Dehumanization and Medical Abuse:

Understanding Munchausen Syndrome by Proxy and Physician Liability

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Abstract

Munchausen Syndrome by Proxy (MSBP), according to the Diagnostic and Statistical Manual of Mental Disorders, is a relatively rare psychiatric disorder and form of child abuse wherein a caretaker will either purposefully induce real symptoms to make their child appear gravely sick or fabricate false medical symptoms, even in the absence of external rewards. It remains difficult to diagnose perpetrators of MSBP because the caretaker's extreme concern for their child's supposed ailments is rationalized as caring and devoted. However, the victim may suffer grievous physical and psychological damage, including death. Thus, it is pivotal that medical professionals and forensic evaluators are conscious of the different warning signs in perpetrators and victims so that they can appropriately intervene and report the suspicions of child abuse to the applicable authorities in their jurisdiction. Under 34 U.S. Code § 20341, mandated reporters working in their professional capacity must report their suspicions of child abuse as soon as they learn of facts that give reason to suspect that a child has suffered an incident of physical injury, sexual abuse, exploitation, or treatment of a child. Failure to report instances of child abuse can result in criminal charges and potential civil liability. While many physicians fear malpractice defamation lawsuits from MSBP perpetrators, they are immune from civil liability if they report under the good faith standard.

Keywords: Munchausen Syndrome by Proxy, induce, fabricate, symptoms, child abuse, civil liability, good faith, criminal charges, immunity.

Dehumanization and Child Medical Abuse:

Understanding Munchausen Syndrome by Proxy and Physician Liability

Lacey Spears was sentenced to 20 years in prison for the death of her 5-year-old son, Garrett Spears (Egan, 2014). Specifically, she was convicted of murdering her son by poisoning him with table salts through his feeding tubes (Egan, 2014). Over Garnett's lifespan, Ms. Spears would persistently bring him to the hospital for various surgeries and medical tests. She gained immense sympathy and a large following on social media platforms after posting "photos and anecdotes about her blonde, blue-eyed son and his myriad of mysterious illnesses which required the use of feeding tubes" (Egan, 2014, p. 78). One Twitter post, written by Ms. Spears in 2009, read, "My sweet angel is in the hospital for the 23rd time**.** Please pray that he gets to come home soon" (Egan, 2014, p. 78). However, just two months later, Garnett died in the hospital after experiencing seizures and Cerebral Venous Sinus Thrombosis, which occurs when blood clots form in the brain's venous sinuses and prevent blood from draining out of the brain (Garcia-Azorin MD et al., 2020).

Following Garnett's death, Ms. Spears posted a candlelight vigil in memory of her son on Instagram. Many dedicated followers offered their sympathies and started a GoFundMe account to raise money for his funeral expenses (Egan, 2014). However, Garnett's death was not a simple medical tragedy. Rather, it was an egregious case of child abuse. Shortly after Garnett's death, Ms. Spears called a friend and asked her to urgently dispose of the bags she used to feed Garnett through a tube in his abdomen (Egan, 2014). The police seized the feeding bags as evidence and discovered a high sodium concentration in the bag. It was revealed that Ms. Spears had been inducing Garnett's illnesses for attention and sympathy by contaminating his feeding tubes, beginning when he was an infant.

Ultimately, Spears was charged with second-degree murder and first-degree manslaughter (Khalil et al., 2022). At her sentencing hearing in New York, Judge Robert Neary acknowledged that she suffered from Munchausen Syndrome by Proxy (MSBP): “a psychological disorder and form of medical child abuse wherein a caretaker either makes up symptoms or induces real symptoms to make the child in their care look sick” (Khalil et al., 2022, p. 1). Thus, Judge Neary elected not to sentence Ms. Spears to the maximum of 25 years in prison before the chance of parole due to the perceived mitigating effect of suffering from MSBP (The Associated Press, 2015).

In a similar case of Munchausen Syndrome by Proxy, Claudine “Dee Dee” Blanchard falsely induced and exaggerated her daughter’s medical symptoms to doctors, which resulted in a series of unwarranted medical surgeries and considerable physical and psychological harm. Throughout her daughter’s hospital visits in Kentucky, her treating physician, Bernardo Flasterstein, suspected that Dee Dee’s daughter was a victim of Munchausen Syndrome by Proxy because her alleged illnesses did not align with medical lab results (Sanders et al., 2020). Additionally, her daughter’s symptoms would improve in the hospital and only worsen when she returned home. However, Dr. Flasterstein failed to report his suspicions of child medical abuse to the authorities and Child Protective Services. Thus, Dr. Flasterstein may be civilly and criminally liable under Missouri Mandatory Reporting statutes for having reasonable suspicions of Munchausen Syndrome by Proxy, but knowingly failing to make a good faith report to the applicable authorities in Missouri.

Munchausen Syndrome by Proxy Defined

Physical, emotional, and sexual forms of child abuse are often the most prevalent forms of abuse widely known to the public. While these forms of abuse are criminal and repulsive,

atypical and lesser-known forms of child abuse exist, and it is essential that the public is educated about them. Munchausen Syndrome by Proxy (MSBP), otherwise known as Factitious Disorder Imposed on Another (FDIA), is defined as:

> A rare psychological disorder and form of child medical abuse most commonly involving caretakers who induce false symptoms upon their child or falsify the child's symptoms, often resulting in unnecessary medical procedures and misdirection, generally to gain the sympathy of medical personnel and the general population. (Hoffman & Koocher, 2020, p. 20)

Perpetrators may intentionally compromise medical lab results and produce false medical history charts to make pediatricians believe their child is gravely sick. British Pediatrician Roy Meadow first coined Munchausen Syndrome by Proxy in 1977, based on the fictional character Baron Munchausen, a man known for false tales and "ridiculously exaggerated exploits" (Flannery, 1994, p. 1). His discovery of the MSBP diagnosis stemmed from his hospital observations of two mothers and their children. One mother purposely poisoned her child with excessive salt, while the other introduced her blood into her infant's blood samples (Meadow, 2002). The MSBP diagnosis was initially met with suspicion due to its use in "some divorce-related false allegation cases" (Meadow, 2022, p. 14). However, it was ultimately accepted by the medical community and implemented in the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980.

