

# Dilemmas Facing Nurses Who Care for Munchausen Syndrome by Proxy Patients

Mary L. Brown

Diagnostic practices, including video surveillance, in Munchausen Syndrome by Proxy can lead to multiple nursing dilemmas. A case study with discussion of these dilemmas and suggestions to deal with them is presented to help nurses cope more effectively with this difficult diagnosis.

**M**unchausen Syndrome by Proxy (MSBP) is an unusual form of child abuse in which a parent fabricates symptoms and falsifies medical history or actually causes illness that results in unnecessary medical evaluation and treatment (Meadow, 1977). Documentation of MSBP has been exemplified by case studies in the literature since it was first identified in 1977 (Meadow, 1977). Children who are victims of MSBP present with common symptoms of seizures, apnea, bleeding, fever, and arrest. Numerous other symptoms and disorders are possible (Klebes & Fay, 1995). The mother is usually identified as the perpetrator. Only one case identified the father as the one who caused the abuse (Makar & Squier, 1990). MSBP is particularly difficult because the majority of cases involve children under 6 years of age (Hosch, 1987).

MSBP as a form of child abuse is a crime. Evidence must be collected in order to remove the child from danger. Because nurses are the primary caretakers of hospitalized children, they play a key role in the observation and surveillance necessary to confirm the diagnosis of MSBP. Many hospitals use surveillance with video cameras to monitor and document the abuse (Rosen, Frost, Bricker, Tarnow, Gillette, & Dunlavy, 1983; Epstein, Markowitz, Gallo, Holmes, & Gryboski, 1987; Meadow, 1987; Smith & Killam, 1994). Nurses are usually the ones who monitor this video taping 24 hours a day, and must intervene when the child is in danger. This role can present multiple dilemmas to pediatric nurses.

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## Case Study

A seven-month-old girl, "Whitney," had a history of apneic spells and was admitted to the Intensive Care Unit (ICU) of a large pediatric hospital after a cardiac arrest at home. She was accompanied by her mother. No other family members were present and no information was available about her father. Her initial work-up was negative and she had no apneic spells while in ICU. Family history revealed that an eight-month-old sister had died the year before with what was diagnosed at that time as Sudden Infant Death Syndrome (SIDS). Whitney was transferred to the general floor after 5 days in the ICU. She was placed on telemetry and a trend pneumogram to monitor her for any reoccurrence of apnea. Numerous studies, x-rays, and work-up for reflux were conducted to determine the cause of the apnea. All studies were negative.

Whitney had three apneic spells while on the general floor. The first two required only stimulation for treatment, while the third required resuscitation and return to the ICU. The floor nurses in reviewing the chart noticed that Whitney only had apneic spells when her mother was present. During these episodes, unusual things happened to the monitoring equipment. Whitney's mother said that her child had pulled off the telemetry pads during the first episode. The second incident occurred when the pneumogram ran out of paper and could not record the event. With the third, the mother turned off the pneumogram because she thought it was not working properly.

When Whitney was in ICU for the second time, she again had no further apneic spells. Doctors, floor and ICU nurses, social workers, and respiratory and recreational therapists met to discuss their concerns and suspicions that Whitney was a victim of MSBP. A plan was reviewed with the legal department and the district attorney was consulted. The group determined that more evidence was needed to prove that the mother was inflicting Whitney's apneic episodes. A room was set-up on a general floor with a video camera placed in the air conditioning vent to observe and record the mother's behavior with Whitney, thus collecting the needed evidence. Whitney was transferred to this room and again placed on telemetry and a trend pneumogram.

