munchausen Syndrome by Proxy*, 21 *J. MED. ETHICS* 9 (1995); Sue Facey, *Munchausen Syndrome by Proxy*, *NURSING TIMES*, Jan. 27, 1993, at 54; Marc



D. Feldman et al., *Concurrent Factitious Disorder and Factitious Disorder by Proxy: Double Jeopardy*, 19 GEN. HOSP. PSYCHIATRY 24 (1997); Geoffrey C. Fisher & Ian Mitchell, *Is Munchausen Syndrome by Proxy Really a Syndrome?*, 72 ARCHIVES OF DISEASE IN CHILDHOOD 530 (1995); Geoffrey C. Fisher et al., *Munchausen's Syndrome by Proxy: The Question of Psychiatric Illness in a Child*, 162 BRIT. J. PSYCHIATRY 701 (1993); David G. Folks, *Munchausen's Syndrome and Other Factitious Disorders*, 13 NEUROLOGIC CLINICS 267 (1995); V. Godding & M. 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legal<sup>17</sup> literature on the subject has been expansive in the past decade.<sup>18</sup> Media coverage has also

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17. See, e.g., Stephen J. Boros & Larry C. Brubaker, *Munchausen Syndrome by Proxy: Case Accounts*, FBI L. ENFORCEMENT BULL., June 1992, at 16; Flannery, *supra* note 9, at 1175; Kathryn A. Hanon, *Child Abuse: Munchausen's Syndrome by Proxy*, FBI L. ENFORCEMENT BULL., Dec. 1991, at 8; Bernard Kahan & Beatrice Crofts Yorker, *Munchausen Syndrome by Proxy: Clinical Review and Legal Issues*, 9 BEHAV. SCI. & L. 73 (1991); Robert Kinscherff & Richard Famularo, *Extreme Munchausen Syndrome by Proxy: The Case for Termination of Parental Rights*, 42 JUV. & FAM. CT. J. 41 (1991); Suelyn Scarnecchia, *An Interdisciplinary Seminar in Child Abuse and Neglect with A Focus on Child Protection Practice*, 31 U. MICH. J.L. REFORM 33 (1997); Melissa Searle, *Munchausen Syndrome by Proxy: A Guide for California Attorneys*, 20 W. ST. U. L. REV. 393 (1993); Beatrice Crofts Yorker, *Covert Video Surveillance of Munchausen Syndrome by Proxy: The Exigent Circumstances Exception*, 5 HEALTH MATRIX: J. L.-MED. 325 (1995); Beatrice Crofts Yorker & Bernard B. Kahan, *The Munchausen Syndrome by Proxy Variant of Child Abuse in the Family Courts*, 42 JUV. & FAM. CT. J. 51 (1991); Marie M. Brady, Note, *Munchausen Syndrome by Proxy: How Should We Weigh Our Options?*, 18 LAW & PSYCHOL. REV. 361 (1994); Tracy Vollaro, Note, *Munchausen Syndrome by Proxy and Its Evidentiary Problems*, 22 HOFSTRA L. REV. 495 (1993).

18. For a discussion of the literature surrounding Munchausen Syndrome and a history of the use of the term in the medical field, see Amirault, *supra* note 15, at 173-75. Attention focused on the disease in France has led to an enormous legal controversy over the definition

increased.<sup>19</sup> In fact, actual video tapes of mothers abusing their children in the hospital can be viewed on the

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of a "novel," as a result of a purportedly fictional novel, *Moloch*, written by French crime novelist Thierry Jonquet. See Ben Macintyre, *Novelist Takes Fact as Fiction in Murder Plot*, TIMES (London), July 4, 1998, at 15. Jonquet's novel is allegedly based on the factual case of Liliane Kazkaz, a 35-year-old nursing assistant, who in 1990 was accused of poisoning her nine-year-old daughter, Caroline. See *id.* Kazkaz continually claimed that she was innocent, but was found dead at her home in Paris in November 1994, just one month before her trial was to begin. See *id.* Days after *Moloch* was published in May 1998, Kazkaz' husband Haitham was placed under formal investigation on suspicion of murdering his wife and attempting to poison Caroline four years earlier. See *id.* Lawyers for the mother have filed suit against the author for posthumous defamation of Liliane Kazkaz, which is possible under French law. See *id.* In response, Jonquet pointed to the enormous publicity of the case and the notoriety of the disease, claiming that it was impossible that his topic could not be "inspired" by real events. See *id.* Others argue that in such a highly publicized case of Munchausen Syndrome by Proxy, the characters are "perfectly identifiable," and that thus the author may "designate a guilty party before a definitive judgment." *Id.*

19. Munchausen Syndrome by Proxy has been the focal point of several TV news broadcasts in the past several years. See generally *Dateline NBC: From Cradle to Grave: Mother of 10 Babies Suspected of Killing All of Them* (NBC television broadcast, Apr. 7, 1998), transcript available in 1998 WL 6615344 (profiling the case of Marie Noe, whose 10 children all died within 15 months of their birth, between 1949 and 1968, in what was then considered to be "America's worst case of Sudden Infant Death Syndrome," but what is now suspected of being a series of cases of Munchausen Syndrome by Proxy); *PrimeTime Live*, *supra* note 3 (reporting on secret tapes made by an English doctor of parents with Munchausen Syndrome by Proxy); *Dateline NBC: Profile: Rush to Judgment?: Teresa and Jeff Timm, Accused of Child Abuse, Were Later Found Innocent After Lack of Evidence and Other Testimony Was Found in Their Favor* (NBC television broadcast, Aug. 29, 1997), transcript available in 1997 WL 7755296 (profiling the case of Teresa Timm, whom authorities at the Nebraska social services agency suspected of Munchausen Syndrome by Proxy, and whose experience was the basis for a TV movie after it was determined that the allegations were a hoax); *48 Hours: Profile: Florida Mother Under Investigation, Suspected of Intentionally Harming Her Child for Attention* (CBS television broadcast, Aug. 7, 1997), transcript available in 1997 WL 7813470; *48 Hours: Profile: Jennifer Bush Is Taken into Protective Custody and Her Mother Is Arrested for Felony Child Abuse* (CBS television broadcast, Aug. 7, 1997), transcript available in 1997 WL 7813469; *48 Hours: Profile: Jennifer Bush, Allegedly Made Ill by Her Mother, Kathy Bush, Remains in Foster Care and Is Thriving: Mother Still Fighting to Regain Custody of Child* (CBS television broadcast, Aug. 7, 1997), transcript available in 1997 WL 7813468 [hereinafter *48 Hours: Jennifer Bush, Allegedly Made Ill*] (all profiling the case of Jennifer Bush, who was hospitalized over 200 times for more than 30 intrusive operations as a result of what Florida Department of Health and Rehabilitative Services authorities believe to be Munchausen Syndrome by Proxy perpetrated by Jennifer's mother, Kathy Bush). The use of covert video surveillance of Munchausen Syndrome by Proxy in the study by Dr. David Southall, see David P. Southall et al., *Covert Video Recordings of Life-Threatening Child Abuse: Lessons for Child Protection*, 100 PEDIATRICS 735 (1997), was profiled on the television news program *PrimeTime Live*. See *PrimeTime Live*, *supra* note 3. For a discussion of the study by Dr. Southall, see *infra* Part II.A and accompanying notes. For the opinion that *PrimeTime Live*'s coverage of the story sought merely to gain ratings, rather than to address the ethical conundrum, see Matt Zoller Seitz, *CBS Beats ABC on Disney Boycott*, STAR-LEDGER (Newark, N.J.), Nov. 25, 1997, at 37.

Suspected and confirmed cases of Munchausen Syndrome by Proxy have consistently been reported in newspapers throughout the United States during recent years. Most notable is the case of Cynthia Lyda. The 31-year-old mother lost custody of her 1-month-old son Benjamin on April 6, 1998. See Melissa Prentice, *Judge Allows Mother Only Supervised Visits*, SAN ANTONIO EXPRESS-NEWS, May 21, 1998, at 1B, available in 1998 WL 5092668 [hereinafter Prentice, *Judge Allows Mother Only Supervised Visits*]. Another son, Gideon, had been taken into custody by the

state in December 1996. See Rick Casey, *Undiagnosed Tragedy (Chapter V): Cindy's New In-Laws Learn About Her Past; Another Baby Arrives—Court Order Obtained to Place New Child Into a Foster Home*, SAN ANTONIO EXPRESS-NEWS, Apr. 15, 1997, at 9A, available in 1997 WL 3168441; Prentice, *Judge Allows Mother Only Supervised Visits*, *supra*.

Lyda's two other sons, Joseph and Daniel, are the subject of separate endangerment charges brought against her, for which she faces up to 212 years in prison. See Prentice, *Judge Allows Mother Only Supervised Visits*, *supra*. Trial for these charges is scheduled for February 1999. See *Briefs: Mother Faces Trial in Boys' Injuries*, SAN ANTONIO EXPRESS-NEWS, June 26, 1998, at 2B, available in 1998 WL 5098475. It is expected that the prosecution alone will call 102 witnesses from around the world. See *id.* Lyda is free on bond, but has been ordered by a federal judge to wear an electronic monitor. See Melissa Prentice & Jacque Crouse, *Mom Accused of Hurting Kids: Munchausen's Syndrome Case Leads to Federal Indictment*, SAN ANTONIO EXPRESS-NEWS, Apr. 30, 1998, at 1A, available in 1998 WL 5089958. Daniel, who is now six years old, has brain damage, which developed after he suffered a cardiac arrest while alone in a hospital room with Lyda, and he essentially remains in a vegetative state. See Rick Casey, *Undiagnosed Tragedy (Chapter VI): Mom's Behavior Leads to Suspicions*, SAN ANTONIO EXPRESS-NEWS, Apr. 16, 1997, at 1A, available in 1997 WL 3168621 [hereinafter Casey, *Undiagnosed Tragedy (Chapter VI)*]; Rick Casey, *Undiagnosed Tragedy: Kids' Mystery Deaths Probed—S.A. Judges Restrict Mom's Contact with Sons*, SAN ANTONIO EXPRESS-NEWS, Apr. 13, 1997, at 1A [hereinafter Casey, *Undiagnosed Tragedy (Chapter I)*].

Additionally, Lyda faces charges stemming from the death of another two-year-old son, Aaron, in 1990, and the death of a foster child, Joshua, in 1993. See Rick Casey, *Undiagnosed Tragedy (Chapter IV): Deaths Spur Dad to Consider Abortion*, SAN ANTONIO EXPRESS-NEWS, Apr. 15, 1997, at 1A [hereinafter Casey, *Undiagnosed Tragedy (Chapter IV)*]; Casey, *Undiagnosed Tragedy (Chapter VI)*, *supra*. Both bodies were exhumed as part of the investigation into the later incident involving Joseph, which was video taped. See Casey, *Prosecutor Hitting Road for Baby Case*, *supra* note 3, at 2A; Casey, *Undiagnosed Tragedy (Chapter I)*, *supra*. Although Lyda's oldest child has never suffered from the effects of Lyda's alleged disease, see Casey, *Undiagnosed Tragedy (Chapter I)*, *supra*, reports suggest that with regard to her other children Lyda demonstrated many of the classic symptoms of one suffering from Munchausen Syndrome by Proxy. See Casey, *Undiagnosed Tragedy (Chapter VI)*, *supra*. Evidence about David Martinez, Lyda's first husband and father of Lyda's first four children, also supports suspicions of the disease, based on the typical "father" role in the Syndrome: "Fathers in MSBP cases are typically absent a great deal because of their jobs, giving the mother both the need for attention and the opportunity to manipulate her child's condition." Rick Casey, *Undiagnosed Tragedy (Chapter II): Dad Recalls Son's Tragic Death—Sergeant Says He Never Saw Seizures Described by Wife*, SAN ANTONIO EXPRESS-NEWS, Apr. 14, 1997, at 1A, available in 1997 WL 3168454.

With regard to eight-month-old Joseph, Lyda was the subject of covert video surveillance by the Air Force Office of Special Investigation at Wilford Hall Medical Center in 1994. See Casey, *Undiagnosed Tragedy (Chapter I)*, *supra*; Casey, *Undiagnosed Tragedy (Chapter IV)*, *supra*; Prentice, *Judge Allows Mother Only Supervised Visits*, *supra*. After ten days of constant video surveillance, Lyda was observed blowing into the feeding tube of her son, Joseph, who writhed in pain and screamed during the incident. See Casey, *Undiagnosed Tragedy (Chapter I)*, *supra*; Casey, *Undiagnosed Tragedy (Chapter IV)*, *supra*; Prentice, *Judge Allows Mother Only Supervised Visits*, *supra*. Other evidence revealed that Lyda had also put formula in the child's stool, put a syringe cap under the child to make him cry during a doctor's visit, put gauze in his feeding line, and poured feces into his feeding bag. See Rick Casey, *Lyda Criminal Trial Previewed This Week*, SAN ANTONIO EXPRESS-NEWS, May 3, 1998, at 2A, available in 1998 WL 5090398; Casey, *Undiagnosed Tragedy (Chapter IV)*, *supra*; Judi Villa & Abraham Kwok, *Former Mesa Mom Accused in Sons' Abuse: Illness Drives Need to Hurt*, ARIZ. REPUBLIC, Apr. 30, 1998, at A1. It is further suspected that Lyda made inappropriate changes on Joseph's ventilator, interfered with discharge planning, and made changes to feeding regimens without a physician's approval. See Casey, *Undiagnosed Tragedy (Chapter VI)*, *supra*. On other occasions when the child was in danger during an apnea episode, she would do nothing. See *id.* Upon restriction of contact between mother and child, Joseph recovered quickly and, within a few months, had all of his

feeding and breathing tubes removed, no longer needed medication, and began to thrive. See Casey, *Undiagnosed Tragedy (Chapter I)*, *supra*. Dr. Keith Kerr testified that, although the child was not seriously injured by the incidents viewed on tape, it was all part of a deceptive plan by Lyda for the child to receive complicated, but unnecessary surgeries and prolonged hospital stays. See Prentice, *Judge Allows Mother Only Supervised Visits*, *supra*.

Much of the federal criminal case hinges on the testimony of witnesses in the civil custody case, particularly regarding visitation. See Casey, *Lyda Criminal Trial Previewed This Week*, *supra*. Immediately after the original charges, Lyda was restricted to supervised visits with only Benjamin and Gideon, wherein Lyda had to wash her hands and face and cover herself in a smock before she could hold the children. See Melissa Prentice, *Disorder Continues to Draw Controversy: Judge to Determine Custody Rights of Parents Linked to Munchausen's Syndrome*, SAN ANTONIO EXPRESS-NEWS, May 5, 1998, at 1B, available in 1998 WL 5090667 (describing the extent of supervised visits with Benjamin and Gideon, which were limited to one hour per week); Melissa Prentice, *Visits by Mom Allowed: Judge to Let Lydas Be with Infant Son*, SAN ANTONIO EXPRESS-NEWS, May 8, 1998, at 1A, available in 1998 WL 5091085 (describing the nature of previous visits with Benjamin and Gideon) [hereinafter Prentice, *Visits by Mom Allowed*]. After a four-day hearing in May, however, it was determined that Lyda could have full, unsupervised weekend visits with Benjamin, before and after which a social worker could examine the child, and during which the social worker was able to appear unannounced. See Rick Casey, *No, Judge Wasn't Nuts in Munchausen's Case*, SAN ANTONIO EXPRESS-NEWS, May 8, 1998, at 3A, available in 1998 WL 5091095; Kelley Shannon, *Judge Alters Visiting Time in Munchausen Infant Case*, AUSTIN AM.-STATESMAN, May 8, 1998, at B6, available in 1998 WL 3609476. One report regarding the custody determination questioned the tactical decision by the attorneys representing the Child Protective Services agency and the children to hold back in presenting all the evidence. See Rick Casey, *The Hovering Boys on the Back Bench*, SAN ANTONIO EXPRESS-NEWS, May 10, 1998, at 2A, available in 1998 WL 5091300. The attorneys presented evidence of only three of the six counts brought against Lyda. See Melissa Prentice, *Munchausen's Judge Urged to Look at Full Story*, SAN ANTONIO EXPRESS-NEWS, May 20, 1998, at 7B, available in 1998 WL 5092444 [hereinafter Prentice, *Munchausen's Judge Urged to Look at Full Story*]. A few days after the decision to allow unsupervised visits with Benjamin, the judge denounced the state's attorneys for withholding "significant, critical evidence" in the custody hearing and overturned his own decision to allow unsupervised visits. Melissa Prentice, *Mother's Visitations Gone: Judge Says He Didn't Previously Have All the Evidence*, SAN ANTONIO EXPRESS-NEWS, May 14, 1998, at 1A, available in 1998 WL 5091842 [hereinafter Prentice, *Mother's Visitations Gone*]. It wasn't until after his decision to allow unsupervised visits that the judge learned of the existence of 60 transcript pages of medical testimony from the Lydas' 1995 divorce hearing by Dr. Keith Kerr, who originally diagnosed Lyda with Munchausen Syndrome by Proxy, which refuted testimony that the children suffered from a genetic disorder. See *id.* For a discussion of Dr. Kerr's testimony, see Prentice, *Munchausen's Judge Urged to Look at Full Story*, *supra*. In his opinion, Judge David Peoples wrote: "Whatever may be the state's reasons for presenting a skeleton case, this court is unwilling to decide such an important child-safety matter without the benefit of all the evidence." Prentice, *Mother's Visitation's Gone*, *supra*. Now, after only one unsupervised weekend visit with Benjamin, Lyda's visitation has been returned to the original supervised visits with both children, during which she and her husband are required to scrub and wear surgical gowns. See Prentice, *Judge Allows Mother Only Supervised Visits*, *supra*. The new order modified the original order insofar as the supervised visits could now occur two times per week instead of only once, and the children's grandmother could continue to attend one of the visits every week. See *id.* The judge also ordered DNA tests to clarify the varying testimony about the existence of a genetic disorder. See *id.*

For a discussion of why it took so long for criminal charges to be brought against Lyda, see Rick Casey, *Another Baby Born to Munchausen Suspect*, SAN ANTONIO EXPRESS-NEWS, Apr. 8, 1998, at 3A, available in 1998 WL 5086727 (suggesting that the delay was due to jurisdictional questions between the state and federal prosecutors). However, for commentary praising the quick action taken by authorities in removing Lyda's newborns, see Melissa Prentice & Jacquie Crouse, *Baby Taken from Mother Being Probed in Deaths of Kids*, SAN ANTONIO EXPRESS-NEWS,

Internet.<sup>20</sup> These expanding sources of information are critical in the effort to introduce the Syndrome to judges, juries, and society as a unique but prevalent form of child abuse. This expanding body of information may be a double-edged sword, however.<sup>21</sup> As medical knowledge of the disease grows and as medical professionals quickly learn that courts are often skeptical about the disease, or require clearer and more convincing evidence that such a bizarre condition with such detrimental effects on the child actually occurs, medical efforts to capture proof of the abuse on video are increasing.<sup>22</sup> Some

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Apr. 8, 1998, at 1B, available in 1998 WL 5086705. Some commentators feel that the only reason action is now being taken is because of the excessive media surrounding the case. See Rick Casey, *Munchausen Suspect Gets Vigorous Defense*, SAN ANTONIO EXPRESS-NEWS, Apr. 12, 1998, at 2A, available in 1998 WL 5087382; Thaddeus Herrick, *State Takes Newborn from Mother: Grand Jury Likely to Investigate Deaths of the Woman's Children*, HOUS. CHRON., Apr. 11, 1998, at 21A.

Commenting on the nature of such cases, Phoenix attorney Tom Ryan, who is known for defending women accused of perpetrating Munchausen Syndrome by Proxy, said: "Cases like this evaporate in the courtroom. I guarantee that will be true of the Lyda case. . . . Munchausen [S]yndrome by [P]roxy does not exist. . . . It will go the way of ritual satanic abuse." *Id.* Ryan, who calls the syndrome the "disease du jour," has won five cases in five years for accused mothers. See Gloria Padilla, *Lawyer Blasts 'Disease du Jour'*, SAN ANTONIO EXPRESS-NEWS, May 4, 1998, at 1A, available in 1998 WL 5091535. Ryan claims that the syndrome is "nothing more than modern day medical McCarthyism" and that it is "being used by fathers to gain sole custody of their children; in response to medical malpractice complaints; and as a way for medical personnel to get rid of a 'pushy' mother." *Id.* He further feels that the syndrome is "used against women by a male-dominated medical community," and that the Lyda case is "the shame of Texas." *Id.*

20. A very short, somewhat distorted clip of the videotape of Cynthia Lyda may be viewed on the Internet. See Rick Casey, *Undiagnosed Tragedy* (visited Jan. 23, 1999) <<http://www.expressnews.com/extras/munch/>>.

21. See Southall et al., *supra* note 19, at 755 (acknowledging the importance of the media in promoting awareness of the disease, but also noting that media attention is attractive to the Munchausen Syndrome by Proxy perpetrator and that the media may assist the perpetrator and hinder child protection); see also Meadow, *What Is, and What Is Not, supra* note 16, at 534 (asserting that overuse of the term "Munchausen Syndrome by Proxy" has confused medical, social work, and legal professionals); Donald & Jureidini, *supra* note 16, at 753 (noting that there has been inconsistency in the application of the term "Munchausen Syndrome by Proxy," which has been compounded by commentators' failures to treat the syndrome as a form of child abuse); Morley, *Practical Concerns, supra* note 16, at 528-29 (suggesting that the qualifications used to define Munchausen Syndrome by Proxy are non-specific and can be misinterpreted; instead, the term should be abandoned altogether in favor of a physical description of what happened to the child); Amirault, *supra* note 15, at 182-83 ("What would appear to mitigate the spread of Munchausen syndrome augments it instead.").

22. See Yorker, *supra* note 17, at 328-29. For a discussion of the use of covert video surveillance in Munchausen Syndrome by Proxy cases, see Roger W. Byard & Richard H. Burnell, *Covert Video Surveillance in Munchausen Syndrome by Proxy: Ethical Compromise or Essential Technique?*, 160 MED. J. AUSTRALIA 352 (1994); T.J. David, *Spying on Mothers*, 344 LANCET 133 (1994) (letter to the editor); Mark A. Epstein et al., *Munchausen Syndrome by Proxy: Considerations in Diagnosis and Confirmation by Video Surveillance*, 80 PEDIATRICS 220 (1987); Donald Evans, *Covert Video Surveillance in Munchausen Syndrome by Proxy*, 308 BRIT. MED. J. 341 (1994) [hereinafter Evans, *Covert Video Surveillance*]; Marc D. Feldman, *Spying on Mothers*, 344 LANCET 132 (1994) (letter to the editor); D.M. Foreman & C. Farsides, *Ethical Use of Covert Videoing Techniques in Detecting Munchausen Syndrome by Proxy*, 307 BRIT. MED. J. 611 (1993); J. Fox, *Covert Video Surveillance of Children: Role of Police*, 307 BRIT. MED. J. 1145 (1993); Jacqueline French, *Pseudoseizures in the Era of Video-Electroencephalogram Monitoring*, 8 CURRENT OPINION IN NEUROLOGY 117 (1995); James D. Frost et al., *Munchausen's Syndrome by Proxy and Video*

legal commentators encourage such efforts.<sup>23</sup> This Article argues, however, that employing covert video surveillance is both unnecessary and unethical as a means of proving Munchausen Syndrome by Proxy, despite the sometimes positive results from such efforts, because the process not only permits child abuse to occur, but also purposely creates an environment conducive to its perpetration. This Article concludes that covert video surveillance unreasonably places a child at risk of abuse, and that any abuse permitted by a medical professional is inherently unethical and should be prohibited. If medical professionals suspect Munchausen Syndrome by Proxy, then they should take every added precaution to confirm the diagnosis through comparative medical conclusions after observing the child's condition when he or she is not within the care and control of the suspected perpetrator.<sup>24</sup> Legal professionals, like prosecutors, attorneys, and judges, should help to promote the health, safety, and well-being of the child by integrating a cumulative medical diagnosis and a *res ipsa loquitur* standard to obviate the need for covert video surveillance. To create an environment where physical and potentially lethal child abuse is anticipated and permitted contravenes both legal reason and medical ethics.<sup>25</sup> Such action, however well intentioned, is tantamount to complicity in the abuse.

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*Surveillance*, 142 AM. J. DISEASES CHILDREN 917 (1988); Raanan Gillon, *Covert Surveillance by Doctors for Life-Threatening Munchausen's Syndrome by Proxy*, 21 J. MED. ETHICS 131 (1995); Paul Johnson & Colin Morley, *Spying on Mothers*, 344 LANCET 132 (1994) (letter to the editor); Brian Morgan, *Covert Surveillance in Munchausen's Syndrome by Proxy*, 308 BRIT. MED. J. 1715 (1994); Brian Morgan, *Spying On Mothers*, 344 LANCET 132 (1994) (letter to the editor); Colin Morley, *Concerns About Using and Interpreting Covert Video Surveillance*, 316 BRIT. MED. J. 1603 (1998); Martin P. Samuels & David Southall, *Covert Surveillance in Munchausen's Syndrome by Proxy: Welfare of the Child Must Come First*, 308 BRIT. MED. J. 1101 (1994) (letter to the editor) [hereinafter Samuels & Southall, *Covert Surveillance: Welfare of the Child Must Come First*]; Martin P. Samuels & David Southall, *Video Surveillance in Diagnosis of Intentional Suffocation*, 344 LANCET 414 (1994); Neela Shabde & Alan W. Craft, *Commentary: Covert Video Surveillance Is Acceptable—But Only with a Rigorous Protocol*, 316 BRIT. MED. J. 1604 (1998); Elliot A. Shinebourne, *Covert Video Surveillance and the Principle of Double Effect: A Response to Criticism*, 22 J. MED. ETHICS 26 (1996); Southall et al., *supra* note 19, at 735; David P. Southall & Martin P. Samuels, *Ethical Use of Covert Videotaping for Potentially Life Threatening Child Abuse: A Response to Drs. Foreman and Farsides*, 307 BRIT. MED. J. 613 (1993); *Spying On Mothers*, 343 LANCET 1373 (1994) (editorial); Terry Thomas, *Covert Video Surveillance—An Assessment of the Staffordshire Protocol*, 22 J. MED. ETHICS 22 (1996); Robert Wheatley, *Covert Surveillance in Munchausen's Syndrome by Proxy: Clinical Investigation, Not Research Activity*, 308 BRIT. MED. J. 1101 (1994) [hereinafter Wheatley, *Covert Surveillance*].

23. See, e.g., Yorker, *supra* note 17, at 346 (favoring use of surveillance when legally valid); Vol-laro, *supra* note 17, at 515 (encouraging video surveillance of the actual occurrence of Munchausen Syndrome by Proxy in hospitals).

24. More effective and more timely medical intervention is critical because the alternative is post-abuse intervention by the social or judicial systems, both which have proven much less effective sources of protection for the child. See Richard D. Krugman, *Unimaginable Images: Seeing Is Believing*, 100 PEDIATRICS 890, 891 (1997).

25. Arguably, as a medical concept, Munchausen Syndrome is itself rooted in moral dilemma. Its origin was first perceived to be of a moral nature; that is, patients were simply duping doctors by falsifying symptoms and illnesses. Eventually, diagnosing the performance pathologically and creat-



Part I of this Article briefly describes Munchausen Syndrome by Proxy. It is beyond the scope of this Article to discuss the intricate dynamics of the disorder and its complicated etiology in great detail. There are numerous medical and some legal resources that discuss these areas, and a partial list of these sources is offered as reference.<sup>26</sup> To understand the context of the unethical nature of video surveillance of the disorder, however, it is necessary to understand the nature of the disorder itself, since the incomprehensible nature of the disorder is used to justify extreme investigative measures. There is extensive debate within the medical field itself regarding whether the term “Munchausen Syndrome by Proxy” should be used to define the perpetrator’s behavior or the abuse resulting from the behavior.<sup>27</sup> The answer to this debate is relevant to the existing discrepancy between how the medical and legal fields treat the disorder and deal with its consequences. Therefore, Part I of this Article will briefly describe the nature of Munchausen Syndrome by Proxy in this context. If the term is used to qualify a perpetrator’s behavior, and the Syndrome is treated as something from which the parent suffers, (i.e., the mother “suffers from Munchausen Syndrome by Proxy”), then the medical and legal fields’ reaction to the Syndrome will tend to focus on the psychiatric assessment of the perpetrator and the family, rather than on the clinical condition of the child.<sup>28</sup> Within this narrow context, this Article

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ing a “medical” term for this concept transformed otherwise “bad” patients into “sick” patients, and displaced the concept from the arena of moral discourse to that of medical discourse. See Amirault, *supra* note 15, at 181.

26. See *supra* notes 16, 17.

27. See Meadow, *What Is, and What Is Not*, *supra* note 16, at 534. Meadow states that observers of the most drastic cases—suffocation and poisoning—see that perpetrating parents share common characteristics. They think that this warrants special approaches in dealing with this unique form of abuse. See *id.* at 535. Therefore, he argues, “it is appropriate to decide how to use the term . . . in a way that is helpful to child protection workers and . . . to the children.” *Id.* He thinks it is inappropriate to say that someone “suffer[s] from Munchausen syndrome by proxy.” *Id.* He advocates following the American Psychiatric Association’s (APA) proposal, see APA, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM IV)* (4th ed. 1994), which applies the term “factitious disorder by proxy” to the perpetrator and his or her behavior, rather than to the resulting abuse. See Meadow, *What Is, and What Is Not*, *supra* note 16, at 534–35. *But cf.* Donald & Jureidini, *supra* note 16, at 756 (suggesting that even this definition is inadequate and should “contain a fifth criterion that makes explicit the central role of the physician in the process, that is, misattribution by physicians of the illness or injury to some medical cause(s), not necessarily clearly defined.”). Thus, it may be used to categorize abusers of the elderly, handicapped, or disabled adults, and not just children. See Meadow, *What Is, and What Is Not*, *supra* note 16, at 535. A third possible qualification of the term is not just the perpetrator, or just the abuse, but a complex *transaction* among parent, child, and physician. See Donald & Jureidini, *supra* note 16, at 756. In any case, as Donald & Jureidini argue, the focus on the perpetrator’s psychological or psychiatric condition should not be overlooked; it is critical to ongoing case management decisions and the prevention of further harm to the child or other children. See *id.* at 758. The focus on diagnosing the perpetrator should not influence the determination of whether child abuse has taken place, however. See *id.*

28. See Meadow, *What Is, and What Is Not*, *supra* note 16, at 538. Meadow argues that the term Munchausen Syndrome by Proxy should be confined to situations in which the perpetrator’s

concludes that "Munchausen Syndrome by Proxy" must be accepted as a form of child abuse that should be dealt with by focusing primarily on the effects on the child.<sup>29</sup> This Article further concludes that employing covert video surveillance to detect or confirm the disorder subverts this primary focus on the child and leads to unethical results.