The exact cause of MSBP is unknown, but the perpetrators, most commonly mothers, have been known to add blood into the urine of their child or poison their feeding tubes, give their child drugs to make them throw up or lose their teeth, heat up thermometers so their child appears to have a fever, alter or forge lab results, coach their child to exaggerate their symptoms or withhold food so it seems that their child cannot medically gain weight (Dossman, 2022). In a

review of 451 cases of MSBP involving hospital admission, 27% of victims had symptoms of respiratory arrest, 25% demonstrated signs of eating disorders, 20% had diarrhea, 17.5% suffered from impaired consciousness, 21% had bruising disorders, 10% had a behavioral disorder, 9.5% allegedly suffered from asthma, 9% had fabricated allergies, and 8.5% suffered from high-grade fevers (Akpinar, 2021). Moreover, due to the child's apparent medical ailments, the caretaker often brings their child to the hospital or the doctor's office on multiple occasions, seemingly out of concern and care. Munchausen Syndrome by Proxy remains controversial to diagnose because the caretaker's overly concerned behavior is often mistaken and rationalized as nurturing and attentive. Consequently, MSBP often goes undetected by doctors, and the victims may face irreversible psychological and physical repercussions, including death.

Diagnostic Criteria and Identifying Potential MSBP Victims

Munchausen Syndrome by Proxy is a psychiatric illness outlined in the 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) under the rubric of Factitious Disorder Imposed on Another (FDIA) (Bertrand et al., 2022). The previous editions of the DSM considered the goals and motivations of the perpetrators for diagnostic purposes. However, the DSM-5 (published in 2013) omitted the perpetrator's motivations for internal or external gain from the diagnostic criteria of MSBP:

> The criteria of a Munchausen Syndrome by Proxy diagnosis include fabrication of symptoms or induction of injury to another (including children, adults, elders, and pets) with an intent of deceiving medical personnel and sympathetic onlookers, even in the absence of external or internal rewards. The DSM-5 establishes these criteria to diagnose factitious disorder by proxy: falsely presenting or causing physical or mental health symptoms in someone else with the intent of deception, authoritatively and falsely

> presenting another (adult, child, or pet) to others as physically or mentally impaired, the deceptive behavior occurs even when there's no obvious gain or benefit, and no other mental health condition can explain these behaviors. (Bertrand et al., 2022, p. 12)

To be diagnosed with MSBP, a caretaker must "admit to the abuse and submit to psychological and psychiatric evaluation" (Apkinar, 2021, p.11). However, MSBP perpetrators are prone to manipulation and dishonesty, and doctors focus on treating a child they presume is genuinely sick. Therefore, diagnosing the disorder remains difficult for psychologists and medical professionals. However, a child's safety is the main priority, and doctors must stay vigilant of signs indicating a case of MSBP. The most common warning signs of a potential MSBP victim include patients that remain ill even in response to efficacious treatments, heal from their ailments at the hospital but become sick again when they go home, are repeatedly admitted to the hospital or brought to multiple doctor's visits, and present with medical symptoms that are highly unusual and inconsistent with lab tests (Yates & Bass, 2017). If these signs are evident, then the doctor(s) or forensic evaluator(s) observing the potential victim may formally diagnose their caretaker with MSBP and must subsequently identify the symptom induction and/or deception that is occurring so they can attend to the welfare of the child. As a result of the malpractice on the victims, the symptoms may result in death or serious bodily injury. Thus, medical professionals should expedite their responses to a potential MSBP case.

Statistical Profile and Characteristics of Perpetrators with Munchausen Syndrome by Proxy

Understanding perpetrator behaviors can aid in the timely identification and intervention of Munchausen Syndrome by Proxy. MSBP perpetrators are commonly mothers of the victims (Apkinar, 2021). Multiple studies consistently showed that 75.6-100% of MSBP perpetrators are

identified as female mothers, who largely possess medical and/or nursing backgrounds (Bass & Jones, 2011; Bools et al., 1993; Meadow, 1977, 1982; Rosenberg, 1987; Sheridan, 2003; Yates & Bass, 2017). Furthermore, in a sample of 796 MSBP perpetrators, Yates and Bass discovered that the median age of an MSBP perpetrator was 27.6 years, and 30% of the abusers had their own histories of childhood maltreatment or relationship abuse (Yates & Bass, 2017). Another prevalent set of research findings by Yates and Bass emphasize the presence of one or more comorbid mental illnesses in perpetrators of MSBP. The most frequent psychiatric diagnoses alongside MSBP are Factitious Disorder Imposed on Self (FDIOS) (30%), which occurs when an individual persistently pretends to have or produces physical or psychological symptoms upon themselves, with or without external motivations; personality disorders (18.6%), a group of mental illnesses that involve long-term patterns of unhealthy thoughts, coping skills, and behaviors that are typically inflexible; and Depression (14.2%), a psychiatric disorder indicative of a low mood for most of the day, approximately on a daily basis (Yates & Bass, 2017). However, individuals with FDIOS are especially at risk for developing MSBP. In a series of cases, caregivers escalated to inducing or presenting false symptoms upon their children or people in their care, when they no longer felt satisfied by the perceived rewards of FDIOS (Yates & Bass, 2017). Conversely, perpetrators of MSBP were found likely to engage in FDIOS behaviors when they are separated from their victims (Libow, 1995). Thus, children of caretakers diagnosed with FDIOS ought to be considered at higher risk for being victimized by MSBP abuse.

Catching an MSBP perpetrator in the act of their abuse is rare because they often act in covert and unnoticeable ways. However, Munchausen Syndrome by Proxy is also identifiable by the patterns of behaviors that the caretaker engages in. Perpetrators are known but not limited to

reporting history that is not supported by medical records, seeking sympathy and publicity, blogging or soliciting donations for their child's "rare illnesses," lobbying for long-term hospitalization, requesting the most invasive or unusual procedures, denying or being reluctant to provide prior medical charts, and not acting as expected when their child's symptoms improve or a diagnosis is ruled out (Yates & Bass, 2017). It is crucial that treating physicians, psychologists, and forensic evaluators become very familiar with the profile and behaviors of an MSBP perpetrator.

