DIAGNOSING THE TRUTH: DETERMINING PHYSICIAN LIABILITY IN CASES INVOLVING MUNCHAUSEN SYNDROME BY PROXY

I. INTRODUCTION: DISTINGUISHING FACT FROM FICTION

The time-honored routine of mothers leading their children through the doors of a doctor's office for a physical examination or check-up has in recent years been undermined by deceptive parents who are intent on abusing both the health of their children and the trust of their physicians. Munchausen Syndrome by Proxy (MSBP)[1] is the clinical term used to describe a frightening form of child abuse in which parents, often the mother, intentionally cause their children to become sick and deliberately falsify important medical data when presenting children for medical attention.[2] This disturbing form of

1. Some medical literature labels this condition Munchausen by Proxy Syndrome. *See, e.g.*, HERBERT A. SCHREIER & JUDITH A. LIBOW, HURTING FOR LOVE: MUNCHAUSEN BY PROXY SYNDROME (1993). This condition may also be referred to as MSP. *See* Marie M. Brady, *Munchausen Syndrome By Proxy: How Should We Weigh Our Options?*, 18 LAW & PSYCHOL. REV. 361 (1994). In addition, the term "Polle Syndrome" has been used to describe those situations in which one person persistently fabricates illness on behalf of another, usually a mother on behalf of her child. *See* Roy Meadow and Thomas Lennert, *Munchausen By Proxy or Polle Syndrome: Which Term Is Correct?*, 74 PEDIATRICS 554 (1984). However, an investigation of the family records of Baron Von Munchausen suggest that Polle Syndrome is an inappropriate title originally derived from incorrect information. *See id.*; *see also* C.N. Verity et al., *Polle Syndrome: Children of Munchausen*, 2 BR. MED. J. 422 (1979).

2. Due to the clandestine nature of MSBP, it is difficult to determine the exact number of annual MSBP cases. However, doctors' growing sensitivity to MSBP cases has caused both a gradual increase in the number of reported MSBP law suits and MSBP medical and legal articles. *See* Jon Jureidini, *Obstetric Factitious Disorder and Munchausen Syndrome By Proxy*, 181 J. NERVOUS & MENTAL DISEASE 135 (1993). In 1977, Dr. Roy Meadow described the first

behavior has forced physicians into the precarious and often conflicting roles of doctor, detective, and, ultimately, defendant.

Since 1977, published cases of MSBP have illustrated the varied forms that the abuse takes, from "the fabrication of fevers and seizures to the poisoning and asphyxiation of children."[3] In MSBP cases, the foundation of the doctor-patient relationship built on trust and disclosure collapses into trickery and deceit.[4] When dealing with

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two cases of MSBP in a British medical journal. For a discussion of these cases, see Roy Meadow, *Munchausen Syndrome By Proxy: The Hinterland of Child Abuse*, 2 LANCET 343 (1977) [hereinafter *Hinterland*]. In 1982, Meadow reported nineteen additional cases in other medical journals. *See* Sushma Jani et al., *Munshausen Syndrome By Proxy*, 22 INT'L J. PSYCHIATRY IN MEDICINE 343, 344 (1992) (citing R. Meadow, *Munchausen Syndrome By Proxy*, 54 ARCHIVES OF DISEASE IN CHILDHOOD 92, 92 (1982)). In 1987, Donna Rosenberg examined a collection of 117 MSBP cases identified over a twenty-one year period. *See id.* (citing D.A. Rosenberg, *Web of Deceit: A Literature Review of Munchausen Syndrome By Proxy*, 11 CHILD ABUSE AND NEGLECT 547 (1987)). By 1992, there were over 200 published cases in which parents feigned or caused illnesses in their children, presented their children for medical attention, and denied knowledge of the etiology of the illness. *See* Jureidini, *supra*, at 135. According to Schreier and Libow, the societal notion of the mother as "devoted caretaker" may foster problems associated with MSBP. *See* SCHREIER & LIBOW, *supra* note 1, at 104. The authors explain that the "seeds of this tragically limited behavioral repertoire are sown early in their lives, in familial arrangements and societal expectations based on gender." *Id.* As the mother typically plays the most important intimate role in the early years of a child's life, MSBP may represent the mother's effort to keep control of her child at all costs. *See id.* at 104-05. The mother in an MSBP case often presents herself as "a very attentive parent, providing continuous care, loving and overprotecting, but frequently showing less concern about the child's illness than the medical professionals. The parent cooperates fully and closely with the medical and nursing staff, and is frequently tearful when discussing the child's 'chronic illness.'" Karen A. Crouse, *Munchausen Syndrome By Proxy: Recognizing the Victim*, 18 PEDIATRIC NURSING 249, 250 (1992).

3. SCHREIER & LIBOW, supra note 1, at 7. A syndrome, such as MSBP, constitutes a cluster of symptoms or signs that are circumstantially related. In contrast to a disease, a syndrome may have multiple or different etiologies. *See* Donna A. Rosenberg, *Web of Deceit: A Literature Review of Munchausen Syndrome By Proxy*, 11 CHILD ABUSE AND NEGLECT 547, 548 (1987).

4. For example, in March 1995, Dr. Roy Meadow addressed the Medico-Legal Society in London, England, and described the case of a five-year-old British child whose mother created a realistic story of illness over a prolonged period of time. *See* Roy Meadow, *Munchausen Syndrome By Proxy*, 63 MEDICO-LEGAL J. 89, 93-94 (1995). The mother's contrived story resulted in the child suffering through nine endoscopies and consuming food through a tube put into one of his chest vessels for a four-year period. *See id.* at 94. Moreover, the child's mother interfered with the feeding tubes by continuously blocking them in order to attract increased attention. *See id.* This case presents a potentially complex legal issue because the mother, although deceptive and meddling, did not directly do anything to hurt the child. Instead, she only had concocted a false story. At the same time, the treating physicians effectively furthered the child's suffering by failing to recognize the child's MSBP symptoms. *See id.*

the parent of a pre-verbal child, a physician must instinctively apply his or her training and listen dependently to a parent's description of the child's symptoms.[5] Inclined to accept this information as true, the physician unknowingly attends to curing a child's ailments under false pretenses. When the physician either fails to cure or unintentionally perpetuates a child's illness, the child's parents increasingly turn to suing the treating physician for malpractice.

In many cases, a physician will simply fail to detect MSBP and, consequently, fail to treat the proper malady. In turn, the child bears the brunt of the abuse and suffers a great degree of harm, often in the form of extensive treatment and illness, or death. Thus, MSBP raises two important questions for physicians: first, how does a physician distinguish fact from fiction so as to not mistakenly fall into a spiraling web of legal liability; and, second, when facing a parent who intends to perpetuate a child's illness, how can a physician solve a medical dilemma without risking exposure to legal liability?

