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COVERT VIDEO SURVEILLANCE OF PARENTS SUSPECTED OF CHILD ABUSE: THE BRITISH EXPERIENCE AND ALTERNATIVE APPROACHES

ABSTRACT. One million cases of child maltreatment and twelve hundred child deaths due to abuse and neglect occur per year. But since many cases of abuse and neglect remain either unreported or unsubstantiated due to insufficient evidence, the number of children who are abused, neglected, and killed at the hands of family caregivers is probably higher. One approach to combat child abuse in the U.K. has been the employment of hospital-based covert video surveillance (CVS) to monitor parents suspected of Munchausen Syndrome by Proxy (MSBP). The use of CVS, however, raises concerns about voluntary informed consent, research on human subjects, privacy, and the appropriateness of healthcare providers to conduct CVS. More broadly, the use of CVS raises concerns about the ethical life of healthcare institutions and their moral obligations to the families and communities they serve. The U.K. protocol for CVS is examined in light of these concerns. Three alternative CVS protocols and two procedures for selecting a protocol are then proposed for use in the U.S. The paper concludes that any CVS protocol selected for use by hospitals ought to be selected by means of open and democratic processes that permit community input and, subsequently, the possibility of a consensus on the moral status and scope of CVS.

KEY WORDS: child abuse, community ethics, covert surveillance, informed consent, provider-patient relationship, privacy, research

INTRODUCTION

The National Committee to Prevent Child Abuse has estimated that one million substantiated cases of child maltreatment and over twelve hundred child deaths due to abuse and neglect occur per year in the U.S.[1] The problem, however, is that since many cases of abuse and neglect remain either unreported or unsubstantiated due to insufficient evidence, the number of children who are actually abused, neglected, and killed at the hands of family caregivers is probably higher. One innovative and controversial approach in the United Kingdom (U.K.) to combat one form of child abuse is the employment of covert video

Theoretical Medicine **25:** 311–327, 2004.

surveillance (CVS) by designated hospitals and healthcare professionals to monitor parents suspected of Munchausen Syndrome by Proxy (MSBP), a psychiatric condition in which a parent induces illness in a child.[2] But the use of CVS raises a host of ethical questions about voluntary informed consent, research on human subjects, privacy, and the appropriateness of healthcare providers to conduct CVS.[3] Furthermore, in light of a growing chorus of criticism over MSBP in the U.K. and an increasing number of overturned convictions of mothers wrongly convicted of killing their babies based on MSBP abuse theory, the use of CVS raises concerns about the ethical life of healthcare institutions and their moral obligations to the families and communities they serve.[4] Thus, as this controversial method of detecting child abuse receives more attention from healthcare institutions in other nations, it becomes increasingly important to have a better understanding of the ethical, social, and political ramifications of hospital-based CVS.[5]

In what follows, I discuss the U.K. protocol and examine some of the ethical and social issues involved with its use in U.S. hospitals. I then discuss three alternative protocols for hospital-based CVS and sketch the outlines of two procedures for selecting a CVS protocol. I conclude that any CVS protocol selected for use by U.S. hospitals ought to be selected by means of open and democratic processes that permit community input and, subsequently, the possibility of a consensus on the moral status and scope of CVS.

THE BRITISH EXPERIENCE WITH CVS

Most of the research on hospital-based CVS has been conducted in the U.K. over the past 20 years.[6] In a 1997 article that appeared in the journal *Pediatrics*, Dr. David Southall summarizes the findings from a study of 39 children, ranging in ages from 2 to 44 months, who had undergone CVS.[7] The results of this study are startling.

The children were initially referred to two hospitals in the U.K. for investigation of apparent life-threatening events (ALTEs). The most common ALTE children presented with was recurrent apneic or cyanotic episodes. CVS revealed abuse and/or induced illness at the hands of a family caregiver in 33 out of 39 suspected cases. The kinds of abuses identified included suffocation, poisoning, strangulation, fractures, and other physical and emotional harms. But, consistent with the most common ALTE of apneic or cyanotic episodes, CVS

revealed that 30 of the 33 patients were subjected to intentional suffocation at the hands of a family caregiver, usually the mother. Southall also determined that the 39 children undergoing CVS had a total of 41 siblings, 12 of whom had died previously. Eleven of these 12 deaths were initially classified as sudden infant death syndrome (SIDS), but after CVS, four parents admitted to suffocating eight of these siblings. On the basis of these findings, it is no surprise that Southall concluded that CVS is a very useful tool for investigating and confirming cases of suspected child abuse, and for helping to protect children from possible future abuses.