The monitor for the video camera was placed in an adjacent vacant patient room and observed 24 hours a day by the nursing staff. This monitor room was set-up as a mock-up room with a "patient" in strict isolation. Nurses entered wearing gowns and masks. A screen was placed to block the view from the hallway. Nurses even gave "report" on this fictitious patient because Whitney's mother was often found eavesdropping on nurses' conversations and was familiar with all aspects of the hospital routine. She might have become suspicious if nurses kept going in and out of a vacant room. Whitney had no spells for four days so the pneumogram was discontinued. No further spells occurred and after seven days Whitney's mother was told by her doctors that Whitney would probably go home soon because her apnea seemed to be resolved. One hour later Whitney's

**Table 1. Warning Signs of MSBP**

- Unexplained, recurrent illnesses or symptoms in the child
- Discrepancies between findings and history
- Signs and symptoms do not occur in mother's absence
  - Positive family history of Munchausen Syndrome, or siblings with same symptoms

**Note:** Jones, J.G., Butler, H.L., Hamilton, B., Perdue, J.D., Stern, H.P., & Woody, R.C. (1986). Munchausen syndrome by proxy. *Child Abuse and Neglect*, 10, 33-39. Used with permission.

**Table 2. Characteristics of Perpetrator**

- Attentive, overly protective and refuses separation
- Needs to control the child's environment
  - Medical background or knowledge
  - Possible history of abuse or Munchausen Syndrome
  - Distant or absent relationship with child's father
  - Quickly gains the admiration of and friendship with staff
  - Delighted in the performance of procedures on the child

**Note:** Modified from Jones et al. (1986); and Zitelli, Seltman, & Shannon (1987).

*mother was observed via the monitor smothering Whitney by pushing her face into the mattress. Whitney could be seen struggling to get free, waving her arms and kicking. The nurse observed for 60 seconds to get enough evidence on tape to clearly show what the mother was doing. As the nurses entered the room, Whitney's mother let go and stated that Whitney was having another spell. Whitney was dusky and gasping and was sent to the ICU to separate her from her mother. Authorities were notified and Whitney's mother was arrested for attempted murder.*

### The Syndrome MSBP

**Warning signs.** Nurses base their care on information and history given by mothers and often work with them to provide care to their young children. The mother of a child with MSBP weaves a web of deception often befriending the nursing and medical staff through contact during multiple hospitalizations. Her constant attention and concern about the child enhances her story and does not fit the profile expected of an abusing parent (Waller, 1983). Whitney's mother often spent time talking with the nurses and praising them for the good job they were doing caring for Whitney. She was very reluctant to leave Whitney and would always stop by the nurses station to tell them where she was going and ask them to turn on the intercom to monitor Whitney. Typically, health care providers who have limited contact with MSBP have difficulty believing they are being fooled by the mother (Klebes & Fay, 1995). The most common warning signs of MSBP are summarized and presented in Table 1. Early identification of possible cases is essential.

Whitney had unexplained and recurrent apneic spells yet all tests were negative. No explanation for the respiratory-cardiac arrests could be found. She had no apneic spells while in ICU where she was under constant observation and away from her mother. Whitney had a suspicious family history in that her sister had died from SIDS at the age of 8 months.

**Characteristics of the perpetrator.** Perpetrators have certain characteristics that also help to identify potential cases (see Table 2).

Whitney's mother was very attentive and protective. She always performed Whitney's care and kept a detailed record of all her spells and treatments. She previously worked as a nurses aide. Whitney's father did not live in the home. The nurses and doctors had praised the mother for her ability to resuscitate Whitney. She requested to be present for all procedures. The mother did not show any signs of distress to painful procedures conducted on Whitney, rather seemingly enjoyed the attention from the hospital staff. She would brag about how many times Whitney had to be "stuck" for blood work and would ask numerous times how soon Whitney would go for her next test. Previous history of abuse of the mother was not known.

### Nurse's Role

Assigning the same nurses to care for children with suspected MSBP facilitates team work and support. These nurses work in a multidisciplinary team including doctors, social workers, child-life workers, lawyers, police and any other discipline involved in the child's care to ensure the syndrome is diagnosed and the child is protected (Crouse, 1992). In one third of the patients with MSBP, abuse continues in the hospital (Zitelli, Sheltman, & Shannon, 1987). Abuse that does not continue in hospital settings is much more difficult to diagnose, thus may continue for years. In suspected cases, detailed histories are carefully documented so any discrepancies are easily recognized (Smith & Killam, 1994). Symptoms observed by the nurse are recorded. Statements by the mother may be pertinent to the case and should be quoted in the chart.