Part I also discusses the legal implications of the Syndrome. While knowledge of the disease within the medical and legal fields is growing, neither field addresses or accepts the disease and its very real consequences. Both fields, however, are quite dependent upon each other's treatment of the disease if the disease is to be properly addressed as a form of child abuse.<sup>30</sup> Thus, the hesitancy of the legal field to fully accept and treat Munchausen Syndrome by Proxy as a unique form of child abuse has serious implications for medical professionals and, more importantly, for the children who are victimized by the disease. Part I also addresses the consequences on children and medical staffs, which include the growing but misguided need for hospital staffs to conduct covert video surveillance of abusive parents perpetrating Munchausen Syndrome by Proxy.

Part II analyzes the ethical dilemma for hospital staffs created by the legal system's hesitancy to accept Munchausen Syndrome by Proxy as a unique form of child abuse. Because judges and juries remain skeptical of the disease and its consequences, hospital staffs are forced to rely on covert video surveillance to prove that the disease actually occurs, results in harmful effects on the child, and is, in fact, a form of child abuse. Part II describes the procedures employed by Dr. David Southall, who uses covert video surveillance as a means of detecting or confirming Munchausen Syndrome by Proxy to assure appropriate criminal dispositions for the perpetrators and appropriate domestic dispositions for the children.<sup>31</sup> Part II argues that the use of covert video surveillance is invalid under a Fourth Amendment analysis and unnecessary. This Article further concludes that orchestrating situations where child abuse is likely or suspected to occur is unethical and should be prohibited. Instead, other, more time-consuming but cautious methods of detection, such as restricting a parent's visits with the child, should be employed

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motivation is to assume a sick role for themselves or another form of attention-seeking behavior. *See id.* at 538.

29. There are generally three reasons why some clinicians have not accepted Munchausen Syndrome by Proxy as a form of child abuse: (1) "Some claim that [Munchausen Syndrome by Proxy] is, or is symptomatic of, a specific psychiatric disturbance in the perpetrator[;] (2) [r]eported mortality and morbidity rates are higher[; and] (3) Munchausen [S]yndrome by [P]roxy seems to be premeditated rather than motivated by acute frustration or rage." Donald & Jureidini, *supra* note 16, at 753.

30. *See* Flannery, *supra* note 9, at 1224-32.

31. *See infra* Part II.A.

in a controlled and protective environment as an alternative. Part II also argues that, when considering the propriety of covert video surveillance, courts should accept the health and safety of the child as paramount, and should temporarily restrict visitation as an alternative to covert video surveillance.

Part III argues that courts can obviate the need for covert video surveillance by integrating the medical and legal perspectives on the Syndrome. Part III suggests that when confronted with Munchausen Syndrome by Proxy, courts should consider all cumulative circumstantial medical evidence, including the change in the child's condition when separated from the alleged perpetrator. Courts should then apply a *res ipsa loquitur* theory to the cumulative evidence, thereby obviating the need for covert video surveillance, while still confirming the diagnosis and protecting the child.

## I. MUNCHAUSEN SYNDROME BY PROXY

### A. *The Dynamics of the Disease*

Munchausen Syndrome by Proxy is an extended form of Munchausen Syndrome<sup>32</sup> which incorporates a child as the recipient of fabricated or falsely induced illnesses.<sup>33</sup> Acute conditions in the child are fabricated or induced by a parent—almost always a mother<sup>34</sup>—to satisfy the perpetrator's need for attention or the need to assume a role of one parenting a child's illness.<sup>35</sup> Thus, the parent is the proxy, who provides information regarding the child's condition, rather than his or her own condition.

Typically, there are four identifiable elements that categorize Munchausen Syndrome by Proxy:

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32. In cases of Munchausen Syndrome, adults pursue hospital admission or medical attention for themselves by fabricating symptoms or actually inducing illnesses or conditions in themselves. See Murray, *supra* note 16, at 343–49. The fabricated symptoms are usually accompanied by dramatic, yet plausible, medical histories. See *id.* at 343–44. The perpetrator usually has nothing to gain by this behavior, other than satisfying the desire to deceive others. See *id.* at 345. This desire is usually satisfied at several hospitals and through numerous doctors. See *id.* at 344. There have been several interpretations of the cause for such behavior, including: a need to suffer; a desire to be the focus of attention; a need to adopt a passive controlling role; an attempt to deceive authority or parent figures; dependency; fulfillment of erotic desires; depression; symbolic castration; and a demonstrated hatred for doctors. See A. Cremona-Barbaro, *The Munchausen Syndrome and Its Symbolic Significance: An In-Depth Case Analysis*, 151 BRIT. J. PSYCHIATRY 76 (1987).

33. See Murray, *supra* note 16, at 343.

34. See Flannery, *supra* note 9, at 1182.

35. See *id.* at 1193.

(1) the child's illness is simulated or produced by a parent or someone acting in a parental role; (2) the parent repeatedly requests medical evaluation and care of the child; (3) the perpetrator denies any knowledge of the etiology; and (4) the symptoms quickly cease when the child and the perpetrator are separated.<sup>36</sup>

While the nature of the fabricated or induced symptoms may take many forms,<sup>37</sup> the most common symptoms are seizures and apnea,<sup>38</sup> bleeding,<sup>39</sup> fever,<sup>40</sup> diarrhea,<sup>41</sup> vomiting,<sup>42</sup> hypertension,<sup>43</sup> rashes,<sup>44</sup> renal stones,<sup>45</sup> and failure to thrive.<sup>46</sup> Some of the most common abuses by the parent are suffocation,<sup>47</sup> insulin

36. Flannery, *supra* note 9, at 1184 (citing Susan O. Mercer & Jeanette D. Perdue, *Munchausen Syndrome by Proxy: Social Work's Role*, 38 SOC. WORK 74, 74-75 (1993)); see Donald & Jureidini, *supra* note 16, at 757 (offering five criteria for suspecting Munchausen Syndrome by Proxy). *But see* Meadow, *What Is, and What Is Not*, *supra* note 16, at 534 (asserting that common factors which indicate Munchausen Syndrome by Proxy lack specificity and may be qualified by other abusive behaviors that are not classified as Munchausen Syndrome by Proxy). See generally Rosenberg, *supra* note 16, at 547-63.

37. One report describes a patient suffering from Munchausen Syndrome who went so far to dupe her doctor into performing a hysterectomy that she scanned the letterheads from previous medical records into her computer and then recreated her own pathology so that a hysterectomy was warranted. See Leo A. Gordon, *Munchausen Patients Have Found the Computer*, 74 MED. ECON. 118 (1997). For a discussion of how perpetrators of Munchausen Syndrome by Proxy abuse support groups on the internet as a forum for their deception, see Joan Stephenson, *Patient Pretenders Weave Tangled "Web" of Deceit*, 280 JAMA 1297 (1998).

38. Seizures or apnea in the child are typically caused by poisoning or suffocation. See Flannery, *supra* note 9, at 1185 n.31 (citing Meadow, *ABC*, *supra* note 16, at 249); see also Rosen et al., *supra* note 16, at 715-20 (discussing apnea); Roy Meadow, *Fictitious Epilepsy*, LANCET, July 7, 1984, at 25, 25-28 (discussing seizure disorders).

39. Bleeding in the child is usually caused by use of the perpetrator's blood, which, typically, is derived from a vaginal tampon, or through the use of raw meat, or coloring agents that are added to the child's stool. See Flannery, *supra* note 9, at 1185 n.31 (citing Meadow, *ABC*, *supra* note 16, at 249); see also Malatack et al., *supra* note 16, at 523-25 (discussing gastrointestinal bleeding).

40. A child's fever may be fabricated by warming a thermometer or altering temperature charts, or may be induced by injecting contaminated material into the child. See Flannery, *supra* note 9, at 1185 n.31 (citing Meadow, *ABC*, *supra* note 16, at 249).

41. Diarrhea in the child is usually caused by the forced ingestion of laxatives. See *id.*

42. The child may be induced to vomit by forced salt ingestion, or vomiting may be mechanically induced. See *id.*; see also James L. Sutphen & Frank T. Saulsbury, *Intentional Ipecac Poisoning: Munchausen Syndrome by Proxy*, 82 PEDIATRICS 453 (1988).

43. Hypertension is fabricated by altering blood pressure charts. See Flannery, *supra* note 9, at 1185 n.31 (citing Meadow, *ABC*, *supra* note 16, at 249.)

44. Rashes can be caused by scratching the child's skin to cause blisters, or through the use of caustics and dyes. See *id.*

45. Renal stones can be caused by the addition of stone and blood to the child's urine. See *id.*

46. A child's failure to thrive may be caused by actually withholding food, or, if in the hospital, by interfering with treatment or even sucking the child's stomach content through a nasogastric tube. See *id.*

47. See R.J. McClure et al., *Epidemiology of Munchausen Syndrome by Proxy, Non-Accidental Poisoning, and Non-Accidental Suffocation*, 75 ARCHIVES OF DISEASE IN CHILDHOOD 57 (1996); Roy Meadow, *Suffocation, Recurrent Apnea and Sudden Infant Death*, 117 J. PEDIATRICS 351 (1990). In the study by Dr. Southall,

injections,<sup>48</sup> ipecac poisoning,<sup>49</sup> administration of laxatives,<sup>50</sup> or other manipulations.<sup>51</sup>

There are basically five groups of people that form the typical inter-relationships in a Munchausen Syndrome by Proxy case, prior to legal involvement. The direct "participants" in the disorder are mothers, fathers, and children. Social workers<sup>52</sup> and doctors<sup>53</sup> are secondarily involved, but play a major role in the dynamics of the perpetration and investigation of the Syndrome. Research reveals that characteristics of individuals in these respective groups are usually consistent.<sup>54</sup> The perpetrator of Munchausen Syndrome by Proxy is usually a natural or adoptive mother,<sup>55</sup> between the ages of twenty-two and thirty-five,<sup>56</sup> who has had some history of psychiatric symptoms or behavioral problems.<sup>57</sup> The mothers are usually cooperative with medical staff and are overzealously involved in the child's care, yet express little concern over the child's illness.<sup>58</sup> The mothers often express that they are the only ones with whom the child seems to make progress.<sup>59</sup> Mothers also are able to predict

30 out of 39 cases of abuse involved some form of suffocation of the child. See Southall et al., *supra* note 19, at 741-44 tbl. 3.

48. See William A. Bauman & Rosalyn S. Yalow, *Child Abuse: Parental Insulin Administration*, 99 J. PEDIATRICS 588 (1981).

49. See Richard B. Colletti & Richard C. Wasserman, *Recurrent Infantile Vomiting Due to Intentional Ipecac Poisoning*, 8 J. PEDIATRIC GASTROENTEROLOGY & NUTRITION 394 (1989); Kenneth W. Feldman et al., *Munchausen Syndrome/Bulimia by Proxy: Ipecac as a Toxin in Child Abuse*, 13 CHILD ABUSE & NEGLECT 257 (1989); Jens Goebel et al., *Cardiomyopathy from Ipecac Administration in Munchausen Syndrome by Proxy*, 92 PEDIATRICS 601 (1993); H. Juhling McClung et al., *Intentional Ipecac Poisoning in Children*, 142 AM. J. DISEASES CHILDREN 637 (1988); Douglas J. Schneider et al., *Clinical and Pathologic Aspects of Cardiomyopathy from Ipecac Administration in Munchausen's Syndrome by Proxy*, 97 PEDIATRICS 902 (1996); Sutphen & Saulsbury, *supra* note 42, at 453 (suggesting that ipecac poisoning in children may be underestimated).

50. See McGuire & Feldman, *supra* note 16, at 289-90 (describing a case study involving the administration of laxatives to induce diarrhea in the child).

51. See Flannery, *supra* note 9, at 1186-87 n.43 (citing Crouse, *supra* note 16, at 249; Malatack, *supra* note 16, at 523-25).

52. For a discussion of the role of social workers in the perpetration and investigation of Munchausen Syndrome by Proxy, see Flannery, *supra* note 9, at 1203-05; see also James Masterson & Jacquelyn Wilson, *Factitious Illness in Children: The Social Worker's Role in Identification and Management*, SOC. WORK HEALTH CARE, Summer 1987, at 21, 21-30; Mercer & Perdue, *supra* note 36, at 74.

53. For a discussion of the role of doctors in the perpetration and investigation of Munchausen Syndrome by Proxy, see Flannery, *supra* note 9, at 1206-09. For accounts of physicians' views regarding Munchausen Syndrome by Proxy, see Mary S. Sheridan, *Parents' Reporting of Symptoms in Their Children: Physicians' Perceptions*, 53 HAW. MED. J. 216 (1994).

54. See Flannery, *supra* note 9, at 1189-1209.

55. See Mercer & Perdue, *supra* note 36, at 76.

56. See HERBERT A. SCHREIER & JUDITH A. LIBOW, HURTING FOR LOVE: MUNCHAUSEN BY PROXY SYNDROME 29 (1993).

57. See Alexander et al., *supra* note 16, at 585.

58. See Flannery, *supra* note 9, at 1189-90.

59. See *id.* at 1190.

when the child will improve,<sup>60</sup> which further evidences to hospital staff that they are knowledgeable and should be trusted regarding the child's care and condition. A surprising number of Munchausen mothers have extensive backgrounds in nursing or some aspect of the medical field.<sup>61</sup> Commonly, Munchausen Syndrome by Proxy mothers usually have experienced an emotionally or physically abusive childhood<sup>62</sup> and are probably involved in an unstable relationship with the child's natural father.<sup>63</sup>

While Munchausen Syndrome by Proxy mothers often share these common characteristics, perpetrators are generally classified into three categories: (1) help seekers, (2) active inducers, and (3) doctor addicts.<sup>64</sup> Help seekers tend to displace their own personal

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60. See *id.* at 1190-91; see also Epstein et al., *supra* note 22, at 222 (describing a mother who predicted her child's improvement before leaving him in the hospital for several days). Some researchers believe that a greater focus on the psychological diagnosis of the perpetrator and on the interaction with the treating psychologist will be helpful in identifying "countertransference," which could be used as a diagnostic tool to best help protect the interests of the child. See Szajnberg et al., *supra* note 16, at 233. "Countertransference" results from the perpetrator's ability to create a disinclination in the clinician to believe that the perpetrator could have performed such acts. See *id.* at 234. This reaction is provoked by the perpetrator's adoption of an "as-if" character, pursuant to which the perpetrator unconsciously presents aspects of themselves that they believe would want to be perceived or diagnosed by the clinician. See *id.* This explains why the same perpetrator may have varied diagnoses by several different clinicians. See *id.*

61. See Libow & Schreier, *supra* note 16, at 606. For a discussion of Munchausen Syndrome by Proxy perpetrated by medical care workers, see Julie Repper, *Munchausen Syndrome by Proxy in Health Care Workers*, 21 J. ADVANCED NURSING 299 (1995); see also *In re Aaron S.*, 625 N.Y.S.2d 786, 788 (Fam. Ct. 1993) (noting that statistics in various studies show that 30 to 50 percent of Munchausen Syndrome by Proxy mothers studied were nurses). Incidences of Munchausen Syndrome by Proxy, many of which involve nurses as the perpetrators, have led researchers to study the phenomenon of nurses who prey on their patients. See Schneider, *supra* note 3. Beatrice Crofts Yorker, Professor of Nursing at Georgia State University, has documented 13 cases of 14 nurses who were involved in 206 suspicious deaths in various hospitals, which led to 47 murder charges and 69 assault charges. See *id.* Eleven nurses were convicted (two convictions were overturned on appeal) and two nurses were found not guilty. See *id.* One hospital orderly admitted to killing 60 patients. See *id.* Yorker concluded that all of the criteria for Munchausen Syndrome by Proxy cases were present in the cases involving the nurses, with the simple substitution of an otherwise "dependent person" in the nursing cases for the child in a Munchausen Syndrome by Proxy case. See *id.*

In Ohio, 32-year-old Sherry Davis pretended to be a nurse and subjected her daughter, 12-year-old Kristy, who is deaf and diabetic, to numerous but unnecessary medications and medical procedures, including a feeding tube in her stomach. See Jane Prendergast, 'This Is Different than Being an Overprotective Parent'; Woman Accused of Making Girl Ill; Abuse Charged After Dozens of Treatments, CIN. ENQUIRER, July 12, 1998, at C1, available in 1998 WL 3778523. Davis is being charged with criminal abuse in the first degree. See *id.*

62. See Mercer & Perdue, *supra* note 36, at 78 ("Some studies report that the mother had a bereft childhood, and a high proportion had been sexually abused."). But see SCHREIER & LIBOW, *supra* note 56, at 20 (stating that evidence of physical and emotional abuse was inconsistent, but loneliness and isolation were common themes in mothers' lives).

63. See Mercer & Perdue, *supra* note 36, at 78 (discussing family dynamics of Munchausen Syndrome by Proxy mothers).

64. See Libow & Schreier, *supra* note 16, at 604.

problems by reporting distressing symptoms in the child.<sup>65</sup> They also thrive on medical attention and intervention and are very receptive to counseling and professional interaction.<sup>66</sup> Contrary to help seekers are active inducers, who resist medical intervention by camouflaging their psychiatric problems with overtly commendable parenting.<sup>67</sup> Doctor addicts closely resemble active inducers, but obsess on the child's illness and demonstrate paranoid tendencies toward the treatment team.<sup>68</sup>

It is rare that fathers are reported as the perpetrators of Munchausen Syndrome by Proxy.<sup>69</sup> Some believe that one reason for underestimated statistics of perpetrating fathers may be that fathers do not typically demonstrate the patterned characteristics demonstrated by the more common, female perpetrators, thereby making detection of the male perpetrator more difficult.<sup>70</sup> Others believe, however, that while usually not the primary perpetrators, fathers commonly take a passive role within the dynamics of the family affected by Munchausen Syndrome by Proxy.<sup>71</sup> Not surprisingly, Munchausen fathers commonly display denial and disbelief of the mother's behavior.<sup>72</sup> In the few studies that have revealed active participation by fathers, some observed common traits have been dominance over female participants and hospital staff, exaggerated affection for the child in the presence of hospital staff, and frustration with medical professionals in failing to diagnose the child accurately.<sup>73</sup> Although it is unclear whether male and female perpetrators demonstrate the same characteristics and traits, it is clear that fathers and male care givers must be closely considered in diagnosing Munchausen Syndrome by Proxy.

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65. See Flannery, *supra* note 9, at 1193.

66. See *id.*

67. See Libow & Schreier, *supra* note 16, at 606; see also Penelope Krener & Raymond Adelman, *Parent Salvage and Parent Sabotage in the Care of Chronically Ill Children*, 142 AM. J. DISEASES CHILDREN 945, 946, 949-50 (1988) (comparing difficulties in dealing with active inducers and "difficult" parents of chronically ill children).

68. See Libow & Schreier, *supra* note 16, at 606-07.

69. See Flannery, *supra* note 9, at 1196 (citations omitted). For a more detailed discussion of fathers' roles in Munchausen Syndrome by Proxy cases, see Jones et al., *The Role of the Male Caretaker*, *supra* note 16, at 245-46; Adel F. Makar & Paula J. Squier, *Munchausen Syndrome by Proxy: Father as a Perpetrator*, 85 PEDIATRICS 370 (1990).

70. See Makar & Squier, *supra* note 69, at 372.

71. See Crouse, *supra* note 16, at 250.

72. See Basil J. Zitelli et al., *Munchausen's Syndrome by Proxy and Its Professional Participants*, 141 AM. J. DISEASES CHILDREN 1099, 1101 (1987).

73. See Flannery, *supra* note 9, at 1197-98.

Although there have been reported cases of adult victims of Munchausen Syndrome by Proxy,<sup>74</sup> the Syndrome is usually perpetrated upon children between infancy and eight years of age.<sup>75</sup> The victims' age is particularly problematic in terms of investigating and providing evidence in court because children of this age may be pre-verbal or incapable of providing reliable testimony.<sup>76</sup> Younger children tend to suffer from direct abuse inflicted by the parent, whereas older children tend to undergo unnecessary diagnostic procedures resulting from factitious injuries or illnesses.<sup>77</sup>

As with mothers—and arguably fathers—there are common characteristics shared by children who are victims of Munchausen Syndrome by Proxy. First, the child usually demonstrates one or more of the commonly fabricated symptoms.<sup>78</sup> Second, the child's condition is usually inconsistent with the medical history offered by the parent.<sup>79</sup> Third, the child typically demonstrates inappropriate behavior for his or her age.<sup>80</sup> Finally, the child learns to treat his or her symptoms and illnesses as preconditions for the parent's love.<sup>81</sup> Despite these commonalities among child victims, there are clear distinctions between the behaviors of younger children versus older children.<sup>82</sup>

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74. See Sigal et al., *Munchausen Syndrome by Adult Proxy*, *supra* note 16, at 696–98; N. J. Smith & M. H. Ardern, *More in Sickness than in Health: A Case Study of Munchausen by Proxy in the Elderly*, 11 J. FAM. THERAPY 321 (1989).

75. See Jones et al., *supra* note 16, at 35.

76. Cf. Flannery, *supra* note 9, at 1199 & n.97 (“As with most forms of child abuse, the victim is often too young to know of his or her predicament or too incapacitated to tell those in authority.”). First-hand accounts of Munchausen Syndrome by Proxy are rare, since the syndrome is so unfamiliar and since the victims are often infants and young children. See *id.* As the syndrome becomes better understood and medical literature regarding the syndrome expands, new reports of Munchausen Syndrome by Proxy are being reported by victims, now adults, who suffered from the disease before it was even identified in 1977. See, e.g., Brian Bergstein, *Psychology—Rare Mental Disorder Blamed for Child Abuse*, DAYTON DAILY NEWS, July 13, 1997, at 16A, available in 1997 WL 11426086 (describing the story of Mary Bryk, who now believes that she was a victim of Munchausen Syndrome by Proxy for eight years in the 1960s, when her mother broke her bones with a hammer and infected her wounds by inserting top soil and coffee grounds under her skin); James Tobin, *A Childhood of Mysterious Pain, A Mother Blamed*, DET. NEWS, Feb. 8, 1998, at A1 (recounting the history of Mary's childhood, which included 24 operations before she turned ten years old); see also Brian Bergstein, *Woman's Allegations Focus on Rare Syndrome: Mother Denies Beating Daughter to Gain Attention*, FORT WORTH STAR-TELEGRAM, July 13, 1997, at 9, available in 1997 WL 11892865; Tobin, *supra* note 3. For a chronicled account of the actual experiences of Mary Bryk, see Bryk & Siegel, *supra* note 16, at 1–7.

77. See SCHREIER & LIBOW, *supra* note 56, at 24–26.

78. See *supra* notes 38–46 and accompanying text.

79. See Crouse, *supra* note 16, at 249.

80. See *id.*

81. See *id.* at 250.

82. See Flannery, *supra* note 9, at 1201 n.111 (citing SCHREIER & LIBOW, *supra* note 56, at 135–37, 143–45).



Each of these respective groups plays a critical role in perpetrating, identifying, and dealing with Munchausen Syndrome by Proxy. It is beyond the scope of this Article to fully discuss the details and dynamics of each group. The fact that each group has different dynamics adds to the difficulty in understanding the relationships among the groups. However, the fact that each group demonstrates common characteristics which, though not determinative, clearly serve as possible indicators of the Syndrome, is extremely relevant to the ethical considerations involved in determining when, or whether, such a drastic measure as video surveillance is necessary or appropriate. It is critical to understand that, regardless of the interplay between the groups, and regardless of whether the term "Munchausen Syndrome by Proxy" is used to describe the perpetrator's behavior or the abuse that results from it, the complicated dynamics of this interplay results in both direct and indirect physical and psychological harm to the child. The Syndrome cannot be treated as if it is caused by one identifiable and treatable psychiatric condition of the perpetrating parent.<sup>83</sup> While, legally, this may be easier and more understandable, it is medically impossible and ethically unsound.

As a matter of research, psychiatric treatment, or narrowly focused discourse in specific branches of the medical field, such perspectives on the Syndrome may be beneficial. In terms of preventing further harm to the child, however, the Syndrome should be viewed solely in terms of its consequences for the child.<sup>84</sup> Thus, the legal field should accept the term and the Syndrome as a form of child abuse, with direct consequences on the child's condition that are caused by the behavior of the parent, rather than as a psychiatric condition of the parent which happens to result in harmful

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83. See Donald & Jureidini, *supra* note 16, at 756 ("[T]he current lack of clarity in the use of the term [Munchausen Syndrome by Proxy] and the ambiguities in its definition lead to overinclusiveness in its use, trivialization of abuse, and a lack of clarity about prognosis and long-term management."). Unless the parent acknowledges the existence and the nature of his or her abuse, which is rarely the case, even where the parent observes himself or herself abusing the child on tape, psychiatric intervention is likely to prove unsuccessful. See Byard & Burnell, *supra* note 22, at 354 (describing how a mother initially denied guilt, even after being informed of a video recording which showed her smothering her baby, but then confessed and pleaded guilty to manslaughter of her first baby and to causing grievous bodily harm to her third child); Krugman, *supra* note 24, at 890; see also Marc D. Feldman, *Denial in Munchausen Syndrome by Proxy: The Consulting Psychiatrist's Dilemma*, 24 INT'L J. PSYCHIATRY MED. 121 (1994); A.R. Nicol & M. Eccles, *Psychotherapy for Munchausen Syndrome by Proxy*, 60 ARCHIVES OF DISEASE IN CHILDHOOD 344 (1985). The dispositional options, then, are to return the child to an abusive parent, for whom psychiatric intervention will be fruitless, or to remove the child from the parent because of the abuse.

84. See Donald & Jureidini, *supra* note 16, at 754 (asserting that the medical profession's failure to treat the syndrome as a form of child abuse actually contributes to the development of the syndrome).

consequences for the child. Accordingly, if the Syndrome is accepted as a condition of the parent, using the child in video surveillance to identify or evaluate this condition would seem conducive to that end despite the continuing harmful consequences for the child. If the Syndrome is accepted as a form of abuse, however, with the focus on the condition of the child, then using the child in video surveillance to perpetuate further abuse is illogical and contrary to its own end. In either case, the perpetuation of child abuse must be viewed as inherently unethical.

### *B. Legal Implications of Munchausen Syndrome by Proxy*

It was not long after Munchausen Syndrome by Proxy was first discovered and defined in 1977 that it produced evidentiary issues for the courts. In 1981, in *People v. Phillips*,<sup>85</sup> Priscilla Phillips appealed a conviction for the murder of her adopted child.<sup>86</sup> The court considered the issue of the admissibility of expert testimony regarding Munchausen Syndrome by Proxy, even though the psychiatrist did not testify about his first-hand observations of the child or the mother; rather, he testified based on the available medical literature about the Syndrome at the time.<sup>87</sup> Phillips argued that the Syndrome was not a recognized illness generally accepted by the medical community and, therefore, medical testimony on the subject was inadmissible.<sup>88</sup> This standard came to be known as the "Kelly-Frye" test.<sup>89</sup> The court held that the "Kelly-Frye" test was not applicable and allowed the testimony, however, finding that the testimony regarding the disorder was relevant to prove or support the mother's motive in perpetrating otherwise inexplicable behavior but not to prove the behavior itself.<sup>90</sup> The court held that "[t]he

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85. 175 Cal. Rptr. 703 (Cal. Ct. App. 1981).

86. *See id.* at 703-04.

87. *See id.* at 711-14. *But see In re M.A.V.*, 425 S.E.2d 377, 379 (Ga. Ct. App. 1992) (holding expert testimony inadmissible because doctor did not observe mother and child), *overruled on other grounds by In re J.P.*, 480 S.E.2d 8, 8 (Ga. 1997).

88. *See Phillips*, 175 Cal. Rptr. at 713.

89. *See People v. McDonald*, 690 P.2d 709, 723-24 (Cal. 1984); *Frye v. United States* 293 F. 1013, 1014 (D.C. Cir. 1923) (holding that systolic blood pressure deception test was not scientifically reliable); *People v. Kelly*, 130 Cal. Rptr. 144, 148 (Cal. 1976) (holding that admission of testimony concerning voice print analysis was not scientifically reliable). The "Kelly-Frye" test is "the rule that evidence based on a new scientific method of proof is admissible only on a showing that the procedure has been generally accepted as reliable in the scientific community in which it developed." *McDonald*, 690 P.2d at 723.

90. *See Phillips*, 175 Cal. Rptr. at 714; *see also Reid v. State*, 964 S.W.2d 723, 729 (Tex. App. 1998) (allowing evidence of Munchausen Syndrome by Proxy to show motive).

existence, nature, [and] validity . . . of the phenomenon characterized as ‘Munchausen [S]yndrome by [P]roxy’ are all matters sufficiently beyond common experience that expert opinion would assist the trier of fact.”<sup>91</sup> Despite the fact that this was the first published opinion dealing with the issue of Munchausen Syndrome by Proxy,<sup>92</sup> that it was only four years after the Syndrome had been discovered, and that Munchausen Syndrome by Proxy had not yet even been listed in the diagnostic manual of the American Psychiatric Association, the court still determined that the “Kelly-Frye” test was inapplicable and that the trial court had abused its discretion in allowing expert testimony about admitted evidence of the Syndrome for limited purposes.<sup>93</sup>

Since *Phillips*, there have been only 31 published court opinions that mention the term “Munchausen Syndrome by Proxy.”<sup>94</sup> Fourteen of those cases do not mention the term within any substantive context—eight mention the term solely in citing to *Phillips* regarding the application of the “Kelly-Frye” test,<sup>95</sup> and five mention it

91. *Phillips*, 175 Cal. Rptr. at 712.