This double duty of responsibility placed on a physician, both to detect MSBP and to cure the resultant illness, demands a potentially unrealistic level of treatment. Accordingly, physicians who are blindsided by parental deception and abuse should not be held to typical standards of care.[6] Instead, parents, the primary culprits in

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5. *See Hinterland*, *supra* note 2. Meadow further explained, "Doctors dealing with young children rely on the parents' recollection of the history. The doctor accepts that history, albeit sometimes with a pinch of salt, and it forms the cornerstone of subsequent investigation and management of the child." *Id.*; *see also* Brady, *supra* note 1, at 364 (citing SANDRA R. MOTT ET AL., NURSING CARE OF CHILDREN AND FAMILIES 600 (2d ed. 1990)) (stating that the typical child-victim is less than six years old and, consequently, not adept at verbalizing his or her experiences); Karen A. Crouse, *supra* note 2, at 249 (stating that the victim of MSBP is usually "an infant or toddler and is rarely over 6 years old, because at that age, a child typically begins to question the perpetrator's actions and talk to others"); Roy Meadow, *Munchausen Syndrome By Proxy*, 299 BRIT. MED. J. 248, 249 (1989) [hereinafter *Munchausen Syndrome By Proxy*]. Meadow stated that a parent's deception typically occurs while the child is extremely young, commonly within the child's first two years. *See id.* If the deception is not discovered before the child reaches school age, some children may actually participate in the deception. In this situation, the mother teaches the child how to trick the doctors and how to lie. *See id.* As a result, many of these children have become independent illness addicts and have grown up to suffer from Munchausen Syndrome. *See id.*

6. *See* Toth v. Community Hosp., 22 N.Y.2d 255 (1968). The *Toth* court maintained that the "law generally permits the medical profession to establish its own standard of care." *Id.* at 262. While expert testimony is not required in a medical malpractice case to establish a prima facie case, evidence that a physician followed accepted community standards of practice usually insulates the physician from any future tort liability. *See id.*; *see also* Benson v. Dean, 232 N.Y.

causing and exacerbating a child's suffering in MSBP cases, should be legally limited from transferring culpability to those physicians whose initial care proves ineffective as a result of the parents' intentional misinformation.

The lines of legal responsibility become blurred, however, when a physician effectively contributes to a child's illness by treating the wrong symptom or simply misdiagnosing a typically identifiable illness. Should a physician be able to evade liability simply by arguing that the parent caused a misdiagnosis as a result of MSBP? The law's ability to fashion a bright line for liability in MSBP cases further weakens when continuous deception intersects with murky medical treatment.

Without concrete regulations to guide physician treatment of MSBP, the medical community increasingly faces the specter of legal entanglement. To date, the American Medical Association has not instituted guidelines to direct treatment of MSBP. Moreover, as parents eagerly look to shift the burden of responsibility outward to the physicians charged with solving this medical puzzle, physicians rarely stand any chance of putting the pieces together before irreparable harm befalls the suffering children.

This Note addresses potential legal liability issues facing physicians who treat MSBP cases. Part II provides a historical overview of the MSBP phenomenon. Part III discusses current legal processes for unraveling the tangled web of MSBP-related liability apportionment. Part IV offers a proposal for evaluating the legal ramifications of a physician's treatment of MSBP in light of the contributory nature of both parental and physician conduct in causing and exacerbating child illnesses. Finally, Part V concludes that

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52, 58 (1921).

According to *Toth*, a second principle demands that a physician should use "his best judgment and whatever superior knowledge, skill and intelligence he has," under the "reasonable person" standard. *Id.* For a discussion of the "reasonable physician" standard, see *infra* Part IV. Thus, evidence that the defendant followed customary practice is not by itself a sufficient test of professional malpractice. *See Toth*, 22 N.Y.2d at 263. If a physician fails to properly use his expertise or judgment, and that failure causes a patient's injury, the physician should not automatically escape liability solely because he followed standard practice. *See id.* Furthermore, the court suggested that there are simply no policy reasons why physicians, who know or believe there are unnecessary risks or dangers in the community practice, should not be required to take appropriate precautionary measures. *See id.*

effective education and training of both new and practicing physicians will best protect the health of abused children.

II. HISTORY OF MUNCHAUSEN SYNDROME BY PROXY

Baron Von Munchausen, an eighteenth century German mercenary and politician, returned from serving in the Russian army to spend his remaining years charming friends with embellished stories of his itinerant adventures and military exploits.[7] Munchausen's tales gained a fabled following in popular literature throughout the twentieth century.[8] In 1951, Dr. Richard Asher first used the Baron's name to describe adult patients with self-induced illnesses who attempted to get admitted to hospitals.[9] Individuals with Munchausen syndrome traditionally offer fanciful stories regarding the nature and origin of their ailments, which they purposely alter at different hospitals.[10] As Dr. Roy Meadow observed, these patients

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7. *See* Bernard Kahan & Beatrice Crofts Yorker, *Munchausen Syndrome by Proxy: Clinical Review and Legal Issues*, 9 BEHAV. SCI. & L. 73, 76 (1991); *see also Munchausen Syndrome by Proxy*, *supra* note 5, at 248.

8. *See* Kahan & Yorker, *supra* note 7, at 76 (discussing how Rudolph Eric Raspe plagiarized the Munchausen tales which were subsequently used to form the basis of a popular children's book entitled *The Amazing Travels and Adventures of Baron Von Munchausen*); *see also* Richard Asher, *Munchausen's Syndrome*, 1 LANCET 339, 339 (1951); Brady, *supra* note 1, at 362; SCHREIER & LIBOW, *supra* note 1, at 6-7.

9. *See* Asher, *supra* note 8, at 339. These hospital-addicted patients, also called "hospital hoboes," traveled great distances for medical attention and told lies much like the characters in the Munchausen tales. *See* Kahan & Yorker, *supra* note 7, at 76; SCHREIER & LIBOW, *supra* note 1, at 29-31.

10. Munchausen Syndrome afflicts an estimated 4,000 to 12,000 Americans. *See* Brady, *supra* note 1, at 362 (citing Loren Pancrantz & Susan Hauser, *Munchausen is More Than a Movie, It's Also the Name of a Bizarre Medical Disorder*, PEOPLE, May 8, 1989, at 95); *see also* Chris Anne Raymond, *Munchausen's May Occur in Younger Persons*, 257 J. AM. MED. ASS'N 3332 n.4 (1987) (discussing a study by Tyson and Fortenberry which found that, in 42% of all cases of Munchausen Syndrome reported since 1980, two-thirds of the patients were female); Judith A. Libow & Herbert A. Schreier, *Three Forms of Factitious Illness In Children: When Is It Munchausen Syndrome By Proxy?*, 56 AM. J. ORTHOPSYCHIATRY 602 (1986). Libow and Schreier suggest that,

> For all the frustration generated by adult Munchausen patients, the Munchausen syndrome by proxy evokes even greater outrage in the medical community. Adult Munchausen patients are highly self-destructive but they generally stop short of suicide in their efforts to obtain medical attention. In the proxy version, on the other hand, the extreme life-threatening interventions of some parents . . . in their efforts to create believable illness are imposed on helpless, often preverbal, children with no ability to limit the damage inflicted.