ETHICAL AND SOCIAL ISSUES

Informed Consent

Although the U.K. protocol for CVS has been shown to be highly effective in confirming suspected cases of child abuse, the employment of hospital-based CVS is morally problematic in many ways.[8] First, take the ethico-legal principle of voluntary informed consent, which is fundamental to the ethical practice of medicine. In simple terms, voluntary informed consent requires that patients, guardians, and surrogates must understand and freely give their permission before any medical interventions can be performed. Moreover, even in situations where patient, family, or surrogate permission is not required, it is generally accepted that healthcare providers should, at least, educate and inform these persons about various medical options and procedures. The main advantage of seeking and gaining informed consent is that it discourages medical paternalism and encourages patient and family autonomy and well being. Voluntary informed consent is also important, because, without it, it is difficult to promote other moral values, such as trust, honesty, privacy and respect for persons. When these values are lacking or in question, it is doubtful that healthcare institutions and providers can effectively serve their patients and communities.[9]

The U.K. protocol for CVS, especially the referral and implementation stages, requires deception on the part of hospitals and providers by proceeding without the informed consent of family caregivers. The referral process for CVS begins when a physician suspects child abuse by a family caregiver and when working openly with the caregiver has failed. At this point, the physician initiates an

"initial multi-disciplinary strategy discussion" in order to determine whether care proceedings are warranted. Because of possible risks to children, those suspected of abuse are not notified of strategy meetings and the potential use of CVS. If these initial care proceedings produce adequate evidence of child abuse, then a "second multi-disciplinary strategy discussion" is held to determine whether CVS is needed. If CVS is deemed necessary, the child will be admitted to a designated hospital capable of CVS.

Of course, there are good reasons, practical and moral, for not informing suspected child abusers that CVS will be used. As common sense suggests, the disclosure of this information would undermine the investigation by tipping-off the suspected abusers, who then would refrain from abusing their child. By telling suspected abusers they will be videotaped, a child is potentially at greater risk of future harms when he or she leaves the hospital. But, even though the U.K. protocol for CVS violates the principle of informed consent, CVS can be justified on grounds that it maximizes a child's best interests by minimizing possible future harms to that child. If we accept this moral justification, which is basic to the U.K. protocol, then the informed consent of family caregivers can be trumped and their moral status subordinated to the child's best interests when abuse is suspected. Nevertheless, the important point here is that the use of CVS creates a conflict between equally important moral principles, the autonomy and informed consent of family caregivers and the best interests of their children.

Research on Human Subjects

We also must consider Southall's claim that CVS is established clinical practice rather than research on human subjects.[10] Given that MSBP requires further study and is not yet itself an official diagnostic category of the American Psychiatric Association, it is difficult to see how CVS with persons suspected of MSBP could be anything but research on human subjects.[11]

If CVS is research on human subjects, then the use of CVS in the U.S. would need to meet the standards established for experimentation on human subjects, which, at minimum, include review by an institutional review board (IRB). Moreover, research on human subjects would require the informed consent of the legal guardians of the children and demonstrate that CVS would produce more benefits than harms for the children who are involved. The first problem with

the U.K. protocol for CVS is that informed consent is unnecessary; the second, is that it is unclear that it consistently produces demonstrably more benefits than harms for the subjects, the children.

Law Enforcement or Medicine?

The U.K. protocol for CVS also raises questions about the appropriate roles of healthcare institutions and providers because it blurs the distinction between law enforcement and medicine. Under the U.K. protocol, nurses are typically trained in the use of CVS. During a routine shift, a CVS nurse watches a television monitor and keeps detailed notes of a suspected abuser's behaviors and interactions with the child. If abuse is observed (e.g., suffocation of a child), the nurse alerts the staff to intervene. Only after abuse is confirmed are police and child protective services contacted and debriefed in order that they may advance the child abuse investigation. It should be noted that an important feature of the U.K. protocol is that nurses who participate in CVS must volunteer and not be required to participate in the direct care of those families that are under surveillance. This is done as a way of protecting these nurses from finding themselves in uncomfortable and compromising situations with those suspected of child abuse.