92. The case of *Bosel v. State*, 398 P.2d 651 (Alaska 1965), was the first case to mention the term “Munchausen Syndrome.” The court was considering the mental state of the criminal defendant, who possibly suffered from the disease. *See id.* at 656.

93. *See Phillips*, 175 Cal. Rptr. at 712–14.

94. *See Thomason v. SCAN Volunteer Servs., Inc.*, 85 F.3d 1365, 1368 (8th Cir. 1996); *Fessler v. State Dep’t of Human Resources*, 567 So. 2d 301, 302 (Ala. Civ. App. 1989); *People v. Stoll*, 783 P.2d 698, 711 (Cal. 1989); *McDonald*, 690 P.2d at 724; *Ramona v. Superior Court*, 66 Cal. Rptr. 2d 766, 776 (Cal. Ct. App. 1997); *Garcetti v. Superior Court*, 57 Cal. Rptr. 2d 420, 435 (Cal. Ct. App. 1997); *People v. Cegers*, 9 Cal. Rptr. 2d 297, 303 (Cal. Ct. App. 1992); *People v. Leon*, 263 Cal. Rptr. 77, 92 (Cal. Ct. App. 1989); *People v. Bowker*, 249 Cal. Rptr. 886, 895 (Cal. Ct. App. 1988); *In re Cheryl H.*, 200 Cal. Rptr. 789, 804 (Cal. Ct. App. 1984); *In re Patrick C.*, 1998 WL 227770, at \*1 (Conn. Super. Ct. May 1, 1998); *In re Aida M.*, 1997 WL 178063, at \*2 (Conn. Super. Ct. Mar. 25, 1997); *Case v. Richardson*, No. FA 910446348S, 1996 WL 434281, at \*2 (Conn. Super. Ct. July 16, 1996); *State v. De Jesus*, No. CR92-73269, 1993 WL 171866, at \*1 (Conn. Super. Ct. Apr. 27, 1993); *In re M.A.V.*, 425 S.E.2d 377, 378 (Ga. Ct. App. 1992); *In re Jordan*, 616 N.E.2d 388, 389 (Ind. Ct. App. 1993); *In re Tucker*, 578 N.E.2d 774, 777 (Ind. Ct. App. 1991); *Geringer v. Iowa Dep’t of Human Servs.*, 521 N.W.2d 730, 730 (Iowa 1994); *In re B.B.*, 500 N.W.2d 9, 12 n.2 (Iowa 1993); *State v. Lumbraera*, 845 P.2d 609, 618–20 (Kan. 1992); *In re Colin R.*, 493 A.2d 1083, 1086 (Md. Ct. Spec. App. 1985); *Commonwealth v. Robinson*, 565 N.E.2d 1229, 1237–38 (Mass. App. Ct. 1991); *Place v. Place*, 525 A.2d 704, 706 (N.H. 1987); *In re C. Children*, 672 N.Y.S.2d 134, 135 (App. Div. 1998); *Straton v. Orange County Dep’t of Soc. Servs.*, 628 N.Y.S.2d 818, 819 (App. Div. 1995); *In re Suffolk County Dep’t of Soc. Servs.*, 626 N.Y.S.2d 227, 228 (App. Div. 1995); *In re Aaron S.*, 625 N.Y.S.2d 786, 787 (Fam. Ct. 1993), *aff’d sub nom. In re Suffolk County Dep’t of Soc. Servs.*, 626 N.Y.S.2d 227, 228 (App. Div. 1995); *In re Jessica Z.*, 515 N.Y.S.2d 370, 371–78 (Fam. Ct. 1987); *Littlejohn v. Cuyahoga County Dep’t of Children and Family Servs.*, Nos. 71354–56, 1998 WL 230443, at \*2 (Ohio Ct. App. May 7, 1998); *In re Dylan C.*, 699 N.E.2d 107, 108 n.1 (Ohio Ct. App. 1997); *Reid v. State*, 964 S.W.2d 723, 725 (Tex. App. 1998); *In re S.R.*, 599 A.2d 364, 364–65, 367–68 (Vt. 1991).

95. *See Stoll*, 783 P.2d at 711; *McDonald*, 690 P.2d at 724; *Ramona*, 66 Cal. Rptr. 2d at 776; *Garcetti*, 57 Cal. Rptr. 2d at 435; *Cegers*, 9 Cal. Rptr. 2d at 303; *Leon*, 263 Cal. Rptr. at 92; *Bowker*, 249 Cal. Rptr. at 895; *Cheryl H.*, 200 Cal. Rptr. at 804.

within a procedural context or as part of the factual background related to other issues.<sup>96</sup> Notwithstanding the holding in *Phillips*, however, courts that have dealt substantively with the issue of Munchausen Syndrome by Proxy have recognized that although the Syndrome may be recognized and accepted within the medical community, it is still a bizarre, perplexing, dangerous phenomenon, with far-reaching consequences,<sup>97</sup> and it is one about which

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96. See *Aida M.*, 1997 WL 178063, at \*2 (stating that the doctors felt the case had suggestions of Munchausen Syndrome by Proxy); *Case*, 1996 WL 434281, at \*2 (stating in discussion of facts of custody dispute that the doctor saw in mother signs of Munchausen Syndrome by Proxy); *Tucker*, 578 N.E.2d at 777 (commenting, in consideration of termination of parental rights, that as a factual matter, the doctor thought the mother might have Munchausen Syndrome by Proxy); *Place*, 525 A.2d at 706 (mentioning Munchausen Syndrome by Proxy as a factual matter addressed by the lower court); *Littlejohn*, 1998 WL 230443, at \*2 (stating that psychologist thought mother might be suffering from Munchausen Syndrome by Proxy).

97. In addition to the medical, legal, and ethical consequences of Munchausen Syndrome by Proxy discussed in this Article, there are also various criminal, administrative, and even economic consequences that arise from the far-reaching effects of the disease. Munchausen Syndrome by Proxy typically involves some criminal consequences for the perpetrators. A typical example is Christina Rubio, who is now serving thirteen years in prison for the death of her son, Pedro, on whom she perpetrated Munchausen Syndrome by Proxy. See Rick Barry, *A Diagnosis in Search of a Disease*, TAMPA TRIB., May 20, 1997, at 1. One man in Kentucky pled guilty to, and is now serving sixteen years in prison for, nine counts of attempted murder after he attempted to suffocate his daughter. See Beverly Bartlett, *Meeting Shows Uses of Medical Science in Investigating Crime*, COURIER-J. (Louisville, Ky.), June 3, 1997, at B3. In Arizona, Stacey Frisinger was sentenced to 45 years in prison for suffocating her three-year-old son, Mitchell. See Jon Burstein, *Frisinger Gets 45 Years in Prison for Slaying Son*, ARIZ. DAILY STAR, Dec. 17, 1997, at 1B, available in 1997 WL 16299418. As in many Munchausen Syndrome by Proxy cases, Frisinger had another child, Neal Jr., who died in 1992 of what was diagnosed as a respiratory infection. See *id.* Julie Skinner has been charged with the murder of her two-year-old son, Lane Ross, after suffocating him in the hospital. See Susan Schramm, *Riley Staff Suspected Mom Suffocated Tot*, INDIANAPOLIS STAR, June 9, 1998, at B1. Skinner admitted to the police that she attempted to suffocate the child on numerous occasions to get attention from the child's stepfather. See *id.*

The Oxford Crown Court in England accepted Munchausen Syndrome by Proxy as sufficient for a plea of "manslaughter on grounds of diminished responsibility," after Caroline Lloyd killed her son with lethal doses of salt. See Richard Duce, *Woman Killed Her Four-Year-Old Son by Salt Poisoning*, TIMES (London), June 18, 1997, at 3. Commenting to the police on what she had done, Lloyd said, "I never wanted him to die. I just wanted him to feel poorly." *Id.* Lloyd was committed to prison for life. See Kate Watson-Smyth, *Mother Given Life for Killing Son by Lacing Drink with Salt*, INDEPENDENT (London), June 18, 1997, at 6. Her psychiatrists say that her disorder is so severe that it is untreatable in the hospital. See Michael Fleet, *Woman Jailed for Killing Son with Salt*, DAILY TELEGRAPH (London), June 18, 1997, at 9, available in 1997 WL 2318153.

Marybeth Davis, a 44-year-old nurse from Pennsylvania, was found guilty of intentionally poisoning her then 10-week-old son, Seth, with insulin in 1981, and with killing her three-year-old daughter, Tegan, with an overdose of caffeine in 1982. See J.R. Withers, *Mother Receives Life Sentence in Deaths; Jurors Find Woman Guilty of Poisoning Children 15 Years Ago*, CHARLESTON DAILY MAIL (W. Va.), Sept. 16, 1997, at 1C, available in 1997 WL 7122170 [hereinafter Withers, *Guilty of Poisoning Children 15 Years Ago*]; Maryclaire Dale, *Diagnosis Called a 'Blatant' Mistake; Marybeth Davis' Children Obviously Abused, Doctor Says*, CHARLESTON DAILY MAIL (W. Va.), Sept. 13, 1997, at 1A, available in 1997 WL 7121780. Davis received a life sentence without the possibility of parole on the first-degree murder charge, and three to

eighteen years for the poisoning charge. See *Guilty of Poisoning Children 15 Years Ago*, *supra*. At the time of sentencing, Davis had two other children, ages 13 and 11, in her care. See Mary-claire Dale, *Davis Guilty of Killing Daughter: Defendant Also Convicted of Poisoning Son, Receives Life in Prison Without Mercy*, CHARLESTON DAILY MAIL (W. Va.), Sept. 16, 1997, at 1A, available in 1997 WL 7122021 [hereinafter Dale, *Davis Guilty*]. In the closing arguments of Davis' criminal trial, the defense attorney accused the prosecution of manufacturing a case of "Munchausen by prosecution . . . where the prosecutor poisons jurors['] minds." See Withers, *Guilty of Poisoning Children 15 Years Ago*, *supra*. Prosecutors believe that the case set a record in West Virginia for the longest interval between a homicide and a conviction. See Dale, *Davis Guilty*, *supra*. In June 1998, Davis petitioned the state Supreme Court to overturn the verdict. See *Woman Wants Child Poison Verdict Gone*, CHARLESTON DAILY MAIL (W. Va.), June 12, 1998, at 9A.

Economic consequences result from either extensive medical bills or tedious criminal trials. For example, the first Munchausen Syndrome by Proxy case in Tennessee, which involved Sharon Hicks, who allegedly killed her two oldest children, Ashley Renee Crawford and James Rippy, is expected to be the most expensive trial in Sumner County's history. See Leon Allgood, *Mother's Murder Trial Raises Medical Issues*, TENNESSEAN (Nashville), Mar. 1, 1998, at 6B, available in 1998 WL 5270187. Hicks is free on bail until her trial, but she is not permitted to have any contact with her other child. See *id.* In Florida, a judge has ruled that the state must pay the legal expenses for Kathy Bush, who faces charges of aggravated child abuse and organized fraud as a result of her alleged Munchausen Syndrome by Proxy. See Douglas C. Lyons, *Judge Grants Bush Public Aid for Trial*, SUN-SENTINEL (Ft. Lauderdale, Fla.), Apr. 26, 1997, at 6B, available in 1997 WL 3099521. Bush compiled legal fees in excess of \$13,000 just for one custody hearing. See *id.* She also faces criminal charges, including fraud, for causing her eight-year-old daughter, Jennifer, to be hospitalized some 200 times and undergo 40 operations, utilizing more than \$3 million in unnecessary medical expenses. See Kestin, *supra* note 3, at 2. For other references to the case involving Kathy Bush, see *supra* note 19. In the Lyda case, see *supra* note 19, one Air Force doctor estimates that the family racked up more than \$4 million in medical costs. See Casey, *Undiagnosed Tragedy (Chapter I)*, *supra* note 19.

Munchausen Syndrome by Proxy is so far reaching that the scope of the syndrome may even have been extended to animal victims. See Marc D. Feldman, *Canine Variant of Factitious Disorder by Proxy*, 154 AM. J. PSYCHIATRY 1316 (1997) (letter to the editor). In a California case, physician Dorothy Calabrese was found guilty of cruelty to animals and faces up to one year in prison for starving her horses and llamas. See Carol Masciola, *Doctor in Horse-Abuse Case Faces Loss of Pets; Courts: She Also Is Suing Officials Who Temporarily Took Her Children Away, Purportedly out of Fear She Was Harming Them*, ORANGE COUNTY REG., May 19, 1998, at B4, available in 1998 WL 2629137.

The Syndrome also affects criminal, civil, and administrative cases in other contexts. For example, in *United States v. Welch*, No. 93-4043, 1994 WL 514522, at \*4 (6th Cir. Sept. 19, 1994), the defendant claimed that the police coerced her confession to the murder of her two children by feeding into her Munchausen Syndrome by Proxy. See *id.* at \*4-\*5. Her doctor testified that individuals with Munchausen Syndrome by Proxy will "comply with the demands of authority figures. The way that, typically, they tend to deal with authority is often, rather than . . . expressing outright rebellion . . . they[] . . . tell a person what they want to hear in order to make some kind of gains." *Id.* at \*3. In *Geringer v. Iowa Department of Human Services*, the diagnosis of Munchausen Syndrome by Proxy prevented the expungement of an abuse report. See *Geringer v. Iowa Dep't of Human Servs.*, 521 N.W.2d 730, 730-32 (Iowa 1994). In *Geringer*, one doctor diagnosed the syndrome; a second doctor refuted the diagnosis. See *id.* at 731. An administrative judge determined the report to be "unfounded," in which case the report could be immediately expunged. See *id.* at 732. A Department of Human Services administrator subsequently determined that the report was neither founded nor unfounded, but was qualified as "undetermined," in which case the report could not be expunged for one year. See *id.* In *State v. Pasicznyk*, No. 14897-1-111, 1997 WL 79501, at \*1 (Wash. Ct. App. Feb. 25, 1997), a diagnosis of Munchausen Syndrome by Proxy was used to support a determination of exceptional sentencing. See *id.* at \*1 n.3.

the medical and legal fields do not yet have a comprehensive understanding.

For example, despite the pioneering efforts of the *Phillips* court, a Massachusetts court in *Commonwealth v. Robinson*,<sup>98</sup> one of the earlier Munchausen Syndrome by Proxy cases, barred prosecutors from introducing any evidence concerning the Syndrome.<sup>99</sup> In *Robinson*, the mother was convicted of involuntary manslaughter for poisoning her child with massive amounts of salt while the child was in the hospital.<sup>100</sup> One year later, in *In re Bowers*,<sup>101</sup> an Ohio court stated that “the advent of [Munchausen Syndrome by Proxy] into the jurisprudence of custodial proceedings has been, relatively, recent in nature,”<sup>102</sup> and it recognized the hesitancy of courts, like that in *Robinson*, to admit evidence of the Syndrome.<sup>103</sup> In a footnote in the opinion, the court acknowledged that, “[a]lthough [Munchausen Syndrome by Proxy] now appears to have been generally accepted as a very real and dangerous condition, there may still be reluctance on the part of some courts to accept this as a bona fide mental illness.”<sup>104</sup>

In *State v. Lumbrera*,<sup>105</sup> a mother who allegedly perpetrated Munchausen Syndrome by Proxy appealed her conviction for the murder of her child.<sup>106</sup> The mother had five other children who died in a similar manner.<sup>107</sup> The trial court had erroneously allowed the prosecutor to mention Munchausen Syndrome by Proxy during his opening statement when there was no subsequent evidence admitted into the record that the defendant suffered from the Syndrome.<sup>108</sup> The judge admonished the jury, stating: “[Y]ou are to completely disregard . . . [the] testimony as it has to do with . . . [Munchausen Syndrome by Proxy], and you are to remove that term from any of your deliberations and strike that from your . . . considerations.”<sup>109</sup>

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98. 565 N.E.2d 1229 (Mass. App. Ct. 1991).

99. *See id.* at 1237–38.

100. *See id.* at 1231.

101. No. 1490, 1992 WL 2870, at \*1 (Ohio Ct. App. Jan. 2, 1992).

102. *Id.* at \*3 n.2.

103. *See id.*

104. *Id.* (citing *Robinson*, 565 N.E.2d at 1238).

105. 845 P.2d 609 (Kan. 1992).

106. *See id.* at 612.

107. *See id.*

108. *See id.* at 619. In his opening statement, the prosecutor said: “[T]he second motive that the State’s going to show is a different type of motive. A motive that people are not necessarily accustomed to hearing about. . . . [It] is called Munchausen Syndrome by Proxy. . . .” *Id.* at 618.

109. *Id.* at 619.

Seventeen years after the *Phillips* court first admitted evidence of the Syndrome, the perplexity of the Syndrome remained evident to the court in *Reid v. State*.<sup>110</sup> In discussing Munchausen Syndrome by Proxy, the *Reid* court noted: “there is a paucity of cases which have considered and discussed Munchausen Syndrome by Proxy.”<sup>111</sup> In addressing the same “Kelly-Frye” issue that was addressed in *Phillips*, the *Reid* court went to great lengths to demonstrate how medical and legal awareness of the Syndrome has developed over time, and yet the disease is still misunderstood and problematic for the courts. The court noted the testimony of Dr. Thomas Bennet, the Iowa State Medical Examiner,<sup>112</sup> who stated:

[T]his theory has been studied, it has been written up in dozens and dozens of articles, and it has . . . achieved widespread acceptance, and it is now being taught in the schools, because if you don’t . . . teach it the doctor won’t think of it; if you don’t think of it you won’t diagnose it because it is such a severe form of child abuse. It has been taught and it is recognized and accepted, it’s even in the latest addition [sic] of the diagnostical manual, the DSM-4 has recognized it, it’s finally made that recognized entity.<sup>113</sup>

In *Reid*, the prosecutor demonstrated to the court the widespread awareness of the Syndrome by offering six photocopies of complete articles and a med-line database search covering the period between 1922 and May 1996, which produced abstracts of 122 articles related to the Syndrome.<sup>114</sup> The prosecutor also produced a bibliography of related articles dating back to 1977,<sup>115</sup> as well as a compilation of seventeen legal articles dealing with the disease.<sup>116</sup> Dr. Bennet also testified that there were many books and publications that discussed Munchausen Syndrome by Proxy,<sup>117</sup> and “dozens and dozens and dozens of experts” (twenty in the state of Iowa, alone) who would be prepared to testify regarding the

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110. 964 S.W.2d 723 (Tex. App. 1998).

111. *Id.* at 725–26. In support of this contention, the court cites two cases. *See Reid*, 964 S.W.2d at 726 (citing *Olivier v. State*, 850 S.W.2d 742, 747 (Tex. App. 1993) and *Crocker v. State*, 573 S.W.2d 190, 200 (Tex. Crim. App. 1978), but both cases mention only “Munchausen Syndrome,” not Munchausen Syndrome by Proxy). Therefore, in effect, *Reid* was the first published case in Texas dealing with the extension of the syndrome to be perpetrated “by proxy.”

112. *See Reid* 964 S.W.2d at 727.

113. *Id.* at 728.

114. *See id.*

115. *See id.*

116. *See id.*

117. *See id.*

disease.<sup>118</sup> The witness concluded that the Syndrome is “universally accepted.”<sup>119</sup> Despite all this evidence about the Syndrome, as in *Phillips*, the court struggled with the appropriate use of expert testimony regarding the disease.<sup>120</sup> As in *Phillips*, the court concluded that the jury could only consider the testimony of the disease as it related to motive, intent, plan, pattern, the absence of illness, mistake or accident, state of mind, medical diagnosis, the child’s relationship with the mother, or the cause of death.<sup>121</sup>

The language used by these courts makes it clear that, since Munchausen Syndrome by Proxy was first identified and described as a medical phenomenon, it has continued to develop as an evidentiary issue for the courts as well. But the effect of the Syndrome on the legal field is even farther reaching. Once a court decides *if* it is going to allow testimony and evidence regarding Munchausen Syndrome by Proxy, it must then decide *how* it is going to use it. Many courts after *Phillips* have struggled with the secondary effect of the Syndrome as it relates to the appropriate disposition for the child. The first case after *Phillips* where a court substantively struggled with the issue of the child’s disposition was *In re Colin R.*<sup>122</sup> In that case, the defendants appealed a finding that their son was a “child in need of assistance (‘C.I.N.A.’).”<sup>123</sup> The hospital staff contacted social services, and members of the Sheriff’s Department obtained a warrant to search the parents’ home.<sup>124</sup> In the mother’s bedroom, the police found hypodermic needles and two vials of diuretics, which she had used to make the child ill.<sup>125</sup> When confronted with this evidence, the mother stated, “‘If I am crazy I am glad you found out about it.’”<sup>126</sup> The child was found to be a C.I.N.A. and was initially placed in foster care.<sup>127</sup> The court affirmed the finding of the lower court that the child was at risk,<sup>128</sup> during the appeal, at a dispositional hearing for the child, however, the lower court sent the child home to his parents with supervision.<sup>129</sup>

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118. *Id.*

119. *Id.*

120. *See id.* at 731–32.

121. *See id.* at 733.

122. 493 A.2d 1083 (Md. Ct. Spec. App. 1985).

123. *Id.* at 1085.

124. *See id.* at 1086.

125. *See id.*

126. *Id.* at 1088.

127. *See id.* at 1086.

128. *See id.* at 1089.

129. *See id.* at 1092.



The court in *In re Bowers*<sup>130</sup> recognized a general trend of findings in Munchausen Syndrome by Proxy cases, yet acknowledged the difficulties inherent in disposing of such cases. The court recognized that in cases where the parent introduces foreign substances into the child's body, the child is typically found to be "abused."<sup>131</sup> In cases where there is no direct ingestion or injection of some physical element, the court will only find abuse if the symptoms of the Syndrome are in conjunction with some other element of abuse or neglect.<sup>132</sup> Having made the distinction, the court recognized the risks of an improper disposition for the child (i.e., returning him or her home to the perpetrating parent), such as when a parent "doctor shops," which leads to increased invasive procedures for the child, or when doctors overlook a true disease because they perceive the parent as "crying wolf."<sup>133</sup> Despite its recognition of these trends and its concern for the risks inherent in returning the child to the parent, however, the court also recognized the difficulties involved in each case and the legal system's role in that difficulty:

[T]he legal system has been criticized as an impediment to managing [Munchausen Syndrome by Proxy] cases because of the skepticism with which those cases are approached. This court, however, takes very seriously the dangerous and potentially lethal effects which such condition may have on its child victims. Nevertheless, we can perceive the difficulty which the trier of fact may experience in distinguishing between a parent with [Munchausen Syndrome by Proxy] and one who is merely over protective [sic] of a minor medical problem. This could be particularly troublesome where . . . the minor child appears healthy and there is no indication whatsoever that the mother is harming her. Under these circumstances, determining the credibility of the expert testimony diagnosing the [Munchausen Syndrome by Proxy] condition would be paramount.<sup>134</sup>

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130. No. 1490, 1992 WL 2870 (Ohio Ct. App. Jan. 2, 1992).

131. See *id.* at \*3 (citing *In re Jessica Z.*, 515 N.Y.S.2d 370, 372 (Fam. Ct. 1987)); see also *People v. Phillips*, 175 Cal. Rptr. 703, 709 (Ct. App. 1981); *In re Colin R.*, 493 A.2d 1083, 1086 (Md. Ct. Spec. App. 1985).

132. See *Bowers*, 1992 WL 2870, at \*4 n.3 (citing *Fessler v. State Dep't of Human Resources*, 567 So. 2d 301, 302 (Ala. Civ. App. 1989)); *In re Tucker*, 578 N.E.2d 774, 776-78 (Ind. Ct. App. 1991); *Place v. Place*, 525 A.2d 704, 709 (N.H. 1987).

133. See *Bowers*, 1992 WL 2870, at \*4.

134. *Id.* at \*5 (citation omitted).

The court in *In re Bowers* heard expert testimony that, even though there was no outward indication of physical abuse, the child was still at extremely high risk for “medical or parental misadventure” given the fictitious nature of the disease and the risks inherent in the disease, which the court expressly recognized.<sup>135</sup> Nevertheless, despite the recognition of the difficulties of diagnosing the disease, the deceptive nature of the disease, the inherent risks of an improper disposition, and its own acknowledgment that the courts have been an obstacle to the further diagnosis and management of these cases, the court affirmed the lower court’s finding that the child was not dependent or neglected and returned the child to the mother.<sup>136</sup>

The same difficulty that confronted the court in *In re Bowers*, which influenced it to return the child to the alleged perpetrator, was faced by the jury in *In re Clarissa M. S.*<sup>137</sup> In that case, where a mother was tried for perpetrating Munchausen Syndrome by Proxy on her daughter,<sup>138</sup> the jury answered three verdict questions: whether the child had been physically abused, whether any neglect had endangered the child, and whether the child, therefore, was in need of services.<sup>139</sup> The jury found that the mother did not neglect

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135. See *id.* at \*4; see also *In re Clarissa M. S.*, No. 94-2017, 1995 WL 27793, at \*3 (Wis. Ct. App. Jan. 24, 1995) (finding jury’s verdict to be inconsistent with evidence because it found no abuse, but that child needed services based on mother’s perpetration of Munchausen Syndrome by Proxy).

136. See *Bowers*, 1992 WL 2870, at \*5, \*6.

137. See *Clarissa M. S.*, 1995 WL 27793, at \*1.

138. In *Clarissa M. S.*, the mother, Sandra S., took Clarissa to numerous doctors and hospitals for alleged emergency treatment for diarrhea and vomiting. See *id.* Clarissa went to the hospital more than thirty times—sometimes twice in one day—before she was six and a half months old. See *id.* Clarissa was subjected to numerous painful procedures, including a rectal sigmoidoscopy, barium enemas, and blood tests. See *id.* Medical personnel became suspicious when Clarissa was presented to three separate hospitals for the same condition, but no medical explanation for the alleged symptoms could be determined. See *id.* Finally, when a hospital tested and discharged Clarissa without any medical diagnosis, only to see her again the next day with her mother alleging the very same symptoms, the medical staff reported Sandra to social services. See *id.* Subsequently, social service workers visited the family as much as three times per week to observe the child and to assist Sandra with her parenting skills. See *id.* In less than one month, Clarissa returned to the hospital, but no illness was diagnosed. See *id.* Upon Clarissa’s return home, a visiting nurse observed that the child was quite healthy. See *id.* The next day, Sandra presented Clarissa, a vomiting and dehydrated little girl with blood in her stool and in need of intravenous antibiotics, to the hospital. See *id.* After finding no medical reason for the symptoms, Clarissa was discharged in a healthy condition. See *id.* The doctor soon diagnosed Munchausen Syndrome by Proxy, and Clarissa was placed in foster care, where she experienced no symptoms and required no hospitalizations. See *id.* at \*2.

139. The verdict consisted of three questions to which the six-person jury gave the following unanimous answers:

Was Clarissa M. [S.] the victim of physical abuse? 6 No

the child and that the child was not seriously endangered because of any neglect by the mother, but it also determined that, based on the mother's diagnosis of Munchausen Syndrome by Proxy, the child was in need of services.<sup>140</sup> Thus, as was problematic in *In re Bowers*, the jury in *In re Clarissa M.S.* determined that, although there was no clearly identifiable physical harm to the child, the nature of the mother's condition warranted that the child receive protective services.<sup>141</sup> The court determined that such a finding was inconsistent, and ordered a new trial.<sup>142</sup> In so doing, however, the court failed to recognize the unique dynamics of the disease and the possibility that the disease may warrant intervention by the courts if the medical and legal fields are going to deal with it collectively and consistently.

Some courts, however, are beginning to consider more fully expert testimony about the dynamics of Munchausen Syndrome by Proxy and to appreciate the interplay among the various parties involved when considering appropriate dispositions for the child. Some courts are beginning to consider the ineffectiveness of therapy treatment or counseling for the perpetrator in alleviating the risk inherent in the Syndrome.<sup>143</sup> Several courts that have dealt substantively with the Syndrome are considering testimony that therapy has proven ineffective for Munchausen mothers, particularly when the mother denies the reality of the Syndrome.<sup>144</sup> For example, in *In re S.R.*, the court considered the termination of the parental rights of the mother, who was diagnosed as having Munchausen Syndrome by Proxy.<sup>145</sup> Because the mother did not

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Did the child's mother Sandra [S.] either neglect, refuse or was unable for reasons other than poverty, to provide the necessary care, food, clothing, medical or dental care or shelter so as to seriously endanger the physical health of the child? 6 No

Is Clarissa M. [S.] in need of protection or services? 6 Yes

*Id.* at \*3 n.5.

140. *See id.* at \*1.

141. *See id.*

142. *See id.* *But see In re B.B.*, 500 N.W.2d 9, 9 (Iowa 1993) (reversing court of appeals decision to return child to mother and holding that, despite lack of physical harm, child was still in need of services).

143. *See, e.g., In re S.R.*, 599 A.2d 364, 366 (Vt. 1991). *But cf. In re M.A.V.*, 425 S.E.2d 377, 378-79 (Ga. Ct. App. 1992) (holding that expert testimony of the ineffectiveness of therapy for Munchausen Syndrome by Proxy was not compelling enough to sever custodial relationship).

144. *See, e.g., M.A.V.*, 425 S.E.2d at 378-79; *S.R.*, 599 A.2d at 366.