"tend to discharge themselves when the game is up. They cause physical suffering to themselves but not usually to their relatives."[11]

In 1977, Dr. Meadow first applied the term "Munchausen Syndrome By Proxy" to a form of child abuse in which parents subject their children to harmful hospital procedures.[12] Meadow described children "whose mothers invented stories of illness about their child and substantiated the stories by fabricating false physical signs"[13] to intentionally cause their children to become gravely ill.[14] As a result, these children often require extensive medical attention, frequently involving ongoing and invasive medical procedures.[15] Because they often purport to have extensive knowledge of both symptoms and treatment protocols, MSBP parents frequently engage in irrational behavior in order to gain access to both physicians and hospitals.[16]

MSBP typically is distinguished by four identifiable elements: (1) a child's illness is induced by a parental figure; (2) a parent repeatedly seeks medical examination and care of the child; (3) the parent denies any knowledge of the progress of the illness; and, (4)

Id. at 602-03. *See also* James C. Overholser, *Differential Diagnosis of Malingering and Factitious Disorder with Physical Symptoms*, 8 BEHAV. SCI. & L. 55, 56 (1990).

11. *Hinterland, supra* note 5, at 345.

12. *See id.* at 343-45. Meadow's first MSBP case analysis documented a six-year period of abuse in which two parents "systematically provided fictitious information about their child's symptoms, tampered with the urine specimens to produce false results and interfered with hospital observations." *Id.* at 343. Such malfeasance forced the child to undergo repeated consultations and anaesthetic, surgical, and radiological procedures. *See id.* In Meadow's second MSBP case study, a male child was intermittently given toxic doses of salt since the age of six weeks. *See id.* at 344. The child's resulting vomiting and drowsiness attacks led to a massive investigation in three different hospitals and eventually culminated in the child's death. *See id.* In both cases, Meadow found that the mothers "skillfully altered specimens and evaded close and experienced supervision." *Id.*

13. *Munchausen Syndrome By Proxy, supra* note 5, at 248.

14. *See* SCHREIER & LIBOW, *supra* note 1, at 5.

15. *See id.*

16. *See id.* (suggesting that MSBP mothers are well-versed in medical conditions and will seemingly stop at nothing in order to gain access to doctors and hospital care); *see also* Michael T. Flannery, *Munchausen Syndrome By Proxy: Broadening the Scope of Child* Abuse, 28 U. RICH. L. REV. 1175, 1189-90 (1994) (finding that MSBP mothers generally cooperate with medical personnel, become overly involved with their child's care, and have medical knowledge to further their actions); Susan O. Mercer & Jeanette D. Perdue, *Munchausen Syndrome by Proxy: Social Work's Role*, 38 SOC. WORK 74, 77 (1993); Libow & Schreier, *supra* note 10, at 606 (explaining that in a large number of cases, the mothers hold extensive knowledge and background in nursing and other medical fields).

the symptoms quickly cease when the child and parent are formally separated.[17] The MSBP label may apply to anyone who persistently fabricates symptoms on behalf of another to purposefully cause physicians to identify that person as ill.[18] The most common perpetrator in MSBP cases is the mother of a sick child.[19]

Although MSBP cases often share many similar characteristics and symptoms, physicians face the daunting task of treating an ever growing list of fictitious or induced symptoms.[20] Because MSBP

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17. *See* Michael T. Flannery, *Munchausen Syndrome By Proxy: Broadening The Scope Of Child Abuse*, 28 U. RICH. L. REV. 1175, 1184 (1994) (citing Mercer & Perdue, *supra* note 16, at 74-75).

18. *See* Roy Meadow, *Management of Munchausen Syndrome By Proxy*, 60 ARCHIVES DISEASE CHILDHOOD 385, 385 (1985) [hereinafter *Management of Munchausen Syndrome by Proxy*].

19. In nearly all reported cases, the mother is the perpetrator of her child's illness. *See* Rosenberg, *supra* note 3, at 555. In Rosenberg's study of 117 reported MSBP cases between 1966 and 1987, there were 97 perpetrators found, 98% of whom were biological mothers and the remaining 2% of whom were adoptive mothers. *See id.* In as many as 75% of the cases, the mother actually induced the illness. *See id.* at 556. In those cases, the mother tended to be the "dominant person in the marriage and to be more intelligent and capable than her husband." *Munchausen Syndrome by Proxy*, *supra* note 5, at 249. The husband played a background role, was often unsupportive of his wife's needs, and was unaware of the harm occurring to the child. *See id.* Karen A. Crouse also suggests that fathers of MSBP children tend to be "distant, unsupportive, and profess a lack of knowledge of their wives' actions." Crouse, *supra* note 2, at 250 (stating that there is "usually a poor emotional relationship between the mother and father of the victim"). MSBP mothers have often suffered a difficult childhood themselves. *See id.*

When MSBP mothers seek care for their ailing children, they typically maintain a relationship with one general practitioner or one specialist. *See Munchausen Syndrome by Proxy*, *supra* note 5, at 249. Additional referrals to other specialists come from the first set of attending physicians. *See id.* In more complicated cases, children are often transferred from hospital to hospital, where they face repetitive examinations. *See id.* MSBP mothers thrive on such constant care and investigation while accompanying their children to different hospitals. *See id.*

20. The following illnesses are the most commonly fabricated medical conditions identified in documented MSBP cases: seizures, allergies, fever, sepsis, hematemesis, fecal urine, cystic fibrosis, thyroid disease, heart disease, acute renal failure, hypoglycemia, diarrhea, sepsis, apnea, metabolic instability, poor weight gain, dermatitis, and Sudden Infant Death Syndrome. *See* Kahan & Yorker, *supra* note 7, at 77; *see also Management of Munchausen Syndrome By Proxy*, *supra* note 18, at 385-86. Warning signals that may alert a pediatrician to the presence of factitious illness include:

> (1) Illness which is unexplained, prolonged, and so extraordinary that it prompts experienced colleagues to remark that they 'have never seen anything like it before'; (2) Symptoms and signs that are inappropriate or incongruous, or are present only when the mother is present; (3) Treatments which are ineffective or poorly tolerated; (4) Children who are alleged to be allergic to a great variety of foods and drugs; (5) Mothers who are not as worried by the child's illness as the nurses and doctors,

maladies are either nonexistent or induced by substances or manipulation, common treatment protocols often fail to effectively treat the actual illness.[21] As a result, such illnesses are likely to recur or intensify.[22]

The inconsistent and unusual patterns of illness that define MSBP cases are early indications that intentional parental deception or manipulation is the cause of a child's ailment.[23] In such cases, physicians are left to determine how best to treat an illness without a complete and accurate description of a child's condition. Moreover, when developing suspicion of a parent's meddlesome and potentially lethal interference with a child's well-being, physicians must also determine how to confront the parent responsible for causing the child's condition.[24]

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mothers who are constantly with their ill child in a hospital (not even leaving the ward for brief outings), and those who are happily at ease on the children's ward and form unusually close relationships with the staff; and (6) Families in which sudden unexplained infant deaths have occurred, and families containing many members alleged to have different serious medical disorders.