Nevertheless, the use of healthcare providers to conduct CVS is objectionable for the following reasons. First, if CVS is simply a means of confirming criminal conduct by caregivers, then CVS is arguably a forensic tool that should be managed by law enforcement officials, not healthcare professionals.[12] Although healthcare providers cooperate with law enforcement authorities, for example, by having a legal obligation to report child abuse, this is very different from having them covertly investigating cases of suspected child abuse. Second, the fact that the U.K. protocol makes CVS duty voluntary misses the larger ethical issue of whether healthcare providers should conduct CVS under any circumstances. In doing so, this oversight ignores the social and ethical implications of CVS for healthcare institutions and the communities they serve.

Opponents of CVS further argue that CVS is not healthcare because no treatment is offered to the child except in those cases where a family member while being secretly videotaped physically assaults the child. Furthermore, since MSBP is not an accepted psychiatric diagnostic category, it is difficult to claim that a clearly established pathophysiological condition or psychiatric disorder is being sought

with CVS. If the opponents of CVS are correct, then CVS has more in common with either law enforcement or research than with medicine. Thus, the burden of proof is on those persons who believe hospital-based CVS is a kind of medical practice.

Along these lines, one possible justification for CVS is that the child, not the suspected abuser, is the designated patient to whom a medical duty is owed. From this perspective, CVS is the practice of preventative medicine.[13] In addition, although the American Psychiatric Association does not yet accept MSBP as a psychiatric condition worthy of diagnostic categorization, proponents could argue that CVS would make it easier to determine whether MSBP is a legitimate psychiatric disorder.[14] Whatever the outcome, CVS would be responsible, in part, for reaching a conclusion about the status of MSBP as a possible diagnostic category. Such a conclusion would be an advancement of medical knowledge and permit healthcare providers to do a better job of diagnosing and treating their patients, whether they suffer from MSBP or not. Consequently, supporters of CVS can take the position that CVS may be of medical benefit to the entire family, not just the abused child.[15]

But, even if CVS can be construed as the practice of medicine, we need to remember that the abuse of a child is still a criminal act subject to legal punishment in both the U.K. and the U.S. Thus, even though CVS might medically benefit dysfunctional families, one ought not to forget that there will be criminal justice implications issuing from the use of CVS. Consequently, there are good reasons for not characterizing CVS as only a medical practice. If this much is granted, then the question about the appropriate role of healthcare professionals in administering CVS remains open.

CVS AND PRIVACY

Personal privacy is morally significant because it protects the self-determination and dignity of persons and families. Without privacy, persons may be subject to embarrassment and manipulation by others who may not have their best interests in mind. This is particularly true in healthcare environments where patients must often reveal personal details in order for healthcare providers to make accurate diagnoses and to prescribe effective treatments. In deciding whether the U.K. protocol for CVS should be imported for use in U.S. public hospitals, we need to assess the possible affects CVS may

have on the privacy interests of patients, families, and the general population.

The fourth amendment of the U.S. Constitution legally embodies and expresses the moral value of privacy. Its purpose is to constitutionally protect the privacy interests of citizens by prohibiting unreasonable searches and seizures by law enforcement officers.[16] Over the past few decades, the importance of healthcare privacy has received attention in a number of court cases. Some cases have concluded that an expectation of privacy is not reasonable in certain areas of a hospital, for example, emergency rooms, hallways, and parking lots.[17] In other cases, however, the courts have concluded that, unlike a private home, hospitals can be characterized as constituted by both public and private domains, meaning that an expectation of at least momentary or limited privacy is reasonable in areas such as patient rooms and bathrooms.[18] There are, of course, exceptions in which a reasonable expectation of privacy can be overridden, for example, the use of wiretaps and hidden cameras by law enforcement officials to monitor criminal activities. In cases like these, police officers, without the consent of those who will be observed, may enter and install audio-video recording devices in areas where it is reasonable to expect privacy, for example, the living room or bathroom of a private residence.[19]

The implementation of CVS by law enforcement officials is not automatic. There are specific legal procedures that must be followed before CVS can be used. These procedures are specifically designed to reduce the threat of unnecessarily violating someone's privacy interests. If these guidelines are not followed, any video evidence obtained in violation of these legal guidelines may be excluded from a court of law and lead to civil liability on the part of the offending officer or law enforcement organization. The guidelines that law enforcement officials must follow specify that there must be (1) a probable cause, (2) a warrant for arrest and search, (3) a detailed description by police of the places and persons to be observed, (4) an explanation why less intrusive forms of surveillance have failed, (5) a restriction on the length of observation needed to acquire evidence of criminal activity, and, of most importance, (6) law enforcement officials must receive court approval for all non-consensual entries and installations of covert videotaping devices.