145. *See S.R.*, 599 A.2d at 366. The mother caused breathing difficulties in *S.R.*, requiring extensive medical evaluations. *See id.* Although the family received extensive services for more than three years prior to the termination of parental rights—including counseling, parent education, and supervised home visits—the services were ineffective because the parents did not acknowledge the “Munchausen Syndrome by Proxy” diagnosis. *See id.*

acknowledge the diagnosis of the Syndrome, the court concluded that the mother's behavior was not likely to change.<sup>146</sup> The psychologist who testified stated that the child "faced a ten-to-twenty percent chance of death based on her parents' denial of th[e] disorder."<sup>147</sup> The court affirmed the termination of parental rights.<sup>148</sup>

In *State v. DeJesus*,<sup>149</sup> a criminal matter in a rare case where the perpetrator of Munchausen Syndrome by Proxy was a grandmother, the defendant requested a reduction in sentence because an expert witness who was prepared to testify that her condition was treatable was not allowed to testify.<sup>150</sup> In making a determination not to reduce the defendant's sentence, the court relied on testimony from another doctor who stated that there was no evidence demonstrating that extreme Munchausen Syndrome by Proxy could be treated with any type of psychotherapy.<sup>151</sup>

In *In re M.A.V.*,<sup>152</sup> however, testimony regarding the ineffectiveness of therapy for the perpetrator led to still other difficulties in dealing with the disease.<sup>153</sup> The court considered similar testimony in determining whether to transfer custody of a sibling of a child who, in an earlier proceeding, was determined to be the victim of Munchausen Syndrome by Proxy.<sup>154</sup> In the earlier case for the younger sibling, B.C.C., the doctor testified that there was "no evidence that therapy for the parent was helpful based on reports of

146. *See id.* at 367. *But see In re C. Children*, 672 N.Y.S.2d 134, 135 (App. Div. 1998) (affirming lower court's findings of abuse but allowing the children to remain in their mother's custody because the mother had obtained treatment for the Syndrome).

147. *S.R.*, 599 A.2d at 367. The doctor also testified that the risk to the child due to the parents' denial increased with the level of stress in the home. *See id.*

148. *See id.* at 368.

149. No. CR92-73269, 1993 WL 171866, at \*1 (Conn. Super. Ct. Apr. 27, 1993). Alleging that her grandchild was having seizures, a grandmother presented the child to the hospital. *See id.* The child was admitted, and the grandmother never left the child's bedside. *See id.* Early one morning, a nurse witnessed the grandmother leaning over the child's crib and, with a sudden motion, breaking the child's leg. *See id.* An examination revealed that the child had suffered other broken bones, which were suspected to be non-accidental. *See id.* The grandmother subsequently received "[a] sentence of eight years, execution suspended after four years, with five years probation." *Id.* One of the conditions of her probation was that she have no contact with any children under 18 years of age. *See id.*

150. *See id.*

151. *See id.*

152. 425 S.E.2d 377 (Ga. Ct. App. 1992).

153. *See id.* at 378-79.

154. *See id.* In the earlier case involving B.C.C., testimony revealed that the mother induced respiratory arrest in the child on two separate occasions by suffocation and drowning before summoning emergency help to resuscitate the child. *See id.* at 378. Upon presenting B.C.C. to various hospitals, the mother gave different names for her and the child, offered various and unreasonable explanations for the child's conditions, and withheld information of the first incident to the second hospital. *See id.* Upon conferring, the doctors at the two hospitals diagnosed Munchausen Syndrome by Proxy. *See id.*

'serial Munchausen[']s Syndrome] by Proxy where one child after another is victimized despite' the parent receiving therapy."<sup>155</sup> Based on that testimony, the court found B.C.C. to be deprived and awarded custody to the state.<sup>156</sup> In a separate hearing, the court considered whether the evidence presented at the hearing for B.C.C. was sufficient to find that M.A.V. was also a deprived child who required placement by the State.<sup>157</sup> The doctor had testified at B.C.C.'s hearing that M.A.V. might be at risk upon the removal of B.C.C. from the home, despite the fact that M.A.V. had not been previously abused.<sup>158</sup> The court held, however, that the evidence of Munchausen Syndrome by Proxy on the younger child did not justify transferring custody of the older sibling.<sup>159</sup>

Despite some progress by the courts in responding to the various effects of Munchausen Syndrome by Proxy, evidentiary and dispositional determinations clearly vary,<sup>160</sup> and there has been no clear and comprehensive focal point in viewing Munchausen Syndrome by Proxy from which other courts may orient their perspective. In

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155. *Id.* at 379 (quoting child psychiatrist Dr. Bernard Kahan).

156. *See id.* at 378.

157. *See id.* at 379.

158. *See id.*

159. *See id. Compare In re Aaron S.*, 625 N.Y.S.2d 786, 793 (Fam. Ct. 1993) (protecting siblings based on the presumption that abusive behavior would continue against them upon removal of abused child), and *Reid v. State*, 964 S.W.2d 723, 734-35 (Tex. Crim. App. 1998) (holding that evidence of Munchausen Syndrome by Proxy regarding subject child's sibling was admissible), with *In re B.C.*, 356 N.W.2d 328, 331 (Minn. Ct. App. 1984) (terminating parental rights based on evidence that mother murdered child's sibling) and *In re R.A.M.*, 755 S.W.2d 431, 435 (Mo. Ct. App. 1988) (justifying termination of parental rights to other children because of abuse to one child). *See also In re I.N.M.*, 735 P.2d 1170, 1174-75 (N.M. Ct. App. 1987) (terminating parental rights in two children despite lacking evidence of abuse of one child); *In re William D.*, 603 N.Y.S.2d 825, 825 (App. Div. 1993) (terminating mother's rights to five children based on evidence that she beat one of their siblings to death).

In 1985, in Oklahoma, Teresa Redd's six-month-old son, Steven, was thought to have died of SIDS. *See Ed Godfrey, Rare Disorder May Be Key in Baby Death*, DAILY OKLAHOMAN, Nov. 17, 1997, at 1 [hereinafter Godfrey, *Rare Disorder*]. In 1996, Redd was suspected of having suffocated her nine-month-old daughter, Lenora, while the child was in the hospital. *See id.* Although Redd was never charged with the death of her son, prosecutors used evidence of Steven's death to prove that Munchausen Syndrome by Proxy was related to Lenora's death. *See Ed Godfrey, Baby's Alarm Didn't Beep, Nurse Testifies*, DAILY OKLAHOMAN, Nov. 20, 1997, at 1; Ed Godfrey, *Doctor Testifies in Child's Death: Defense Expert Won't Rule Out SIDS as Cause*, DAILY OKLAHOMAN, Dec. 4, 1997, at 34. A jury found Redd guilty of first-degree murder of Lenora, and Redd was sentenced to life in prison without the possibility of parole. *See Jury Convicts Oklahoma Woman in Her Infant's Death*, DALLAS MORNING NEWS, Dec. 10, 1997, at 26A, available in 1997 WL 16183512.

Other cases of Munchausen Syndrome by Proxy have been reported in Oklahoma, such as one involving Jeff and Linda Hastings, whose parental rights were terminated after allegations were made that Linda spit into her son's intravenous tube while he was in the hospital. *See Godfrey, Rare Disorder, supra*. Laura Bateman was sentenced to 15 years in prison for inserting air and urine into her daughter's intravenous tube while in the hospital. *See id.*

160. *See supra* notes 85-159 and accompanying text.

fact, in *Bowers*, the court specifically expressed the sentiments of most courts dealing with Munchausen Syndrome by Proxy in that they "adopt no hard rule, or litmus test, for determining neglect or dependency whenever there is a diagnosis of [Munchausen Syndrome by Proxy]."<sup>161</sup> The decisions detailed above imply that, in effect, these courts have adopted a rule that each Munchausen case must be reviewed on an ad hoc basis, including evidentiary decisions and the effect of the evidence on other, substantive determinations. As a result, the original difficulty remains: how can the legal field effectively, comprehensively, and consistently address the medical implications associated with the disease while still adhering to the legal mandate placed on the courts to protect the rights and interests of all of the parties involved, particularly the interests of the child?

### *C. Medical Implications of Munchausen Syndrome by Proxy*

In addition to the legal implications of Munchausen Syndrome by Proxy,<sup>162</sup> the Syndrome also has medical implications. The foremost medical implication of Munchausen Syndrome by Proxy is the obvious physical effect on the child, which can occur in a variety of ways. First, and most obviously, is the direct infliction of physical harm on the child by some specific act of the perpetrator that results in symptoms that the physician cannot explain.<sup>163</sup> The second way a child may be harmed is by the perpetrator's fictitious presentation of the child as ill, which normally results in extensive tests and, often, intrusive procedures to identify or correct a non-existent condition.<sup>164</sup> In some cases, the child does suffer from a real condition that warrants treatment, but the perpetrator induces other symptoms, further complicating already existing symptoms.<sup>165</sup>

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161. *In re Bowers*, No. 1490, 1992 WL 2870, at \*4 (Ohio Ct. App. Jan. 2, 1992).

162. See discussion *supra* Part I.B.

163. Courts should be suspicious of abuse when parents' explanations of a child's injuries or symptoms are inconsistent with medical testimony or if the condition of the child cannot be medically explained. See, e.g., *In re M.S.H.*, 656 P.2d 1294, 1297 (Colo. 1983) (noting that nature of child's injury was inconsistent with parents' explanation); *In re Sonia H.*, 576 N.Y.S.2d 165, 167 (App. Div. 1991) (noting unexplained injuries to child); *In re Jessica M.M.*, 504 N.Y.S.2d 850, 853 (App. Div. 1986) (noting that parents' explanations for infant's multiple fractured ribs and broken arm were inconsistent with medical evidence).

164. In one scenario, a child endured approximately 100 operations to correct a condition that did not exist because the mother was making up the child's condition. See *PrimeTime Live*, *supra* note 3.

165. In Vancouver, a 37-year-old mother lost custody of her adopted ten-year-old daughter after doctors suspected she caused infections around the child's intravenous lines and

A third possibility exists when, although the child suffers from a real condition, the doctor overlooks it because of a history of the mother presenting the child with conditions that do not exist.<sup>166</sup> Also, if a parent is falsely accused of perpetrating the Syndrome, the child could have a real condition that warrants treatment but would not be presented for treatment because the parent fears medical suspicion and subsequent legal involvement.<sup>167</sup> Of course, psychological harm to the child may result from being victimized by the disease, and in cases where the Syndrome has been determined to exist, the child may be psychologically or emotionally harmed by being removed from his or her family.<sup>168</sup> In each scenario, related harms affect the perpetrator, such as criminal prosecution, therapy, and separation from her existing or future children.<sup>169</sup>

In addition to the physical effects on the child and the related effects on the mother and family, there are general implications for the medical profession. As medical knowledge and understanding of Munchausen Syndrome by Proxy grow, so does the disagreement among medical professionals over an accurate definition of Munchausen Syndrome by Proxy, and how it is qualified.<sup>170</sup> This disagreement appears magnified as the effects of the Syndrome

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after she collected \$70,000 from an insurance policy. See Neal Hall, *Kamloops Mother Fails to Regain Custody of Daughter: A Judge Rules It Was Likely the Woman Harmed the Child to Draw Attention to Herself*, VANCOUVER SUN, Mar. 13, 1997, at B1. The girl suffered from cerebral palsy and fetal alcohol syndrome and has trouble eating and speaking. See Neal Hall, *Mother Temporarily Denied Custody of Special-Needs Child*, VANCOUVER SUN, Mar. 27, 1997, at B2; *Mom Loses Custody Fight for Disabled Girl*, CALGARY HERALD, Mar. 13, 1997, at A17, available in 1997 WL 5643172.

166. Dr. C. Thomas Clark has stated:

If doctor shopping was allowed to occur . . . [and] if [the perpetrator] convince[s] someone unknown to that person that the child was ill . . . more evasive procedures would be done until the child is put at risk either from the procedure or if they continue in our practice . . . they would be at risk for us missing a diagnosis by overlooking the mother's complaint as being valid.

*Bowers*, 1992 WL 2870, at \*4.

167. See *In re Jessica Z.*, 515 N.Y.S.2d 370, 378 (Fam. Ct. 1987).

168. See *id.* ("Removal of the child to the unknown circumstances of foster care . . . would result in the child's separation not only from . . . [her] . . . mother, but from her father, her sibling, and her grandparents . . . [which] . . . would cause her further trauma, and possibly permanent damage.")

169. Michele Lynn Price pled guilty to manslaughter and aggravated child abuse charges after smothering her 14-month-old daughter, Bonnie Jean Bolden, in March 1996. See Sue Carlton, *Mom Pleads Guilty in 1-Year-Old's Death*, ST. PETERSBURG TIMES (Fla.), Mar. 27, 1997, at 4B, available in 1997 WL 6188866. Hospital staff became suspicious of Price when she used a different name to admit the child to the hospital because she had already lost custody of two other children after allegations of child abuse. See *id.* Price agreed to ten years in prison and twelve years of probation, during which time she is allowed to have no contact with children and must inform authorities if she becomes pregnant. See *id.*

170. See Meadow, *What Is, and What Is Not*, *supra* note 16, at 534.

enter the legal field. As this Article demonstrates, a common understanding of the Syndrome in these contexts is critical to the medical and legal fields' cooperative efforts to deal with the effects of the Syndrome, particularly as they apply to the children who are victimized by it.

Because professionals continue to disagree regarding the qualification of the disease, and because the medical and legal fields respond inconsistently to the disease, the degree to which medical professionals must demonstrate that the disease actually exists and how much the child is harmed by the Syndrome varies considerably. This uncertainty about how the legal community will deal with the effects of Munchausen Syndrome by Proxy has forced the medical community to resort to covert video surveillance in order to bridge the gap between the professions in managing the disease, assuring the safety of the child, and assuring criminal prosecution and treatment for the perpetrator.

#### *D. The Need for Covert Video Surveillance*

Many cases of suspected Munchausen Syndrome by Proxy are not treated appropriately and promptly because medical professionals hesitate to cloak parents with the inherent implications of the diagnosis.<sup>171</sup> This reaction causes medical staffs to focus their attention on gathering evidence to prosecute the suspected perpetrator, rather than focusing on the child's condition and the level of precautions necessary to assure the child's safety, while still assuring an appropriate diagnosis.<sup>172</sup> Even the highest suspicion by medical authorities is sometimes insufficient to overcome the legal field's hesitancy to accept the disease. In one case where a woman was indicted for allegedly suffocating her child while they were alone in a hospital room, but where video surveillance was not used, one expert doctor testified that it was seventy to

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171. See Donald & Jureidini, *supra* note 16, at 757. For a discussion of a case involving Munchausen Syndrome by Proxy (described therein as "factitious disorder by proxy"), where a physician who reported his suspicions of the disorder was sued by the parents when the suspicions proved to be false, see Marc D. Feldman & David B. Allen, "False-Positive" Factitious Disorder by Proxy, 89 MED. J. 452 (1996).

172. One study demonstrates that covert video surveillance is not always necessary to remove the child from an abusive parent. In the study, although 32 of 34 children subjected to covert video surveillance were taken into protective custody, not all of the parents had been abusive during the surveillance. See Morley, *supra* note 22, at 1604 (citing Wheatley, *Covert Surveillance*, *supra* note 22, at 1101-02). If the children were placed into foster care regardless of the results of the surveillance, then the use of the surveillance to achieve that end was unnecessary. See *id.*



eighty percent likely that she caused the injury.<sup>173</sup> However, the prosecutor who reviewed the case and declined to prosecute said, “[t]hat’s the definition of a reasonable doubt. It’s just not good enough for a criminal case.”<sup>174</sup> The mother subsequently filed a civil malpractice claim against the hospital. After a ten to two verdict for the hospital, the jury members were asked who they felt was responsible for the death. Eleven members said the mother was responsible, but one of those eleven felt the hospital could have been more vigilant in protecting the child.<sup>175</sup> This example demonstrates how the hospital is saddled with the diagnosis and treatment of the child, the confrontation of the parent, the difficulty of confirming suspicions, the hesitancy of the legal field, the possibility of civil liability, and the strict standard of proof established by the courts. Understandably, many medical professionals favor the use of covert video surveillance,<sup>176</sup> which, when effective, resolves many of these difficulties for the medical profession. As this Article demonstrates, however, the use of covert video surveillance only leads to further ethical and legal complications and the additional risk of harm to the child.

## II. COVERT VIDEO SURVEILLANCE IN CASES OF MUNCHAUSEN SYNDROME BY PROXY

### A. *The Study by Dr. David Southall*

Covert video surveillance of the Syndrome as it occurs has been employed by dozens of hospitals.<sup>177</sup> The most public and controversial were two hospitals in London and North Staffordshire where Dr. David Southall has been taping occurrences of Munchausen Syndrome by Proxy for more than ten years.<sup>178</sup> The videos taken by the doctor in this study show children being abused by their parents in the hospital.<sup>179</sup> One video shows a man smothering his six-week-old son, while hospital staff sit idly by,

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173. See Rick Casey, *Child Abuse, Lies and, Too Rarely, Videotape*, SAN ANTONIO EXPRESS-NEWS, Apr. 13, 1998, at 3A, available in LEXIS, Market Library, PROMT File.

174. *Id.* (quoting Judge Cynthia Morales, who prosecuted the case).

175. *See id.*

176. See, e.g., Shabde & Craft, *supra* note 22, at 1603–05; Shinebourne, *supra* note 22, at 26–31; Southall et al., *supra* note 19, at 735–60.

177. See *PrimeTime Live*, *supra* note 3.

178. See Southall et al., *supra* note 19, at 736.

179. See *PrimeTime Live*, *supra* note 3.

videotaping the abuse.<sup>180</sup> Yet even the mother of the child who was being suffocated by his father claims that, were it not for the video surveillance conducted by Dr. Southall, the father surely would have killed their son.<sup>181</sup>

The ethical dilemma created by such tactics can be seen in the very language used by supporters of the tactic to describe the need for such extreme measures. For example, Dr. Southall states: "The kind of abuse that we've been working on involves premeditated, sadistic abuse. And this is the kind of abuse that we feel must be stopped."<sup>182</sup> Southall's statement is inherently contradictory, however. It describes the abuse as insidious, sadistic, and something that must be prevented, yet to effectuate this prevention, the very insidious and sadistic abuse sought to be prevented is orchestrated and permitted. In fact, Dr. Southall's study seems to report more on the comparative uses and effectiveness of covert video surveillance than it does on the study's ability to actually protect the children in the study from harm.<sup>183</sup> If not readily apparent as an ethical abhorrence, it must be concluded that promoting a condition in a child which, as Dr. Southall describes it, "may cause death or permanent neurologic impairment . . . [and] . . . may be accompanied by immeasurable suffering"<sup>184</sup> poses, at the very least, an ethical, if not a legal, dilemma.

The study by Dr. Southall was conducted between June 1986 and December 1994.<sup>185</sup> Throughout the study, thirty-nine patients underwent covert video surveillance.<sup>186</sup> Extensive family information

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180. *See id.*

181. *See id.*

182. *Id.*

183. The "objective" of the study, as expressly stated in its "abstract," was "[t]o describe historic markers and clinical observations of life-threatening child abuse as diagnosed using covert video surveillance (CVS)." Southall et al., *supra* note 19, at 735. Although the scope of the study must be considered within its educational context, it is interesting—even shocking—to note that "to protect the children in the study and prevent them from being harmed" is not mentioned as part of the "objective" of the study. Rather, it is stated that covert video surveillance is used in the study "as a clinical tool" in the investigation of suspected cases of abuse. *Id.* Even the stated "outcome" of the study does not include "protection of x number of children," but rather includes only "[c]onfirmation of attempted suffocation or other child abuse from CVS." *Id.* These statements clearly indicate that the subject of the study is the ability of CVS to confirm suspicions, rather than for children to be protected.

184. *Id.*

185. *See id.* at 736.

186. *See id.* Of the 39 patients, covert video surveillance had been initiated on 36 patients because of a previous apparent life-threatening event (ALTE), one patient for suspected strangulation, one patient for fabricated epilepsy, and one patient for severe failure to thrive and suspicion of poisoning. *See id.*

was gathered from child protection cases, social workers, police, health professionals, and psychiatric reports.<sup>187</sup>

In the study, parents who were suspected of abusing a child were invited to bring the child to the hospital for observation.<sup>188</sup> The child was placed in a hospital room arranged with four hidden cameras.<sup>189</sup> Nurses were stationed approximately twenty yards away from the child's room as observers viewed the parent and child on video.<sup>190</sup> When abuse was observed, the observer sounded an alarm and the nurse would immediately move to the child's room to check on the child's condition.<sup>191</sup>

In one television excerpt that showed some of Dr. Southall's videos of abuse, at least three videos were shown where the parent attempted to smother the child.<sup>192</sup> The narrator notes: "Experts say depriving an infant of oxygen for as little as [fifty] to [sixty] seconds can cause permanent brain damage."<sup>193</sup> In Dr. Southall's study, Ray Needham, a former police inspector, was in charge of dispatching the nurses to the child's room upon the observation of abuse on the video; he asserted that nurses were dispatched to the room within twenty-five seconds of the beginning of the abuse.<sup>194</sup> However, of the thirty-nine incidents of abuse recorded by Dr. Southall's videos, thirty-three of the children endured life-threatening attacks.<sup>195</sup> Thirty of the incidents involved intentional suffocation;<sup>196</sup> two involved

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187. See *id.* The 39 family histories of abusive parents gathered in the study revealed that: 25 cases involved fabricated or induced illness in the parent; 23 parents were diagnosed by a psychiatrist as having a personality disorder; 15 parents deliberately harmed themselves through drug overdose or self-mutilation; there were 15 cases of nonfatal abuse in siblings of the children undergoing the video surveillance, 12 of which were proven or admitted, three of which were suspected; ten parents suffered severe behavioral problems as a child or adolescent; nine parents experienced sudden and unexpected child deaths in their families; nine parents were involved in some form of criminal activity in addition to the abuse of the child in the study; and several parents had been involved in other unusual activities—three had been involved with some sort of fire, three had had extensive involvement with the media, two had falsely posed as nurses, and two were known to have demonstrated cruelty to animals. See *id.* at 739 tbl. 2. Of the abusing parents, 19 were married; 11 were single without a partner; four were single with a partner; and five were divorced. See *id.* Of the 39 parents, 29 were older than 20 years of age at the time of the birth of the subject child; seven were between 17 and 19 years of age; and three were under 16 years of age. See *id.*

188. See *PrimeTime Live*, *supra* note 3.

189. See Southall et al., *supra* note 19, at 737.

190. See *PrimeTime Live*, *supra* note 3.

191. See *id.*

192. See *id.*

193. *Id.*

194. See *id.*

195. See *id.*

196. See *id.* Of the 30 incidents of suffocation captured by covert video surveillance, 18 cases involved suffocation by hand or hands; eight involved some form of fabric, cloth, or article of clothing; and three involved the use of a pillow, one of which also involved a clear plastic wrapping. See Southall et al., *supra* note 19, at 741–44 tbl. 3.

poisoning;<sup>197</sup> and, in one case, the mother actually broke the child's arm.<sup>198</sup> When confronted with the argument that exposing any child to further abuse is wrong, Dr. Southall responded:

This part of [the] . . . argument I understand. If we had enough evidence it would have been wrong to have gone ahead with covert surveillance. And in every case, we did not feel that we had enough evidence. What must go on in the home of these families is going to be far in excess of anything that happens in the hospital.<sup>199</sup>

Still, other occurrences observed on tape were not interrupted by hospital staff—incidents like kicking and slapping the child, disconnecting monitors, forcing ingestion of disinfectant and other objects, cruelly waking the child from sleep, and roughly pushing the child away as the child reached out to the parent for comfort or affection.<sup>200</sup> These abuses were not interrupted because the hospital staff was waiting for something more abusive to occur. Dr. Southall stated, “we were looking for . . . a life-threatening abuse. . . .”<sup>201</sup> Dr. Southall describes this aspect of the surveillance as the worst part of his work, yet he insists that the end justifies the means.<sup>202</sup> In support of this contention, Dr. Southall relies on the fact that British authorities took action in thirty-eight of the thirty-nine cases that were captured on tape.<sup>203</sup> In those cases, the child was usually removed from the abusive parent and placed in long-term foster care.<sup>204</sup> In one case, after a father was arrested for the abuse caught on Dr. Southall's tape, he confessed to also murdering another child, whom he had suffocated only two years earlier and who was originally thought to have died from Sudden Infant Death Syndrome (SIDS).<sup>205</sup> Surprisingly, 12 siblings of Dr. Southall's 39

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197. See *PrimeTime Live*, *supra* note 3.

198. See *id.*

199. *Id.*

200. See *id.*

201. *Id.*

202. See *id.*

203. See *id.*

204. See *id.*

205. See *id.* SIDS is defined as follows:

SIDS is the sudden and unexpected death of an apparently healthy child under one year of age whose death remains unexplained after the performance of an adequate postmortem investigation including an autopsy, investigation of the scene and circumstances of the death and exploration of the medical history of the infant and family.

patients had previously died suddenly or unexpectedly—11 were originally suspected to have died of SIDS.<sup>206</sup> After Dr. Southall's study, three other parents confessed to murdering seven of their own children.<sup>207</sup>

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[hereinafter Knox, *Deadly Deception*]. The article notes: "SIDS accounts for one-third of all deaths among infants older than one month. . . ." *Id.* SIDS is the leading killer of babies between the ages of one week and one year, at a rate of one in every five hundred infants. See Peter Gorner, Editorial, *When a Child Dies: Why Does the Pendulum of Blame Have to Swing Back 25 Years?*, TULSA TRIB. & TULSA WORLD, Nov. 2, 1997, at G2. Between 3500 and 4500 babies die of SIDS every year in the United States. See *id.* In 1995, there were approximately 3300 reported cases of SIDS. See Knox, *Deadly Deception*, *supra*. As early as 1972, it was thought that SIDS was hereditary; however, a growing knowledge about Munchausen Syndrome by Proxy has seriously questioned that theory. See Knox, *Deadly Deception*, *supra*.

Since 1977, when Munchausen Syndrome by Proxy was first introduced as a form of child abuse, see Meadow, *The Hinterland of Child Abuse*, *supra* note 16, at 343–45, many supposed SIDS cases have been revealed to have actually been caused by Munchausen Syndrome by Proxy. See, e.g., Flannery, *supra* note 9, at 1194–95 n.81 (discussing the case of Waneta Hoyt, who was originally thought to have lost five children to SIDS, but who, 23 years after the death of her fifth child, was discovered to have murdered all five of her children); Brian Maffly, *Three Infant Deaths at Day-Care Home Raise Questions, Lead to Lawsuit; SIDS Deaths Raise Questions, Lead to Lawsuit*, SALT LAKE TRIB., Mar. 2, 1998, at D1 (describing the case of Karen Biddulph, in whose care three babies died of what was originally thought to be SIDS but was later suspected to be murder); Joe O'Dowd, *Mother Admits Killing 5 Infants; Textbook Sudden Infant Death Syndrome Case Turns Out to Be Infanticide*, PITT. POST-GAZETTE, Apr. 5, 1998, at B6, available in 1998 WL 5242195 (describing the case of Marie Noe, who confessed in 1998 to killing five of her ten children where all ten children were thought to have died of SIDS and eight had died in her care). In some cases, mothers have been found to have murdered up to nine of their children under the guise of SIDS. See Knox, *Deadly Deception*, *supra*.

Although it is impossible to pinpoint accurate statistics regarding the prevalence of cases that are thought to be SIDS but are actually Munchausen Syndrome by Proxy cases, some experts state that "95[%] to 98[%] of all SIDS cases are correctly diagnosed. . . ." *Id.* Other experts place the true homicide percentage of SIDS cases at as much as 10%. See *id.* Still others suggest that as many as 20% of suspected SIDS deaths are actually caused by parents killing their infants. See *PrimeTime Live*, *supra* note 3. What is becoming more certain, however, is that the likelihood of multiple cases of SIDS in one home is extremely rare. See Maffly, *supra*. The odds of three SIDS deaths in one home, like the Biddulphs', are as high as one in 1.88 trillion. See *id.*

The increased awareness and suspicion of child abuse in cases where SIDS was originally suspected may do a disservice to the SIDS research community, see Gorner, *supra* (criticizing the sensationalization of "serial cases of child abuse," like that portrayed in RICHARD FIRSTMAN & JAMIE TALAN, *THE DEATH OF INNOCENTS* (1997), which contends that serial abuse cases may have been covered up by supporters of SIDS research. See also Cyril H. Wecht, *The Death of Innocents: A True Story of Murder, Medicine, and High-Stakes Science*, 279 JAMA 85 (1998) (book review of *THE DEATH OF INNOCENTS*).

206. See Southall et al., *supra* note 19, at 738.

207. See *PrimeTime Live*, *supra* note 3. Increased awareness of the disease, which has allegedly led to increased false accusations of the disease, has even led to the formation of a Mississippi-based organization called "Mothers Against Munchausen [S]yndrome by [P]roxy Allegations (MAMA)," whose members believe that allegations of Munchausen Syndrome by Proxy are used by doctors to evade malpractice lawsuits or simply to rid themselves of cases in which they are unable to render an accurate medical diagnosis. See Knox, *Deadly Deception*, *supra* note 205.

Some experts, however, feel that medical professionals too often overlook factors that should raise suspicions of Munchausen Syndrome by Proxy. See *id.* For example, at

In Dr. Southall's study, the determination of whether to use covert video surveillance in 37 of the 39 cases was authorized after a "multiagency planning meeting," which was organized and chaired by social service professionals.<sup>208</sup> It was decided that those were extreme cases in which covert video surveillance "was the only mean [sic] through which abuse could be confirmed or refuted and long-term protection ensured."<sup>209</sup> In one of the cases, the use of video surveillance was authorized after an inter-agency telephone conversation, based on what was perceived to be an "immediate threat to the child."<sup>210</sup> In another case, surveillance was initiated after only a "close discussion" with Dr. Southall.<sup>211</sup>

Interestingly, at the outset of the surveillance, the Staffordshire police initially refused to participate in the surveillance unless trained nursing observers were present.<sup>212</sup> Dr. Southall, however, "considered the surveillance aspect of . . . [the] work to be police activity."<sup>213</sup> Eventually, Dr. Southall reluctantly agreed to train the nursing staff in covert video surveillance so that it could continue.<sup>214</sup>

During the surveillance, electronic communication between the observers and a senior pediatric nurse was divided between low-priority and high-priority calls.<sup>215</sup> Upon a low priority call, when, for example, the parent might disconnect the child's monitor, the senior nurse would merely contact the observing team by telephone for discussion.<sup>216</sup> If an episode of abuse was observed, the ward nurse would dispatch immediately to the child's room, ideally

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Massachusetts General Hospital, one specialist studied 156 cases of repeated apnea episodes or cessation of breathing cases—20 of which involved patient deaths—and determined that although 56 of the cases should have raised suspicions of abuse, very few were documented or referred to the proper authorities. *See id.*; Richard A. Knox, *Suspicious Surface in Cases Termed 'Sudden Infant Death'*, BOSTON GLOBE, Sept. 9, 1997, at A1, available in Lexis, News Library, BGLOBE file. Red flags of abuse in cases that would otherwise be diagnosed as SIDS cases include the following scenarios: a child who has suffered numerous apnea episodes dies; a child whose sibling has died of SIDS or has also suffered numerous apnea episodes dies; the only witness to an apparent life-threatening event is always the same care giver; and the life-threatening incident occurs when the child is reportedly awake. *See* Richard A. Knox, *Some SIDS Deaths Linked to Munchausen Syndrome by Proxy*, FORT WORTH STAR-TELEGRAM, Sept. 21, 1997, at 38, available in 1997 WL 11907471.