Id.; *see also* Mark S. Dine & Mark E. McGovern, *Intentional Poisoning of Children—An Overlooked Category of Child Abuse: Report of Seven Cases and Review of the Literature*, 70 PEDIATRICS 32, 33-34 (1982). Dine and McGovern present a chart of cases of abuse by poisoning, distinguishing presentation from the agent and providing the ultimate outcome:

Presentation	Agent	Outcome
Apnea	Pepper	Death
Anorexia, Stridor, Hypernatremia	Table salt (abused in hospital)	Death
Fever, diarrhea, blood in stool	Phenolphthalein (abused in hospital)	Survival
Choking, seizures	Table salt;	Survival
Lethargy, twitching, abdominal distension	Amitriptylene, nortriptylene	Survival

See id.; *see also* SCHREIER & LIBOW, *supra* note 1, at 225-28 app. A (providing a list of all possible signs and symptoms of MSBP recognized by the authors).

21. *See* SCHREIER & LIBOW, *supra* note 1, at 15.

22. *See id.*

23. *See, e.g.*, *In re* Aaron S., 625 N.Y.S.2d 786 (N.Y. Fam. Ct. 1993) (unexplained history of central apnea and hospitalization for dental surgery); *In re* Jessica Z., 515 N.Y.S.2d 370 (N.Y. Fam. Ct. 1987) (mother forced ingestion of sufficient quantities of laxatives to cause severe diarrhea, blood infections, and dehydration).

24. Cases of MSBP serve as a reminder that doctors must accept, at times, medical histories offered by parents, and related laboratory findings, with more than mere skepticism. *See Hinterland*, *supra* note 5, at 345. Dr. Meadow also suggested that, "we may teach, and I

In attempting to cure a troublesome or unexplainable illness, physicians search for "[s]igns associated with the syndrome [that] are not necessarily proof of the syndrome."[25] Thus, the inherent potential for misdiagnosis forces physicians into the precarious role of balancing several interests. First, an attempt to treat a child without full disclosure from the parent creates a risk of error due to falsified information. Second, the physician must avoid causing greater harm to a child due to a misdiagnosis of the child's malady or a failure to accurately diagnose MSBP. Finally, the physician must be aware of the possibility of alienating a wrongly accused or suspected parent.[26]

While distinguished by its medically deceptive and clandestine nature, MSBP simply represents an alternative form of child abuse.[27] This type of *medical* abuse appears in various forms. MSBP occurs, for example, when parents who have a legitimately ill or disabled child seek to intentionally prolong the child's illness, increase the degree of disability, or ensure that the child is designated as incapacitated when the opposite is true.[28] As Dr. Vincent Guandolo noted, "[d]eliberate parental involvement of their progeny in a fraudulent game of medical "hide and seek" is a disturbing form of child abuse."[29]

Consequently, physicians must distinguish a nervous,

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believe should teach, that mothers are always right; but at the same time we must recognise that when mothers are wrong they can be terribly wrong." *Id.*

25. *Id.*

26. *See Management of Munchausen Syndrome By Proxy*, *supra* note 18, at 385. Meadow explained, "Even though the fabrication of symptoms and signs may continue for several years and be gross, it can be most difficult to detect. Nevertheless, effective management for the child and the family is even more difficult." *Id.*

27. The National Committee for the Prevention of Child Abuse defines child abuse as "'a nonaccidental injury or pattern of injuries to a child.'" Tracy Vollaro, Note, *Munchausen Syndrome By Proxy and Its Evidentiary Problems*, 22 HOFSTRA L. REV. 495, 495 (1993) (quoting Kerrie Marzo, *Anatomical Simulator of the Most Common Physical Signs of Child Abuse*, 107 PUB. HEALTH REPRESENTATIVE 218, 218 (1992)); *cf.* Flannery, *supra* note 17, at 1209. According to the Council on Scientific Affairs, more than one million children in the United States are abused annually. *See* Vollaro, *supra*, at 495 (quoting AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect, 254 J. AM. MED. ASS'N. 796 (1985)). Of these one million children, 700,000 are neglected or maltreated, 300,000 are physically abused, and 140,000 are sexually abused. *See id.* Between 2,000 and 5,000 abused children die annually as a result of their injuries. *See id.*

28. *See Munchausen Syndrome By Proxy*, *supra* note 5, at 248.

29. Vincent L. Guandolo, *Munchausen Syndrome by Proxy: An Outpatient Challenge*, 75 PEDIATRICS 526, 526 (1985).

inexperienced parent from an abusive, attention-seeking parent in determining the existence of MSBP. This is often an arduous task as anxious parents typically worry about the health of their children and, consequently, seek repeated and redundant treatment.[30] In turn, a child must endure unpleasant visits and treatments at the parent's insistence.[31] Nonetheless, an over-anxious parent is not necessarily an abusive parent.[32] Most physicians are not likely to classify such parents as abusive unless a parent's persistence and refusal to accept a physician's advice becomes excessive, thereby endangering or impairing the quality of the child's life.[33]

Dr. Meadow found that children who are falsely labeled as ill suffer five main consequences: (1) such children receive unnecessary and harmful examinations and treatments; (2) MSBP parents abusive actions will effectively induce genuine disease in their children; (3) an MSBP child may die suddenly as a result of the offending parent's misjudgment of the degree of harm that he or she has inflicted on his or her child; (4) a child may develop chronic invalidism by accepting a false illness story and identifying herself as disabled or unable to work, attend school, or function in a normal society; and (5) an MSBP child may develop Munchausen Syndrome as an adult.[34] In light of these recognized consequences, it is clear that fabricated illnesses imposed by deceitful parents place both children and physicians in dangerous positions. Convincing tales of weekly epileptic seizures, for example, "will cause the doctor to embark on detailed investigations and prescribe anticonvulsant treatment."[35] If a parent persistently and persuasively relates a believable history of illness, the mere recitation will likely prompt a treating physician to undertake an entire regimen of tests and treatments.[36]

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30. *See Munchausen Syndrome By Proxy*, *supra* note 5, at 248.
31. *See id.*
32. *See id.*
33. *See id.*
34. *See id.* at 249.
35. *Id.*
36. *See id.*

III. PHYSICIAN RESPONSIBILITY—WHAT LEVEL, WHAT RISK?

A. The Role of the Physician

As physicians begin the task of identifying and treating children's ailments, they must remain cognizant of potentially contradictory medical symptoms and parental reports. Absent a clear initial picture of how to proceed with effective treatment, doctors must "listen carefully to parents' worries and . . . believe them when they say their child is ill."[37] As a result, doctors are initially forced to work within the parameters of a parent's description of a child's health.[38] Physicians must cautiously accept a parent's story as a means of evaluating a chronic illness until further demonstrative information becomes available.[39]

When parental behavior turns from apparent familial idiosyncrasies to medically and ethically unsound behavior, however, the behavior often signifies child abuse. At that point, physician intervention becomes a necessity.[40] For example, a scenario in which a child is intentionally covered with aluminum foil and forced to sleep on the back of an upturned cupboard to avoid suspected allergens "amounts to child abuse,"[41] and corrective action must be instituted. Playing the multiple roles of doctor and detective, physicians should take the lead in working to end such abuse.