During the diagnostic phase of MSBP, children are often separated from their mothers to determine if symptoms continue to occur. All visits by the mother are observed during and after for any increase in symptoms. Specimen collections are monitored to ensure against tampering by the mother.

The best way to protect MSBP children is to remove them from the harmful environment created by the mother (Epstein et al., 1987). Temporary separation can help document lack of symptoms when the mother is not present, but documentation of fictitious illnesses is necessary to protect children on a long term basis by legally removing them from their homes. Even with the confirmed diagnosis of MSBP and proper reporting to a children's protection agency, legal systems without knowledge of MSBP often fail to adequately protect the child (Waller, 1983). Visual evidence is often required to convince the courts that parents could do such horrendous things to their children.

### Dilemmas

Several dilemmas can be identified in this situation. Caring for children with suspected MSBP may cause nurses to question their ability to trust their belief in parent's reports of patient history and in their own observations of loving relationships between parent and child. This doubt could affect their ability to care for future pediatric patients. Four dilemmas are presented.

**Confidentiality.** This is always a concern when caring for patients. Although court approved, video taping parents and

patients without their permission evokes feelings of violation of privacy. Nurses were concerned about Whitney's mom being observed while dressing.

**Deceptive measures.** These are often required to carry out monitoring of the videotape and can be uncomfortable to nurses who usually serve in the role of parent advocate. Nurses caring for Whitney understood the reasons and the importance for videotaped observation. Even so, after the evidence was obtained, many nurses expressed uneasiness about the role they had to play in order to protect Whitney. Some said they felt like they were "spies" and "detectives" and this was not what they learned in nursing school. They resented that they had to play these roles because the courts would not believe what Whitney's mother was doing to Whitney without visual evidence.

**Endangerment of the child.** The necessity of watching the mother abuse the child for a period of time long enough to clearly show what she was doing was very difficult. Nurses were distressed at having to watch Whitney being smothered without immediately intervening. They felt that they were not doing their job of protecting and caring for a child.

**Division of staff.** Nurses often feel shock, anger, and disbelief at the suspected diagnosis of MSBP. Some go through a period of denial and refuse to believe others' suspicions (Blix & Brack, 1988). The diagnosis of MSBP can divide a nursing staff.

The nurses who first dealt with Whitney felt that Whitney's mother could be causing her spells. Those who first suspected the mother as the perpetrator had a difficult time convincing others, including the doctors, of their suspicions.

### Helpful Hints

**Written plan.** Before monitoring begins, all disciplines involved should meet to discuss guidelines of observation and intervention. A clear written plan is designed by the team and approved by administration and the legal department to cover all aspects involved in collecting evidence. This plan includes protocols identifying signs and symptoms that would require immediate intervention during videotaping of an abusive episode. Guidelines as to when to intervene based on drop in heart rate and other parameters are determined so that nurses are not left to have to decide when to intervene. Names and phone numbers of whom to call after abuse has been documented should be determined prior to beginning videotaping. These procedures will help decrease nurses' uncertainty and uneasiness related to wondering if they are doing the right thing.

**Advance preparation.** Mandatory, periodic inservices with the nursing staff about all forms of child abuse including potential causes and discussion of feelings evoked will help prepare staff for potential difficult patient care situations. After education and discussion of MSBP, increased knowledge lead to a better understanding and increased effectiveness of the nursing staff. When confronted with a patient with suspected MSBP, preparation of the room for videotaping includes preparation of the nursing staff. An explanation that the primary responsibility is to protect the patient and that the purpose of the videotaping is to document the abuse helps put it into perspective (Epstein et al., 1987). Possibly having the ability to monitor from a remote room would decrease the amount of deceptiveness that was necessary when using a room close to the patient's room. Abuse most often occurs in the child's bed, so the camera can be aimed in this direction. Aiming the camera also ensures privacy in the rest of the room and helps decrease nurses' feelings of invasion.