208. Southall et al., *supra* note 19, at 736.

209. *Id.*

210. *Id.*

211. *Id.*

212. *See id.* at 737.

213. *Id.*

214. *See id.*

215. *See id.*

216. *See id.*

never more than twenty-five seconds after the onset of the abuse.<sup>217</sup> In cases of suffocation, Dr. Southall felt that because the child was not likely to show signs of cerebral hypoxia for up to sixty or seventy seconds, a twenty-five second lapse from the onset of the suffocation until intervention was permissible.<sup>218</sup> The delay “helped ensure that the video evidence was adequate for legal purposes.”<sup>219</sup> Shockingly, not until one parent broke her child’s arm while under surveillance were “the guidelines for observers [ ] modified for earlier intervention if the parents’ behavior indicated imminent abuse involving physical violence of this type.”<sup>220</sup> After an episode of abuse, the nurse would remain with the child until police arrived.<sup>221</sup> The abusive incidents were of sufficient intensity that ward nurses and observers were offered individual counseling following the episodes, and any nurse who felt uncomfortable with the surveillance procedure was free to discontinue his or her participation.<sup>222</sup>

Under British law, the breach of privacy involved in the surveillance process is not illegal.<sup>223</sup> Because the hospital trust lawfully occupied the premises, they were entitled to use video surveillance there.<sup>224</sup> In a British proceeding in which the use of covert video surveillance was considered, the court held: “If a doctor considers that covert video surveillance is essential for the treatment of his patient, the doctor would be entitled to undertake this process without parental consent, provided that he is satisfied that there is no risk that the patient will come to any serious harm.”<sup>225</sup>

A North Carolina case illustrates vividly the quandary of those who watch and wait for the abuse to happen. The case involved a mother who suffocated her child—not just once, but three separate times, all within two hours, all of which were videotaped by hospital staff.<sup>226</sup> The first incident of smothering lasted for fifty-one seconds before a nurse interrupted the abuse.<sup>227</sup> The second incident lasted for an additional fifty seconds.<sup>228</sup> Larry Brubaker, an FBI agent who specializes in Munchausen Syndrome by Proxy cases, described the

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217. See *id.* “Episode of abuse” is a relative term; however, participants in the study stated that they would not interfere with certain clearly abusive activities because they were not “life-threatening” events. See *PrimeTime Live*, *supra* note 3.

218. See Southall et al., *supra* note 19, at 737.

219. *Id.*

220. *Id.*

221. See *id.*

222. See *id.*

223. See *id.*

224. See *id.*

225. *Id.* (quoting *In re DH, A minor (Child Abuse)*, Fam. L. Rep. 619–716 (1994)).

226. See *PrimeTime Live*, *supra* note 3.

227. See *id.*

228. See *id.*

child's response to the abuse as he watched the video: "[S]he's having a lot of difficulty holding that child down to have the child quit breathing. You can see how much he is fighting. . . . That child is fighting back. . . . [I]t's no different than a rape victim or a victim of any other type of assault [who]'s fighting back."<sup>229</sup> He described another incident of a father suffocating his daughter, uninterrupted, for more than a minute: "You can see her little feet . . . at the bottom of the screen just kicking, vehemently kicking."<sup>230</sup>

### *B. The Legal Issues in the Use of Covert Video Surveillance*

The employment of covert video surveillance to prove Munchausen Syndrome by Proxy raises two legal questions: whether the use of such surveillance is a "search," as defined by the Fourth Amendment,<sup>231</sup> and whether the employment of surveillance violates the caregiver's right to privacy. The use of video surveillance is inherently intrusive and susceptible to abuse.<sup>232</sup> Video surveillance triggers Fourth Amendment considerations when it intrudes upon one's reasonable expectation of privacy.<sup>233</sup> Thus, under a Fourth Amendment analysis, the propriety of covert video surveillance depends upon a series of related issues, the first of which is whether the surveillance constitutes a search.<sup>234</sup> For the surveillance to constitute a search, the trier of fact must find that the subject had an actual, subjective expectation of privacy, and that his or her expectation of

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229. *Id.* A North Carolina mother pled guilty to attempted murder and lost her parental rights. *See id.* She was sentenced to three years in prison, of which she served thirteen months. *See id.* She obtained counseling while in prison and claims that she can control her urges, even though she is not cured. *See id.* At the time of the broadcast, she was in the process of becoming a licensed nurse. *See id.*

230. *Id.*

231. The Fourth Amendment of the U.S. Constitution guarantees individuals freedom from unreasonable searches and seizures. *See* U.S. CONST. amend. IV. The Fourth Amendment provides:

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation and particularly describing the place to be searched, and the persons or things to be seized.

*Id.*

232. *See* United States v. Torres, 751 F.2d 875, 882 (7th Cir. 1984) (describing electronic visual surveillance as "inherently indiscriminate"); State v. Thomas, 642 N.E.2d 240, 247 (Ind. Ct. App. 1994).

233. *See* Katz v. United States, 389 U.S. 347, 352-53 (1967); *see also* Smith v. Maryland, 442 U.S. 735, 740 (1979).

234. *See supra* note 231.



privacy was one that society would find reasonable.<sup>235</sup> If the surveillance is considered a search under the Fourth Amendment, a search warrant is required to sustain its use.<sup>236</sup> A warrantless search may be conducted if the situation qualifies under one of three exceptions to the warrant requirement relevant to the context of this Article.<sup>237</sup> First is the exigent circumstance, where there must be probable cause to believe that a person is in imminent harm or that evidence may be destroyed.<sup>238</sup> The second is the private party exception, where a private party who is not acting with government interests conducts the search.<sup>239</sup> The third exception requires the consent of the party involved in the search.<sup>240</sup>

This Section argues that covert video surveillance of Munchausen Syndrome by Proxy does not qualify under any of these three exceptions to the Fourth Amendment warrant requirement. Furthermore, this Section argues that, given the standard required to procure a warrant, the evidence required to obtain the warrant is also sufficient to temporarily restrict the parent's supervision of the child, which is preferable to placing the child at risk of harm by conducting the surveillance. Finally, even if a warrant were required, procurable, and necessary, this Section argues that it is simply medically unethical to place the child at risk through the use of covert video surveillance.

1. *Is it a Search?*—The Fourth Amendment provides: “The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated. . . .”<sup>241</sup> In the landmark case of *Katz v. United States*, the United States Supreme Court expanded the Fourth Amendment protection from property and possessory interests to unreasonable invasions of personal privacy.<sup>242</sup> In *Katz*, the Court held that “[w]hat

235. See *Minnesota v. Olson*, 495 U.S. 91, 95–96 (1990); see also *Katz*, 389 U.S. at 361 (Harlan, J., concurring).

236. See *Katz*, 389 U.S. at 357–59.

237. Exceptions to the Fourth Amendment warrant requirement that are not applicable within the context of this Article include search incident to a lawful arrest, see *Chimel v. California*, 395 U.S. 752, 762–68 (1969); seizure of contraband in an automobile, see *Carroll v. United States*, 267 U.S. 132, 158–59 (1925); and searches made in “good faith,” see *United States v. Leon*, 468 U.S. 897, 926 (1984).

238. See *Ker v. California*, 374 U.S. 23, 47 (1963) (Brennan, J., concurring).

239. See *Burdeau v. McDowell*, 256 U.S. 465, 475 (1921) (holding that the Fourth Amendment warrant requirement was not intended to apply to the activities of individuals who are not employed by the government).

240. See *Zap v. United States*, 328 U.S. 624, 630 (1946); *Davis v. United States*, 328 U.S. 582, 593–94 (1946).

241. U.S. CONST. amend. IV.

242. See *Katz v. United States*, 389 U.S. 347, 350–53 (1967) (holding that eavesdropping on telephone booth conversation constituted an unreasonable search and seizure). For a

a person knowingly exposes to the public, even in his own home or office, is not a subject of Fourth Amendment protection. But what he seeks to preserve as private, even in an area accessible to the public, may be constitutionally protected."<sup>243</sup> Justice Harlan's concurring opinion voiced a rationale of the case: a "search," which triggers the protections afforded by the Fourth Amendment, occurs any time police investigatory activities infringe on an "expectation of privacy" that "society is prepared to recognize as 'reasonable.'"<sup>244</sup> Therefore, covert video surveillance of Munchausen Syndrome by Proxy will only be a search that would trigger a Fourth Amendment analysis if the parent has a reasonable expectation of privacy in the hospital room where the surveillance takes place.

2. *Is There a Reasonable Expectation of Privacy in a Hospital Room?*—Courts have interpreted the phrase "expectation of privacy" to mean that the person claiming a Fourth Amendment violation must have manifested an intention that his or her conduct will be private.<sup>245</sup> In *Katz*, where the defendant claimed a reasonable expectation of privacy in a phone booth,<sup>246</sup> the Court reasoned that the question is not whether the subject space is "accessible to the public" at other times, but whether it is a "temporarily private place," in which its "momentary occupants' expectations of freedom from intrusion" are manifestly intended.<sup>247</sup> It is reasonable to conclude that a Munchausen mother manifestly intends that the hospital room in which she perpetrates the Syndrome will be private, at least at the moment of action; otherwise she would not act or would act in the presence of hospital staff, which would defeat her very intention—deceiving the hospital staff by what she does to the child in private. The very nature of the behavior demonstrated in Munchausen Syndrome by Proxy makes the behavior one which is manifestly intended to be private.<sup>248</sup> The second prong of the *Katz* test is more problematic: whether the expectation of privacy is reasonable.<sup>249</sup>

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discussion of *Katz*, see Elan Gerstmann, *Letting Katz out of the Bag: Re-evaluating Probable Cause in the Context of Electronic Eavesdropping*, 22 *LOV. U. CHI. L.J.* 193 (1990).

243. *Katz*, 389 U.S. at 351–52 (citations omitted).

244. *Id.* at 361 (Harlan, J., concurring).

245. See, e.g., *Smith v. Maryland*, 442 U.S. 735, 740 (1979); *United States v. Tabor*, 635 F.2d 131, 137 (2d Cir. 1980).

246. See *Katz*, 389 U.S. at 348–50.

247. *Katz*, 389 U.S. at 361 (Harlan, J., concurring).

248. The fact that, in one study, six of at least eight mothers who were confronted with evidence obtained via covert video surveillance expressed outrage at the violation of their privacy supports this contention. See *Yorker*, *supra* note 17, at 339–40.

249. See *Smith*, 442 U.S. at 740; *Katz*, 389 U.S. at 361 (Harlan, J., concurring).

The Supreme Court has determined that a reasonable expectation of privacy depends upon whether the expectation is based on “understandings that are recognized and permitted by society.”<sup>250</sup> Commentators who advocate or accept the propriety of covert video surveillance in Munchausen Syndrome by Proxy cases rely on courts that state that an expectation of privacy is not reasonable in a hospital room.<sup>251</sup> In *Buchanan v. State*,<sup>252</sup> the court held that there was no reasonable expectation of privacy when there is a constant flow of medical personnel in and out of the room.<sup>253</sup> However, the holding in *Buchanan* must be viewed as very narrowly limited to the emergency room of a hospital,<sup>254</sup> and not necessarily applying to the room where video surveillance for Munchausen Syndrome by Proxy is commonly employed. Although a holding that even a semi-private hospital room does not provide a setting wherein one may reasonably expect privacy due to the fact that doctors, nurses, visitors, and roommates have regular, unfettered access to the room is not unheard of,<sup>255</sup> other courts recognize that hospital rooms carry some indicia of privacy, even if not to the degree otherwise enjoyed in one’s private home.<sup>256</sup> Hospital rooms are not considered “public places” for purposes of Fourth Amendment analysis.<sup>257</sup> Yet other

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250. *Rakas v. Illinois*, 439 U.S. 128, 143–44 n.12 (1978); *see also Taborda*, 635 F.2d at 138 (requiring that “the action occur in a place in which society is prepared, because of its code of values and its notions of custom and civility, to give deference to a manifested expectation of privacy”).

251. *See, e.g., Yorker, supra* note 17, at 340 (“The health care community, child protective services, and the courts support the idea that society would not consider an expectation of privacy in a pediatric hospital room to be ‘reasonable.’”); *cf. United States v. George*, 987 F.2d 1428, 1432 (9th Cir. 1993); *People v. Courts*, 517 N.W.2d 785, 786 (Mich. Ct. App. 1994); *People v. Hayes*, 584 N.Y.S.2d 1001, 1002–03 (Sup. Ct. 1992). *But cf. David Grande-Cassell*, Note, “*Scalpel, Forceps, Hemostat, Fourth Amendment. . .*”: *The Michigan Court of Appeals Gives Criminal Suspects Protection Against Searches and Seizures of Clothing Held by Hospitals*, *People v. Jordan*, 9 T.M. COOLEY L. REV. 217, 228 (1992) (citing *Morris v. Commonwealth*, 157 S.E.2d 191, 194 (Va. 1967) (comparing hospital room paid for by patient to a hotel room paid for by guest, requiring a warrant to do a search)).

252. 432 So. 2d 147 (Fla. Dist. Ct. App. 1983).

253. *See id.* at 148.

254. *See id.* at 147; *see also Pitt v. State*, Nos. A-6292, 3730, 1997 WL 796503, at \*3 (Alaska Ct. App. Dec. 24, 1997) (holding that, even if the defendant had an actual expectation of privacy in a hospital emergency room, that expectation was not reasonable); *State v. Smith*, 559 P.2d 970, 976 (Wash. 1977) (holding that a defendant had no reasonable expectation of privacy in his clothing located in a semipublic area of the hospital); *Wagner v. Hedrick*, 383 S.E.2d 286, 291–92 (W. Va. 1989) (holding that a defendant who was taken to hospital emergency room following a motorcycle accident did not maintain a reasonable expectation of privacy in his clothing because the area was freely accessible to police officers).

255. *See, e.g., Courts*, 517 N.W.2d at 786; *Campos-Garcia v. State*, No. A14-93-00076-CR, 1995 WL 150238, at \*8 (Tex. Crim. App. Apr. 6, 1995).

256. *See, e.g., Jones v. State*, 648 So. 2d 669, 675 (Fla. 1994); *Morris v. Commonwealth*, 157 S.E.2d 191, 194 (Va. 1967).

257. *See Jones*, 648 So. 2d at 676–77. *But cf. Green v. Chicago Tribune Co.*, 675 N.E.2d 249, 252 (Ill. App. Ct. 1996) (holding that the general public has no right to enter a private

courts have held that the constant flow of medical personnel does not preempt a patient's otherwise reasonable expectation of privacy within "his" or "her" own room.<sup>258</sup>

Because of the unique circumstances surrounding the dynamics of Munchausen Syndrome by Proxy and its surveillance, additional factors are relevant in the Fourth Amendment analysis of whether an expectation of privacy is reasonable. For example, the circumstances under which one is brought to the hospital may be significant.<sup>259</sup> In cases not involving Munchausen Syndrome by Proxy, the defendant is typically rushed into a common area of the hospital, most likely the emergency room—where others are free to move about—where the defendant has little or no control over the circumstances.<sup>260</sup> The emergency room, by its very nature, functions as a freely accessible area over which a patient has no control and where his privacy is diminished. For example, in a hospital emergency room during the throes of an emergency, a patient may neither expect to restrict access to the room to specific individuals according to his or her desire, nor to regulate whether other patients or families are present in the room.

In a private or semi-private hospital room, however, although the hospital staff must enter the room regardless of the patient's wishes, the patient may at least restrict the access of visitors or non-medical personnel. In that way, a patient may control the degree of privacy within the room. In fact, it is possible for the hospital to respect a patient's request for privacy in the room for a certain time period; such a request would be unreasonable in an emergency

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hospital room in use); *Courts*, 517 N.W.2d at 786 (holding that, while patients in hospitals have a legitimate expectation of privacy in their closed closets or drawers, the privacy interest is not similar to the expectations of privacy people have in their homes and hotel rooms, where one legitimately expects to keep the whole world out; thus, the hospital room is a sufficiently public place such that the police may lawfully enter without a warrant to make an arrest when supported by probable cause).

258. *See, e.g.*, *People v. Cook*, 710 P.2d 299, 304 (Cal. 1985); *People v. Brown*, 151 Cal. Rptr. 749, 754 (Ct. App. 1979); *Morris v. Commonwealth*, 157 S.E.2d 191, 194 (Va. 1967) (affording patient in hospital room same privacy as guest in hotel room).

259. *See Wagner*, 383 S.E.2d at 291 (holding that the defendant's expectation of privacy was diminished because of the circumstances under which he was brought to the emergency room).

260. *See id.* These "common area" cases typically involve the emergency room. *See, e.g.*, *United States v. George*, 987 F.2d 1428, 1430 (9th Cir. 1993); *Pitt v. State*, Nos. A-6292, 3730, 1997 WL 796503, at \*3 (Alaska Ct. App. Dec. 24, 1994); *Buchanan v. State*, 432 So. 2d 147, 148 (Fla. Dist. Ct. App. 1983); *People v. Torres*, 494 N.E.2d 752, 753-55 (Ill. App. Ct. 1986); *see also State v. Abislaiman*, 437 So. 2d 181, 183 (Fla. Dist. Ct. App. 1983) (holding that the defendant had no reasonable expectation of privacy in hospital parking lot); *State v. Herbest*, 551 A.2d 442, 444 (Me. 1988) (holding that the defendant had no reasonable expectation of privacy in reception area of hospital emergency room); *Sullivan v. District Court of Hampshire*, 429 N.E.2d 335, 338-39 (Mass. 1981) (holding that the plaintiff could have had no expectation of privacy in hospital canteen, a common area open to all hospital staff).

room setting. Even when a patient consents to the presence of hospital employees in the room, it has been held that such consent does not waive the otherwise reasonable expectation of privacy from police intrusion that one may enjoy in a hospital room.<sup>261</sup> The court in *People v. Brown* held:

[T]he question of privacy in a hospital does not merely turn on a general expectation of privacy in use of a given space, but to some degree depends on the person whose conduct is questioned. Clearly, although by checking himself into a hospital, a patient may well waive his right of privacy as to hospital personnel, it is obvious that he has not turned “his” room into a public thoroughfare.<sup>262</sup>

The rooms used in covert video surveillance in a hospital must be made private by the hospital staff. Were they not private, the surveillance would be pointless. Additionally, as in the study by Dr. Southall,<sup>263</sup> the mother and child generally do not come to the hospital on an emergency basis where they are treated randomly in a room where covert video surveillance is being used. Instead, they are requested to come to the hospital under the auspices of testing or treatment<sup>264</sup> (or perhaps they were already being treated, unnecessarily, in the hospital), but then are purposely situated in a room that, at the time of surveillance, will be made private by the hospital staff for the sole purpose of conducting surveillance.<sup>265</sup>

An additional factor courts may consider that is especially relevant to Munchausen surveillance cases is whether the individual “took normal precautions to maintain his privacy—that is, precautions customarily taken by those seeking privacy,”<sup>266</sup> and how the individual uses the location.<sup>267</sup> In Munchausen cases, perpetrators typically take precautions to ensure their behavior is private—that no one else is in the room or sees them—since privacy and deception are the very essence of perpetrating the Syndrome. On the surveillance tapes, one can see a parent who is about to harm the child checking the door to see if anyone is approaching the room. Therefore, based on both the dynamics of the disease itself and the necessary environment for covertly videotaping the perpetration of

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261. See *Brown*, 151 Cal. Rptr. at 754–55.

262. *Id.* at 754.

263. See Southall et al., *supra* note 19, at 735.

264. See *PrimeTime Live*, *supra* note 3.

265. See *id.*

266. *Rakas v. Illinois*, 439 U.S. 128, 152 (1978) (Powell, J., concurring).

267. See *id.* at 153 (Powell, J., concurring).

the disease, it is reasonable to conclude that perpetrators have a reasonable expectation of privacy in the hospital room in which they are observed.

3. *Is a Warrant Required?*—Lower courts have permitted the use of warrantless video surveillance when it covers areas that are in “plain view.”<sup>268</sup> Because one may have a reasonable expectation of privacy in a hospital room, the use of covert video surveillance to detect Munchausen Syndrome by Proxy in the hospital must be considered a “search” for Fourth Amendment purposes.<sup>269</sup> Therefore, in order to conduct the search legally, either a warrant must be obtained or one of the exceptions to the warrant requirement must apply.<sup>270</sup> As noted above, three commonly accepted exceptions that are potentially relevant to the issue of video surveillance of suspected perpetrators of Munchausen Syndrome by Proxy are: (1) exigent circumstances; (2) consent; and (3) lack of government involvement or exclusive involvement by a private party.<sup>271</sup>

*i. The Exigent Circumstances Exception to The Warrant Requirement*—The United States Supreme Court has recognized that sometimes “[t]here are exceptional circumstances in which, on balancing the need for effective law enforcement against the right of privacy, it may be contended that a magistrate’s warrant for search may be dispensed with.”<sup>272</sup> To show that “exigent circumstances” exist, probable cause must show that, if a warrant must be obtained, evidence will be imminently destroyed, a suspect will escape, or a risk of danger to the police or other persons exists.<sup>273</sup>

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268. See *United States v. Felder*, 572 F. Supp. 17, 20 (E.D. Pa. 1983) (requiring no warrant for surveillance of an open work area), *aff’d*, 722 F.2d 735, 735 (3d Cir. 1983); *State v. Abislaiman*, 437 So. 2d 181, 182–83 (Fla. Dist. Ct. App. 1983) (holding that footage of a drug transaction taken from a surveillance camera in a hospital parking lot was admissible); *Sponick v. City of Detroit Police Dep’t*, 211 N.W.2d 674, 690 (Mich. Ct. App. 1973) (holding that video surveillance conducted in local bars was admissible without a search warrant because camera was simply making a permanent record of what the general public could witness).

269. See *supra* Part II.B.1.

270. See U.S. CONST. amend. IV.

271. See, e.g., *Minnesota v. Olson*, 495 U.S. 91, 100–01 (1990) (exigent circumstances); *United States v. Jacobsen*, 466 U.S. 109, 113–14 (1984) (Fourth Amendment’s requirement for government action); *Schneekloth v. Bustamonte*, 412 U.S. 218, 221 (1973) (consent exception). Of course, the scope of the Fourth Amendment exceptions to the warrant requirement is not limited to these exceptions. In his concurring opinion in *California v. Acevedo*, 500 U.S. 565 (1991), Justice Scalia noted that the “‘warrant requirement’ had become so riddled with exceptions that it [had become] basically unrecognizable.” *Id.* at 582 (citing Craig M. Bradley, *Two Models of the Fourth Amendment*, 83 MICH. L. REV. 1468, 1473–74 (1985) (cataloguing more than twenty exceptions to the Fourth Amendment warrant requirement)).

272. *Johnson v. United States*, 333 U.S. 10, 14–15 (1948).

273. See *Minnesota v. Olson*, 495 U.S. 91, 91–100 (1990).

The typical Munchausen Syndrome by Proxy case fits into none of these warrant exceptions. First, no imminent risk of destruction of evidence exists in Munchausen Syndrome by Proxy cases. Indeed, there is no evidence to be destroyed in these cases because the very aim of video surveillance is to *create* evidence. Thus, the first criterion for the exigent circumstance exception to the warrant requirement is inapplicable in Munchausen cases.

The second criterion—the risk that the suspect will escape—is also inapplicable to Munchausen cases. It may be argued that, without direct video evidence of a perpetrator's child abuse, the perpetrator will eventually kill the child, continue to abuse the child at home, or possibly continue the abuse and deception at another hospital. However, none of these possibilities implies that the perpetrator will “escape,” and they are thus insufficient to satisfy the second criterion for the exigent circumstance exception.

The third criterion—that there is a risk of danger (in this case, to the child)—provides the strongest argument that video surveillance should be allowed as an exigent circumstance exception to the search warrant requirement. However, three reasons exist why this criterion is also not met in most Munchausen Syndrome by Proxy cases. First, when video surveillance is being considered, although the child is presumably in the hospital, the surveillance is not yet being conducted so the child can be observed at all times by hospital staff. There is no imminent harm to the child because the mother is neither alone with the child in the room nor about to harm the child. Second, the hospital staff or the police themselves create the environment that places the child at risk; the situation is not the same as one where the mother is currently in the process of perpetrating the crime and where there is insufficient time to obtain a warrant in order to videotape her behavior. In the time it would take for hospital staff to conclude that their suspicions warrant surveillance, to contact the police, and to set up the surveillance or move the child to a surveillance-ready room, a warrant could be obtained. Moreover, in Munchausen cases, the hospital staff is very much in control of the environment and the dynamics of the setting, and, to a certain degree, can regulate the imminence of the risk to the child simply by monitoring the child and by being present in the room. Therefore, the child need be placed in no danger until a warrant is obtained. Third, any evidence indicating a risk of harm to the child so great that the delay in obtaining a warrant would allow the child to be injured must necessarily also be sufficient evidence upon which to restrict the parent's supervision of the child until the risk can be either con-

firmed as legitimate or dismissed as unfounded. Therefore, Munchausen Syndrome by Proxy cases cannot qualify under the exigent circumstances exception to the Fourth Amendment warrant requirement.

*ii. The Consent Exception to the Warrant Requirement*—A subject's consent to surveillance satisfies the second exception to the warrant requirement.<sup>274</sup> To be valid, the consent must be given voluntarily and without coercion.<sup>275</sup> The Supreme Court has held that a third party who is acting as an agent of the principal subject may consent to a search.<sup>276</sup> In *Stoner v. California*, police pursuing a lead on a robbery went to the hotel where the defendant was staying.<sup>277</sup> Because the defendant was not in, the police obtained access to the defendant's room from the night desk clerk employed by the hotel.<sup>278</sup> Upon entering the defendant's room, the police found evidence implicating him in the robbery.<sup>279</sup> The Supreme Court reversed Stoner's conviction, holding: "Our decisions make clear that the rights protected by the Fourth Amendment are not to be eroded by strained applications of the law of agency or by unrealistic doctrines of 'apparent authority.'"<sup>280</sup> The Court held that only the defendant himself, as a subject of the search, or an agent appointed by him, could waive the right to be free from unreasonable searches.<sup>281</sup> Because the defendant did not anticipate that type of intrusion simply by being a guest at the hotel, the Court held that there was no consent given, and that the search was invalid.<sup>282</sup>

Similarly, in searches involving covert video surveillance of Munchausen Syndrome by Proxy neither the mother nor the child gives consent to the search, and the hospital has no authority to waive the constitutional rights of the mother, who does not contemplate such a search merely by admitting her child to the hospital. Therefore, because neither subject of the search (the mother or the child) consents, and because hospital employees are not appointed

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274. See *Schneckloth v. Bustamonte*, 412 U.S. 218, 221 (1973).

275. See *id.*

276. See *Stoner v. California*, 376 U.S. 483, 488 (1964); see also *Illinois v. Rodriguez*, 497 U.S. 177, 182–89 (1990) (allowing police to enter a home where they reasonably believed a third party had authority to grant consent to a search); Tammy Campbell, Note, *Illinois v. Rodriguez: Should Apparent Authority Validate Third-Party Consent Searches?*, 63 U. COLO. L. REV. 481, 486 (1992).

277. See *Stoner*, 376 U.S. at 484–85.

278. See *id.* at 485.

279. See *id.* at 485–86.

280. *Id.* at 488.

281. See *id.* at 489.

282. See *id.*



as agents of the mother, the typical Munchausen search would not qualify under the consent exception to the warrant requirement.

*iii. The Private Party Exception to the Warrant Requirement*—The third exception to the Fourth Amendment warrant requirement is the “private party” exception.<sup>283</sup> The Fourth Amendment applies only to searches and seizures conducted by government officials or third parties acting on behalf of the government.<sup>284</sup> The only limitation is that any evidence discovered by a private party must be legally acquired by the government if it is to be valid.<sup>285</sup> Despite the limited scope of Fourth Amendment protection to cases involving searches by private parties, no precedent supports the proposition that private searches insulate subsequent government use of the evidence from Fourth Amendment scrutiny.<sup>286</sup> State- or federally-operated hospitals are considered government agencies.<sup>287</sup> In the event that hospital personnel are considered to be private parties, the validity of the search will depend on the purpose for which the search was conducted.

Generally, there are three reasons a hospital might videotape a mother suspected of Munchausen Syndrome by Proxy: (1) to conduct research; (2) to monitor the child’s physical condition; or (3) to pursue criminal prosecution. The first two reasons do not apply to covert surveillance of Munchausen Syndrome by Proxy cases because the video in those situations is not likely to be conducted covertly. In those situations, the parents would be informed of and, most likely, would consent to the surveillance, knowing that it was for the child’s benefit or for other medical purposes.

In *United States v. Black*,<sup>288</sup> the court held that medical personnel who initiated a search of an unconscious patient’s personal property and completed a physical exam revealing drugs, were considered private parties and were, therefore, exempted from the restrictions of the Fourth Amendment.<sup>289</sup> The court reasoned that the search was not conducted for the purpose of criminal prosecu-

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283. See *Burdeau v. McDowell*, 256 U.S. 465, 475 (1921).

284. See *United States v. Jacobsen*, 466 U.S. 109, 113–14 (1984) (quoting *Walter v. United States*, 447 U.S. 649, 662 (1980) (Blackmun, J., dissenting)).