As the reported number of MSBP cases grows each year,[42] physicians must search for tell-tale signs of MSBP both to protect children from further harm and to protect themselves from exposure

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37. *See id.* at 248; *see also* Guandolo, *supra* note 29, at 528 (quoting E. Clarke and S.C. Melnick, *The Munchausen Syndrome or the Problem of Hospital Hoboes*, 25 AM. J. MED. 6, 12 (1958)). Dr. Guandolo warns that, "One of the essential attributes of the physician must be a readiness to accept the patient's story, and if we should ever cast doubts upon the veracity of his statements the whole structure of clinical medicine would be undermined." *Id.*

38. *See id.*

39. *See id.* at 529.

40. According to James D. Frost, Jr., "[N]o effort should be spared to determine the precise cause of the patient's condition in the most straightforward manner possible, while simultaneously minimizing additional risks." James D. Frost, Jr. et al., *Munchausen's Syndrome by Proxy and Video Surveillance,* 142 AM. J. DISEASES CHILDREN 917, 917 (1988).

41. *Munchausen Syndrome By Proxy*, *supra* note 5, at 249.

42. *See supra* note 2.

to legal liability.[43] Although the "ability to function as a health-care provider would be compromised by continually doubting the truthfulness of parental report,"[44] physicians should intervene when they suspect such abuse.

B. The Physician's Role in Upholding State Family Codes

To encourage physicians who suspect abuse to intervene without hesitation, state legislatures have created substantive standards for uncovering and reporting child abuse or neglect that physicians and health care practitioners must meet. These reporting codes should be extended to suspected MSBP cases so that physicians will take a more aggressive and proactive approach to MSBP, rather than waiting for further signs of abuse. In the absence of national standards for treating MSBP cases, state family laws can provide direction to health care practitioners and courts for evaluating physician conduct. This section examines the effect of abuse reporting statutes on MSBP cases under the Texas Family Code, a code that is typical of state standards across the United States.[45]

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43. *See Munchausen Syndrome By Proxy*, *supra* note 5, at 250. According to Dr. Meadow, MSBP may exist if:

> 1) The illness is unexplained, prolonged, or extremely rare; 2) The symptoms and signs have a temporal association with the mother's presence . . . ; 3) The mother is a hospital addict and more anxious to impress the doctor than she is worried about her child's illness; 4) The treatment prescribed is ineffective and not tolerated; 5) In the family history there are multiple illnesses and similar symptoms in other members of the family.

Id.

44. Kahan & Yorker, *supra* note 7, at 78.

45. *Cf.* MO. REV. STAT., §§ 210.109-211.115 (1995). Section 210.110 (1995) of the Missouri Revised Statutes defines abuse as "any physical injury, sexual abuse, or emotional abuse inflicted on a child other than by accidental means by those responsible for the child's care, custody, and control, except that discipline including spanking, administered in a reasonable manner, shall not be construed to be abuse." § 210.110. Furthermore, under section 210.115:

> When any physician . . . engaged in the examination, care, treatment or research of persons and any other health practitioner . . . has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately report or cause a report to be made to the division in accordance with the provisions of sections 210.109 to 210.183.

Under Chapter 261 of the Texas Family Code,[46] a person having "cause to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect by any person shall *immediately* make a report."[47] Thus, the Texas statute

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Id. Section 210.135 provides that any person in such a reporting role "shall have immunity from liability, civil or criminal, that otherwise might result by reason of such actions. Provided, however, any person, official or institution intentionally filing a false report, acting in bad faith, or with ill intent, shall *not* have immunity from any liability, civil or criminal." *Id.* (emphasis added).

Section 11166.5 of the California Penal Code requires

> any child care custodian, health practitioner. . . who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

CAL. PENAL CODE § 11166.5 (1996). Under the California statute, "health practitioner" includes physicians and surgeons. *See id.*

In addition, section 11171(a) of the California Penal Code allows physicians, surgeons or dentists, and their agents, to take skeletal X-rays of a child without the consent of the child's parent or guardian for the purpose of diagnosing child abuse and determining the extent of such abuse. *See* § 11171(a).

Under section 11172 of the California Penal Code, no health practitioner who reports a "known or suspected instance of child abuse shall be civilly or criminally liable for any report required or authorized by this article." *Id.* Subsection (c) of this section explains, however, that "even though [the state legislature] has provided immunity from liability to persons required to report child abuse, that immunity does not eliminate the possibility that actions may be brought against those persons based upon required reports of child abuse." *Id.* § 11172(c).

Like the comparable Texas statute, California Penal Code section 11172(e) states that:

> Any person who fails to report an instance of child abuse which he or she knows to exist or reasonably should know to exist, as required by this article, is guilty of a misdemeanor and is punishable by confinement in the county jail for a term not to exceed six months or by a fine of not more than one thousand dollars ($1000) or by both.

Id. § 11172(e).

46. TEX. FAM. CODE ANN. § 261.101 (1996).

47. *Id.* § 261.101 (emphasis added). Subsection (b) further details a practitioner's duty to report:

> If a professional has cause to believe that a child has been or may be abused or neglected, the professional shall make report *not later than the 48th hour* after the hour the professional first suspects that the child has been or may be abused or neglected. A professional may not delegate to or rely on another person to make the report.

Id. (emphasis added). In addition, this subsection defines "professional" to include teachers, nurses, doctors, and day-care employees. *See id.* Subsection (c) further states that the rule will apply without exception to "an individual whose personal communications may otherwise be

effectively mandates that physicians be vigilant when treating symptoms that even remotely suggest MSBP abuse. The Texas rule also suggests that physicians are not required to know that abuse is the definitive cause of a patient's medical complications. Rather, the mere possibility of abuse qualifies for notification under the law.[48] As a result, if a physician treating MSBP fails to report alleged or suspected offenses when she believes that a child's welfare is endangered, the physician has committed an offense punishable under Texas state law.[49]

Thus, the Texas law places a premium on aggressive physician intervention to combat parental abuse in situations where MSBP may be present. A physician who suspects MSBP, yet continues to treat suspicious symptoms as though no abuse has occurred, places multiple parties at risk: the child continues to suffer medical complications, the parent continues to abuse the child, and the physician continues to risk legal liability.[50] While the abuse committed may not be visible to the naked eye, the law does not distinguish between physical and medical abuse.[51] Thus, both physicians and children are better protected if physicians assert their legal right to report suspected cases of MSBP.

While the Texas law holds physicians to a relatively high standard of responsibility in reporting abuse, intervening physicians receive an added measure of protection through the law's immunity provision.[52] Such protection is a necessary safeguard for MSBP-treating physicians because MSBP abuse is frequently well-disguised.

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privileged," including an attorney or a medical practitioner. *Id.*

48. *See id.* § 261.103.

49. *See id.* § 261.109; *cf.* CAL. PENAL CODE § 11172(e).

50. *See* Peter W. Goss and Peter N. McDougall, *Munchausen Syndrome by Proxy—A Cause of Preterm Delivery*, 157 MED. J. AUSTL. 814, 816 (1992) (quoting T.L. McGuire & K.W. Feldman, *Psychological Morbidity of Children Subjected to Munchausen Syndrome By Proxy*, 83 PEDIATRICS 289 (1989)).

51. *See* TEX. FAM. CODE ANN. § 261.001 (defining abuse to include both physical and mental injury).