**Group support.** During the diagnostic phase when the

patient is being videotaped, daily conferences with all disciplines should be held to discuss and to compare observations and confirm or revise plans. Key contact persons are identified as liaisons among disciplines and information can be passed on in private before shift report. Group support and open communication among nurses and with physicians are important to help all involved deal more effectively with this difficult situation (Blix & Brack, 1988). Recognition of the dilemmas that nurses face in this situation and discussion of feelings help nurses feel that they have support. Interviews with nurses after dealing with a case of MSBP showed that when they found other team members had similar feelings, it was easier to verbalize these feelings and be more at ease about the roles they had to play (Blix & Brack, 1988).

MSBP presents a multitude of nursing dilemmas and requires a multidisciplinary approach with open communication among team members. Awareness of these dilemmas is the beginning step in planning care for these children. Continued support for nurses and other health care members is necessary throughout the diagnostic process. Specific protocols and open communication of feelings will help nurses deal more effectively with these families.

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# Commentary on Dilemmas Facing Nurses Who Care for Munchausen Syndrome by Proxy Patients

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**M**unchausen Syndrome by Proxy (MSBP), in which mothers knowingly harm their own children, has been referred to as a dance of deceit. The deceitful dance described by Mary Brown in the accompanying article is of a mother who was seemingly lovely to the nurses and physicians while attempting to suffocate her own child at the same time. Brown does an excellent job of alerting pediatric nurses to the disturbing aspects of this form of child abuse that may be witnessed by nurses more than they realize (Hochhauser & Richardson, 1994). Brown describes the dilemma of nurses' participation in entrapment of the mother by video surveillance.

This ethical commentary will expand upon Brown's article in a broader sense. The article will elaborate upon (a) who mothers are that might behave in this way, as presented by MSBP experts Schreier and Libow of Children's Hospital in Oakland, California; (b) how nurses might resolve dilemmas over participation in concealed surveillance of mothers, using the Burck Ethical Decision-Making Model; (c) what the procedure should be on the use of covert video surveillance according to the American Federal Bureau of Investigation (FBI); and (d) why there is a need for formalized critical incident debriefing for nurses who witness abuse of children by their parents.

## The Mothers

The idea that a mother would intentionally hurt her child goes against everything that we believe about motherhood. The healthy mother wants to provide for her children the best situation possible, including the best education, the best living environment, and certainly the best health that she can obtain for them. In our ideal of motherhood, mothers strive to meet the needs of their children, to keep them whole, happy and safe. But it is true that some women who become mothers are not mentally healthy, and the needs of these mothers may supersede their ability to provide what is best for their children.

Child psychiatrists Schreier and Libow (1993) write articulately of the impoverishment of the early lives of the women who commit this type of abuse. This is a subset of women who as children were not heard, who did not have their needs met for love and belonging, or who did not have a parent or authority figure "attend" to them. Perhaps for the first time, when presenting a child to a pediatrician for illness consultation, the woman receives the undivided attention

and respect of a prominent adult. The power of the physician's interest, in contrast to her own feelings of inadequacy, carries great appeal (p. 119). The pediatrician, as he or she learned in training, treats the mother as an interested collaborator and expert in the care of her child. In Munchausen Syndrome by Proxy, the mother who hungers for this appreciation gradually finds herself taking steps to remain in this medical world, even at the expense of her child's life (p. 119). Each new procedure ordered and each new medical setback suffered by her child further includes her participation in a world of professionals that show nurturance for her and respect for her opinions.

It is Schreier and Libow's opinion that MSBP mothers get "hooked" on the role of devoted caregiver to replace the powerlessness, emptiness and loneliness of their own lives. Thus the child is simply a vehicle for more and more involvement – the more dramatic the rescue, the more obscure the reported disease, the sicker the better. When a child actually dies from the covert abuse or fabrications, these mothers are actually surprised and saddened, and frequently go on to enter their next child into the medical system.

