

syndrome by proxy. The main feature of the syndrome is that 'the affected person invents or creates symptoms in his or her charge in order to gain medical attention'.¹ There is no evidence to suggest that this was ever Miss Allitt's motive. I remain convinced that it is a useful diagnostic term and that it is not invalidated by its misuse on a single occasion.

SPECIFICITY

Dr Morley is right that many of the criteria used to identify situations in which Munchausen syndrome by proxy should be suspected are relatively non-specific and cannot be considered as diagnostic on their own. Nevertheless the presence of several criteria does, if nothing else, raise the chances that the child is at risk. All paediatricians would obviously agree that it is crucial to listen carefully to the information provided by the carers and I am sure we would all also agree that at times we fail in this respect.

Although it is obviously true that the child will probably spend more time with the carer under suspicion than other family friends and relatives, natural recurrent events usually are witnessed by others at some time or another. It is therefore essential to obtain independent corroborative evidence rather than relying on the statement of the carer. It is also important to stress that the onset of the event must be seen as otherwise the cause will remain in doubt.²

Inconsistent histories are a more useful pointer than has been claimed by Dr Morley. Much weight has been placed on the importance of identifying inconsistencies in the description of events in the diagnosis of child abuse. If they are helpful in that condition they are also useful in the identification of Munchausen syndrome by proxy. It is possible to make a case that the only diagnostic role of overt cardiorespiratory (or electroencephalographic)³ monitoring is that a sequence of events can be documented which may differ very considerably from the history described by the carer.

Sadly, along with child physical and sexual abuse Munchausen syndrome by proxy does occur and can constitute a real threat to the survival of the child. Inevitably if we are to identify these children, we will have to suspect some carers who are totally innocent. Dr Morley's article reminds us of the effects of these suspicions on the carer and the family. We cannot, however, put our heads in the sand and pretend that Munchausen by proxy does not occur.

A D MILNER

Department of Paediatrics,
United Medical and Dental School,
St Thomas's Hospital,
London SE1 7EH

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Is Munchausen syndrome by proxy really a syndrome?

Geoffrey C Fisher, Ian Mitchell

Munchausen syndrome by proxy was first described by Meadow in 1977.¹ Given the trend against the use of eponyms it has been suggested that a more appropriate term is factitious illness by proxy.² We have reviewed the syndrome elsewhere³ and essential criteria for diagnosis have been provided by Rosenberg.⁴ Meadow has advanced a useful list of warning signs.⁵ Munchausen syndrome by proxy/factitious illness by proxy is thought to be rare. A parent, nearly always the mother, falsifies illness in her child or children by fabricating a history and/or by producing symptoms or signs. The child is presented for medical care with 'illnesses' that are unexplained, prolonged, and unresponsive to all approaches. Symptoms occur only in the mother's presence.

Almost any clinical picture can be fabricated.^{4 6-8} Common presentations are epileptic seizures^{6 9} and infant apnoea,¹⁰⁻¹² though fabrications of complex or rare diseases occur.¹³⁻¹⁷ Munchausen syndrome by proxy/factitious illness by proxy is the cause of significant morbidity and mortality. Sometimes more

than one child in the same family is victimised.¹⁸⁻²⁰

The mothers have unusually close relationships with hospital staff, and about one third have previous complete or partial nurse training or other health profession associations. Many varied psychiatric diagnoses have been applied to the perpetrators, and some demonstrate features of Munchausen's syndrome themselves, though how many is uncertain. Distant and uninvolved partners are typical and the mothers appear to have few social outlets. We can call these prototypical cases.

'Not quite Munchausen syndrome by proxy/factitious illness by proxy'

Physicians are well aware of parents who anxiously insist that their children are ill. In paediatric practice the parent who claims their child has 'multiple allergies' is common, as is the overprotection of epileptic children because of suspected seizures. In some cases, as a result of parental anxieties, severe restrictions

Faculty of Medicine,
University of Calgary,
Departments of
Psychiatry and
Paediatrics
G C Fisher

Departments of
Paediatrics
I Mitchell

Correspondence to:
Dr G C Fisher, University of
Calgary, Alberta Children's
Hospital, 1820 Richmond
Road SW, Calgary, Alberta
T2T 5C7, Canada.