52. Section 261.106 provides that a person "acting in good faith who reports or assists in the investigation of a report of alleged child abuse or neglect or who testifies or otherwise participates in a judicial proceeding ... is immune from civil or criminal liability." *Id.* § 261.106(a). A person who reports "the person's own abuse or neglect of a child or who acts in bad faith or with malicious purpose in reporting alleged child abuse or neglect is not immune from civil or criminal liability." *Id.* § 261.106(c).

Like the Texas law, most state laws require that notice be given *only* by those physicians having "reasonable cause to believe that a child has been abused" and penalize only those physicians "who knowingly or willfully" fail to do so.[53] In effect, such immunity provisions remove a physician's fear of potential retribution by a disgruntled or mistakenly accused parent.

Despite the potential for endless parental claims alleging wrongful physician conduct, courts have repeatedly erred on the side of shielding physicians from liability when they have reported suspected child abuse. For example, in *Maples v. Siddiqui*,[54] the parents of a child temporarily removed from their custody brought medical malpractice charges against the treating pediatrician.[55] The Supreme Court of Iowa held that the state immunity statute that protects physicians from such charges precluded liability.[56] In this manner, physicians receive an extra level of protection from potential legal liability. Such protection may help to combat the actions of abusive parents who suffer from MSBP or engage in other forms of child abuse.

C. Consequences of a Failure to Report MSBP

While state laws may provide a layer of protection for physicians who suspect abuse, this insulation should not overtake or lessen their duty to diagnose and treat illnesses.[57] For example, in *First*

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53. Cechman v. Travis, 414 S.E.2d 282, 284 (Ga. Ct. App. 1991). The relevant Georgia statute does not require that notice be given by those physicians "'who should have had reasonable cause'" to suspect child abuse and it does not penalize those physicians "'who fail to discover and report'" suspected instances of child abuse. *Id.* (quoting GA. CODE ANN. § 19-7-5 (1997)).

54. 450 N.W.2d 529 (Iowa 1990).

55. *See id.* at 529. The physician recommended that the baby be placed in foster care because he was not gaining weight while in the care of his parents. *See id.* It was later discovered that the child suffered digestive disorders that caused the weight problem. *See id.* The physician attributed the child's failure to grow to poor parental care. The doctor reached this conclusion after the child was admitted to the hospital for a second time for failure to gain weight. *See id.*

56. *See id.* at 530.

57. *Cf.* Ferraro v. Chadwick, 270 Cal. Rptr. 379, 386 (Cal. Ct. App. 1990) (holding that, "The legislature, in addressing the serious problem of child abuse, determined that bestowing absolute immunity upon the enumerated professionals for 'authorized' as well as 'required' reporting was appropriate."); Michaels v. Gordon, 439 S.E.2d 722, 725 (Ga. Ct. App. 1993)

Commercial Trust Co. v. Rank,[58] the administrator of the estate of a child filed suit against a family practitioner for medical negligence and failure to report suspected child abuse.[59] Over a three-month period, the child visited her physician on four occasions, at which times her mother provided unreasonable explanations for her child's various injuries.[60] Despite her initial concerns of possible abuse, the treating physician did not report her suspicions.[61] Even after repeatedly treating suspicious conditions, including broken bones, swollen eyelids, and head trauma, the physician remained silent.[62] Under circumstances such as these, a physician should be held jointly responsible for contributing to a child's death.

If treating physicians maintain their silence despite the presence of signs of abuse, such as those in *Rank*, children may be forced to return home and face continued injury. The case of *Landeros v.*

(stating that the statutory immunity covers good faith reporting, including licensed pyschologists who participate in reporting possible abuse beyond the initial report.)

58. 915 S.W.2d 262 (Ark. 1996).

59. *See id.* at 263. In Arkansas, "medical injury" is defined under the Medical Malpractice Act as

> any adverse consequences arising out of or sustained in the course of the professional services being rendered by a medical care provider, whether resulting from negligence, error, or omission in the performance of such services[,] . . . or from failure to diagnose[,] . . . or otherwise arising out of or sustained in the course of such services.

ARK. CODE ANN. § 16-114-201(3) (1993).

60. *See Rank*, 915 S.W.2d at 263-64. On June 12, 1992, Mary Ellen Robbins took her one-year-old child for a checkup. At that visit, the physician noticed that the child's forearm was angulated and swollen, and an X-ray revealed fractures to both of the bones of the child's lower left arm. *See id.* The physician referred the mother to another physician, to whom the initial physician communicated her concern about possible child neglect. *See id.* Less than a month later, in response to the mother's complaint that her child was "wobbly" and unbalanced, the physician concluded that the mother gave her child too much juice. *See id.* A few weeks later, the mother and child returned to the physician's office, at which time the physician observed swelling on the right side of the child's head. *See id.* The mother suggested that a fall from the week before had caused the swelling above the child's right ear. *See id.* The following day, the child returned with swollen eyes and purple discoloration. The mother informed the physician that the new bruises were related to a fall down several stairs that occurred the week before. *See id.* at 264. When the physician then discussed the possibility of abuse with the child's mother, the mother denied that possibility and asserted that her boyfriend was "not the type to have a bad temper." *Id.* at 264. The child died a few months later after being left at home with the mother's boyfriend. *See id.*

61. *See id.*

62. *See id.*

Flood[63] underscores the importance of avoiding this possibility. In *Landeros*, a physician failed to detect a skeletal fracture, diagnosable by simple X-rays.[64] The physician's failure to properly diagnose the child's condition led to his failure to report the abuse that had produced the child's condition. As a result, the continued abuse seriously harmed the child.[65] The Supreme Court of California held that both the physician and the hospital could be held liable for the injuries sustained by the child if they negligently failed to diagnose and report the abuse.[66]

D. Balancing Physician Responsibility with Physician Immunity from Suit

In *D.L.C. v. Walsh*,[67] a father and his child brought medical malpractice charges against a group of physicians and a hospital for negligently misdiagnosing sexual abuse of the child.[68] The court held that an initial investigation of suspected abuse is "so inextricably linked to the resulting report that it would be illogical to deny immunity for it. To hold otherwise would discourage individuals from reporting suspected child abuse."[69] Similarly, in *Awkerman v.*

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63. 551 P.2d 389 (Cal. 1976).
64. *See id.*
65. *See id.*
66. *See id.* at 396-97.
67. 908 S.W.2d 791 (Mo. Ct. App. 1995).
68. *See id.* In *Walsh*, a three-year-old child, "JLC," spent three nights with her father pursuant to a joint custody agreement. *See id.* at 793. After returning home, JLC's mother noticed that JLC was walking bow-legged and claiming that her "bottom hurt." *Id.* The mother contacted a psychologist who was previously employed by the family and expressed concern that JLC had been sexually molested. *See id.* After examining JLC, the psychologist, while unable to make a firm diagnosis of child abuse, concluded that there was reason to suspect sexual assault. *See id.* State law required the psychologist to report the alleged offense and, as a result, charges of child abuse were filed against the father. *See id.* After a social services agency concluded that the charges were unfounded, the father filed a malpractice suit against both the psychologist and the hospital. *See id.* at 794. The court dismissed the petition based on immunity laws. *See id.*; *see also* Lehman v. Stephens, 499 N.E.2d 103 (Ill. App. Ct. 1993) (denying parents' damages claims for physician malpractice after their minor child was admitted to a hospital for observation on suspicion of abuse and neglect); Bird v. W.C.W., 868 S.W.2d 767 (Tex. 1994) (holding that a mental health professional owes no duty to a parent not to negligently misdiagnose the condition of the parent's child); *cf.* Watterson v. Page, 987 F.2d 1 (1st Cir. 1993); Michaels v. Gordon, 211 Ga. App. 470 (Ga. Ct. App. 1993); Williams v. Coleman, 488 N.W.2d 464 (Mich. Ct. App. 1992).
69. *Walsh*, 908 S.W.2d at 799.