285. See *Walter*, 447 U.S. at 656; *Coolidge v. New Hampshire*, 403 U.S. 443, 487–90 (1971).

286. See *Walter*, 447 U.S. at 660 n.2 (White, J., concurring).

287. See *Yorker*, *supra* note 17, at 343; see also 40 AM. JUR. 2D *Hospitals & Asylums* § 2 (1968). Hospitals created by the agreement of private individuals and managed by people selected by those private individuals are considered private corporations, even though they may be dedicated to public service under the terms of their charter and notwithstanding their receipt of state aid via tax exemptions or appropriations. See *id.*

288. No. 88-5266, 1988 WL 107375, at \*1 (6th Cir. Oct. 14, 1988).

289. See *id.* at \*1–\*3.

tion, but rather for the medical treatment of the subject, and, therefore, was not conducted with the interest of the government in mind.<sup>290</sup> Evidence obtained by private actors may be subject to the exclusionary rule if the government explicitly instigates the search, however.<sup>291</sup>

Typically, video surveillance in a Munchausen case is conducted covertly in order to pursue criminal prosecution of a parent already suspected of perpetrating harm on the child. In such cases, the police are usually contacted and are involved in the surveillance. This arrangement suggests that the hospital is not acting as a private party and is, therefore, subject to Fourth Amendment scrutiny and the warrant requirement.<sup>292</sup>

*d. Even If Required, a Search Warrant Is Not Necessary*—In cases where a warrant is required, because the subject has a reasonable expectation of privacy and there are no applicable exceptions to the warrant requirement, the government must show probable cause in order to obtain a warrant to conduct the search.<sup>293</sup> All Circuit Courts of Appeal have held that the standard of probable cause in surveillance cases is the same as that for traditional warrants.<sup>294</sup> The Supreme Court has held that probable cause exists when, given practical, common-sense consideration, the totality of the circumstances set forth a “fair probability that contraband or evidence of a crime will be found in a particular place.”<sup>295</sup> To satisfy

290. See *id.* at \*3.

291. See *United States v. Walther*, 652 F.2d 788, 793 (9th Cir. 1981) (holding that evidence obtained by a private actor may be excluded where the government encourages, directly or indirectly, the private citizen to engage in activity that the government is prohibited from pursuing); *State v. Cox*, 674 P.2d 1127, 1130 (N.M. Ct. App. 1983) (applying the Fourth Amendment to a search conducted through joint efforts between the police and private citizens). At least one court has placed the burden of proof upon the defendant to demonstrate that the government was involved in the private search. See *State v. Dold*, 722 P.2d 1353, 1356 (Wash. Ct. App. 1986).

292. Even in the rare case where a private hospital initiates covert video surveillance in a Munchausen case without police involvement and without intention of using the tape as evidence to prosecute the parent or to pursue an appropriate disposition for the child, but rather conducts the surveillance solely for the child’s medical treatment, I would argue that such surveillance is still medically unethical because it places the child at risk.

293. Cf. *Draper v. United States*, 358 U.S. 307, 310–11 (1959) (holding that the Fourth Amendment requires *all* searches to be based upon probable cause, even when a warrant is not required).

294. See *Gerstmann*, *supra* note 242, at 218–27 (citing circuit court cases and questioning whether the standard of probable cause for eavesdropping should be higher than that in traditional warrant applications).

295. *Illinois v. Gates*, 462 U.S. 213, 238 (1983). The Supreme Court did not specifically define the term “fair probability.” The Court stated instead that: “[S]tandards such as proof beyond a reasonable doubt or by a preponderance of the evidence, useful in formal trials, have no place in the magistrate’s decision.” *Id.* at 235. Accordingly, there is no formally-defined threshold to be met for probable cause.

that probable cause exists, the government must have more than a mere suspicion, but is not required to present evidence that would confirm guilt.<sup>296</sup> There need not be a *prima facie* showing of criminal activity, but there must be a probability that such evidence will be found.<sup>297</sup> In considering the totality of the circumstances, the court may consider several factors, including the reliability of the information, the basis of the knowledge, corroboration of facts, and the extent of the detail.<sup>298</sup>

Despite the inconclusive nature of Munchausen Syndrome by Proxy cases, more often than not there is likely to be sufficient medical evidence to satisfy the probable cause requirement based on the doctor's reasonable suspicions, the child's unsolvable medical history, and increasingly, the characteristics and dynamics of the family and its members that may indicate Munchausen Syndrome by Proxy.<sup>299</sup> If there is enough evidence to show probable cause that the child is at risk, then there should be enough evidence to remove the child temporarily from the unsupervised care of the suspected perpetrator until suspicions can be confirmed or withdrawn.<sup>300</sup> The standard for such a response is generally that such action is in the best interest of the child.<sup>301</sup>

Although the standard required to obtain a warrant may be lower than the standard required to remove a child from the custody of a parent, in the case of Munchausen Syndrome by Proxy, there is only a temporary infringement on the parent's right to

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296. See *Locke v. United States*, 11 U.S. 339, 348 (1813).

297. See *Gates*, 462 U.S. at 235 (quoting *Spinelli v. United States*, 393 U.S. 410, 419 (1969)).

298. See *United States v. Zayas-Diaz*, 95 F.3d 105, 111 (1st Cir. 1996).

299. Dr. Southall noticed common characteristics among children who had been suffocated, including bleeding from the nose or mouth, a sibling who died suddenly and unexpectedly, and hemorrhages of the face. See *Southall et al.*, *supra* note 19, at 745. Clearly, his study was useful in identifying characteristics and traits that may be used in assessing the risk in other suspected cases. Other characteristics common to the perpetrators, such as certain psychiatric and social history traits, are also identifiable, but more elusive. See *id.* Dr. Southall noted that further research is needed to assist in more effectively defining the personality disorders that are indicators of abuse. See *id.* One physician noted, after reviewing Dr. Southall's study, that there are two telling findings in the study that could help in the early diagnosis of apparent life threatening events, such as those occurring in Munchausen Syndrome by Proxy cases: (1) the presence of oral or nasal bleeding; and (2) a family history involving other sibling deaths. See *Krugman*, *supra* note 24, at 890.

300. See, e.g., *In re Jordan*, 616 N.E.2d 388, 390 (Ind. Ct. App. 1993) (upholding against a due process challenge in a Munchausen Syndrome by Proxy case a state's detention statute allowing removal of a child for up to 72 hours without a hearing based on probable cause to believe that the child was in need of services). Compare *id.* (holding that probable cause that child is in need of service is sufficient to remove child) with *Minnesota v. Olson*, 495 U.S. 91, 95 n.1 (holding that probable cause of exigent circumstances is necessary to obtain warrant under Fourth Amendment).

301. See *infra* note 303.

provide unsupervised care for the child while in the hospital. Given that there is enough evidence to show a strong suspicion that the child is otherwise at risk, it is arguably sufficient that the child be supervised until the medical team can determine whether the child's condition improves once the alleged perpetrator is no longer providing unsupervised care, rather than to subject the child to the suspected harm. Thus, there is no need for a warrant (nor video surveillance) because there is sufficient evidence to restrict the parent's unsupervised care of the child. In fact, in some cases of suspected Munchausen Syndrome by Proxy, courts have restricted the parent's supervision of the child before the alleged perpetrator has been found guilty.<sup>302</sup> Typically, the standard required in applying a restriction on visitation, such as supervision, is simply that it be in the "best interest" of the child.<sup>303</sup> To modify the parent's custody of the child, however, the higher standard of clear and convincing evidence must be shown.<sup>304</sup> Thus, in considering the options, the court may choose between covertly surveilling the child with the parent, in which case the child is at risk, or temporarily separating the child from the parent's sole supervision, in which case the child is assured protection. If a court is willing to accept probable cause as the standard to conduct surveillance when a child is at risk, then it should also be willing to separate the

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302. See, e.g., *supra* note 19 (describing the case of Cynthia Lyda).

303. See *Acklin v. Acklin*, 690 So. 2d 869, 871 (La. Ct. App. 1997) ("A modification of visitation rights is not so substantial as a change in actual physical custody. . . . As such, a showing [of] . . . the best interest of a child is sufficient.") (citations omitted); *Lancaster v. Brenneis*, 417 N.W.2d 767, 768 (Neb. 1988) (stating that questions concerning visitation of a child are resolved by considering the best interest of the child); *Alfano v. Alfano*, 542 N.Y.S.2d 313, 314 (App. Div. 1989) (stating that the determining factor in imposing supervised visitation is the best interest of the child); *In re W.S.*, 939 P.2d 196, 199 (Utah Ct. App. 1997) (stating that the legal standard governing visitation orders is the best interest of the child); *Peterson v. Peterson*, 818 P.2d 1305, 1308 (Utah. Ct. App. 1991) (stating that the standard governing visitation orders is the best interest of the child); *Mary Ann P. v. William R.P.*, 475 S.E.2d 1, 10 (W. Va. 1996) (holding that supervised visitation should be ordered when necessary to protect the best interests of the child); cf. *McKay v. Johnson*, No. C6-95-1626, 1996 WL 12658, at \*4 (Minn. Ct. App. Jan. 16, 1996) (holding that court shall modify visitation when in the best interest of the child and that court shall restrict visitation when visitation is likely to endanger child's physical or emotional health or impair child's emotional development). *But see Heldebrandt v. Heldebrandt*, 623 N.E.2d 780, 785 (Ill. App. Ct. 1993) (holding that trial court's use of best interest standard rather than serious endangerment standard in a motion to restrict visitation of a parent was reversible error); Margaret Tortorella, Note, *When Supervised Visitation Is in the Best Interests of the Child*, 30 FAM. L.Q. 199, 202 (1996) (discussing modification of traditional best interest standard to endangerment standard to curtail visitation).

304. See *Santosky v. Kramer*, 455 U.S. 745, 768 (1982). The termination of a parent's custody of a child is more intrusive than an adjudication of abuse or neglect or than subjecting a parent to supervision in raising his or her children. See *In re Colin R.*, 493 A.2d 1083, 1089 (Md. Ct. Spec. App. 1985).

child from the parent, under the same probable cause standard, so that the child is not at risk. This analysis obviates the need for covert video surveillance and avoids unnecessary risk to the child.

*C. The Practical and Ethical Issues in the  
Use of Covert Video Surveillance*

Application of the Fourth Amendment to the issue of covert video surveillance illustrates a few scenarios where the use of covert video surveillance to detect Munchausen Syndrome by Proxy may be legally validated—when the surveillance is not considered a search, when the surveillance is considered a search but qualifies as a valid exception to the requirement for a search warrant, and when a warrant is required and granted based on a finding of probable cause.<sup>305</sup> In each scenario, however, covert video surveillance should not be employed because, even if legally justified, it is either ethically intolerable or simply illogical. In cases where the surveillance is not considered a search, it is still unethical for a doctor or hospital staff to take any action that would magnify the risks to the children. Where the search qualifies as an exception to the need for a warrant, such as where no government interest is involved, the surveillance still poses a risk to the child and should not be promoted or accepted. In other scenarios, such as when a warrant may be obtained or when exigent circumstances preempt the need for a warrant, if there is enough evidence to obtain a warrant or to preempt the requirement for a warrant, then logically, there should be enough evidence to temporarily restrict the parent's access to the child until a diagnosis of Munchausen Syndrome by Proxy may be confirmed or ruled out.<sup>306</sup> There are additional practical and ethical concerns, however, that relate to the covert video surveillance process.

1. *The Practical Issues*—Even some experts who have testified in covert video surveillance cases have recognized inherent problems in its use.<sup>307</sup> The very mode by which the subjects are maneuvered into observation is questionable. Arguably, it is the covert nature of

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305. See *supra* notes 231–304 and accompanying text.

306. Terry Thomas notes: “If sufficiently strong evidence exists to justify the use of CVS [covert video surveillance] it might be argued that it also exists to tip the balance in favour of action without recourse to CVS.” Thomas, *supra* note 22, at 22.

307. See, e.g., Morley, *supra* note 22, at 1603 (arguing that covert video surveillance violates the liberty interests of the parent and child and should be used only as a last resort for diagnosing the child's condition).

the surveillance that leads to a successful outcome.<sup>308</sup> Therefore, before the commencement of surveillance, a bias toward suspicion of the alleged perpetrator must already exist; otherwise the surveillance would not be used.<sup>309</sup> While this bias does not invalidate the use of video surveillance per se, it warrants comment. As a tactical matter, it is worth noting that a subject of video surveillance is not randomly assigned to a hospital room equipped with video cameras that are then used by the hospital to capture abuse on video tape serendipitously. Dr. Southall's study is a case in point.<sup>310</sup> The

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308. See, e.g., Byard & Burnell, *supra* note 22, at 352 (suggesting that employing alternative techniques in their study, such as videotaping only after informed consent, would have placed the infant at risk of serious morbidity or death).

309. In the study conducted by Dr. Southall, almost all of the subjects were referred from other hospitals and had already been suspected of experiencing or perpetrating life threatening events. See Southall et al., *supra* note 19, at 736. Dr. Southall admits that there was "certainly a bias toward referrals," and that the figures in his study "cannot provide a true epidemiologic indication of the frequency of intentional suffocation as a mechanism for ALTE [apparent life threatening events]." *Id.* Some commentators, concerned over the use of covert video surveillance, note that there are no accurate studies wherein the subjects were observed, free of any history or previous bias, and that the studies therefore lack any objective statistical validity. See Morley, *supra* note 22, at 1604.

310. See David P. Southall & Martin P. Samuels, *Guidelines for the Multi-Agency Management of Patients Suspected or at Risk of Suffering from Life-Threatening Abuse Resulting in Cyanotic-Apnoeic Episodes*, 22 J. MED. ETHICS 16 (1996) (describing the protocols used in Dr. Southall's study) [hereinafter Southall & Samuels, *Guidelines*]. Interestingly, although the guidelines offer suggestions on the optimal application of covert video surveillance *when* it is employed, the guidelines offer no criteria to determine *if* covert video surveillance should be employed. With regard to its use, the Guidelines provide:

5.2 CVS should begin preferably early in the week and not at weekends. This allows the maximum number of working days to be available when adequate senior medical staff and ward staff are on duty.

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5.4 Child and parent must not move into the surveillance cubicle until all preparations required for CVS are completed.

5.5 Cameras must be positioned to allow observation of child at all times, but must not be invasive of the parents' privacy when he, she, or they are not handling the child or equipment. To ensure adequate observation and safety of the child, attention must be paid to:

- (a) adequate lighting of the cubicle . . .
- (b) the sound levels . . .
- (c) adequate communication systems between the observers of the video surveillance and ward staff . . .
- (d) access to the cubicle . . .
- (e) functioning of equipment.

referred patients were specifically placed in a cubicle already equipped for video surveillance.<sup>311</sup> Some feel that this scenario is artificially conditioned because the parent must stay with the child in a cubicle all day and is told that the staff is looking for “acute life threatening events,” which may sound alarms, but which the nurses may not hear.<sup>312</sup> Consequently, the parent feels the child’s life is at stake and must remain with the child in case such an event were to take place. This produces a stressful environment and may lead to behavior that is not otherwise demonstrated by the parent in a less stressful, more natural setting.<sup>313</sup> One might conclude that “[c]overt video recordings of the parent’s behaviour are unlikely to represent how he or she behaves at other times” and “do[] not ‘provide certainty over the diagnosis.’”<sup>314</sup>

Once surveillance is arranged, a primary concern is that the behavior of the parent is open to various interpretations. Generally, when an observed parent demonstrates suspicious behavior that observers believe could lead to an assault or harm to the child, the observers wait for a short period of time—usually twenty-five seconds, but sometimes for as long as one minute<sup>315</sup>—to confirm their

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5.8 To provide continuous video surveillance, there will be two nursing staff . . . on duty at any one time who must undergo prior training. . . . In some instances it would be appropriate for medical staff to be present to aid interpretation of the parent/child interaction.

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5.10 During CVS, two videotapes will be used simultaneously. . . . At the conclusion of recording, videotapes and logs will be stored by . . . police, and available to social services. . . . If no proceedings are being considered, then the tapes and log sheets will form part of the medical record and will be retained by the [hospital].

5.11 Following an observed incident, police and a child protection social worker will be asked to attend. They will be responsible for proceeding with the investigation, including any discussion with the alleged perpetrator and for providing immediate protection for the child. The nurse in charge of the ward will ensure the cubicle is secured until advised by the police.

*Id.* ¶¶ 5.2–5.11, at 18–19.

311. *See id.* ¶ 5.4, at 19.

312. Morley, *supra* note 22, at 1604.

313. *See id.*

314. *Id.*

315. As noted above, in one case of covert video surveillance, the parent suffocated the child on three separate occasions within a two-hour period; two of the occasions lasted for almost one minute. *See PrimeTime Live, supra* note 3. Even in Dr. Southall’s study, the descriptions of the observations made during covert video surveillance tell of numerous, continuous, and often uninterrupted, occasions of inappropriate and obviously painful behavior perpetrated on the child. *See Southall et al., supra* note 19, at 755–56.

suspicious and to be certain that the video has captured sufficient evidence to protect the child in the future or to prosecute the parent. However, any discrepancy in interpretation could easily lead to harm to the child<sup>316</sup> or to false accusations against a grieving, caring

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316. For example, as noted above, one of the children in Dr. Southall's study suffered a broken arm during the video surveillance. See Southall et al., *supra* note 19, at 737, 755–56, 757; see also H. Klonnin et al., *Non-Accidental Fracture Occurring in Hospital*, 74 ARCHIVES OF DISEASE IN CHILDHOOD 89 (1996) (letter to the editor) (describing the same case). The log of the child's case indicates that video surveillance began at 12:44 PM. See Southall et al., *supra* note 19, at 755. At 2:02 PM, the mother slapped the child on the head and repeated this behavior at 2:03 and 2:09 PM, without interruption. See *id.* At 2:53 PM, the mother tore up the nursing record and threw it out the window of the hospital. See *id.* Five minutes later, the visibly angry mother began swearing at the child, accusing the child of being the reason why she had to remain in the hospital, and then began ordering the child to kiss her. See *id.* at 755–56. Less than three minutes later, the mother was observed roughly patting the child's face 14 times, forcibly pressing her hand against the child's face in an unusual manner, and shaking the child like a doll. See *id.* at 756. No hospital personnel interrupted the mother at this point. At 3:02 PM, the mother deliberately and forcefully bent the child's elbow backwards beyond 180 degrees. See *id.* The child began screaming in pain and the mother pressed the alarm for the nurse. See *id.* When the nurse arrived, the mother explained that the child caught her arm in a toy. See *id.* A doctor examined the child and was unsure whether there was a fracture of the child's arm. See *id.* Unbelievably, the mother was again left alone with the child and within thirty seconds again bent the child's arm backwards and broke the child's arm. See *id.*

Commenting on this incident, Dr. Southall writes:

The log of case 24 illustrates the dilemma for observers faced with abusive behavior that did eventually result in an injury to the infant. During observation of the events leading to the injury, we had decided to intervene only if the mother's behavior was considered sufficiently violent to produce or be about to produce an injury. Without seeing the videorecordings for the logs, it is difficult for the reader to know precisely the degree of violence that accompanied, for example, a slap to the infant's head or an episode of shaking. We might be criticized for risking a serious injury such as a subdural hemorrhage and, in retrospect, we might have avoided the incident in which the child's arm was fractured. We acknowledge that the risk of an unexpected violent act is a potential problem during CVS and that more discussion and experience are needed to minimize the risk of such adverse outcomes.

*Id.* at 754.

In another case in Dr. Southall's study, the log of the surveillance, taken over a period of six days, describes continuous and uninterrupted abusive behavior by the child's father while the child is in the hospital:

Day 1

Time, 22:51 PM: the father said to the infant, "I will bounce you off the canteen roof."

22:52 PM: the father said to the infant that when the infant became older he "will beat, whip, remove fingernails, and amputate his limbs."

Day 2

Time, 14:03 PM: the father deliberately wakes him up.



parent.<sup>317</sup> Also problematic is that any accusation of abusive or inappropriate behavior will be denied by the innocent parent.

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14:11 PM: the father wakes him by tweaking ear.

14:13 PM: repeated.

14:15 PM: repeated.

14:17 PM: repeated.

14:19 PM: the father flicks his eyelids while asleep.

14:22 PM: the father obstructs his nasal orifices for 20 seconds before a nurse enters.

21:38 PM: the father wakes him from sleep.

21:38 PM: the father pinches his hand to wake him again.

21:39 PM: the father fingers around his nose; the infant awakes.

21:41 PM: the father places his hand over the mouth; the infant struggles for 25 seconds. The father hears a noise outside and stops.

#### Day 3

Time, 21:51 PM: the father puts his finger into the infant's throat.

21:53 PM: as above; the infant gags and cries, and the mother appears.

22:29 PM: the father pinches his hands. Infant wakes from sleep, cries, and then sobs. The father tells the mother who comes in that the infant had "just woke up crying."

#### Day 6

Time 21:16 PM: the father digs his nail into the infant's palm repeatedly. The infant cries.

21:20 PM: the father pinches his left hand.

21:38 PM: the infant is asleep. The father shouts "wakey, wakey," and the infant wakes up.

21:38 PM: the father pinches his hand.

21:39 PM: the father fingers around the infant's nose; the infant cries.

21:41 PM: the father suffocates the infant by placing his right hand over the nose and mouth and forcing the back of the infant's head into his left hand. The infant struggles for 25 seconds before a noise outside the room causes the father to remove his hand. The infant takes a gasp of air and starts crying.

*Id.* at 755.

317. Colin Morley, who has testified as an expert witness in seven cases in which covert video surveillance has been used, comments on the difficulty of interpreting the behavior

Although a sincere and truthful denial, it will be construed as a "typical" response by one who suffers from Munchausen Syndrome by Proxy.<sup>318</sup> Thus, not only may appropriate behavior of an innocent parent be misinterpreted as abusive, but an appropriate response by an innocent parent to a false accusation may be further misinterpreted as indicative of guilt. Thus, there are practical concerns inherent in the use of covert video surveillance that may

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that is being observed: "Actions that appeared to me to be innocent were interpreted as attempts to harm the child: a mother cuddling a fussing child into her breast; playing with the child by putting a hand over his face; brushing the teeth of an irritable child; or smacking a fractious child." Morley, *supra* note 22, at 1603. Even in the case of Cynthia Lyda, *see supra* note 19, one neonatologist testified that, based on her observation of the video, which showed Lyda blowing forcefully into her son's feeding tube, the mother appeared to be acting appropriately. *See* Melissa Prentice, *Doctor Finds Mom's Actions OK*, SAN ANTONIO EXPRESS-NEWS, May 6, 1998, at 1B, available in 1998 WL 5090804 (discussing Dr. Alice Gong's statement that it might have been appropriate to blow through the tube if the child's feeding tube were blocked); *see also* Melissa Prentice, *Doctors Debate Munchausen's Findings*, SAN ANTONIO EXPRESS-NEWS, May 7, 1998, at 1B, available in 1998 WL 5091007 (discussing Dr. John Jeffrey's opinion that, while Lyda may suffer from poor judgment, she does not suffer from Munchausen Syndrome by Proxy, and that she was only acting "in what she considered her son's best interest"). Jeffrey has reviewed twelve similar cases and has agreed with only two diagnoses of Munchausen Syndrome by Proxy. *See id.*

The result of a discrepancy in interpreting the behavior on covert video is clearly demonstrated in a West Virginia case involving 18-year-old Tabithy Thaxton. In Thaxton's case, a hospital video surveillance tape was used to try to prove that Thaxton attempted to suffocate her four-month-old son Sebastian. *See* Maryclaire Dale, *Mother Raised Suspicions*, CHARLESTON DAILY MAIL (W. Va.), Nov. 20, 1997, at 1A, available in 1997 WL 7133734. The mother of two was initially placed under surveillance because she frequently brought her child to the hospital for respiratory problems and pneumonia, which is a red flag for cases of Munchausen Syndrome by Proxy. *See* Brad McElhinny, *Teen Mom Was Under Stress*, CHARLESTON DAILY MAIL (W. Va.), Nov. 19, 1997, at 1A, available in 1997 WL 7133417; Dale, *supra*. The police who observed the tape alleged in their complaint that Thaxton turned off the child's heart monitor and squeezed the child against her chest in an effort to suffocate the child. *See* McElhinny, *supra*. The complaint further alleged that the child cried and struggled for air as the mother eyed the door to see if anyone was coming. *See id.* Thaxton was arrested and charged with attempted murder after police observed the tape; she was jailed for five days and her children were placed in the custody of the state. *See* Kay Michael, *Tale of Tape Ends with Teen's Release: Attempted Murder Charge Against Ripley High School Senior Dropped*, CHARLESTON DAILY MAIL (W. Va.), Nov. 22, 1997, at 1A, available in 1997 WL 7134226. However, charges were dropped when prosecutors determined, after reviewing the hospital tape, that there was insufficient evidence to prove that Thaxton made such an attempt. *See id.* Prosecutors reviewed the tape and determined that Thaxton was merely "holding and rocking her crying child, then carrying him around the hospital room in an apparent attempt to calm him." Michael, *supra*.

As noted by District Judge David Peebles, who presided over the Lyda case, *see supra* note 19, another problem associated with video surveillance is that, where the public has the opportunity to view the video (as was true in the Lyda case), "[t]he judiciary as an institution can lose its credibility when the public sees one thing on TV and comes to a conclusion that is completely contradictory to what a judge [who hears the medical facts] decides." Prentice, *Visits by Mom Allowed*, *supra* note 19.

318. *See* Morley, *supra* note 22, at 1603 (noting that it is difficult for the accused parent to defend himself or herself because denials are typical of Munchausen Syndrome by Proxy).

tarnish the effectiveness of the technique in confirming an accurate diagnosis and in protecting the child.

2. *The Ethical Issues*—In responding to some of the medical and practical problems associated with the use of covert video surveillance, supporters of the tactic are also confronted with ethical concerns.<sup>319</sup> For example, one of the practical problems with covert video surveillance is that there are no objective, neutral studies, which use subjects without regard to case histories to validate the statistics regarding the effectiveness of the method.<sup>320</sup> Should such studies be conducted? One might argue that it would be unethical and unlawful to conduct video surveillance in cases where there is no suspicion of parental misconduct. While this may be legally accurate, it is inconsistent to assert that it is unethical to perform covert video surveillance on parents who are not harming their children, but ethical to perform such surveillance on other parents who, although suspected of harming their children, may not be doing so. If covert video surveillance is unethical in one instance, it is unethical per se—suspicions do not obviate ethics. As a legal matter, however, suspicions may obviate the need for video surveillance and, when supported by enough circumstantial evidence, may obviate the right of alleged perpetrators to supervise their children without restrictions.

One of the unethical elements in the employment of covert video surveillance is the concept of a doctor deceiving a parent—presumably an innocent parent—into believing that his or her child may be experiencing a serious medical condition or life-threatening event, when the doctor in fact suspects that the child is either perfectly well or, at most (if the parent is innocent), that the child is experiencing an unexplainable condition.<sup>321</sup> In response to this concern, commentators who favor surveillance argue that innocent parents worry anyway, and that such grave statements about the child's health are not really misleading or violative of a parent's rights, since the child may actually be experiencing the serious problem of Munchausen Syndrome by Proxy.<sup>322</sup> But however much the doctor's statements wind up being accurate, and however laudable the doctors' intentions, the ends simply do not justify the means. Doctors should not lie to patients, or parents of patients,

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319. See Basil J. Zitelli et al., *In Reply*, 142 AM. J. DISEASES CHILDREN 918, 918 (1988) (replying to Frost et al., *supra* note 22, at 917) (arguing that, although covert video surveillance may be legal, it raises ethical concerns).

320. See Morley, *supra* note 22, at 1604.

321. See *id.*

322. See Shabde & Craft, *supra* note 22, at 1605.

for the sake of diagnosis, particularly when doing so places the child at substantial risk.

Indeed, the most significant unethical factor inherent in the use of covert video surveillance is the potential harm to the child. This factor overshadows even the few scenarios where the use of such surveillance is not legally invalidated. Advocates of covert video surveillance justify the risk of harm to the child by relying on the principle of “double effect”—that is, the act of surveillance is viewed as acceptable because its objective is good and because that objective may be achieved by the act of surveillance, albeit with incidental and unavoidable harm.<sup>323</sup> However, supporters of video surveillance mistakenly view the harm involved primarily as the invasion of the parents’ privacy; they acknowledge the risk of harm to the child only as a secondary issue.<sup>324</sup> Perhaps because the sadistic nature of Munchausen Syndrome by Proxy is so underestimated or inconceivable, the magnitude of the potential harm to the child in conducting the surveillance is not fully appreciated. The concept becomes clearer when applied to sexual abuse or some other form of “sadistic” abuse, such as burning with cigarettes. Would any doctor not question the ethics of placing a child alone in a private room with one who is suspected of sexually abusing the child and then, upon the perpetration of the sexual abuse, simply observing for fifty, thirty, even ten seconds for the sake of confirming suspicions? If it takes thirty seconds of suffocation or fifteen slaps on the head to warrant intervention in the surveillance of Munchausen Syndrome by Proxy cases, how many cigarette burns would have to be observed before a doctor intervened to protect the child—regardless of the criminal outcome for the perpetrator? Would *any* doctor justify his or her ethics in support of surveillance of *these* types of abuse? Why, then, is it justified for suffocation or the injection of foreign matter? Indeed, the fact that doctors would *not* justify the use of surveillance with these other forms of abuse makes the surveillance inherently unethical.

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323. See *id.* at 1605; see also Shinebourne, *supra* note 22, at 27 (arguing that surveillance avoids the harm of separating the child from the parent on inadequate information, but ignoring the harm to the child inherent in conducting the surveillance).

324. The primary focus on harm to the parent rather than harm to the child during surveillance is evidenced by the argument that covert surveillance is ethical when the video camera is focused only on the child’s bed, but unethical when the camera brings into view the entire cubicle, so that the parent could be observed while away from the immediate presence of the child. See, e.g., Frost, *supra* note 22, at 917. If the primary concern were the harm to the child, then narrowing the physical scope of the camera to just the child’s bed would not take the surveillance outside the realm of being unethical, since the risk of harm to the child is the same, regardless of where the camera is focused.

