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Munchausen's syndrome and child psychiatrists

Sir,

I would like to pick up the comments made by Professor Roy Meadow in his very fascinating and important overview of the management of Munchausen's syndrome by proxy.¹ He puts forward a very pertinent question as to how it is that relatively few of these cases have been helped by the intervention of child psychiatrists. My own view of their lack of involvement in the field of child abuse generally is as follows:

(1) Until more recent times when there has been an increasing focus on emotional and sexual abuse, most child abuse cases seen in this country have been infants or preschool children. For a child psychiatrist to become closely involved with very young children usually means that he has to work within a paediatric hospital.

(2) After the pioneering work of the National Society for the Prevention of Cruelty to Children's (NSPCC) Special Unit in the 1960s, the model of treatment of child abuse, physical abuse, and neglect has come to be located in contexts which have a strong social services or NSPCC bias. The work of 'parenting the parents' who themselves have been abused has been focused in these contexts. Care proceedings and statutory work supported by paediatric focusing on developmental issues has been the norm.

(3) Munchausen disease by proxy is a diagnosis usually made in a paediatric setting, and the deep involvement of a paediatrician as described by Professor Meadow certainly attests to this. Thus, although the children may be older, the same factors hold.

(4) It is of interest to note that in our recent work with sexually abused children² the older children—predominantly 11 to 15 years at presentation—are referred, in the main, not through paediatricians but by social services departments or the police.

A working team where a child psychiatrist and a paediatrician have time for regular psycho-social meetings or reviews of their work, means that each will share in issues which are their joint concern. I have learnt a considerable amount and have also been able to contribute through the very close linking of child psychiatrists and paediatricians in our own hospital, hence the possibility of recognising the syndrome of 'non-accidental poisoning' in 1976.³ This is not the case throughout the country and there are too few child psychiatrists to enable them to share as deeply in the work as we have been able to do ourselves. Child psychiatrists appointed to a particular

area and community have responsibilities towards educational services, social services, general practitioners, and other community agencies in their area, and inevitably paediatric linking can only be a small part of their work. Without regular time and contact the subtleties of a condition such as Munchausen by proxy will be missed and the child psychiatrist will not have a role.

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Apnoea monitors and sudden infant death

Sir,

Regarding Dr Wright's criticism¹ of the report from the Foundation for the Study of Infant Death and the British Paediatric Respiratory Group,² Professor Milner has additional support for his statement 'There are published reports of babies dying while attached to a monitor'. In both cases the mother, a trained nurse, responded to the monitor alarm with cardiopulmonary resuscitation but in one was unable to revive the infant³ and in the second the infant died on a ventilator 10 hours later.⁴ The monitor did respond to apnoea, as it did in Kelly's experience,⁵ so Dr Wright's contention that 'There is no recorded instance of a death where the alarm failed to detect apnoea' is correct, even if resuscitation was unsuccessful.

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