Tri-County Orthopedic Group,[70] the Michigan Court of Appeals emphasized that if plaintiffs could sue physicians for malpractice when they report abuse, "the immunity granted to a physician who files a child abuse report would be entirely emasculated since a litigant could always assert that an incorrect diagnosis of child abuse constituted malpractice."[71] As the *D.L.C.* and *Alkerman* courts have found, physicians' freedom to report abuse without fear of retaliatory legal action for potentially misplaced allegations best preserves a child's interest in MSBP cases by allowing physicians to critically evaluate claims of illness made by parents.

E. Parental Malpractice Charges: Evidence and Burden of Proof

Parents alleging medical malpractice in MSBP cases must meet an initial burden of proof by presenting evidence of abuse sufficient to create a triable issue of material fact. In *Straton v. Orange County Department of Social Services*,[72] parents brought medical malpractice charges against a social services agency that sought custody of an allegedly abused child.[73] The allegations of abuse were based on medical testimony that the child would continue to suffer MSBP abuse if left in the care of her mother.[74] Although the family court authorized an extensive medical evaluation and protection for the child over a one-year period, the child was ultimately returned to her parents.[75]

The *Straton* court held that parents alleging medical malpractice under these circumstances must "produce evidentiary proof in admissible form sufficient to require a trial of material questions of fact on which [they] rest[ed] [their] claim . . . mere conclusions,

70. 373 N.W.2d 204 (Mich. Ct. App. 1985).

71. *Id.* at 207.

72. 628 N.Y.S.2d 818 (N.Y. 1995).

73. *See id.* at 819.

74. Ashley Straton, a chronically ill child, was taken to various doctors and hospitals without successful treatment. *See id.* After her mother's refusal of a doctor's suggestion that Ashley be admitted for psychological examinations, the doctor reported the Stratons to the Orange County Department of Social Services. *See id.* Ashley was hospitalized and treated for one year, during which time her mother was not permitted to have contact with her. *See id.*

75. Following this prolonged evaluation, the family court determined that Ashley's condition did not improve by the separation and thereupon returned Ashley to her parents. *See id.*

expressions of hope or unsubstantiated allegations or assertions are insufficient."[76] Under this analysis there is a high burden of proof for parents alleging medical malpractice against physicians or social service agencies. Additionally, parents must provide expert medical opinion evidence in order to demonstrate the merits of their claims.[77]

Like the more typical forms of child abuse, for which courts place a high burden of responsibility on treating physicians because physical ailments are typically readily visible, physicians treating MSBP cases should share a similar burden. Although more difficult to diagnose immediately, MSBP remains a recognized form of child abuse. Thus, it follows that physicians should bear the same responsibility and receive the same scrutiny in treating the elements of this abuse. For example, if a child's first visit to her physician reveals a broken fibula, the physician must question the parents for possible explanations of the injury. Regardless of the information presented, the physician should give some credence to the parents' report. A second visit two months later may reveal a similar injury. Again, the physician may be inclined to accept the parents' explanation. Still, the recurrence of dubious explanations of injury must force treating physicians to both suspect and evaluate the possibility of abuse. The mere treatment of injuries or symptoms without sufficient questioning fails to fulfill a physician's social and professional responsibility. Furthermore, physicians must report to the appropriate authorities any and all suspicions of child abuse or neglect the instant the abuse is detected. When dealing with volatile MSBP cases, a physician's hesitancy to confront possible abuse both endangers the safety of the abused child and exposes the physician to a greater degree of liability for malpractice.

F. Legal Solutions

Without full disclosure from parents and assistance from other professionals, doctors "may unknowingly play an active role in harming children of Munchausen Syndrome by Proxy when the

76. *Id.* (quoting Zuckerman v. City of New York, 49 N.Y.2d 557, 562 (N.Y. 1980)).

77. *See* Romano v. St. Vincent's Med. Ctr., 577 N.Y.S.2d 311 (N.Y. App. Div. 1991); *see also* Fiore v. Galang, 478 N.E.2d 188 (N.Y. 1985).

disorder is not timely or correctly diagnosed."[78] Doctors must simultaneously exercise their medical expertise with some measure of detective work to uncover indications of MSBP when attempting to cure a child's maladies. Physicians must also critically assess overly-persistent parents who continually demand review of a child's sickness.[79] The truth underlying a parent's deception typically surfaces only after a physician repeatedly attempts to reconcile reported symptoms with applied diagnoses. As skepticism grows, physicians begin "to identify clinical evidence that highlighted historical inconsistencies . . . ."[80]

In applying the heightened burden placed on initially unsuspecting physicians, courts should weigh the effect of punishing physicians for parental trickery. To counter charges of misdiagnosis or negligence, physicians face the high costs of a legal defense, damage to both their reputation and practice, and the possible loss of their medical licenses. With such high stakes, courts should seek to balance the competing goals of encouraging physicians' reports of abuse and administering of proper treatment.

IV. PROPOSAL

As the number of MSBP cases continues to grow, the medical and legal communities must develop a coherent set of procedural and substantive guidelines for dealing with prevention, detection, and legal responsibility. Although MSBP cases typically exhibit case-specific factors and issues, a standard set of legal criteria with which to evaluate MSBP-based malpractice charges will ensure more consistent treatment of these claims. As one author suggests, "the inconsistent treatment of [MSBP] by the various jurisdictions stems from the absence of a uniform analytical standard to be applied to such family law issues."[81] Regardless of the individual characteristics of MSBP cases, the law ultimately must rationally and fairly

78. Flannery, *supra* note 17, at 1206.

79. *See* William W. Waring, *The Persistent Parent,* 146 AM. J. DISEASES CHILDREN 753, 753 (1992) (noting that "Parental persistence in the diagnosis and treatment of a child's illness can be examined by asking whether it is congruent with the child's morbidity.").

80. Guandolo, *supra* note 29, at 529.

81. Brady, *supra* note 1, at 371.

apportion legal responsibility for wrongful or negligent conduct and provide some basic measure of protection to the children who bear the brunt of such conduct.[82]

When evaluating a physician's legal responsibility for precipitating the further injury of an MSBP child, courts should apply a "reasonable physician" standard.[83] When applying this standard, courts should collectively consider the following factors:[84]

1. *Extent of medical harm prior to physician intervention.* If, based on expert medical testimony, a court finds that the harm caused by a parent prior to seeking medical attention has created an untreatable or severe condition that no physician could reasonably be expected to remedy, courts should err on the side of physician immunity from malpractice. This

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82. *Id.* Marie M. Brady explains that the

> judiciary has an implicit duty to ensure a normal and healthful environment for the child's development. For some, this may mean preserving the home life as much as possible. For others, it may be more prudent to remove the child from the environment where the chance of abuse is a virtual certainty.