of the child's life result, from bizarre diets to social withdrawal.²¹ McKinlay notes 'the parent who provokes sickness behaviour in the child, refuses to accept psychological mechanisms, seeks multiple opinions, insists on repeated investigations, and ruins the child's life'.²² Closely related is the 'masquerade syndrome' in which mothers keep children at home from school for long periods with apparent chronic illnesses, the illness being a 'masquerade' for an enmeshed relationship with the child.²³

Woollcott *et al* described four cases of mothers who, combined, consulted a total of 99 physicians in eight states.²⁴ They attributed symptoms (of long standing) to nearly every organ system. Their beliefs verged on the delusional and their thinking exhibited a paranoid style. They were resistant to psychiatric assessment and refused psychotherapy. Intense overinvolvement and symbiotic ties occurred between the mothers and children. The authors named this 'doctor shopping'. These parents were not deliberately falsifying history or physical signs, rather they were convinced that illness was present. Doctor shopping has also been described in parents of mentally handicapped children.²⁵

Child psychiatrists frequently meet parents who insist that a 'brain disease', often attention deficit disorder, is responsible for a child's behavioural disturbance. Also common are demands made of psychiatrists to 'fix' behaviourally disturbed children, deflecting away from other possible antecedents, such as dysfunctional family systems. Sometimes multiple consultations are sought in the quest for the 'cause'. The focusing or maintaining of the child in an illness role serves some function for the family system.

The deliberate poisoning of children is another method of inducing clinical symptoms and signs in a child, who is presented with medical conditions, the cause of which the parents claim no knowledge. Schnaps *et al*²⁶ notes several cases of poisoning that were previously reported under the diagnosis of Munchausen syndrome by proxy.^{1 27 28} Meadow⁶ considers cases of poisoning to be 'extremely similar' to Munchausen syndrome by proxy/factitious illness by proxy and Waller²⁹ references 23 case reports of the 'two overlapping syndromes'. If poisoning is the vehicle for presenting children as ill then such

cases have usually been included under the rubric of Munchausen syndrome by proxy/factitious illness by proxy.

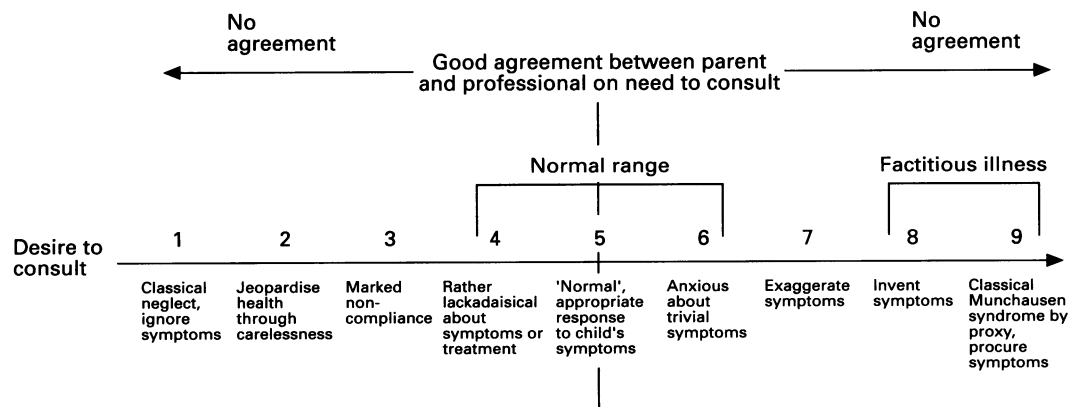
Issues in classification

Given the extensive and varied presentations ranging from insisting illness is present through to fabricating history and actively inducing illness, Libow and Shreier suggested a classification scheme.³⁰ They described three groups: active inducers, help seekers, and doctor addicts.

Active inducers are the 'prototypical' cases – characterised by dramatic symptoms actively induced by a parent. The victims are young and brought frequently for medical attention. Few in-depth psychological, psychiatric, or dynamic formulations have been completed on these perpetrators, because they rarely engage in assessment or treatment. Even so 'the most consistent picture emerging is of an anxious and depressed mother who uses an extreme degree of denial, dissociation of affect, and paranoid projection'. Although descriptions of the mothers' behaviours are often given, clear diagnoses are frequently lacking, though depression,^{31 32} personality disorders,^{18 27 33 34} and functional illnesses³⁵ have been noted. Symbiosis between mother and child is common, as is relative absence of the husband.