The Case of Dee Dee and Gypsy Rose Blanchard

One of the most disconcerting and egregious cases of Munchausen Syndrome by Proxy involved a mother, Claudine "Dee Dee" Blanchard, who made falsified claims about her daughter's health that resulted in a series of dire medical diagnoses and unnecessary medical procedures. Dee Dee Blanchard was born in Louisiana in 1967 and grew up with her family in Golden Meadow (Abdurrachid & Gama-Marques, 2022). She was one of five siblings who asserted that from a young age, Dee Dee would steal money from her family and deny her mother food when she grew ill. Moreover, Dee Dee became pregnant with her daughter, Gypsy Rose Blanchard, by her now-estranged husband, Rob Blanchard, when she was 24 years old. However, after her birth in 1991, Rob and Dee Dee divorced, and Dee Dee took her newborn to live with her. Rob was subsequently excluded from Gypsy's life due to Dee Dee's rage and jealousy.

When Gypsy was an infant, DeeDee made it appear that she had sleep apnea and brought her to the hospital numerous times, even though tests found no signs of the condition (Abdurrachid & Gama-Marques, 2022). Deedee's claims escalated, and she convinced people in her community that Gypsy suffered from Leukemia, muscular dystrophy, seizures, childhood

dementia, gum disease, a life-threatening sugar allergy, asthma, severe learning disabilities, and hearing and visual impairments. In reality, Gypsy was a very healthy young girl. Over multiple instances, Dee Dee induced drooling, gum disease, and tooth decay in Gypsy when she used a topical anesthetic to numb her gums before doctor visits. Additionally, Dee Dee poisoned Gypsy's feeding tubes with Roundup weed killer and gave her medication that would cause her hair to fall out to maintain the cancerous appearance (Walters & MacIntosh et al., 2019). To maintain control over Gypsy and deceive sympathetic onlookers, Dee Dee forged her daughter's birth certificate to make it appear that Gypsy was born in 1995 rather than 1991. Moreover, Dee Dee's acts of medical deception awarded Dee Dee financially by providing the duo with a small house and a wheelchair ramp in Missouri, free trips to Disneyland, and backstage passes to concerts. Additionally, they were afforded free flights to see doctors and receive (unwarranted) surgeries for Gypsy's supposed ailments at the Children's Mercy Hospital in Kansas City (Clough, 2020). When surrounding families or doctors suspected that Dee Dee was engaging in fraudulent behavior, she would move to a different state with Gypsy to avoid detection (Clough, 2020).

Dr. Bernardo Flasterstein, a pediatric neurologist who treated Gypsy in Missouri, suspected that she was a victim of Munchausen Syndrome by Proxy when he realized that her alleged muscular dystrophy diagnosis was unfounded. He ordered MRIs and blood tests to validate his initial suspicions, which ultimately showed no abnormalities. Additionally, Dr. Flastersten contacted Gypsy's previous neurologist, who revealed that her muscular dystrophy tests had all come back negative. He subsequently confronted Dee Dee, telling her there was "no reason that Gypsy couldn't walk or needed to be confined to a wheelchair" (Walters & MacIntosh et al., 2019, p. 15). He watched Gypsy stand up and hold her weight for

approximately ten minutes. Thus, Dr. Flasterstein wrote medical notes where he indicated that "there is a strong possibility of Munchausen Syndrome by Proxy, with maybe some underlying unknown etiology to explain her symptoms" (Walters & MacIntosh et al., 2019, p. 15).

Dr. Flasterstein failed to report his concerns to Child Protective Services because he was instructed to treat the pair with "golden gloves" (Walters & MacIntosh et al., 2019, p. 16). In 2009, an anonymous caller contacted the police and revealed Dee Dee's use of different names and birth certificates for Gypsy, and "suggested that she was in better health than presented by her mother" (Walters & MacIntosh et al., 2019, p. 16). This tip resulted in a police wellness check at the Blanchard residence. However, the officers genuinely perceived Gypsy as mentally disabled. They accepted Dee Dee's explanation that she tampered with Gypsy's birth certificates to make it difficult for her "abusive" ex-husband to find her and Gypsy. Without consulting Gypsy or her father, the officers closed the file.

Unfortunately, Gypsy could never advocate for herself due to her mother's psychological and physical abuse toward her. Doctors always assumed she was a minor; thus, they trusted her mother's judgment. Dee Dee would consistently squeeze her hand very tight when she said anything to doctors to suggest that she was not genuinely sick or functioned beyond her "stunted mental capabilities" (Dossman, 2022, p. 12). Afterward, Dee Dee would tie Gypsy's arms to her bed and strike her with coathangers as punishment. She went even further and forged her daughter's signature on legal guardianship documents to further her abuse and control (Dossman, 2022). Gypsy was scared into silence and could no longer tolerate living under false pretenses.

The Murder of Dee Dee Blanchard

Over time, Gypsy discovered that she could walk and did not suffer from the severe ailments her mom claimed she was afflicted by. She grew in independence and came to the

revelation that her mother was falsifying her alleged illnesses and diminished mental capacities. In fact, during one of Gypsy's many hospital visits, she recalled seeing a copy of her original birth certificate (Dossman, 2022). However, Dee Dee told her that the birth certificate she saw was a misprint, but Gypsy was suspicious of her explanation. Furthermore, she finally realized that she was an abuse victim, leading to multiple escape attempts. In 2011, she went to a hotel room with a man she met online while her mother was asleep (Dossman, 2022). However, Dee Dee stormed the man's house and showed him Gypsy's forged birth certificate that presented her as 16 when she was actually 20 years old. When she forced Gypsy home with her, she smashed her personal laptop with a sledgehammer and threatened to smash her fingers if she ever snuck out again. Dee Dee then proceeded to strap her and handcuff her to their bed as a punishment for her actions. Gypsy wanted to report her abuse to the police, but her mother had filed paperwork with the police claiming that she was mentally incompetent (Dossman, 2022). Hence, she feared the police would not believe her testimony and evidence.