Id.

83. With a reasonable physician standard, physicians similarly situated in a community can provide an accurate gauge by which to judge another physician's behavior. *Cf.* Toth v. Community Hosp., 22 N.Y.2d 255, 263 (N.Y. 1968). The *Toth* court refused to recognize any justification for the position that there is no tort liability as a matter of law when other reputable physicians think that a physician has acted prudently under given circumstances. *See id.* The court explained that

> it is not unreasonable to impose upon a physician, who believes that added precautions are necessary, the obligation that he act diligently in taking the necessary safety measures. This conclusion is nothing more than an application of the rule that a physician should at all times use his own best judgment and care.

Id. Ultimately, the court suggested that fairness and the avoidance of any strict liability principle would seem to imply that the physician should not be held liable when he or she has exercised his or her best judgment. *See id.* at 263 n.2; *see also supra* note 6 and accompanying text.

Furthermore, in California, courts have consistently held that the appropriate standard of care requires a physician to employ, in both diagnosis and treatment, a reasonable degree of knowledge and skill as compared to other members of his profession in similar circumstances. *See* Landeros v. Flood, 551 P.2d 389, 392-93 (Cal. 1976); Brown v. Colm, 522 P.2d 688 (Cal. 1974); Bardessono v. Michels, 478 P.2d 480 (Cal. 1970).

84. This set of criteria is not exhaustive and no one factor necessarily should be given more weight than another. Rather, courts must determine the appropriate weight of each factor in light of the individual facts and issues presented in each case. The criteria include questions and concepts that courts should ask or consider when evaluating the validity of a claim.

standard should be high enough such that, for a finding of physician non-liability, a child's condition must have been so extreme[85] that a physician had no medically identifiable means of curing the malady or symptom.

2. *Nature of the medical condition.* Based on expert testimony and the local community standard of care, courts should determine whether the MSBP condition was a commonly recognizable symptom or condition that a physician should be reasonably expected to identify. Irrespective of the misleading information and falsified data provided by parents, a court must ask whether a prudent physician would be expected to remedy the child's problem. Similarly, courts should determine whether the wrongful action allegedly taken by the physician was an error within medical protocol, regardless of the MSBP diagnosis.

3. *Repetitive nature of the injury.* Courts should consider whether a physician's treatment of an MSBP child was the first time that the physician had evaluated the child, or whether the MSBP child's injuries were similar to types of injuries that the physician had diagnosed in the child in the past. If a court finds the injury to be a repeated injury, it must then consider whether the physician should have been aware of a possible MSBP condition. If the physician should have known of a possibility or likelihood of MSBP, the court should weigh this factor against the physician. In addition, courts should establish what period of time is too long before a physician must take responsibility for perpetuating an MSBP condition.

4. *Reasonable standard of care.* In civil cases, courts should determine when a reasonably prudent physician would recognize typical MSBP symptoms. To set a fixed number of visits or conditions as a prerequisite to assigning legal blame to a physician would be ineffective in light of the myriad possible conditions in MSBP cases. The varying levels and methods of parental deception necessitate fact-specific analyses by a

85. The severity of the child's condition should be determined according to expert medical testimony and the standards set forth below.

reviewing court.

5. *Physician's level of knowledge.* Courts should expressly encourage physicians to report possible child abuse if there is the slightest belief or possibility of resultant harm. In turn, courts should vigorously apply and enforce state codes regarding the reporting of child abuse and neglect.

6. *Consideration of the physician's assessment.* Courts should review chart documentation and available medical records in order to accurately analyze the nature of the physician's role in treatment.[86]

Once a court collectively considers the aforementioned criteria, it must evaluate the possibility of finding joint and several liability for the harm done to the child. Further, if a relevant state law allows, a court should follow the comparative fault doctrine by assessing percentages of fault for the parties involved.[87]

V. CONCLUSION: AWARENESS BREEDS PREVENTION

The medical and legal communities must work together to protect the interests of abused children and deceived physicians.[88] Through

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86. *See* Howard Dubowitz & Donald C. Bross, *The Pediatrician's Documentation of Child Maltreatment*, 146 AM. J. DIS. CHILD. 596, 596 (1992) (noting that "[a]ssessment and documentation are especially important in cases of child maltreatment with regard to the possible involvement of the legal and judicial systems"). Dubowitz and Bross suggest that a medical record qualifies as a legal document subject to subpoena by all participants in a court proceeding. *See id.* at 597.

A physician's initial assessment of a child's symptoms may provide significant support in a legal proceeding: "[A] state's attorney's decision to prosecute an alleged perpetrator or to seek a protective order for a child might primarily be determined by the medical assessment." *Id.* at 596. As a legal document, a child's medical record may provide a court with a clear and detailed analysis of the relevant symptoms and diagnoses and, subsequently, shield the physician from legal liability for malpractice. *See id.*

87. In essence, under a modified joint and several liability system, the estate of a child, or whoever brings a case on behalf of a child, may have the opportunity to hold both the mother and the physician liable for harm incurred by the child.

88. MSBP cannot be addressed comprehensively without the medical and legal communities developing an inter-disciplinary understanding of MSBP's definition, causes, and consequences. *See* Flannery, *supra* note 17, at 1181. Flannery asserts that the dichotomy of MSBP awareness levels among the medical and legal professions relates to the acceptance of MSBP as a pervasive disorder. *See id.* at 1233 (noting that "[e]ven though modern medicine has accepted Munchausen Syndrome by Proxy as abusive behavior, the legal field has been

aggressive training, medical personnel[89] will become better able to identify and treat symptoms of MSBP with greater frequency and success.[90] In recognizing that a complete understanding of why MSBP occurs remains beyond the grasp of current medical knowledge, physicians charged with treating the illness must be vigilant in detecting and evaluating signs of possible abuse. Though not the cause of MSBP, physicians can provide the first line of defense in countering parents' attempts to harm their child.

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hesitant, perhaps even resistant, to broaden its scope of abuse to include the far-reaching effects of this bizarre and mysterious disorder").

89. Personnel may include, but is not limited to, physicians, social workers, nurses, and child protection services. *See* Keith L. Kaufman et al., *Munchausen Syndrome By Proxy: A Survey of Professionals' Knowledge*, 13 CHILD ABUSE & NEGLECT 141, 144 (1989) (suggesting that "contact with physicians may be the key colleagial [sic] relationship in obtaining knowledge regarding MSBP"). As many community service professionals lack regular contact with physicians, a key source of knowledge regarding MSBP may be unavailable to them.

90. *See* SCHREIER & LIBOW, *supra* note 1 (finding that "[I]t is critical that child protection workers, attorneys, judges, and other involved people have a working knowledge" of MSBP). Moreover, mental health professionals and physicians involved in child abuse cases have an ethical responsibility to educate other professionals and provide appropriate reading material for their edification. *See id.*

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