Help seekers appear like 'classical' cases, but are different in important respects; the children are presented less frequently or only once. The mother's needs differ from classical Munchausen syndrome by proxy/factitious illness by proxy and they are more open to psychotherapeutic intervention. Libow and Shreier believe these cases are different from 'true examples' of Munchausen syndrome by proxy/factitious illness by proxy, largely on the grounds of the primary motivation. The cases were 'replete with domestic violence, unwanted pregnancies, and single parenthood – all social realities'. The mothers were anxious and depressed.

Doctor addicts are defined as mothers 'obsessed with the goal of obtaining medical treatment for non-existent illness'. Doctor addict types differ from prototypical Munchausen syndrome by proxy/factitious illness by proxy in that the children are older and the mothers are antagonistic, suspicious, and paranoid. Libow and Schreier speculate that



Parents' desire to consult for their child's symptoms. (Reproduced with permission from Eminson and Postlethwaite.³⁷)

these cases can best be understood as an expression of 'a more paranoid personality'. Masterson *et al* have considered the relationship between Munchausen syndrome by proxy/factitious illness by proxy cases (doctor addict type) and cases of respiratory illness, the symptoms of which were exaggerated to an extreme degree by parents.³⁶ They concluded that the groups were remarkably similar on six indices with the only difference being the absence of an organic basis in the doctor addict types.

Eminson and Postlethwaite advance a dimensional model (see figure).³⁷ Two dimensions are proposed, the first is the appropriateness of parents' desire to consult. At the midpoint of this dimension is the 'normal range' of health care seeking for children by parents, with almost complete agreement between the physician and parent about the need to consult. Some parents may exhibit increased anxiety (and present more frequently than necessary) and others will be 'rather lackadaisical about symptoms or treatment'. Physicians are familiar with each of these 'normal' variations.

Well outside the normal range are parents whose level of concern is very different to the physicians'. At one pole are those who demonstrate classical neglect of their children's well-being, and at the opposite pole 'the difference between the parents' desire to consult and the objective professional view of their child's health is so huge that the parents have to procure illness, in order to force doctors to investigate and treat it'. Midway between the anxious parents and those who induce illness in their children are parents who exaggerate their children's symptoms but do not actively fabricate.

The second dimension offered by Eminson and Postlethwaite is the ability of parents to distinguish the child's needs from their own. Three groups are described: firstly those who cannot distinguish their needs from their child's, and place their own requirements foremost (classical neglect and prototypical Munchausen syndrome by proxy/factitious illness by proxy). The second group are parents who are inconsistent and variable in distinguishing their child's needs (falling between the central normal range and both poles of the first dimension). Finally there are parents whose perceptions of the child's needs are accurate and uninfluenced by their own needs.

In summary two approaches to understanding the 'syndrome' have been ventured, one a categorical system and the other dimensional. Libow and Shreier's categories are useful and have particular value in the treatment of the perpetrator, prognosis, and child safety issues. Their groups appear very similar but differ according to the primary motivation behind the abuse. This differentiation, however, occurs 'after the fact'. Distinguishing between types is difficult, if not impossible, when presented with an individual child in the office or on a medical unit, and particularly so when detailed investigative histories have not been acquired. All that is initially known is that fabrication is suspected or confirmed. The dimensional method of Eminson and

Postlethwaite places Munchausen syndrome by proxy/factitious illness by proxy firmly in context of other, better understood, forms of child abuse (neglect) and allows flexibility in considering that the same case may present on different parts of the dimension at different times. The implications regarding the origins of the perpetrator's behaviour (that is an unawareness of the child's needs) are extensive and considered in the discussion.