Gypsy eventually gained access to the internet once again and connected with Nicholas Godejohn on a Christian dating app. He had a history of mental health conditions and had criminal charges for indecent exposure (Walters & MacIntosh et al., 2019). Nonetheless, their online conversations escalated from innocent flirtation to sexting and BDSM (Bondage and Discipline, Dominance and Submission, Sadochism, and Masochism). Furthermore, as their conversations continued, they began formulating their plans to kill Dee Dee. Godejohn believed he would by Gypsy's 'knight in shining armor' by saving her from her abuse and starting a new life together (Walters & MacIntosh et al., 2019). On the other hand, Gypsy was essentially a battered woman and did not believe in any other viable solutions to end her appalling abuse.

In June 2015, Godejohn arrived at Gypsy's house while her mother was asleep. Gypsy provided Godejohn with a knife and duct tape to stab her mother to death in her sleep (Walters & MacIntosh et., 2019). He proceeded to stab Dee Dee 17 times while Gypsy hid in the nearby bathroom with her ears covered. The couple fled the crime scene and traveled to Godejohn's home in Wisconsin. A few days later, however, the pair was apprehended by the Wisconsin Police and the SWAT Teams. Godejohn was ultimately sentenced to life in prison for first-degree murder, while Gypsy was sentenced to 10 years for second-degree murder.

Public outcry and criticism presently exist against the criminal justice system and Dr. Flasterstein, suggesting he could have prevented this tragedy of medical abuse from escalating into murder if he had reported his suspicions that Dee Dee was abusing her daughter. Unfortunately, physicians continuously performed unnecessary medical procedures on Gypsy while she was healthy and functional. However, a significant concern for physicians in reporting MSBP is that the caretaker may file medical malpractice or defamation lawsuits against the doctors who report the abuse (Gaffen, 2020). However, physicians are required by law to report suspected instances of Munchausen Syndrome by Proxy, a described form of child abuse, just as they are mandated to report forms of physical and sexual abuse. Failure to report cases of child abuse can result in criminal charges, a loss of professional licenses, and civil liability.

Examining Physician Liability: An Overview of Reporting Standards in Cases of Child Abuse

As public awareness about the abhorrent effects of child abuse grew, the importance of protecting the welfare of children became a priority for government officials. In 1974, Congress enacted the Child Abuse Prevention and Treatment Act (CAPTA), the first major federal legislation addressing child abuse (Moxley, 2012). CAPTA requires states to have "legal

procedures in place for receiving and responding to allegations of abuse or neglect and for ensuring children's safety" to receive state grant funds (Moxley et al., 2012, p. 18). The act is continuously being reauthorized, most recently in 2003 with the Keeping Children and Families Safe Act. This most updated version of CAPTA:

> Authorizes formula grants to states to help improve their child protective services; competitive grants and contracts for research, demonstration, and other activities related to better identifying, preventing, and treating child abuse and neglect; and formula grants to states for support of community-based child abuse and neglect prevention services. (CRS Reports, 2022, p. 73)

While the funds for these CAPTA programs expired in 2008, Congress appropriated $110 million in 2009 and 2010 to continue funding the goals of CAPTA and the Keeping Children and Families Safe Act (CRS Reports, 2022). CAPTA also authorizes grants to improve how states investigate and prosecute child abuse cases.

States are primarily left to determine how they will implement child abuse laws due to the Tenth Amendment of the United States Constitution. The Tenth Amendment declares that the Federal Government only holds powers expressly delegated to it; otherwise, the powers belong to the states and the people (McAffee et al., 2006). However, a federal statute does exist in reference to mandatory reporting, classifications of child abuse, immunity for good faith reporting, and the prospective training of mandatory reporters. Under 34 U.S. Code § 20341(a)(1), mandatory reporting is required for covered persons who suspect instances of child abuse and civil immunity is afforded when a report is made with integrity and good faith under Section (g):

> A person who, while engaged in a professional capacity or activity described in subsection (b) on Federal land or in a federally operated (or contracted) facility, learns of facts that give reason to suspect that a child has suffered an incident of child abuse, shall as soon as possible make a report of the suspected abuse to the agency designated under subsection (d) and to the agency or agencies provided for in subsection (e), if applicable. (Gaffen, 2020, p. 2)

If a covered professional fails to immediately report suspicions of child abuse to the child protective services or local law enforcement agency, they are subject to a fine and/or imprisonment of no longer than six months. To encourage reporting, the statute declares that covered individuals who make reports under the good faith standard are immune from civil action commenced by alleged perpetrators or other involved parties. Moreover, many state legislatures have modeled their reporting laws after the federal statute standards to encourage physicians who suspect abuse to intervene without hesitation. For example, Texas Family Code Chapter 261 states that "a person having reasonable 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" (Perman, 1998, p. 279).

Like the federal statute, the Texas State Code mandates that physicians are not "required to know that abuse is the definitive cause of a patient's medical injuries" (Perman, 1998, p. 280). The mere possibility of abuse qualifies for notification to the authorities. If a physician treating MSBP fails to report suspected offenses "when he or she believes that a child's welfare is endangered," they have committed a criminal offense (Perman, 1998, p. 280). MSBP is generally more difficult to detect than physical abuse because it is not usually visible to the naked eye; however, the law does not delineate medical and physical abuse. Thus, it remains explicitly clear

that physicians shall report suspected instances of MSBP, even though it is a less conventional form of child abuse.