Although as health care professionals we must be committed to rescuing children who are helpless victims of this abuse, this is probably one of the saddest situations of family dynamics that exists. And as one component of the syndrome is for the mother to particularly befriend the nurses and spend considerable time with them, it may feel really painful when the nurses must participate in exposing the mother for who she really is.

## Using the Burck Ethical Decision Making Scale

Nurses have traditionally seen parents as partners in the care of their children. When nurses are asked to relook at parents as perpetrators of a crime, and to participate in the apprehension of such parents, a cognitive dissonance occurs. Such a role was not taught to nurses in nursing school, (nor taught to physicians in medical school). As in most ethical dilemmas, there is a state of competing harms. The guaranteed right to privacy of individuals, in this case the right to be videotaped only with consent, lies in balance with the need to assure safety for a child whose life is in danger. I suggest that the use of the Burck Ethical Decision Making Model (1996) can be employed to help nurses decide whether they will participate in activities of covert surveillance.

Burck (1996) developed an ethical decision making scale, using a linear continuum between actions which are absolute obligations and actions which are absolute prohibitions (see Figure 1). The scale allows conflicting moral obligations to be placed on the scale and judged by relative magnitude. In this case, one can balance the contending obligations of (a) preventing parental harm by not violating the constitutional right to privacy with (b) covert surveillance of parents which may safeguard the life of the child. The ethical decision is then made by honoring the obligation

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Figure 1. Obligation-Prohibition Scale (Burck, 1996)

Obligation		Permissibility		Prohibition		
absolute	stringent	more preferable	less preferable	stringent	absolute	
	X				X	
			A			

which weighs more heavily on the scale. In the case of participating in covert video taping, honoring the right to privacy is a traditional nursing obligation, and whenever possible, it should be stringently observed. The harm of the child's continued abuse and possible death, however, is an absolute prohibition, and thus weighs more heavily.

It may be that not every nurse feels comfortable with where I personally have placed the harms on this scale (see X marks in figure 1 above). Therefore I would suggest that nurses must *voluntarily* participate in the covert surveillance, and if they do not wish to do so, they should be allowed another assignment. It is of interest to note that support in the United Kingdom has not been exclusively in favor of violating civil rights to protect a child. English physician Foreman and philosopher Farsides in the *British Medical Journal* (1993, p. 611) state opposition to covert videotaping, calling it a "breach of trust between caregivers and patient," "unethical," and "causative of exposing the child to further abuse." Evans (1994, p. 342), also an English philosopher, states that it is "not the business of medicine to perform forensic investigations." Debate both pro and con has filled the literature (Byard & Burnell, 1994; Frost, Glaze, & Rosen, 1988; Epstein, Markowitz, Gallo, Holmes, & Gryboski, 1987; Meadow, 1987; Samuels & Southall, 1994; Southall & Samuels, 1993; Southall, Stebbens, Rees, Lang, Warner, & Shinebourne, 1987; Tenney, 1994; Wheatley, 1994; Wheeler, Nade-Ajayi, & Kiely, 1994). Baker (1996) has discussed the need for nurses to abide by their own personal values when making decisions about the care they deliver.

### Proper Use of Video Surveillance

Of note is that covert surveillance by video camera is in itself unconstitutional under American law. The Fourth Amendment of the United States Constitution reads:

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

The Constitution has thus been interpreted to make the following rules regarding electronic surveillance (Yorker, 1995):

- That a judicial order approving electronic surveillance certifies that normal investigative procedures have been tried and have failed or reasonably appear to be unlikely to succeed or are too dangerous.
- That the warrant contain a description of what is sought and what offense it relates to.
- That the surveillance be no longer than necessary to accomplish the objective, and in any event no longer than 30 days.
- That the interception be conducted in such a way as to minimize the interception of communications not subject to warrant.