Discussion

The term Munchausen syndrome by proxy is derived from Asher's description of Munchausen's syndrome.³⁸ Although a useful term it may have led to confusion in some areas. To psychiatrists (who are accustomed to descriptive diagnoses) it may imply that there is an 'illness Munchausen syndrome by proxy' that perpetrators 'have', but more importantly suggest that perpetrators have Munchausen's syndrome themselves and manifest their pathology via their child. This is mistaken as only a minority of perpetrators appear to have Munchausen's syndrome. Morris suggested using the term factitious illness by proxy.² Though not included in the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition, revised (DSM 3R) of the American Psychiatric Association,³⁹ factitious illness by proxy is derived from the DSM 3R diagnosis factitious illness. Factitious illness is a purely descriptive term and assumes no aetiological basis; the diagnosis is made by meeting certain agreed upon criteria. Discarding the eponym may appear progressive and in keeping with DSM tradition but little is different; implied Munchausen's syndrome is only replaced by implied factitious illness.

Another question is whether a diagnosis of Munchausen syndrome by proxy or factitious illness by proxy is a paediatric or psychiatric one. To answer this, it is important to consider who makes the diagnosis. In nearly every case it is a paediatrician who raises a suspicion that fabrication has occurred when discrepancies are noted between the perpetrator's history, physical findings, or course of an illness. When such suspicions are advanced or confirmed the paediatrician will then make the diagnosis. It is clear that a 'diagnosis' of Munchausen syndrome by proxy/factitious illness by proxy only describes a single or series of observed anomalies and discrepancies. The word diagnosis is usually understood as the identification or inferring of the presence of a disease by means of the patient's symptoms. Munchausen syndrome by proxy/factitious illness by proxy is not a diagnosis in a traditional sense but an observational description with implications regarding cause. In making an observation that a fabrication has occurred there should be no diagnostic assumptions made about parental psychopathology. We have observed in clinical practice, however, that at the point the observation is made or the label Munchausen syndrome by proxy/factitious illness by proxy applied there appears to be an almost automatic reaction by many medical and adjunct staff to assume an illness called

Munchausen syndrome by proxy/factitious illness by proxy is present in a parent. It has also been observed by us the frequency with which child protection social workers and lawyers ask 'does the mother have Munchausen syndrome by proxy?' as if it were a diagnosable disease entity with specific psychopathology that is the same in all cases. It is suggested that these suppositions are a consequence of this terminology (with embedded assumptions, such as the words 'by proxy'), and a misunderstanding of the roles and duties of the involved paediatricians and psychiatrists.

The word syndrome is also misleading. A generally accepted definition is 'a grouping of symptoms and signs that recurrently appear temporally together in many persons'.⁴⁰ The situation with Munchausen syndrome by proxy/factitious illness by proxy is different, the victims do not have a specific collection of symptoms nor do the perpetrators. The victims present with a wide variety of symptoms and signs indicating the possible presence of varied medical illnesses and the perpetrators demonstrate an extensive assortment of psychopathological dysfunctions, syndromes, and illnesses.

These observations have far reaching implications. If it is a situation or parental behaviour (a fabrication) that has come to be known as Munchausen syndrome by proxy or factitious illness by proxy then logically there cannot be a disease or illness entity, or a condition, or even a syndrome called Munchausen syndrome by proxy or factitious illness by proxy that perpetrators have. Instead perpetrators have various psychological, psychiatric, and environmental 'pathways' leading to a behaviour of fabricating illness in a child. Such pathways could include, for example, personality disorder, or depressive illness, or severe family and social stressors. Some, such as depressive illness, may be found to be more amenable to assessment and treatment than others, for instance personality disorder. Strictly speaking the terms Munchausen syndrome by proxy or factitious illness by proxy should only be reserved for those rare occurrences when a perpetrator clearly has Munchausen's syndrome or factitious illness themselves and for various unique individual psychodynamic reasons, manifests this psychopathology via their child or children. Most adult patients with Munchausen's syndrome/factitious illness present themselves, not their children, to physicians. In the cases reported most perpetrators appear to have varied psychological difficulties apart from Munchausen's syndrome or factitious illness.

Strong support for this conceptualisation is implicit in the work of Eminson and Postlethwaite.³⁷ In child neglect there are various parental psychological problems that interfere with the parent's awareness of the child's physical and emotional needs and in such cases it is not asserted that the neglecting parent has a syndrome known as 'child neglect'. Rather combinations of parental social, psychological, and psychiatric pathology lead to the relative unawareness of the child's needs. The situation is the same with fabricated illness in childhood, which is, for all intents and purposes, also

an unawareness of the child's individuality.