How does the U.K. protocol measure up to these fourth amendment guidelines? First, the U.K. protocol does not mandate the use of law enforcement officials to conduct CVS. Remember, the U.K.

investigators trained nurses for CVS. Under U.S. legal guidelines, law enforcement officials are the only persons who have the legal authority to violate the privacy of its citizens, and they can only do so under highly restricted and specified circumstances. Thus, in light of the fourth amendment and the importance we give to privacy interests, it is questionable whether nurses or any other healthcare professional in public hospitals should qualify for this task. This may seem a rigid standard when the welfare of a child is at stake, but, unlike the U.K. protocol, U.S. legal guidelines better protect the privacy interests of its citizens and maintain a clearer distinction between medicine and law enforcement. Second, because we are protected from unreasonable searches and seizures by U.S. guidelines, less intrusive forms of surveillance must be attempted before CVS can be used. The U.K. lacks similar constitutional protection and, therefore, the U.K. protocol for CVS does not have this restriction. The problem, then, is that the U.K. protocol does not include the possibility of less intrusive forms of surveillance.

There are, of course, good reasons for not using less intrusive forms of surveillance, in particular, poorer outcomes for children suspected of being abused at the hands of caregivers. Nevertheless, unless we give less importance to the moral value of privacy in the U.S. and allow more intrusive violations of our privacy to occur more easily, the U.K. protocol for CVS may be unacceptable for use by public hospitals by current U.S fourth amendment guidelines. Moreover, the use of CVS in the U.S. is even more problematic, given that MSBP is not an official diagnostic category of the American Psychiatric Association.

Another limitation of the U.K. protocol affecting the privacy of citizens deals with the disposition of the videotapes produced during CVS. There are three possible outcomes. In the first scenario, if CVS results in criminal proceedings against a family caregiver, the tapes are to be given to the police. In the second scenario, if CVS leads to civil proceedings, the tapes are to be given to Social Services. In the third and final scenario, the tapes remain the property of the hospital when no abuse is demonstrated with CVS. It is important to note that when no abuse is observed the U.K. protocol for CVS does not require the hospital to destroy the tapes, nor does it require the hospital to tell the family that they were under secret observation by hospital staff.[20]

To summarize, the U.K. protocol for CVS raises many ethical questions about informed consent, research on human subjects, the

appropriate roles of healthcare institutions and providers, and the conditions under which the privacy interests of persons may violated. The position held by Southall and expressed in the U.K. protocol is that the moral value of minimizing possible future harms to children outweighs the harms done to family caregivers. Thus, informed consent and privacy can be trumped when it is deemed that a child's interests are at stake.[21]

THREE ALTERNATIVE CVS PROTOCOLS

I now turn to an examination of three alternative protocols for CVS, each of which reflect a different ranking of the moral values and principles already discussed in this paper.

Protocol One

In Protocol One, children would present with the same indications of abuse (i.e., ALTEs) that are required to trigger the U.K. protocol for CVS. But, unlike the U.K. protocol, in which family caregivers are not told that an investigation is being initiated, this model would require healthcare providers to (1) confront the caregivers, (2) arrange a trial separation, and (3) monitor the child's vital signs for a specified period of time. If no further ALTEs occurred during this observation period, this would suggests that the caregiver was responsible for inducing the child's traumas. However, if additional ALTEs do occur, this would suggests that the caregiver was not involved in child abuse.

What are the benefits of Protocol One? First, the moral status of family caregivers is honored because healthcare providers do not deceive them. Conversely, this approach also allows healthcare providers to maintain their integrity by allowing them to act in an honest manner. Second, children are not subjected to further violent assaults. Remember, under the U.K. protocol, CVS requires a family caregiver to abuse the child before abuse can be confirmed and the staff can be alerted. Although the threat of serious harm may be minor with CVS, there is no such threat of similar harm under Protocol One. Third, the value of privacy is protected and, fourth, the tendency to resort to wider forms of covert video surveillance is not reinforced.