Overview of Consequences of Failing to Report Child Abuse

State and Federal laws general place a premium on aggressive intervention in cases of suspected child abuse to prevent a child from being forced home to face continued abuse and psychological damage. In the case of *Landeros v. Flood*, an 11-month-old girl, Gita Landeros, was taken by her mother to physicians for the diagnosis and treatment of a leg fracture (7 Cal. 3d 399, 131 Cal. Rptr. 69, 551 P.2d 389 (1976)). The fracture indicated that a twisting force might have inflicted it. The origin of the fracture, however, was allegedly unknown to the mother. Additionally, there were other injuries to Landeros, all of which appeared to have been caused by other people. However, the child's treating physician, Dr. A. J. Flood, failed to detect a skeletal fracture easily diagnosable through X-Rays. Furthermore, the physician's failure to properly diagnose Landeros' ailments consequently led to "his failure to report the abuse that had produced the child's condition" (7 Cal. 3d 399, 131 Cal. Rptr. 69, 551 P.2d 389 (1976) at 3).

As a result of Dr. Flood's negligence, Landeros suffered permanent physical injury at the hands of her mother and her common-law husband. Years later, Gita Landeros (plaintiff) filed suit in 1971, alleging that Dr. Flood negligently failed to detect her abuse and thus did not report her injuries to the proper authorities under California state law. The California Supreme Court favored the plaintiff and held that "a physician is required to possess and exercise, in both diagnosis and treatment, that reasonable degree of knowledge and skill which is ordinarily possessed and exercised by other members of his profession" (7 Cal. 3d 399, 131 Cal. Rptr. 69, 551 P.2d 389 (1976) at 4). The court also declared that Dr. Flood and the hospital that treated

Landeros may be held civilly and criminally liable for Landeros' injuries by failing to report her abuse to the authorities under Section 11160 of the California Penal Code.

Immunity for Mandated Reporters: The Good Faith Standard

The consequences of failing to report suspected instances of child abuse, including Munchausen Syndrome by Proxy, often result in potential criminal charges and civil liability. However, mandated reporters, including physicians, are afforded a layer of legal protection to encourage reporting and intervention on behalf of a potential child abuse victim. In *D.L.C.V v. Walsh,* a father and his child lodged medical malpractice charges against a group of doctors, accusing them of falsely alleging child sexual abuse after a social services agency concluded that the sexual abuse charges were unfounded (*D.L.C. v. Walsh*, 908 S.W.2d 791 (Mo. Ct. App. 1995)). However, the court held that the reporting physician who initiated the initial investigation was afforded immunity from civil liability. An initial investigation of suspected child 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" (*D.L.C. v. Walsh*, 908 S.W.2d 791 (Mo. Ct. App. 1995) at 10).

Thus, as physicians report suspicions of child abuse in good faith, malpractice and defamation lawsuits cannot be successfully commenced against them. The good faith standard, in its broad definition, is when a mandated reporter, who is acting within the scope of their professional responsibilities, reports a potential incident of abuse or wrongful conduct without malicious intentions, for which the reporter has reasonable cause or suspicion to believe abuse has occurred against a minor, even if the allegations cannot be fully substantiated (Gaffen, 2020). In about 17 states, good faith reporting is presumed unless proven otherwise. However, good faith can be voided by knowingly and maliciously making a false report of child abuse. In the

case of *Harville v. Vanderbilt University,* the Sixth Circuit Court of Appeals addressed the issue of physician immunity for reporting a potential case of Munchausen Syndrome by Proxy. Ruth and Steven Harville filed suit against Dr. Seth Scholer, Dr. Karen Crissinger, and Dr. Suzanne Starling, all doctors at Vanderbilt University, for "falsely" claiming that the Harvilles' son, Joseph, was a victim of Munchausen Syndrome by Proxy (*Harville v. Vanderbilt University, Inc*., 95 F. App'x 719 (2003)). The Harvilles alleged the doctors were liable for medical malpractice, malicious prosecution, abuse of legal process, outrageous conduct, fraud, negligent misrepresentation, and emotional distress.

The Tennessee court ruled in favor of the doctors, citing Tennessee Code. Ann. § 37-l-410(a), which protects physicians from civil liability for reporting suspected child abuse in good faith (Gaffen, 2020). The plaintiffs, who bore the burden of proof for demonstrating bad faith, failed to show clear and convincing evidence that the doctors were malicious and knowingly made a false report of MSBP (*Harville v. Vanderbilt University, Inc*., 95 F. App'x 719 (2003) at 6). The court stated that even a poorly researched or negligent diagnosis would not meet the burden required to demonstrate bad faith. This high standard was implemented because encouraging child abuse reports remains a compelling governmental interest.

Similarly, in *Yuille v. Department of Social and Health Services,* the court held that "good faith could be satisfied even if the physician did not investigate or verify the abuse, as the duty to investigate lies with the authorities, not the individual making the report" (Gaffen, 2020, p. 15). A policy requiring physicians to investigate and meet a burden of evidentiary proof would likely hinder reports of child abuse. Insofar as a physician makes a report of MSBP with sincere intentions ("pure heart and empty head") and concern for the child's welfare, they are protected from civil liability (Gaffen, 2020). The physicians in *Yuille* met the standard for good faith

reporting because they acted in the child's best interest, consulted with the child's previous doctors, and worked with the Hospital's team when diagnosing Munchausen Syndrome by Proxy. The courts set a low standard and continue to err on the side of caution regarding child safety; the potential risks of injury to a child outweigh the likelihood of damage to the alleged perpetrator's reputation.

Missouri Standards for Reporting Cases of Child Abuse:

Potential Liability of Dr. Bernardo Flasterstein

The Missouri Statute for mandated reporting is similarly modeled after the federal statute and the Texas Family Code, which imposes aggressive intervention in instances of suspected child abuse. Section 210.115 of the Missouri Penal Code reads:

> When any individual identified above 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. (MDSS, 2020, p. 7)

An investigation and initial burden of proof of child abuse are not necessary under Missouri law to make a report; instead, the mandated reporter, including physicians overseeing the care of an alleged MSBP victim, must merely have reasonable suspicion that child abuse has occurred and report in good faith to receive immunity from civil liability under Mo. Rev. Stat. §210.135.1 (MDSS, 2020). The immunity from liability is only voided if a report is knowingly, maliciously, and falsely filed, severely punishable by criminal charges. Moreover, failure to report reasonable suspicions of child abuse is a Class A misdemeanor "for a person who is obligated under the law to report," punishable by up to one year in jail and/or a fine of no more than $2000 (MDSS, 2020, p. 9).