If the above is considered an acceptable reformulation of what Munchausen syndrome by proxy/factitious illness by proxy is and is not, ongoing confusion is probable. The expression Munchausen syndrome by proxy is unlikely to be easily displaced, particularly because it is attractive and emotive with increasing media and public interest, and factitious illness by proxy is a new label gaining acceptance. It can be argued that there is a strong case for abandoning the terms Munchausen syndrome by proxy and factitious illness by proxy completely, or at least restricting their use only to situations where a perpetrator has diagnosed Munchausen's syndrome or factitious illness themselves. A position of advocating that paediatricians do not 'diagnose' Munchausen syndrome by proxy or factitious illness by proxy but rather 'describe' the observed situation on the basis of history and examination findings, for example, factitious or induced apnoea or epilepsy, is appealing for a number of reasons:

- The label is descriptive and obvious
- The paediatrician's medical duty is apparent
- Implicit assumptions about specific perpetrator illness are avoided
- The consulting psychiatrist or psychologist is free to identify and speculate on the perpetrator psychopathological pathways (and only one is Munchausen syndrome by proxy or factitious illness by proxy) leading to the parent's behaviour and the situation of fabrication.

This conceptualisation also adapts well to the cases described by Meadow as not quite Munchausen syndrome by proxy/factitious illness by proxy,⁶ and the exaggeration portion of Eminson and Postlethwaite's dimension. Based on history and findings, a paediatrician may diagnose parental exaggeration of asthmatic symptoms for example, once again allowing the psychiatrist to speculate on the pathway (for example anxiety, neurotic illness, or social stress) leading to the parental behaviour.

Conclusions

The condition known as Munchausen syndrome by proxy/factitious illness by proxy does not appear to satisfy criteria for acceptance as a discrete medical syndrome because of the wide variations in presentation and perpetrator psychopathology. The circumstances are 'situations' of fabrication observed and described by paediatricians on the basis of history, examination, and investigation. It is recommended that paediatricians abandon making a diagnosis of Munchausen syndrome by proxy or factitious illness by proxy and instead diagnose the specific fabricated or induced medical illness(es) or condition(s) they encounter. The role of the psychiatrist or psychologist is one of defining and diagnosing the psychopathology leading to the perpetrator's behaviour. The terms Munchausen syndrome by proxy and factitious illness by proxy should be severely restricted to occurrences where a perpetrator has Munchausen's syndrome or factitious illness themselves *and* manifests their

psychopathology via the child. This redefinition clarifies the roles of paediatricians and psychiatrists and is free of embedded assumptions.

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What is, and what is not, 'Munchausen syndrome by proxy'?

Roy Meadow

Flamboyant terminology has as many problems as advantages. 'Munchausen syndrome by proxy' was used originally for journalistic reasons. Munchausen syndrome was a commonly used term, applied to adults who presented themselves with false illness stories.¹ Therefore it was plagiarised and adapted to apply to children who were presented with a false illness story invented by someone else (a proxy).² While the introduction of the new term, in 1977, achieved its aim in leading to the recognition of many under recognised, ill described, and new forms of child abuse; its over use has led to confusion for the medical, social work, and legal professions. It has been used most in relation to fabricated illness of children which meets the following criteria:

- (1) Illness in a child which is fabricated by a parent, or someone who is in *loco parentis*.
- (2) The child is presented for medical assessment and care, usually persistently, often resulting in multiple medical procedures.

(3) The perpetrator denies the aetiology of the child's illness.

(4) Acute symptoms and signs of illness cease when the child is separated from the perpetrator.

As a diagnostic aid, these criteria lack specificity: many different occurrences fulfil them. It is common for children suffering physical or other forms of abuse to be presented repetitively for medical assessment, and for the perpetrating parent to deny that they have injured the child. It is common for such parent's actions to result in multiple medical procedures and, usually, the signs of injury abate when the child is separated from the perpetrator. Yet most of that abuse should not be classified as Munchausen syndrome by proxy.

Historical background

The original two index cases, for which the term was used, were memorable for particular

Department of
Paediatrics and Child
Health, St James's
University Hospital,
Leeds LS9 7TF

Correspondence to:
Professor Meadow.