Although Protocol One has some nice features, it also has limitations. First, on the basis of suspicion rather than proof, families

may experience great emotional strain and stigma from a forced separation. Second, law enforcement officials, without proof of criminal conduct, may have to be involved to prevent disgruntled family caregivers from removing their child from the hospital. Third, a lack of further ALTEs is not strong evidence that the earlier detected episodes were induced. For example, earlier apneic episodes could have been spontaneous occurrences. On the other hand, the occurrence of an ALTE while the child is under observation is not decisive evidence that earlier episodes were not induced by a family caregiver. CVS, on the other hand, would eliminate this uncertainty.

Protocol Two

Like Protocol One, Protocol Two would have the same ALTE indicators used to trigger the U.K. protocol. In this second model, however, family caregivers are told first that video monitoring will be among the forms of care provided to their child. In addition, caregivers are informed that Child Protective Services will be notified if the child is removed from the hospital. Again, as in Protocol One, the occurrence or nonoccurrence of ALTEs while the child is under observation is only suggestive, not decisive, of the guilt or innocence of a family caregiver.

One benefit of Protocol Two is that healthcare providers do not have to engage in subterfuge. By being open with family caregivers, healthcare providers can maintain their moral integrity and honor the privacy and dignity of family caregivers. Second, the connection between family caregivers and child is not disrupted by a forced separation. Recall in Protocol One there is the threat that family caregivers and children could experience stigmatization and emotional strain if they are forced to separate. Finally, as in Protocol One, Protocol Two does not encourage or reinforce a wider usage of CVS.

One significant pitfall of Protocol Two is that if family caregivers were abusing their child, they would probably refrain from abusing their child while under observation in the hospital. This, of course, would leave the child vulnerable to possible future abuses at the hands of caregivers once the child is discharged from the hospital. Second, if family caregivers attempted to remove their child from the hospital, the police and child protective services may need to be involved. Under the U.K. protocol, the family caregivers do not know their child is being monitored, in which case a scenario in which

the caregivers become upset and choose to leave the hospital is minimized, if not entirely eliminated. Third, as in Protocol One, a lack of further ALTEs is not decisive evidence that detected episodes were induced, nor is the occurrence of an ALTE decisive proof that earlier episodes were not induced.

Protocol Three

Unlike the U.K. protocol and the previous two protocols, a third model would have a lower threshold at which a child abuse investigation could be initiated. As a result, CVS would be expanded to include a wider range of cases. Under this third model, if a child presents with any suspicion of abuse by family caregivers, not just the ALTEs specified by Southall, healthcare providers would need to seek professional confirmation and, if obtained, initiate CVS.

What are the benefits of Protocol Three? First, because more children are subjected to CVS, the success rate for detecting and stopping child abuse would likely be higher than Southall's success rate, which was very good. Second, unlike the other two protocols, but similar to the U.K. protocol, if CVS indicates that suspicions were unwarranted, no direct damage is done to families under Protocol Three because families have no knowledge that CVS has been conducted.

Protocol Three is not without problems. First, it relies on deceiving and invading the privacy of families. In this way, the dignity and self-determination of families are indirectly damaged. Second, children who undergo CVS are at risk of harm by their caregivers. Third, by lowering the threshold for CVS and increasing the range of cases to be monitored, the number of false positive diagnoses could multiply as the number of suspected child abuse cases multiply. Finally, this model would probably reinforce a trend toward a more general use of CVS and correlative erosion of privacy and trust in healthcare settings.[22]

TWO PROCEDURES FOR DECIDING AMONG PROTOCOLS

The U.K. protocol and the three alternatives presented above each have their strengths and weaknesses. However, beyond the contents of each CVS protocol is the problem of determining the procedures by which a specific CVS protocol should be selected. Although many

procedures are imaginable, I will limit my discussion to two possible approaches.

The Expert Approach

The first approach is to have experts in child abuse to decide which CVS protocol to use. The justification for this "expert approach" is simply that since experts would be responsible for initiating CVS and are in a better position to identify and understand the clinical realities of child abuse, and must deal with the on-site practical problems of using CVS, they ought to be the ones who decide.