The aggressive premium in the Missouri Statutes regarding mandatory reporting is addressed in the case of *State v. Brown* (140 S.W.3d 51 (Mo. 2004)). In this case, a minor boy, Dominic James, died from abusive head trauma after being sent home from the hospital (140 S.W.3d 51 (Mo. 2004) at 4). Nurse Brown, who treated James at the hospital, suspected he was the victim of abuse after he was admitted for unconsciousness. However, Brown admitted that she did not document the child's bruises or call the child abuse hotline, even though she was aware of her obligation to report potential instances of child abuse. This resulted in her being charged with failure to report child abuse and failure to report child abuse to a physician. Furthermore, Brown argued that the Missouri Mandatory Reporting Statute was overly broad and vague in its scope. Still, the Missouri Supreme Court held that Section 210.115 was readily comprehensible by ordinary people and that the government has a compelling interest in protecting the welfare of minors (140 S.W.3d 51 (Mo. 2004) at 7). Medical professionals play an essential role in detecting child abuse in medical settings, and knowingly disregarding that obligation, especially with reasonable cause, warrants criminal penalties.

The case of *Brown* resembles Dr. Bernardo Flasterstein's failure to report Gypsy Rose Blanchard's abuse while treating her in Missouri. He had reasonable suspicions that Dee Dee was medically abusing her daughter based on inaccurate medical symptoms and inconsistent lab results. Dr. Flasterstein even investigated his suspicions and collected strong circumstantial evidence by contacting Gypsy's previous doctors and learning that her tests for muscular dystrophy had all been negative. An investigation to collect conclusive proof is not required under the Missouri reporting statute; however, Dr. Flasterstein further assessed the situation and recorded his suspicions of MSBP in his medical notes. But, he failed to report his suspicions and evidence to the Child Abuse/Neglect Hotline telephone number maintained by the Children's

Division (MDSS, 2020), even though he acknowledged his role as a mandatory reporter. Additionally, he would have likely been afforded immunity protection based on his viable suspicions and search for the truth. Thus, he could be charged with failure to report child abuse under Mo. Rev. Stat. § 210.115.1 (140 S.W.3d 51 (Mo. 2004) at 12). As outlined in *Brown,* misunderstanding the reporting statute or fearing retribution are not justifiable reasons for failing to attend to the welfare of a child. While Gypsy's MSBP abuse had not killed her yet, she suffered over two decades of induced injuries and psychological abuse at the hands of her mother. She became a battered woman and resorted to killing her mother. Gypsy's actions of premeditated murder were not excused in a court of law; however, the judge overseeing her trial recognized her as a victim of MSBP and believed that the medical community systematically failed her (Hoffman & Koocher, 2020).

General Steps for Intervening in Cases of Munchausen Syndrome by Proxy

In cases of suspected Munchausen Syndrome by Proxy where a mandated reporter files a report to the applicable authorities, Child Protective Services (CPS) involvement may trigger the legal authorization of "surveillance or separation as a means of confirming or failing to confirm a finding of abuse or neglect" (Hoffman & Koocher, 2020, p. 761). Additionally, CPS may work directly with law enforcement officials to collect documents relating to the victim's medical history and the alleged perpetrator's internet searches and financial histories, etc. (Hoffman & Koocher, 2020). The authorities may also collect collateral information from the alleged victim's counselors, teachers, or anyone who regularly observes them. During the investigative process, it is essential to gain detailed evidence for thorough analysis as the interests of the vulnerable victims are placed above the perpetrator's interests. However, law enforcement officials and other professionals involved in the case must still abide by the procedures of due process, which

is afforded to individuals accused/suspected of criminal activities. Suspected perpetrators of MSBP, as with any potential defendant, are entitled to the presumption of innocence and must be alerted to the team's suspicions of abuse and the referral to CPS.

It is prudent for the investigative team to formally confront an alleged abuser of allegations lodged against them in the form of a meeting. The meeting should be framed as 'informing sessions' in an effort to prevent either party from going in with a confrontational or belligerent mindset (Hoffman & Koocher, 2020). The caretakers are often first advised that there has been no evidence to support any medical conditions or the necessity of medical treatments for their child. They are subsequently informed that the illnesses are believed to be fabricated and/or induced (Hoffman & Koocher, 2020). In some instances, caregivers may be asked to repeat back medical information that the team has collected. Regardless, however, it is pivotal that mental health professionals are present at these meetings because the alleged abuse may attempt to prove that their child's illness is genuine, and some perpetrators have attempted suicide following confrontations of their actions. Mental Health experts have the expertise and skill sets to de-escalate crisis situations and provide separate therapeutic/medical intervention for the abuser and the victim. Furthermore, after confronting the parties and recommending further steps for potential treatment, additional evidence collection may commence to solidify a criminal case against the MSBP perpetrator.

Strategies for Confirming MSBP: Surveillance

Video surveillance of the caregiver and the victim at home and in hospital settings has been previously used to confirm or not confirm suspected cases of Munchausen Syndrome by Proxy. Recording has been extremely helpful in "documenting certain symptoms or parental behaviors" (Hoffman & Koocher, 2020, p. 761). In a study conducted in Atlanta, Georgia from

1993-1997, 41 children were closely monitored with hidden cameras in suspected cases of child medical abuse (Connelly, 2003). Ultimately, MSBP was diagnosed in 23 patients: in 13 cases, secretive video recording was required to make a diagnosis, and in the five other cases, was supportive of the MSBP diagnosis (Connelly, 2003). The use of covert surveillance within the study also exonerated parents accused of perpetrating MSBP in four cases (Connelly, 2003). Thus, the researchers conducting the study concluded that covert surveillance is necessary to make a timely and conclusive diagnosis of MSBP. They contended that protecting children should be at the forefront of social priorities.