In justifying the use of surveillance in the face of the harm of which the child is at risk, some commentators refer to the potential harm only in the context of situations in which the surveillance was of an innocent parent.<sup>325</sup> In that scenario, Shinebourne observes that “[c]overt video surveillance (CVS) did not result in harm to the child, and most importantly did not result in removal of the child from an innocent parent.”<sup>326</sup> In these rare situations, however, that conclusion is obvious because the parent is innocent. Shinebourne makes no mention of the more common scenarios, however, where the parent is not innocent and the child struggles for life as the parent suffocates the child for thirty seconds at a time and makes no mention of the fact that, in the former scenario, the privacy rights of an innocent parent were violated.<sup>327</sup> Illogically, Shinebourne comments: “I can think of nothing more cruel and harmful for the child and the mother . . . [than] taking the child away from the parents on inadequate evidence.”<sup>328</sup> Shinebourne simply ignores the harmful effect of covert video surveillance on the child, stating: “Covert video surveillance (CVS) is a diagnostic activity that causes no harm to the child. . . .”<sup>329</sup> Given the statistical likelihood of confirmed suspicions over false accusations,<sup>330</sup> and the

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325. See, e.g., Shinebourne, *supra* note 22, at 27.

326. *Id.*

327. See generally Shinebourne, *supra* note 22. One mother accused of perpetrating Munchausen Syndrome by Proxy who was subjected to covert video surveillance in the hospital writes:

During the three weeks of secret observation my baby was kept in a cubicle for the whole time and not allowed out even for an hour; was kept connected to a physiological monitor for the whole of this time and not allowed out of her cot even for meals; and was not allowed to sit in a high chair for feeding—I had to feed her through the bars. I was not allowed to bath her during this time, and, even though she was walking when she went in the hospital, by the time she came out she could not walk. During this period of secret observation I was not offered any respite by the staff and was not offered food. I had to ask a nurse to sit with my daughter so that I could get food. I had no food at all one day because the nurses were too busy to relieve me.

Being filmed in this way infringed my human rights and my rights as a mother.

Gwyneth Tenney, *Covert Surveillance in Munchausen’s Syndrome by Proxy: An Infringement of Human Rights*, 308 BRIT. MED. J. 1100, 1100–01 (1994) (letter to the editor). For a commentary denying the allegations raised by Ms. Tenney, see Samuels & Southall, *Covert Surveillance: Welfare of the Child Must Come First*, *supra* note 22, at 1101–02 (letter to the editor) (asserting that the logs for the subject case contradict the allegations raised by the mother).

328. Shinebourne, *supra* note 22, at 27.

329. *Id.* at 28.

330. For example, in the study by Dr. Southall, suspicion of abuse was confirmed in 33 of the 39 cases studied. See Southall et al., *supra* note 19, at 735. Thus, removal of the child without placing the child at further risk by conducting video surveillance would have been appropriate in those cases.

more significant risk of harm to the child during covert video surveillance, compared to the effect of temporary separation from the sole presence of a parent (which, in most situations where a parent is guilty, has a protective effect), it is simply illogical to use covert video surveillance before temporary restrictions on supervision.

To other commentators, the ethical debate over the use of covert video surveillance to detect or confirm Munchausen Syndrome by Proxy entails two separate moral issues: (1) whether the surveillance should be regarded as research and, therefore, require assessment by a Research Ethics Committees (REC) before implementation, and (2) whether the surveillance is morally justified in certain sorts of extreme cases.<sup>331</sup> Some argue that the surveillance tactics described in this Article, like those employed by Dr. David Southall, should be considered “research” and therefore, should, be reviewed and approved by an ethics committee.<sup>332</sup> Others, including Dr. Southall himself, argue that in extreme cases, surveillance is an established method of clinical practice that is appropriate for some, but not all, cases of Munchausen Syndrome by Proxy and, therefore is, morally justified.<sup>333</sup>

Regardless of the level of the ethical debate—whether it is simply a question of research and protocol, or whether it rises to the level of moral justification—broader considerations are present at both

331. See Gillon, *supra* note 22, at 131–32 (suggesting that covert surveillance should be used only when there is no other available alternative that will better protect the child, and when the surveillance has been considered by an ethics committee and approved on an individual basis by a judge).

332. See, e.g., Evans, *supra* note 16, at 12 (contending that using covert video surveillance to detect Munchausen Syndrome by Proxy entails considerable research and that, therefore, its use should be reviewed by an ethics committee before implementation); see also Evans, *Covert Video Surveillance*, *supra* note 22, at 341–42 (1994) (characterizing surveillance as research rather than as clinical practice because no treatment is provided for the child).

333. See, e.g., David Southall & Martin P. Samuels, *Some Ethical Issues Surrounding Covert Video Surveillance—A Response*, 21 J. MED. ETHICS 104, 105 (1995) (responding to Dr. Evans’ criticism by arguing that the protocol employed by Dr. Southall was morally justified because no other protocol would be successful in such extreme cases). Although Dr. Southall’s argument that his protocol is morally justified involves a distinct ethical question from the question of whether or not the protocol is considered research and warrants review by an ethics committee, Dr. Southall additionally responds that his protocol was submitted to a Research Ethics Committee, which agreed that it was *not* research but suggested that it should be reviewed by an individual hospital ethics committee. See *id.* For a counter-response from Dr. Evans, see Donald Evans, *Covert Video Surveillance—A Response to Professor Southall and Dr. Samuels*, 22 J. MED. ETHICS 29, 29 (1996) (suggesting that the doctors’ response did not address the concerns raised in the initial criticism—that there was a research interest in the use of surveillance). For a second response by Southall and Samuels, see David P. Southall & Martin P. Samuels, *Reply to Dr. Evans Re Covert Video Surveillance*, 22 J. MED. ETHICS 32, 32 (1996) (arguing that, despite the harm faced by the child during the surveillance—which they claim is caused by the parent, not by the surveillance—surveillance is necessary because of the high standard of proof necessary for the courts).

levels. For example, it is the “moral tradition of medicine . . . to trust the patient and in any case not to impose treatment or any other medical intervention in the absence of consent, whether explicit, implicit or given by an acceptable proxy.”<sup>334</sup> There is no consent in covert video surveillance. Instead, medical professionals are deliberately deceiving parents, deliberately invading their privacy interests,<sup>335</sup> and deliberately producing the environment where the abuse of a child is likely, or at least, suspected, to occur. Advocates of surveillance assert that “[w]hen there is sound evidence that the parent is acting *against* the interests of the child, and endangering the child, the customary right of the parent to make decisions on behalf of the child may be forfeited.”<sup>336</sup> There are inconsistencies in this response, however. First, if the evidence showing that the parent is acting against the best interest of the child and endangering the child is so sound, then covert surveillance should be unnecessary. Instead, based on the sound evidence that the child is being abused, the medical staff should be able to diagnose abuse by separating the parent and child and assessing the child’s progress. Although this process may be more time consuming, it is less deceptive, less dangerous, and certainly less harmful to the child. However, the practicality of employing this more cautious protocol will largely depend on the cooperation of the legal field.

Just as advocates of covert video surveillance acknowledge the ethical dilemma of the surveillance and the perspective of those who assert that it is “troublesome” to allow such abuse to occur or to put a child through such painfully horrific episodes, opponents of covert video surveillance may also acknowledge the attractiveness of any means of intervention that so successfully uncovers proof of the occurrences. After all, Dr. Southall’s study suggests that the abuse perpetrated in the hospital on some children was “frequent[], if not almost continuous[].”<sup>337</sup> Dr. Southall justifies the use of surveillance by asserting that the abuse would have occurred anyway: “That it was detected in the caring and child-centered environment of a hospital raises the possibility that even more severe abuse may have been inflicted at home.”<sup>338</sup> Even if this is true, it cannot justify the infliction of abuse of such a “sadistic nature.”<sup>339</sup> Indeed, Dr. Southall likens Munchausen abuses to abuses resulting

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334. Gillon, *supra* note 22, at 132.

335. *See id.*

336. *Id.*

337. Southall et al., *supra* note 19, at 739.

338. *Id.*

339. *Id.* Dr. Southall himself uses this phrase to describe the abuse that occurs. *See id.*

in "brutal injuries, such as cigarette burns or multiple fractures."<sup>340</sup> Dr. Southall states: "It is difficult . . . to accept that placing a burning cigarette on a child's body could represent a legitimate form of punishment or an impulsive act of anger."<sup>341</sup> Is it any less difficult to accept, or even imagine, that placing a burning cigarette on a child's body could represent a legitimate form of medical research?<sup>342</sup>

Rather, in Munchausen cases doctors should focus on protecting the child without the risk of harm inherent in the surveillance. Advocates of surveillance contend, however, that any evidence outside the scope of covert video surveillance is circumstantial evidence and is, in most cases, insufficient to assure protection of the child and prosecution of the perpetrator.<sup>343</sup> However, now that Munchausen Syndrome by Proxy is becoming more familiar to the professions, and now that the common dynamics of the Syndrome are becoming more determinative in identifying and diagnosing the disease, both courts and some medical professionals are beginning to view the Syndrome from a different perspective when balancing the interests involved, especially as the necessity of resorting to video surveillance becomes more questionable.<sup>344</sup>

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340. *Id.* at 740.

341. *Id.*

342. In no other type of child abuse—for example, burning with cigarettes—would it be ethical for a medical staff to arrange for the perpetrator to burn the child with cigarettes in an effort to prove that the abuse caused the child's condition. Donald and Jureidini state: "[C]onfirmation [of abuse] is by physical examination [of the victim]. . . ." Donald & Jureidini, *supra* note 16, at 753–54. Likewise, Colin Morley notes: "'If you suspected a man of sexually abusing a child you would not put him in a room alone with the girl and see what happened. Some of these children could have been protected earlier.'" Mark Henderson, *Multiple Cot Deaths May Be Result of Abuse*, *TIMES* (London), Oct. 27, 1997, at 4 (quoting Colin Morley, consultant pediatrician at Addenbrooke's Hospital in Cambridge, regarding the study by Dr. Southall).

343. See, e.g., Byard & Burnell, *supra* note 22, at 356 ("[C]ircumstantial evidence may not carry as much weight as a videotape of the event in legal proceedings."); Epstein et al., *supra* note 22, at 223 (fearing circumstantial evidence is insufficient to obtain solid documentation of the acts).

344. Even advocates of surveillance acknowledge that the decision to employ covert video surveillance is made only when the diagnosis is already fairly certain. See Epstein et al., *supra* note 22, at 223. Many others support the argument made in this Article that if there is enough evidence to use covert video surveillance, then there is enough evidence to use other, less risky methods to confirm the diagnosis. See, e.g., Morgan, *supra* note 22, at 1374 (acknowledging that in many cases there is already enough presumptive evidence of abusive behavior by the parent that using covert video surveillance to justify the child being placed under supervision "smacks of vindictiveness"); Thomas, *supra* note 22, at 23 (noting that if there is sufficiently strong evidence to justify covert video surveillance, it is arguable that the same evidence would justify taking action without recourse to covert video surveillance). At least one recent study empirically supports the argument that the child can be adequately protected by separating the child from the perpetrator, without relying on covert video surveillance. See P. Davis et al., *Procedures, Placement, and Risks of Further Abuse After Munchausen*



*D. Balancing the Interests*

Covertly videotaping suspected perpetrators of Munchausen Syndrome by Proxy clearly affects three interests: (1) the privacy interest of the alleged perpetrator; (2) the interest of the government in obtaining reliable, convincing evidence of abuse for criminal prosecution and/or an appropriate disposition for the child; and (3) the interest in protecting the welfare and safety of the child. This Article has demonstrated that, within the scope of the Fourth Amendment, the alleged perpetrator generally will have a reasonable expectation of privacy in the hospital surveillance setting, such that the surveillance constitutes a search that requires a warrant based on probable cause.<sup>345</sup> Arguably, however, the warrant and the search (the surveillance) are unnecessary because there is an alternative means of protection available that carries much less risk of harm to the child and is not completely adverse to the interests of the parent (assuming the parent is the alleged perpetrator). Restricting the parent's supervision of the child by requiring temporary supervision of their interactions allows the parent to continue to "parent" the child, care for the child, make decisions for the child, and be in the presence of the child. The showing necessary to place such restrictions on the parent, a showing that such a restriction is in the best interest of the child, is no lower a standard for the government than that necessary to procure a warrant based on probable cause to conduct the surveillance. Thus, in cases where a court would otherwise authorize the employment of potentially harmful covert video surveillance to confirm suspicions of child abuse, it should instead order temporary removal from the unsupervised care of the parent to see if the child's condition improves. This should confirm either some perpetration of factitious or abusive behavior by the parent, or some continuing, undefined medical complication in the child. By ordering supervision for the parent, the court assures the best interest of the child and avoids the potential for further harm to the child by the parent in the hospital.

This balancing of interests between the State's need to obtain evidence for criminal prosecution, the parent's interest in privacy, and the State's need to protect the safety and welfare of the child is a vital part of deciding whether to allow covert video surveillance to

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*Syndrome by Proxy, Non-Accidental Poisoning, and Non-Accidental Suffocation*, 78 ARCHIVES OF DISEASE IN CHILDHOOD 217, 221 (1998) ("Without covert video surveillance a high proportion of suffocation victims were protected effectively.").

345. See *supra* Part II.B.

confirm suspicions of Munchausen Syndrome by Proxy. The United States Supreme Court's reasoning in balancing the welfare of the child against other constitutional interests suggests how other courts might rule when considering similar interests within the context of a Munchausen Syndrome by Proxy case. In *Maryland v. Craig*,<sup>346</sup> the Court balanced the State's interest in protecting children against a defendant's Sixth Amendment right to confront the witness against her at trial, and held that the interest in protecting the safety and welfare of children is paramount.<sup>347</sup> The Court's analysis in *Craig* is suited for application to the dilemma of balancing the interests in cases of covert surveillance of Munchausen Syndrome by Proxy.

In *Craig*, the defendant was tried on several charges related to her alleged sexual abuse of a six-year-old child.<sup>348</sup> The State attempted to produce the child's testimony by a statutorily-permitted procedure, whereby the child would testify via one-way closed circuit television.<sup>349</sup> The State had produced medical evidence demonstrating that if the child were to testify in the courtroom, the child would suffer severe emotional distress.<sup>350</sup> Craig objected to the procedure as violative of her Sixth Amendment right to confront the witnesses against her.<sup>351</sup> The trial court held that the process did not violate the Sixth Amendment because Craig still essentially retained the right to confront the child.<sup>352</sup> Consequently, the procedure was employed, and Craig was convicted.<sup>353</sup> The Maryland Court of Appeals reversed the conviction and remanded for a new trial, finding that, although the Sixth Amendment is not an absolute guarantee to a face-to-face confrontation in the courtroom, the State court did not find that the child would suffer harm if the procedure were not employed.<sup>354</sup> The Supreme Court granted certiorari to address the effect of the state's interest in protecting

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346. 497 U.S. 836 (1990).

347. *See id.* at 855.

348. *See id.* at 840.

349. *See id.* The procedure would allow the judge to receive the testimony of the child witness, who was alleged to have been the victim of sexual abuse by the defendant. *See id.* During the testimony, the child, prosecutor, and defense counsel are in a separate room, while the judge, jury, and defendant remain in the courtroom. *See id.* at 841. The child is then examined and cross-examined in the separate room, while those remaining in the courtroom observe the child's testimony on a video monitor. *See id.* The defendant has electronic contact with the defense counsel, and objections can be made and ruled on by the judge as if the testimony were being given in the courtroom. *See id.* at 842.

350. *See id.* at 842-43.

351. *See id.* at 842.

352. *See id.*

353. *See id.* at 843.

354. *See id.*

children on the defendant's Sixth Amendment right to confront the witnesses against her.<sup>355</sup>

Application of the Court's analysis in *Craig* to the issue of covert video surveillance requires balancing the child's best interest against a competing interest. In *Craig*, the competing interest is the defendant's interest in confronting the witnesses against her; in Munchausen cases, the competing interest is the government's interest in obtaining evidence.<sup>356</sup> Note, however, that in this analysis, the harm from which the child is to be protected is the harm inherent in the employment of covert video surveillance, not simply the future protection of the child once he or she is removed from the hospital. The alternative to surveillance suggested—restriction of the parent's unsupervised care of the child—directly competes with both of these interests; i.e., it prohibits the evidence-gathering interests of the government and interferes with the parent's unfettered right to raise her child without supervision. The special evidentiary procedure in *Craig* may be likened to the restriction on the parent's supervision of the child in suspected Munchausen cases, where both restrictions are implemented as a means of protecting the child, but are implemented narrowly in an attempt to recognize and respect the competing interests to the greatest extent possible; that is, to restrict visitation rather than to modify custody altogether. Both procedures restrict the defendants' rights—to confront a witness in *Craig*, and to privately parent a child in Munchausen cases. In Munchausen cases, however, the court must weigh the interest in protecting the child from harm (not by conducting the surveillance, but by *not* conducting the surveillance) against the government's interest in prosecuting the alleged perpetrator.

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355. *See id.*

356. The parent's right to privately parent her child without supervision is not *per se* a competing interest when surveillance is being considered, since it is not specifically balanced against the risk of harm to the child. Rather, the parent's right to unsupervised care of the child in the hospital is only an issue when restricting supervision is considered. I have argued above that, at this level of analysis, the best interest of the child should outweigh that interest. *See supra* notes 300–03 and accompanying text. The mother's right to unsupervised care of her child must, however, play a part in the analysis as an unavoidable consequence of prohibiting covert video surveillance in Munchausen cases. In reviewing the evidence presented to the trial court, the *Craig* Court of Appeals remanded the case, finding that the judge "did not explore any alternatives to the use of one-way closed-circuit television." *Craig*, 497 U.S. at 859. Although the Supreme Court found that consideration of alternatives could strengthen the grounds for using other protective measures, it did not require that such evidence be considered as a prerequisite for the use of closed circuit television. *See id.* at 860. Similarly, in the case of Munchausen Syndrome, a lack of alternatives would not be a prerequisite for the use of surveillance. Since the only other alternative is to allow the child to leave the hospital with the suspected perpetrator, however, the court may be more inclined to view a restriction on supervision as the least restrictive *viable* alternative.

In *Craig*, the Court details its long held reluctance to restrict the constitutional protections afforded defendants by the Sixth Amendment.<sup>357</sup> The Court provides that “any exception to the right ‘would surely be allowed only when necessary to further an important public policy’—i.e., only upon a showing of something more than the generalized, ‘legislatively imposed presumption of trauma’ . . . .”<sup>358</sup> The Court added that “in certain narrow circumstances, ‘competing interests, if “closely examined,” may warrant dispensing with confrontation at trial.’”<sup>359</sup> Consequently, it equated the face-to-face scenario with a “*preference*,” which “‘must occasionally give way to considerations of public policy and the necessities of the case.’”<sup>360</sup> The Court further indicated its hesitancy to restrict the Sixth Amendment protection except “where denial of such confrontation is necessary to further an important public policy” or “state interest.”<sup>361</sup> The Court recognized child protection as a sufficiently compelling state interest to restrict the Sixth Amendment protection.<sup>362</sup> Thus, the Court determined that, if the State can make a threshold showing that the special restriction on the otherwise affordable competing interest is necessary to protect the welfare of the child and can show that the child will be harmed if the restriction is not employed, it will allow the restriction.<sup>363</sup>

The reasoning in *Craig* is applicable to the issue of using covert video surveillance in Munchausen cases. First, the backdrop of

357. See *Craig*, 497 U.S. at 844 (quoting *Coy v. Iowa*, 487 U.S. 1012, 1016 (1988); citing *Kentucky v. Stincer*, 482 U.S. 730, 748, 749–50 (1987); *Pennsylvania v. Ritchie*, 480 U.S. 39, 51 (1987); *California v. Green*, 399 U.S. 149, 157 (1970); *Snyder v. Massachusetts*, 291 U.S. 97, 106 (1934); *Dowdell v. United States*, 221 U.S. 325, 330 (1911); *Kirby v. United States*, 174 U.S. 47, 55 (1899); *Mattox v. United States*, 156 U.S. 237, 244 (1895)).

358. *Craig*, 497 U.S. at 845 (quoting *Coy*, 487 U.S. at 1021).

359. *Id.* at 848 (quoting *Ohio v. Roberts*, 448 U.S. 56, 64 (1980) (quoting *Chambers v. Mississippi*, 410 U.S. 284, 295 (1973) (citation omitted))).

360. *Id.* at 849 (quoting *Mattox*, 156 U.S. at 243).

361. *Id.* at 850, 852.

362. The Court notes:

We have of course recognized that a State’s interest in ‘the protection of minor victims of sex crimes from further trauma and embarrassment’ is a ‘compelling’ one. . . . [W]e have sustained legislation aimed at protecting the physical and emotional well-being of youth even when the laws have operated in the sensitive area of constitutionally protected rights.’

*Id.* at 852 (quoting *Globe Newspaper Co. v. Superior Court*, 457 U.S. 596, 607 (1982); citing *New York v. Ferber*, 458 U.S. 747, 756–57 (1982); *FCC v. Pacifica Found.*, 438 U.S. 726, 749–50 (1978); *Ginsberg v. New York*, 390 U.S. 629, 640 (1968); *Prince v. Massachusetts*, 321 U.S. 158, 168 (1944)) (altered capitalization in original); see also *Osborne v. Ohio*, 495 U.S. 103, 109 (1990) (“[A] State’s interest in ‘safeguarding the physical and psychological well-being of a minor’ is ‘compelling.’” (quoting *Ferber*, 458 U.S. at 756–57)).

363. See *Craig*, 497 U.S. at 855–56.

each analysis is similar: in *Craig*, the Court recognized that there is no “*absolute* right to a face-to-face meeting with witnesses . . . at trial.”<sup>364</sup> In Munchausen cases, the competing interest—the government’s interest in searching for evidence for prosecution—is also not absolute; in certain situations, it must give way to other interests.<sup>365</sup> Likewise, a parent’s right to raise her child without supervision is also not absolute, but may be restricted when it is in the best interest of the child to do so.<sup>366</sup>

Second, both in *Craig* and in Munchausen cases, medical evidence is offered demonstrating that, if a special procedure is not employed, the child will suffer harm. In *Craig*, the Court determined that evidence of severe emotional distress was sufficient to meet this threshold.<sup>367</sup> The Court supported the “State’s traditional and ‘transcendent interest in protecting the welfare of children,’” especially when “buttressed by the growing body of academic literature documenting the psychological trauma suffered by child abuse victims who must testify in court. . . .”<sup>368</sup> Similarly, in Munchausen cases, courts should consider the growing body of literature regarding Munchausen Syndrome by Proxy, especially studies like that of Dr. Southall, that document the severe and sadistic harm that may befall the child when covert video surveillance is employed.<sup>369</sup>

Third, in *Craig*, the Court allowed a restriction on the Sixth Amendment protection, which it was historically hesitant to allow, because the special procedure involved other safeguards that assured retention of the essence of the protected right (the right to confront witnesses).<sup>370</sup> In *Craig*, the closed circuit television testimony still allowed the defendant to view the child, cross-examine the child, object to testimony, and have the jury view the demeanor of the child.<sup>371</sup> In Munchausen cases, the special procedure—

364. *Id.* at 844.

365. *Cf. id.* at 849–50 (explaining that the confrontation clause must sometimes give way to other interests in the criminal trial process). The government’s interest in obtaining evidence in a criminal prosecution is, of course, limited by the protections afforded by the Fourth Amendment. *See* U.S. CONST. amend. IV.

366. *See, e.g., In re B.B.*, 500 N.W.2d 9, 12 (Iowa 1993) (stating that although parents have a legitimate interest in the integrity of the family unit, that interest is not absolute, and conditions may be placed on parents’ visitation).

367. *See Craig*, 497 U.S. at 856.

368. *Id.* at 855 (quoting *Ginsberg v. New York*, 390 U.S. 629, 640 (1968) (quoting *People v. Kahan*, 206 N.E.2d 333, 334 (N.Y. 1965))).

369. It is imperative that courts considering covert video surveillance in Munchausen cases recognize the inherently deceptive nature of the disease, the minimal degree to which medical and legal professionals are aware of, or even believe, the effects of the disease, the difficulty in diagnosing and confirming the disease, and the significant risk of harm that every child faces during each incident of surveillance. *See* discussion *supra* Part I.A.

370. *See Craig*, 497 U.S. at 851.

371. *See id.* at 842.

temporarily restricting the parent's unsupervised care of the child—also retains the essence of the protected interest, the right of the parent to care for her child. The parent may still be with the child, care for the child, and make decisions for the child. Likewise, the government's interest in obtaining evidence is still viable (the child can still be observed and treated), and the child's medical condition outside the unsupervised care of the parent may be compared with the child's previous condition, which itself may confirm suspicions of abuse. While both procedures are less than ideal, both allow the defendant to retain a protected right while assuring the health and safety of the child, which the Supreme Court has held to be of paramount concern.<sup>372</sup>

The *Craig* Court also supported its holding by noting that, within the context of child testimony, when the child is traumatized by having to testify face-to-face (i.e., when the restriction is not employed) the harm caused to the child would “*disserve*” the goal of the protected interest.<sup>373</sup> In *Craig*, the protected interest was the truth-seeking purpose of the Sixth Amendment.<sup>374</sup> Similarly, if a child is at risk of harm from Munchausen Syndrome by Proxy because of video surveillance, the employment of the surveillance disserves the government's interest in protecting the child from the harm of Munchausen Syndrome by Proxy. If the court is to protect the interests of the child in balancing the interests involved in the determination to use covert video surveillance, then in accordance with *Craig*, the most effective and appropriate means of doing so is to avoid the use of covert video surveillance and, instead, to employ the less harmful—but equally effective—method of separating the child from the alleged perpetrator.

### III. OBTAINING THE NEED FOR COVERT VIDEO SURVEILLANCE BY INTEGRATING MEDICAL AND LEGAL RESOURCES

As the medical profession identifies more cases of Munchausen Syndrome by Proxy, it develops a greater understanding of the consistencies in the dynamics of each case.<sup>375</sup> Experience also teaches the medical profession that therapy and counseling does little for

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372. *See id.* at 852–53, 855.

373. *Id.* at 857.

374. *See id.* (“[F]ace-to-face confrontation ‘may so overwhelm the child as to prevent the possibility of effective testimony, thereby undermining the truth-finding function of the trial itself.’” (quoting *Coy v. Iowa*, 487 U.S. 1012, 1032 (1988) (Blackmun, J., dissenting))).

375. *See Flannery, supra* note 9, at 1181–1209.

the perpetrators of Munchausen Syndrome by Proxy, particularly for those who deny the existence of the disease.<sup>376</sup> The medical profession may have a working definition of the Syndrome, so that when one doctor tells another doctor, "I suspect Munchausen Syndrome by Proxy," the other physician will be able to make an independent observation and determine whether he or she concurs with the opinion. This working definition or diagnosis may not be equally helpful to a judge or jury, however, who must determine whether a child was abused, neglected, or remains at risk. In Munchausen Syndrome by Proxy cases, there is no one psychological test or piece of evidence (such as a fingerprint, DNA sample, or eye witness) that can tell a court that abuse has been perpetrated on a child and that the abuse was perpetrated by a particular person. Instead, the Syndrome, by nature, is a circumstantial puzzle that, when pieced together correctly, only paints a picture that resembles other, similar, circumstantial puzzles. Thus, in drawing the definitional connection between what the medical field describes as Munchausen Syndrome by Proxy and what the legal profession qualifies as child abuse, there are two options: (1) the medical field may produce that one piece of evidence—that smoking gun—that video tape—that conclusively evidences that "this mother abused this child;" or (2) the medical profession may describe the dynamics of what it has generally accepted to be "Munchausen Syndrome by Proxy" and describe the facts or the circumstances of the case. The court may then take into account all of the circumstances and determine that "this case is just like those cases that the medical profession described as Munchausen Syndrome by Proxy." The difference between these two options is that the first option entails an inherent risk of harm to the child. If the court is to avoid the added risk to the child inherent in the first option by employing the second option instead, however, it must be able to reach a legal conclusion regarding abuse or neglect based solely on medical descriptions of circumstantial evidence. It must be able to conclude that the circumstantial evidence in any given case equates with Munchausen Syndrome by Proxy, but it must also make the hard rule—the litmus test—that the court in *In re Bowers* refused to make—that Munchausen Syndrome by Proxy constitutes child abuse.<sup>377</sup> Some courts have begun the transition from option one to option two<sup>378</sup> and have thereby obviated the need for covert video

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376. See *supra* notes 143–59 and accompanying text.

377. See *In re Bowers*, No. 1490, 1992 WL 2870, at \*4 (Ohio Ct. App. Jan. 2, 1992).

378. See, e.g., *In re Aaron S.*, 625 N.Y.S.2d 786 (Fam. Ct. 1993); *In re Jessica Z.*, 515 N.Y.S.2d 370 (Fam. Ct. 1987).

surveillance.<sup>379</sup> If courts deciding appropriate dispositions in Munchausen Syndrome by Proxy cases wish to accomplish this, they must first accept a cumulative diagnosis of the Syndrome and then apply a *res ipsa loquitur* standard.

### A. A Cumulative Diagnosis

In an effort to facilitate earlier intervention by confirming suspicions and making a diagnosis based on cumulative circumstantial evidence, some courts in recent Munchausen Syndrome by Proxy cases have adopted a different perspective in the way they determine the credibility of the medical diagnosis and the precautions they take to confirm the diagnosis.<sup>380</sup> That is, some courts have become more flexible in accepting evidence of what the medical profession has diagnosed as Munchausen Syndrome by Proxy. In turn, courts are taking added, but less risky, precautions to confirm the diagnosis.<sup>381</sup>

In *State v. DeJesus*, the court respected a doctor's testimony that "[a] diagnosis of [Munchausen Syndrome by Proxy] is not made on the basis of psychological testing but, rather, on the match between known facts and history of the case and known features of [Munchausen Syndrome by Proxy]."<sup>382</sup> Although the case considered the effectiveness of therapy and the propriety of a suspended sentence,<sup>383</sup> the acknowledgment by the court regarding the manner in which a court may consider the sufficiency of the diagnosis<sup>384</sup> was a first step toward restricting visitation as a means of confirming the diagnosis, preventing additional harm, and obviating the need

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379. See *infra* Part III.A.