This expert approach has its merits, but there is a problem with letting such a small multidisciplinary group of individuals make this important decision. The problem is that the decision of the best model of CVS to use is not simply a matter of professional expertise or competence in detecting child abuse. The decision involves balancing contending moral values and directing the actions of other people and agencies, for example, nurses, law enforcement officials and Child Protective Services. Moreover, as the cases of U.K. women wrongly convicted of killing their children clearly demonstrate, the choice to use CVS could affect families and communities in profoundly negative ways. Consequently, there are good reasons to think that the decision to use any protocol for CVS ought to go beyond the opinions of a small group of professional experts.

The Community Approach

A second and more acceptable approach would expand the decision-making process to the community level. The reason why this "community approach" is desirable over the "expert approach" is that the use of CVS affects the roles medical professionals and healthcare institutions play in our society. This, in turn, affects everyone else who depends on these institutions and professionals. Therefore, consistent with the principles of fairness and respect for persons, the morally acceptable thing to do is to include as many persons as possible in the decision to use CVS in hospitals.

If CVS policies are developed in consultation with interested community members in an open and democratic manner, one benefit is that decisions about disclosure, consent, risk, and the proper role of healthcare providers would have the moral authority of the community behind them. By engaging in public discussions about CVS,

there is the potential that a community consensus on CVS can be established. This was not done in the U.K. and is not currently being done in the U.S.A. community-wide discussion about CVS would probably be more cumbersome and less efficient than having a small group of experts decide, but this is the price we must pay for living in an open and democratic society. Of course, we could rely entirely on child abuse experts to decide whether CVS should be used, but then we would have to pay a higher price that requires us to relinquish our moral responsibility for ethical decision making and the formulation of social policy.

CONCLUSION

The U.K. protocol for CVS has been successful in confirming cases of suspected child abuse at the hands of family caregivers, but is ethically and socially problematic for use in the U.S. The U.K. protocol and the three alternative protocols discussed in this paper each emphasize and balance various moral values in different ways. Each protocol has its good and bad points.

As important as the substance of each CVS protocol is the method by which one selects a protocol for use is equally important. A protocol for hospital-based CVS may be effective in detecting child abuse, but it is likely to lack moral authority if it is not arrived at through democratic means and supported by those larger communities that hospitals are supposed to serve. The U.K. protocol for CVS fails to do this and, thereby, its moral authority is questionable, even with its good results. Finally, for any CVS protocol we might select, its effectiveness cannot be known unless it is tested against other CVS protocols. The problem, however, is that it is unclear whether CVS is research on human subjects. Thus, before any CVS protocol is adopted, we must first determine whether MSBP is a legitimate psychiatric disorder and, second, form a consensus on CVS's status as either medical practice or medical research on human subjects.

ACKNOWLEDGEMENTS

The author would like to thank Dr. James L. Nelson for his helpful insights at an early stage of my research on covert video surveillance.

NOTES

[1] C.-T. Lung and D. Daro, *Current Trends in Child Abuse: The Results of the Annual 1995 Fifty-State Survey* (Chicago: National Committee to Prevent Child Abuse, 1996).

[2] The American Psychiatric Association considers Munchausen Syndrome (MS) to be a Factitious Disorder characterized by the intentional production or feigning of physical symptoms, a psychological need to assume the sick role, and a lack of external incentives such as economic gain. In MSBP, a child functions as a proxy for the abuser's psychological need to assume the sick role and to receive attention from medical personnel. Unlike MS, however, the belief that MSBP is a legitimate psychiatric disorder continues to divide the medical community. In fact, the APA claims that further study is required of MSBP before it can become an official diagnostic category in DSM-IV. See American Psychiatric Association, "Factitious Disorder by Proxy," in "Appendix B: Criteria Sets and Axes Provided for Further Study," *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, DC: American Psychiatric Association, 2000), pp. 781–783. In this paper, I do not address whether MSBP should become an official diagnostic category of the APA. Instead, assuming that MSBP is a legitimate disorder, as is the case in the U.K., I examine the ethical appropriateness of CVS.