Even though there is no explicit presumption of the right to privacy in public hospital and clinical settings, the use of surveillance in cases of MSBP is an ethically and legally sensitive issue (Connelly, 2003). Many legal experts contend that while prior court precedents have held that there is no explicit reasonable expectation of privacy in hospital rooms and public spaces due to the constant traffic flow of medical personnel and other patients, signs that warn hospital guests of general surveillance parameters and loss of privacy ("the facility is monitored and recorded by cameras") would not be fully comprehended by caretakers or potential abusers (*Buchanan v. State*, 119 Nev. 201, 69 P.3d 694 (Nev. 2003); *State v. Abislaiman*, 437 So. 2d 181 (Fla. Dist. Ct. App. 1983)). The general population can conclude that hospitals are not comparable to private living spaces such as houses and apartments. However, the ordinary person would also not expect a hospital to be monitored in the same way as prisons, which typically mandate 24/7 surveillance monitoring in bed cells (by staff members of the same gender), day rooms, hallways, and other common areas.

In *Katz v. United States,* the US Supreme Court established the "reasonable expectation of privacy" standard, specifically during audible phone calls and conversations" (389 U.S. 347

(1967)). The plain view doctrine effectively protected soundless video recordings in public spaces such as open fields and shopping centers, etc. However, the *Katz* standard of privacy expanded to surveillance in bathrooms and rooms with a lock door and the absence of a warrant (Connelly, 2003). The expansion was aimed at preventing illicit sexual activities and voyeurism. Thus, a caretaker may expect privacy in a bedroom due to parental intimacy and the possibility of a patient undressing. If covert surveillance is implemented as an intervention/detection technique by CPS or medical personnel, it may be necessary to consult a lawyer or the hospital's general counsel to implement constitutional protocols. Legal experts suggest that hospitals and clinical settings should make it a requirement to obtain a warrant or the accused caregiver's consent prior to proceeding with surveillance (Yates & Bass, 2017). The imminence of serious harm to a child would meet the exigent circumstances of the Fourth Amendment, which allows for warrantless and non-consensual searches and seizures. There are, however, different avenues for intervening in cases of MSBP that are less intrusive and involve the consent and collaboration of the accused.

Strategies for Confirming MSBP: The Separation Test

In 1986, Dr. Jones and his colleagues first suggested that it was necessary to separate a potential Munchausen Syndrome by Proxy victim from their alleged perpetrator to see if their medical symptoms still occur, as well as to protect the welfare of the child (Pankratz, 2010). This form of separation has gained increased acceptance by the medical community as a viable intervention technique (Hoffman & Koocher, 2020, p. 761). If the child's symptoms consistently improve during the separation, but worsen when they return with their caretaker, strong circumstantial evidence indicates MSBP. Legally, caretakers are informed of the reason for the separation and the involvement of the state child protective services.

However, the drawback of the separation test is that its guidelines are broad. For example, law enforcement officers report that there is no set period for how long the alleged victim would have to be without symptoms to decide whether sufficient evidence exists to charge a caretaker (Pankratz, 2010). Another concern regarding the separation test is that the professionals observing the child's progress during the separation will likely have confirmation bias. In one case, a nurse observing an alleged victim's progress during the separation period had a preconceived belief that the child's reflux symptoms would significantly improve outside his mother's care (Pankratz, 2010). The male nurse subsequently reported that the child's symptoms improved even when they were not; he described the symptoms within the framework of his prior biases. Moreover, some experts suggest that allegations of MSBP should be investigated by a multidisciplinary team who will work with the alleged perpetrator to exclude false information and honor due process (Pankratz, 2010).

Strategies for Confirming MSBP: Preliminary Screening

The preliminary screening questionnaire is an emerging strategy for detecting Munchausen Syndrome by Proxy and instances of child medical abuse (MCA). The goal of the questionnaire is to screen for early identification of MCA among children admitted to the hospital (Greiner et al., 2013). The questionnaire most commonly includes known symptoms of MCA and caregiver/child medical histories. Each item is scored either 1 or 2 points if there is a positive indicator based on the hospital charts of "child protective services-confirmed MCA patients" (Greiner et al., 2013, p. 1). This assessment aims to be objective to preclude personal biases from hindering accurate assessments of MCA, including Munchausen Syndrome by Proxy.

One study by Dr. Greiner and her colleagues in 2013 explored the effectiveness of preliminary screening tools. Specifically, they tested a hospital's preliminary questionnaire by reviewing the hospital charts of confirmed MCA victims through child protective services. Furthermore, they compared the results of the MCA charts with charts of children who were admitted to the "hospital for apnea, vomiting/diarrhea, and seizures who were not diagnosed with MCA" (Greiner et al., 2013, p. 40). The study ultimately found that screening instruments successfully identified differences in characteristics of MCA victims, caregivers/perpetrators, and illnesses during hospitalization that "may allow for earlier detection of MCA" and referral for further assessment to a forensically-attuned, multidisciplinary team (Greiner et al. 2013, p. 41). Notably, MCA patients have bruising, toxic drug levels, chronic vomiting and apnea, and diarrhea after hospital discharge. Additionally, caregivers diagnosed with MSBP have comorbid mental illnesses such as Borderline Personality Disorder and Narcissistic Personality Disorder. They also choose doctors who fail to detect their abuse and repeatedly suggest medical testing and invasive procedures.

Treatment Options for Perpetrators of MSBP

Munchausen Syndrome by Proxy treatment is generally the result of an intervention on behalf of the child's doctor, the courts, or a separate protective agency. Furthermore, the caregiver is usually referred or mandated to attend psychological therapy, even in the event that the caretaker denies abusing their child. Unfortunately, seldom information exists regarding viable and effective psychological treatments for perpetrators because they are often unwilling to admit to any problems or abusive behaviors. However, psychologists have identified Cognitive Behavioral Therapy as a potentially effective treatment regimen for caregivers with MSBP. Cognitive Behavioral Therapy (CBT) is defined as "a directive therapy, which means the

therapist leads the process, teaching patients how to develop effective ways of coping with a range of mental and behavioral problems" (Sanders & Bursch, 2020, p. 2). During counseling sessions, the mental health professional will work with patients to identify cognitive distortions in their thought processes that lead to unwanted or destructive behaviors (Sanders & Brush, 2020). The goal is to identify and change negative thought patterns and behaviors that spiral and negatively affect a patient's mental state. CBT has ultimately been found useful in treating patients with a range of personality disorders (which often simultaneously exist in perpetrators with MSBP) and for increased coping and improving distress tolerance (Sanders & Bursch, 2020). Nevertheless, more innovative psychological models are being studied and proposed as potentially effective treatments specifically for MSBP based on an exceptional amount of expert experience with therapeutic models and techniques.