380. In Florida, for example, Patricia Young is accused of making her two children sick. See Leiser, *supra* note 3. The judge separated the children from the mother on a temporary basis, agreeing to the social worker's request for time "to see if the children's health continues to improve in their mother's absence." *Id.* For an example of how courts are becoming more cautious with regard to the child's safety and more restrictive of parental contact during the investigation of suspected Munchausen Syndrome by Proxy, see *supra* note 19 (discussing the disposition of the case involving Cynthia Lyda). Regarding the court's most recent decision to reverse its order of unsupervised visits between Lyda and her youngest son, District Judge David Peeples, in mandating supervised visits, said: "[T]his court is unwilling to decide such an important child-safety matter without the benefit of all the evidence." See Prentice, *Mother's Visitations Gone*, *supra* note 19; see also *State v. DeJesus*, No. CR92-73269, 1993 WL 171866, at \*1 (Conn. Super. Ct. Apr. 27, 1993); *Reid v. State*, 964 S.W.2d 723, 732 (Tex. App. 1998); *In re Clarissa M.S.*, No. 94-2017, 1995 WL 27793, at \*2 (Wis. Ct. App. Jan. 24, 1995).

381. See *supra* note 380.

382. *DeJesus*, 1993 WL 171866, at \*1.

383. See *id.*

384. See *id.*



for covert video surveillance. The importance of doing so was voiced by the *Reid* opinion, which stated that expert testimony was part and parcel of the diagnosis, which could not be made without application to the facts of the case:

Under the peculiar and special circumstances of the psychiatric condition known as [Munchausen Syndrome by Proxy] and its diagnosis, the experts' use of the facts . . . in pursuing and determining their medical diagnosis, in explaining the diagnosis to the jury, and giving their opinion as to the cause of [the child's] death was . . . permissible . . . testimony as an aid to the jury in determining the guilt or innocence of appellant. . . . [B]y its very nature, the [Munchausen Syndrome by Proxy] diagnosis depends upon expert testimony . . . and is necessary to aid the jury in deciding the ultimate issue of guilt or innocence in cases such as this.<sup>385</sup>

In *In re Clarissa M.S.*, the court accepted testimony from a doctor, who diagnosed Munchausen Syndrome by Proxy.<sup>386</sup> The doctor testified that the diagnosis was based entirely on circumstantial evidence, and could only be made after the symptoms in the child dissipated during the six-week period when the child was removed from the perpetrator's care.<sup>387</sup> The doctor testified:

The only real way you . . . diagnose the disease is [to] remove the child from the perpetrator or perpetrator from the child and if that happens those symptoms should go away because if there's some underlying disease, whether the [alleged] perpetrator is there or not should make no difference. The child should continue having the symptoms of the disease. So it's the [separation] that confirms the diagnosis.<sup>388</sup>

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385. *Reid*, 964 S.W.2d at 732.

386. See *In re Clarissa M.S.*, 1995 WL 27793, at \*2-\*3.

387. See *id.* at \*3.

388. *Id.* at \*2. This statement is not entirely accurate, although the inaccuracy only further supports the need for separation as a circumstantial source of evidence. The statement is incorrect because it *would* make a difference if the alleged perpetrator were with the child if the cause of the symptoms were some underlying disease. If the alleged perpetrator is *not* the cause of the child's condition, but is suspected of being so, and the symptoms of some underlying illness continue in the presence of the alleged perpetrator, there is no indication that the alleged perpetrator is *not* the cause of the symptoms because their presence is continual. Therefore, it is *imperative* that the alleged perpetrator *not* be present during the trial period so that, if the symptoms *do* continue, the absence of the alleged perpetrator will indicate that the source of the symptoms lies elsewhere. This clarification supports the value of temporarily

Similar testimony was offered in *Thomason v. SCAN Volunteer Services, Inc.*, where the court heard evidence that "there was not any medical reason that had been found for apnea, [and that] the only way to know for sure whether or not that was happening would be for the child to be in a neutral setting."<sup>389</sup> Likewise, in *Reid* the doctor testified that the Syndrome is diagnosed by further testing or removing the child from the alleged perpetrator, at which time the signs and symptoms will resolve themselves if the alleged perpetrator was the cause.<sup>390</sup> Beatrice Crofts Yorker has noted: "Getting good smoking-gun evidence is very, very hard. . . . [T]he most important, definitive way of knowing whether or not the mother is causing harm to the child is, if upon separation from the mother or the perpetrator, the child's physical condition improves dramatically and they thrive."<sup>391</sup>

The testimony in these cases demonstrates that suspicions of the Syndrome *can* be confirmed through the temporary separation of the alleged perpetrator and the child without placing the child at further risk through covert video surveillance. Of course, the remedy works both ways; it may also dispel suspicions and prove that the Syndrome is not being perpetrated by the parent. There are cases where, upon the separation of the child from the alleged perpetrator, the child's symptoms continued, thereby evidencing that the alleged perpetrator was *not* the cause of the child's condition and that, although Munchausen Syndrome by Proxy was suspected, it should not have been diagnosed. For example, in *Stratton v. Orange County Department of Social Services*,<sup>392</sup> the child, Ashley, was ill for her entire life, and the mother was suspected of perpetrating Munchausen Syndrome by Proxy.<sup>393</sup> Consequently, Ashley was separated from all contact with her mother.<sup>394</sup> After one year, Ashley's condition did not improve.<sup>395</sup> Determining that the parents were not the source of Ashley's condition, the Family Court returned her to her parents.<sup>396</sup> Likewise, in *Thomason*, the child was

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separating the suspected perpetrator and the child and allowing the child's condition to confirm suspicions.

389. *Thomason v. SCAN Volunteer Servs., Inc.*, 85 F.3d 1365, 1372 n.5 (8th Cir. 1996) (quoting deposition testimony of SCAN worker Andrea Goin).

390. *See Reid*, 964 S.W.2d at 727.

391. *48 Hours: Jennifer Bush, Allegedly Made Ill*, *supra* note 19 (quoting Beatrice Crofts Yorker, expert on Munchausen Syndrome).

392. 628 N.Y.S.2d 818 (App. Div. 1995).

393. *See id.* at 819.

394. *See id.*

395. *See id.*

396. *See id.*

returned to the parents after being separated for two weeks.<sup>397</sup> When the child's condition did not improve during the separation, the case was dismissed for insufficient evidence of abuse.<sup>398</sup>

While unfortunate in its premise, in certain respects this scenario can be viewed positively for the following reasons: it helps to resolve the issue of diagnosing Munchausen Syndrome by Proxy; it rules out another possible cause of the child's condition; it clears a grieving parent who was falsely suspected of abuse; it reunites a sickly child with a parent after a temporary separation; and it alleviates the necessity of potentially harmful covert video surveillance. This scenario can also be viewed negatively, however, for the following reasons: it potentially adds to the list of invasive tests and procedures already performed on the child; it falsely accuses a grieving parent of abusing her child; it separates a sickly child from a loving parent; and it subjects the hospital, doctor, or social service agency to potential civil liability. For example, in *Straton*, the parents brought medical malpractice and false imprisonment claims against the social service agency.<sup>399</sup> Although they had had no contact with their child for an entire year throughout the ordeal, their claims were dismissed.<sup>400</sup> Likewise, in *Thomason*, the parents brought a section 1983 due process claim for interference with their family integrity.<sup>401</sup> The court held that, while the parents had a right to family integrity under section 1983, they did not have a right to be free from child abuse investigation.<sup>402</sup> The court qualified the restriction on their visitation with the child as an investigation of potential child abuse and dismissed their claims.<sup>403</sup> Many other lawsuits have been filed against hospitals for allegations of Munchausen Syndrome by Proxy raised against the parents.<sup>404</sup>

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397. See *Thomason v. SCAN Volunteer Servs., Inc.*, 85 F.3d 1365, 1369 (8th Cir. 1996).

398. See *id.* at 1369–70.

399. See *Straton v. Orange County Dep't of Soc. Servs.*, 628 N.Y.S.2d 818, 819–20 (App. Div. 1995).

400. See *id.*

401. See *Thomason*, 85 F.3d at 1370.

402. See *id.* at 1371.

403. See *id.* at 1372–73.

404. Dr. Patricia Siegel, a pediatric psychologist and child abuse authority at Children's Hospital of Michigan, has stated: "There's lack of institutional support very often. . . . Nobody wants to get involved because there's fear of litigation." James Tobin, *Diagnosis: Illness Often Is Hard to Detect; Clever Deceptions, Fear of Lawsuits May Shroud Syndrome*, DET. NEWS, Feb. 9, 1998, at A4 (quoting Dr. Patricia Siegel, concerning the role of litigation in Munchausen Syndrome by Proxy diagnoses).

In 1996, doctors at the Vanderbilt University Medical Center accused Julie Patrick of perpetrating Munchausen Syndrome by Proxy on her 11-month-old son, Philip. See Catherine Trevison, *Parents Sue VU Over Mysterious Death of Infant*, TENNESSEAN (Nashville), Oct. 8, 1997, at 1B, available in 1997 WL 14650216. A year after the child's death, in a \$60 million lawsuit filed in United States District Court, Patrick accused the hospital staff of providing negligent

Notwithstanding that restricting parents' right to visitation with their child has certain negative effects, the court's goal should be to diagnose the child's condition accurately in a way that most fairly considers all of the interests involved. To do so, courts should consider all of the cumulative evidence, including expert testimony about the disease, and accept the credibility of the diagnosis by matching the circumstantial evidence in the case to the expert medical testimony about the dynamics of the Syndrome. Part of the circumstantial evidence that should be considered, which many experts feel is the most important piece of evidence, should be the change or consistency in the child's condition after a temporary restriction on the alleged perpetrator's visitation with the child.<sup>405</sup>

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medical care which led to the child's death. *See id.* In the lawsuit, Patrick claimed that doctors worsened the child's mysterious condition by performing invasive procedures that caused the child's infection to spread, by ignoring symptoms, and by giving him high doses of steroids that damaged the child's kidneys. *See id.* As the child's condition worsened, however, doctors became suspicious, and the Department of Children's Services took custody of the child on September 6, 1996. *See id.* The Patricks were seldom able to see their son in the weeks before he died on October 7, 1996. At a subsequent juvenile court hearing, one doctor testified that Patrick had injected fecal matter into the child's intravenous feeding tube. *See id.* When an autopsy of the child did not reveal any evidence that Patrick had harmed her son, however, the state dropped the case. *See id.* Although blood tests revealed that the child may have been suffering from an undiagnosed tumor, the hospital administration contends that the case was riddled with complications that pointed to Munchausen Syndrome by Proxy and supported the hospital staff's actions. *See id.* For example, the child was presented to the hospital after several treatment episodes at hospitals in Philadelphia, New Orleans, and Memphis; Patrick sometimes challenged the decisions of the medical staff; Patrick was extensively involved in the child's condition and diagnosis, even publishing the child's medical history on the Internet. *See id.* All of these symptoms fit the "profile" for warranted suspicions of Munchausen Syndrome by Proxy. *See discussion supra* Part I. The Patricks now publish a World Wide Web page for MAMA—Mothers Against Munchausen Syndrome by Proxy Allegations—which warns parents that they can easily fit the profile by simply advocating for their child. *See id.*

Ellen Storck, who continues to fight her case of false allegations of Munchausen Syndrome by Proxy, *see generally infra* note 425, filed a lawsuit against the New York Department of Social Services and others, alleging civil rights violations. *See Storck v. Suffolk County*, No. 97-9110, 1998 WL 398817, at \*2 (2d Cir. June 5, 1998).

California physician Dorothy Calabrese, who was found guilty of cruelty to animals and faces up to one year in prison for starving her horses and llamas, filed a civil rights lawsuit against numerous officials for the removal of her four children in 1995. *See Masciola, supra* note 97. Calabrese is seeking more than \$4 million in damages arising from officials' allegations that she was treating her children for nonexistent medical problems and causing them harm for reasons related to personal aggrandizement. *See id.* No charges were brought against her, and the children were returned after two weeks. *See id.*

405. For example, Donna Rosenberg, M.D., Assistant Professor of Pediatrics at the University of Colorado in Denver, cautions that physicians should always choose protecting the child over obtaining evidence, even though video surveillance does not always result in harm, commenting: "Don't send the [child] home to be poisoned again so that you can gather gastric juices. The next time you see him, he may present DOA." Janice Rosenberg, *Patient by Proxy*, AM. MED. NEWS, Dec. 16, 1996, at 18, available in 1996 WL 11860617; *see also In re Aaron S.*, 625 N.Y.S.2d 786, 792 (Fam. Ct. 1993) (explaining that the strongest support for doctor's opinion that Munchausen Syndrome by Proxy was being perpetrated was the fact that the child's condition subsided when he was removed from the mother's care).

After considering this evidence, the court should be inclined to find that Munchausen Syndrome by Proxy either has or has not been perpetrated without having to resort to covert video surveillance in either case. Some courts have taken a further step to support their inclination by applying a *res ipsa loquitur* standard to their consideration of the cumulative evidence.<sup>406</sup> The application of this standard assures the safety of the child by obviating the need for covert video surveillance and narrowing the gap between the medical diagnosis of the Syndrome and a court's hesitancy to accept the diagnosis and to respond with an appropriate disposition for the child.

### B. A *Res Ipsa Loquitur* Standard

The Family Court in New York has applied a *res ipsa loquitur* standard in two cases of Munchausen Syndrome by Proxy—*In re Jessica Z.*<sup>407</sup> and *In re Aaron S.*<sup>408</sup> In these cases, the court recognized the difficulty in dealing with the phenomenon of Munchausen Syndrome by Proxy.<sup>409</sup> Yet the court demonstrated that the application of a *res ipsa loquitur* standard does not mean that the child will automatically be removed from the parent.<sup>410</sup> Despite the application of this strict standard, the court may still implement a disposition best suited for the child's well-being. The court in *In re Aaron S.*, following its decision *In re Jessica Z.*, provided that when video surveillance is not used and the parent is separated from the child, a *res ipsa loquitur* standard is applied to judge whether or not Munchausen Syndrome by Proxy is a factor.<sup>411</sup>

The *res ipsa* standard was first applied in *Jessica Z.*, where the court acknowledged the medical profession's urgings to become more aware of the reality of the Syndrome and of its effect in the legal and medical fields.<sup>412</sup> In *Jessica Z.*, the mother, Lori Z., was ac-

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406. See discussion *infra* Part III.B.

407. 515 N.Y.S.2d 370, 377 (Fam. Ct. 1987).

408. 625 N.Y.S.2d at 789.

409. See *Aaron S.*, 625 N.Y.S.2d at 787–88; *Jessica Z.*, 515 N.Y.S.2d at 372.

410. See *Jessica Z.*, 515 N.Y.S.2d at 378 (holding that, despite the determination that mother perpetrated Munchausen Syndrome by Proxy and a finding of abuse, the child was not removed from the parents' home because removal posed additional risks to the child).

411. See *Aaron S.*, 625 N.Y.S.2d at 789.

412. See *Jessica Z.*, 515 N.Y.S.2d at 372. Acknowledging the admonitions of the medical profession, the court heeded the urges of medical experts: "It is incumbent on medical personnel involved with such children and families to educate the legal authorities about this form of child abuse to insure [sic] [the] proper care for the children." *Id.* (quoting Orenstein & Wasserman, *supra* note 16, at 624).

cused of repeatedly causing her daughter Jessica to ingest large quantities of laxatives to cause her to have severe diarrhea, infection of the blood, dehydration, and extended hospitalizations.<sup>413</sup> In addressing these facts, the court considered that “the [S]yndrome may be far commoner than previously supposed but . . . its true incidence is unknown because detection is so inherently difficult.”<sup>414</sup> It further recognized that there are “obstacles to appropriate diagnosis and management” of Munchausen Syndrome by Proxy cases, which include “skepticism of the legal authorities presented with the paradox of a parent who appears to be seeking the best medical care for the child, and to love and dote on the child, while at the same time causing the child’s illness, suffering and even death.”<sup>415</sup>

In the 14-day trial, the court heard from 21 witnesses, including 12 doctors and one psychologist. All of the evidence was circumstantial, with the exception of a lab result indicating that the child had ingested laxatives.<sup>416</sup> A critical piece of circumstantial evidence was the fact that the child’s condition markedly improved after the child’s contact with the mother was restricted with supervision.<sup>417</sup> Based on that fact, the court was able to draw the conclusion that the child would not have suffered, were it not for his mother’s abuse.<sup>418</sup> Under the statutorily imposed *res ipsa loquitur* standard:

proof of injuries sustained by a child or of the condition of a child of such a nature as would ordinarily not be sustained or exist except by reason of the acts or omissions of the parent or other person responsible for the care of such child shall be prima facie evidence of child abuse. . . .<sup>419</sup>

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413. *See id.* at 370–71.

414. *Id.* at 371.

415. *Id.* (citing David A. Waller, *Obstacles to the Treatment of Munchausen by Proxy Syndrome*, 22 J. AM. ACAD. CHILD PSYCHIATRY 80, 81 (1983) (regarding study where five of 23 children who were victims of Munchausen Syndrome by Proxy died)). Other obstacles noted by the court were the following: “(1) failure to appreciate fully the relationships of [Munchausen Syndrome by Proxy] to non-accidental poisoning of children; (2) the striking symbiotic tie between mother and child; [and] (3) the highly persuasive denial typical of the parent/perpetrator. . . .” *Id.* Commenting on how doctors can be duped into overlooking the possibility of the Syndrome, the court quoted Dr. Newman’s testimony that “[e]veryone was so trusting—so helpful—so satisfied with the efforts of the doctors and staff.” *Id.* at 373.

416. *See id.* at 372–77.

417. *See id.* at 374.

418. *See id.* at 377.

419. N.Y. FAM. CT. ACT § 1046(a)(ii) (McKinney 1983). For application of the *res ipsa loquitur* standard to other cases of abuse or neglect, see *In re Tara H.*, 494 N.Y.S.2d 953, 956 (Fam. Ct. 1985) (applying *res ipsa loquitur* theory not only to cases where the child never leaves the parents’ control, but also to cases where the parent has primary custody during the

The *Jessica Z.* court held that the *res ipsa* standard is particularly applicable when no other explanation for the child's condition is offered.<sup>420</sup>

Despite these findings by the court and the application of the *res ipsa loquitur* theory, the court still balanced all of the risks inherent both in leaving the child with the perpetrating parent and in placing the child in foster care.<sup>421</sup> The court recognized that if the child were to remain at home with the parent, the parent might perpetrate the abuse on the child again, simulate the abuse that was already perpetrated on the child, or avoid treating a legitimate illness in the child because the parent felt threatened by legal proceedings if treatment were sought.<sup>422</sup> The court also recognized the harm caused by removing the child from her parent and placing her in foster care, however.<sup>423</sup> The court held that the appropriate disposition for the child was to remain in the mother's care, with therapeutic intervention.<sup>424</sup>

The New York Family Court again applied the *res ipsa loquitur* theory in *In re Aaron S.*<sup>425</sup> Like the court in *In re Jessica Z.*, this court

critical period when the child sustains the injury); *In re Charmine W.*, 402 N.Y.S.2d 19, 20 (App. Div. 1978); *In re Tashyne L.*, 384 N.Y.S.2d 472, 473 (App. Div. 1976).

420. See *In re Jessica Z.*, 515 N.Y.S.2d at 377. The court noted the only other case in New York that involved Munchausen Syndrome by Proxy. See *id.* (citing N-943-84 (N.Y. Fam. Ct. 1985) (theory applied against both parents, who allegedly had contaminated the child's IV lines with corrosive substances)).

421. See *id.* at 378.

422. See *id.*

423. See *id.*

424. See *id.* The court acknowledged the medical evidence that, historically, therapeutic intervention had failed to be effective in preventing recidivism, but since none of the parties challenged the disposition, the court returned the child to the perpetrator. See *id.* The doctor testified, notwithstanding medical evidence to the contrary, that, in his experience, confrontation resulted in the cessation of behavior and that therefore he felt that, with appropriate safeguards in place, there was no harm in the child returning to the care of the mother. See *id.*

425. 625 N.Y.S.2d at 786. There is a long history of facts in the case, which has been highly publicized in the media. Aaron Storck was initially removed from his mother's care in 1992, after New York authorities suspected his mother suffered from Munchausen Syndrome by Proxy. See *Storck v. Suffolk County*, No. 97-9110, 1998 WL 398817, at \*1 (2d Cir. June 5, 1998); see also Douglas C. Lyons, *Teen In Custody Fight Flees Cops, Goes Home with Mom*, SUN-SENTINEL (Ft. Lauderdale, Fla.), June 21, 1997, at 6B. He was later placed with relatives in Ohio, where he was joined by his mother. See *id.* In violation of a court order restricting the mother to supervised visits with the boy, the family later moved to Florida, and Ellen Storck filed a lawsuit against New York state officials, doctors, and social workers, alleging civil rights violations. See *Storck*, 1998 WL 398817, at \*2; see also Chau Lam, *Court: Woman Must Return Son*, NEWSDAY, July 4, 1997, at A20. In June 1997, however, authorities in New York obtained a court order for Aaron to be returned to New York. See Lyons, *supra*. When the child saw the police coming, he fled. See *id.* Subsequently, a federal court judge ruled that the boy must be returned to New York. See Lam, *supra*. Ellen Storck protested the ruling, however. See David Cazares, *Son, Mother Make Plea for Help: Don't Let N.Y. Officials Separate Us*, SUN-SENTINEL (Ft. Lauderdale, Fla.), Aug. 23, 1997, at 2B. In January 1998, all parties agreed for the family to

again stated its concern for the difficulties involved in even accepting that the Syndrome exists.<sup>426</sup> Likewise, the court accepted that “[Munchausen Syndrome by Proxy] is a diagnosis reached after examining the total picture presented, not any one specific factor.”<sup>427</sup> Noting the progression of the diagnosis, which includes the separation of the child and the alleged perpetrator as part of the cumulative diagnosis, the court found that:

suspicion . . . is raised when a child presented to a doctor has one or more medical problems which do not respond to treatment or which follow an unusual course which is persistent and puzzling, has unexplainable physical or laboratory findings which are physically or clinically impossible and where such puzzling and/or bizarre symptoms abate spontaneously when the child is separated from his parent.<sup>428</sup>

With regard to confirming the diagnosis, the court expressly presented the two available options: “surreptitious videotaping of the mother inducing symptoms . . . [or] an immediate and almost miraculous recovery when contact with the mother was curtailed and strictly monitored.”<sup>429</sup> While the court did not specifically condemn the use of covert video surveillance, it stated that without it, the court must apply a *res ipsa loquitur* theory where the circumstantial evidence is cumulative and the abatement of the illness upon separation from the alleged perpetrator speaks for itself.<sup>430</sup> Of the two options offered by the court for confirming the diagnosis, the latter is legally, medically, and ethically more favorable, because it more completely protects the child, and it equally confirms or refutes the suspicions of the diagnosis. Even the court in *In re Aaron S.* stated, “The strongest support for [the diagnosis of Munchausen Syndrome by Proxy] is that [the child] has had no [symptoms] since he was removed from his mother’s care.”<sup>431</sup> Commenting on the

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undergo a comprehensive evaluation while Aaron remained in the care of Social Services, having only supervised visits with his mother. See Douglas C. Lyons, *Mother, Son Fight to Reunite, Tests Planned; Mom Accused of Causing Her Child’s Illness*, SUN-SENTINEL (Ft. Lauderdale, Fla.), Jan. 21, 1998, at 8B. On June 5, 1998, the U.S. Court of Appeals for the Second Circuit denied Storck’s appeals of the district court’s denial of her injunction to prevent the Department of Social Services from retaining custody of the child and her request for removal of the case to federal court. See *Storck v. Suffolk County*, No. 97-9110, 1998 WL 398817, at \*1, \*3-\*4 (2d Cir. June 5, 1998).

426. See *Aaron S.*, 625 N.Y.S.2d at 787.

427. *Id.* at 788.

428. *Id.*

429. *Id.* at 789.

430. See *id.*

431. *Id.* at 792.



process for reaching the diagnosis, the court provided: "The finding that he is the victim of [Munchausen Syndrome by Proxy] has, as its basis, a cumulation of behaviors encompassing the last four years; no one particular procedure, treatment, or hospitalization can be the basis of that determination. Rather the entire course of conduct must be examined."<sup>432</sup>

With regard to the diagnosis of Munchausen Syndrome by Proxy, the holdings in *In re Jessica Z.* and *In re Aaron S.* are consistent, which is unusual, given the varied history of Munchausen Syndrome by Proxy cases. A comparison of the dispositions in the two cases clearly shows the ongoing dependency between the medical and legal fields in working towards consistent and appropriate dispositions for the children. The fact that, in both cases, the court required the consideration of cumulative evidence and the application of the *res ipsa loquitur* theory did not affect the court's consideration of the appropriate disposition for the children; that was entirely dependent on medical interpretation and insight.<sup>433</sup> In *In re Jessica Z.*, despite a history of medical evidence to the contrary, the court returned the child to the perpetrating parent based on the doctor's belief that the harmful behavior would cease upon confrontation.<sup>434</sup> Contrary to the finding in *In re Jessica Z.*, however, the court in *In re Aaron S.* found that "Once a condition, status, state of facts or state of mind is found to exist it is presumed to continue. . . . [Munchausen Syndrome by Proxy] conduct will not spontaneously abate with the finding of neglect."<sup>435</sup> Thus, the court in *In re Aaron S.* extended the application of its findings to the mother's other children.<sup>436</sup> The court was concerned that, once the subject child was removed from the mother's care, she would project the same behavior onto her other children.<sup>437</sup> Acting on this concern, the court held that "a court cannot and should not 'await broken bone or shattered psyche before extending its protective cloak around [a] child.'"<sup>438</sup>

Despite the differing dispositions likely to occur when a court considers the best interest of each individual child on an ad hoc basis, the important consistency drawn from *In re Jessica Z.* and *In re Aaron S.* is that both apply a standard, comprehensive framework for dealing with Munchausen Syndrome by Proxy. The application

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432. *Id.* at 794.

433. *See id.*; *see also In re Jessica Z.*, 515 N.Y.S.2d 370, 378 (Fam. Ct. 1987).

434. *See Jessica Z.*, 515 N.Y.S.2d at 378.

435. *Aaron S.*, 625 N.Y.S.2d at 794 (citing *In re Iris C.*, 363 N.Y.S.2d 7, 8 (A.D.2d 1974)).

436. *See id.* at 794.

437. *See id.*

438. *Id.* (quoting *In re Anthony*, 366 N.Y.S.2d 333, 336 (1975)).

of that framework in these disparate cases suggests that if courts will admit and consider cumulative circumstantial medical evidence of Munchausen Syndrome by Proxy and apply a *res ipsa loquitur* legal theory to it, then courts and medical professionals will be able to avoid the necessity of relying on covert video surveillance. This approach will avoid further harm to the child and intrusion against the parent, and still effectively and conclusively confirm or dispel suspicions of abuse. Even under the language of the guidelines resulting from Dr. Southall's study, covert video surveillance *should* not be necessary. Under the North Staffordshire guidelines, "[c]overt video surveillance could be used where it is agreed that evidence sufficient to ensure protection for the child through care proceedings is not already available from other sources."<sup>439</sup> Thus, if courts continue to move in the direction of recent precedent in Munchausen Syndrome by Proxy cases, where cumulative circumstantial evidence tips the balance of interests in favor of protecting the child from the abuse inherent in the surveillance, particularly in states like New York, where the *res ipsa loquitur* theory is applied, then evidence sufficient to confirm suspicions without relying on covert video surveillance would be available.

#### CONCLUSION

In cases where a child is likely to be subject to covert abuse by a parent, one may argue that the interest in protecting the child from such abuse supersedes the ethical obligation not to deceive the parent or infringe upon his or her privacy interests. Employing the very abuse that is sought to be avoided in achieving this end, however, is medically, legally, and ethically invalid. Medically, this argument may be justifiable for some; for others, not. Although reasonable medical minds may differ, this Article concludes that it is medically contradictory and unsound to inflict harm in the name of preventing harm.

Legally, the infliction of harm in the name of preventing harm is unnecessary and unsupportable. It will remain so unless courts determine that Munchausen Syndrome by Proxy is a rare and unique form of abuse that warrants specialized investigation and intervention techniques, which otherwise would not be legally justified. More so, it is beyond legal justification for a medical professional to assume the role of fact-finder, and unilaterally to qualify a parent's

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439. *Guidelines, supra* note 310, ¶ 3.3, at 17.

legal rights and interests based upon those facts. Thus, even if conceptually the use of covert video surveillance to detect or confirm Munchausen Syndrome by Proxy were legally justified by a court of law based on the extreme and rare circumstances that accompany the disease, the employment of such measures should be considered and approved on an ad hoc basis by a court of law, not by the subjective whims of a frustrated and suspicious medical staff.

Ethically, this Article concludes that it is contrary to the inherent tenets of the medical profession, to the best interest of children, and to logic and reason, to allow a child to struggle through sixty seconds of suffocation in the interest of either research or confirming suspicions. Those interests, in any case, should be satisfied through less cruel and less dangerous means. That is not to say that the alternative should be taken lightly. It defies logic, however, to assert that there is sufficient evidence to convince a judge that a child should be purposely subjected to cruel and possibly fatal abuse, yet that this same evidence is insufficient to convince a judge that, in the interest of a child's safety and well-being, the child should be temporarily separated from the parent until suspicions can be confirmed or dispelled.

Fighting fire with fire by employing child abuse to prevent child abuse is ludicrous and unethical, however satisfying or necessary the result. The solution to the medical and ethical dilemma of employing covert video surveillance to detect or confirm Munchausen Syndrome by Proxy lies in the willingness and ability of judges and juries to accept the disease as a unique form of child abuse that warrants unique consideration, such as that given by the Family Court of New York, which considers cumulative circumstantial evidence of Munchausen Syndrome by Proxy and to it applies the *res ipsa loquitur* theory. While judges may find accepting the reality of the disease unnerving, it should not take the perpetuation of evil to bring about good, when all that is required to do justice is an open mind, a willingness to err on the side of caution, and a Hippocratic resolve to "first, do no harm."