The Supreme Court has recognized that there will be exceptions to the need or ability to obtain a search warrant. These exceptions generally apply to an imminent threat to human life.

Because there has been no specific law encoded for the use of hidden video cameras, Fiatal (1989) in the *FBI Bulletin* outlines the recommended handling of covert electronic surveillance. His recommendations are:

- Seek a court order for non-consensual entry and installation
- Set the particulars that will be looked for
- Describe the need for video surveillance
- Restrict the length of time
- Minimize observation of non-pertinent activity to prevent observation of innocent non-criminal activity
- Use the camera only when the individual suspected is in the area of observation.
- Seal videos and provide security for their handling.

When video surveillance is going to be used in a hospital facility, it is recommended that the hospital attorney and risk management are contacted. It has also been suggested that such an activity go through the ethics committee or research committee of the hospital, although timeliness and the need for security might preclude waiting for these committees to deliberate.

### The Need for Critical Incident Debriefing

The nurses who watched the video surveillance in Brown's article witnessed a horrible sight: that of a mother pushing her child's face into the mattress to cause apnea. Brown rightly states that nurses who witness such an event on the video tape will need emotional support afterwards. Others who have written about the video surveillance of mothers who are harming children made no mention of staff support (Byard & Burnell, 1994; Epstein et al, 1987; Southall & Samuels, 1993; Southall et al, 1987). Blix and Brack (1988) describe the physical and emotional trauma that occurred to nurses who participated in identification of a MSBP mother even prior to the use of video surveillance.

It is important to recognize the need for creating a formalized system to support nurses who participate in covert video surveillance. Critical incident debriefing has its roots in care for fire fighters and rescue personnel that witness horrible events (Mitchell, 1983). The process has been well adapted by emergency room nurses (Burns & Harm, 1993). A critical incident has been defined as an extraordinary clinical event that has the potential to cause unusually strong emotional reactions (Burns & Harm, p. 431). The debriefing is a tool to formalize the use of trained mental health staff to provide near-immediate psychological support to the personnel affected by the traumatic event. Linton, Kommor, and Webb (1993) and Rubin (1990) describe the creation of a debriefing team and delineate the phases of a debriefing. They suggest that a debriefing be conducted in a formal, structured sequence (see Table 1). Although this reference used only trained mental health professionals for debriefings, it is likely that hospital clergy or ethics consul-

Table 1. Debriefing Sequence of Actions

1. Introduction of the mental health staff and assuring confidentiality;
  2. Each individual involved states who they are, what their role was, and in their own words, what happened. All are encouraged to speak.
  3. Participants then voluntarily share how they felt during the incident, and if they have ever felt this way before.
  4. Participants describe the worst part of the incident and how they reacted. Psychological and physiological aftereffects are described.
  5. Any stress reactions left from the incident are discussed. The mental health professionals observe indicators for additional help for any members of the group.
  6. Stress reduction techniques are offered. Rubin (1990) suggests that debriefers remind nurses witnessing such trauma that stress is a normal reaction to an abnormal situation. Ways that the group can support each other are discussed.
- A summary is given by the team and referrals are made as needed.

tants could also facilitate the group. The important point is that debriefing be available to lower the pain level of the nurses, help each person mobilize resources, and put closure to such an event

Nurses in pediatrics witness great joy in their work when children make gains toward recovery. They also, however, bear witness to great pain. Of all the stressful events identified by Burns and Harm (1993) in their survey of 682 emergency room nurses, the critical events nurses found the most disturbing were most often related to the harm of a child. Munchausen Syndrome by Proxy is one event that will cause pediatric nurses more distress than their training ever prepared them for. The clinical manager who creates an environment of support for staff; ensures that nurses participate voluntarily in surveillance; is knowledgeable about how surveillance is to be handled; and who invites mental health workers, the clergy, or the ethics consultant onto the unit; will be assisting the staff in handling this dilemma with the least pain possible.

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