The ACCEPTS Model (acknowledgement, coping, empathy, parenting, taking charge, and support), proposed by Dr. Mary Sanders and Brenda Busch, is a five-step psychological model of therapy that applies to the individual treatment of the MSBP perpetrator (Sanders & Bursch, 2020). The first letter of the ACCEPTS acronym, "acknowledge," aims to facilitate an environment where an MSBP perpetrator (or their partners/spouses) would feel comfortable enough to acknowledge deceptive behaviors and unhealthy coping mechanisms (Sanders & Bursch, 2020). This would mean providing a safe space free of judgment while assisting the client to overcome denial (Sanders & Busch, 2020). The mental health professional may explore the client's past history/story with them, which may provide clues about how they were potentially mistreated, dehumanized, or abused which led to their desire to intensely seek out sympathy from others (Sanders & Bursch, 2020). If such trauma is identified, evidence-based trauma therapy programs can attend to their unresolved trauma and be the first effective

treatment phase for MSBP. Furthermore, the C in ACCEPTS, "coping," is when the therapist and client identify healthy coping skills for perpetrators when they have the urge to falsify symptoms or induce real illnesses upon their child (Sanders & Bursch, 2020). In sessions, the mental health professional may identify times where the client was able to cope differently and more appropriately. Therapists, however, may have clients who need to establish entirely new coping mechanisms. The most effective coping skills capitalize on community and social support systems. Individuals closest to the abuser can "validate the past painful experiences and emotions of the abuser, participate in ongoing meaningful and healthy relationships with the abuser, provide second opinions related to the need for care seeking, and raise concerns during times of relapse" (Sanders & Bursch, 2020, p. 13). The sense of belonging is integral to human welfare and can play an exponential role in healing from past trauma and loneliness.

Once the client's mental health history and experiences of trauma are explored and significantly attended to, the second phase of the ACCEPTS Model begins with the practice of empathy. During counseling sessions, the therapist will help the abuser take the child's perspective and understand the child's experience of the medical abuse (Sanders & Bursch, 2020). Mentalization-based- therapy (MBT), which focuses on differentiating one's own emotional state of mind to that of other people, is typically successful in developing perspective taking and empathy (Sanders & Bursch, 2020). Moreover, if the abuser can meet with their child under supervision, this can be a practical opportunity to practice empathy and discover their perceptions of what appropriate child care encompasses (Sanders & Bursch, 2020). Overtime, the abuser's therapist may implement support groups, parenting lessons, medications, couples/parenting therapy (with the potential of integrating therapy with the victim) into a holistic treatment plan. Individual therapy would continue, but the addition of expanded

resources could cultivate a stronger support network. Additionally, extra resources can aid the abuser and their spouse to develop more robust parenting skills (Sanders & Bursch, 2020). Parenting classes and therapies such as Parent–Child Interactive Therapy (PCIT) aim to work on unhealthy attachments and general parenting skills if the parent is able to safely work with their child (Sanders & Bursch, 2020). The goal is for perpetrators to support their child's increased physical and mental functioning and allow the child to have developmentally appropriate independence (Sanders & Bursh, 2020).

Following a perpetrator's substantial progress with coping skills and resisting harmful urges, the therapist can start formulating future parent-child interactions. The welfare of the child is always the most important consideration when reuniting them with their abusive parents. Thus, if the abuser is facing criminal charges or in any situation where reunification would be risking the child's safety, it would not be appropriate to take this action. The parent must fully accept responsibility for their abuse, improve their parenting skills, and prove that they understand their child's needs and are able to resist maladaptive behavior before parent-child interactions are even considered (Sanders & Bursch, 2020). In the event that the abuser cannot practice their newfound skills directly with their children, their therapist can help them improve their interactions with other people they encounter.

Case studies have shown that treatment is effective for MSBP abusers who admit to their abusive behaviors, show empathy for their victim(s), and have a nonjudgmental support system (Sanders & Bursch, 2020). Treatment, however, still remains a difficult endeavor for MSBP perpetrators because they are likely to deny the abuse and rationalize their actions as caring for their child. Future research, while it may be difficult to conduct, should explore the success rates

of the ACCEPTS model and evaluate whether it should become a more standardized form of therapy for MSBP.

Conclusion

Munchausen Syndrome by Proxy is a severe form of child medical abuse that often goes undetected and unreported due to a lack of knowledge and practical skills regarding the illness. However, failing to detect or report suspicions of child medical abuse can result in permanent physical injuries and death. Therefore, it is pivotal that physicians and mandatory reporters are trained and kept apprised of the signs and characteristics of MSBP and Medical Child Abuse in general. Physicians and other mandatory reporters are not always privy or adequately trained to detect the abuse or fear retribution if they report their suspicions of MSBP. Thus, emphasizing good faith reporting in the form of ongoing education is critical for intervening in suspected cases of Munchausen Syndrome by Proxy. Additionally, all 50 American States should add a module on the signs and symptoms of Child Medical Abuse within mandatory reporter training. False accusations still remain a concern to families and medical experts because of the aggressive intervention statutes required in reporting child abuse. Thus, to further balance the rights of the parents and avoid false positive diagnoses while working in the child's best interest, there is a need to broaden the variety of medical experts that observe a potential victim of MSBP. The intervention in MSBP could be sharpened by employing more forensically attuned clinicians and therapists trained to assess potentially criminal and abusive behavior.

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