[3] Since suspected cases of MSBP constitute only a small fraction of all child abuse and neglect cases, only a small subset of child abuse cases has been eligible for hospital-based CVS. This is likely to remain the case. Unlike persons with a diagnosis of MSBP, most child abusers will not be admitted to a hospital because they don't have a psychological need to assume the sick role and probably work hard at not drawing the attention of medical personnel or anyone else for that matter. The rarity of CVS, however, does not make its use any less ethically problematic. See M. Epstein et al., "Munchausen Syndrome by Proxy: Considerations in Diagnosis and Confirmation by Video Surveillance," *Pediatrics* 80 (1987): 220–224.

[4] Dr. Roy Meadow, the pediatrician credited with discovering MSBP, has appeared as an expert medical witness at the trials of mothers convicted of killing their children. Many of these court rulings have been subsequently overturned and many more are currently under legal review. Dr. Meadow's research on MSBP is now under increasing scrutiny by the U.K. medical profession, courts, and media. For more on this issue, see the following: Tracy Lawson, "Why an Expert Witness is in the Dock," *The Scotsman*, Saturday 24 January 2004, and Margarette Driscoll, "The Child Abuse Myths Unravel," *London Times*, February 1, 2002. Also see the *Mothers against Munchausen by Proxy Allegations* website at http:/www.msbp.com.

[5] See R. Connelly, "Ethical Issues in the Use of Covert Video Surveillance in the Diagnosis of Munchausen Syndrome by Proxy: The Atlanta Study – An Ethical Challenge for Medicine," *HEC Forum* 15, no. 1 (2003): 21–41. Also see W. Vaught and J. Fleetwood, "Covert Video Surveillance in Pediatric Care," *Hastings Center Report* 32, no. 6 (2002): 10–11 and K. Bennett, "Munchausen Syndrome by Proxy Abuse," *Journal of Child Health Care* 4, no. 4 (2002): 163–166.

[6] M.P. Samuels et al., "Fourteen Cases of Imposed Upper Airway Obstruction," *Archives of Disabled Children* 67 (1992): 162–170. Also see D.P. Southall et al., "Apnoeic Episodes Induced by Smothering: Two Cases Identified by Covert Video Surveillance," *British Medical Journal* 294 (1987): 1637–1641.

[7] D.P. Southall et al., "Covert Video Recordings of Life-Threatening Child Abuse: Lessons for Child Protection," *Pediatrics* 100 (1997): 735–776.
[8] D.P. Southall and M.P. Samuels, "Guidelines for the Multi-Agency Management of Patients Suspected or at Risk of Suffering from Life-Threatening Abuse Resulting in Cyanotic-Apnoeic Episodes," *Journal of Medical Ethics* 22 (1996): 16–21. Also see the following: T. Thomas, "Covert Video Surveillance – An Assessment of the Staffordshire Protocol," *Journal of Medical Ethics* 22 (1996): 22–25; R. Gillon, "Covert Surveillance by Doctors for Life-Threatening Munchausen's Syndrome by Proxy," *Journal of Medical Ethics* 21 (1995): 131–132; D.E. Hall et al., "Evaluation of Covert Video Surveillance in the Diagnosis of Munchausen Syndrome by Proxy: Lessons from 41 Cases," *Pediatrics* 105, no. 6 (2000): 1305–1312; C. Morley, "Concerns about Using and Interpreting Covert Video Surveillance," *British Medical Journal* 316 (1998): 1603–1605.
[9] G. Tenney, "Covert Surveillance in Munchausen's Syndrome by Proxy: An Infringement of Human Rights," *British Medical Journal* 308 (1994): 1100–1102.
[10] D. Evans, "Covert Video Surveillance – A Response to Professor Southall and Dr. Samuels," *Journal of Medical Ethics* 22 (1996): 29–31. Also see D.P. Southall and M.P. Samuels, "Some Ethical Issues Surrounding Covert Video Surveillance – A Response," *Journal of Medical Ethics* 21 (1995): 104-105, 115.
[11] See note 2, above.
[12] D. Evans, "The Investigation of Life-Threatening Child Abuse and Munchausen Syndrome by Proxy," *Journal of Medical Ethics* 21 (1995): 9–13.
[13] E.A. Shinebourne, "Covert Video Surveillance and the Principle of Double Effect: A Response to Criticism," *Journal of Medical Ethics* 22 (1996): 26–28.
[14] See note 2, above.
[15] It should be noted that since the potential benefits are not established, at least not for those undergoing CVS, it is reasonable to conclude that this simply amounts to research on human subjects without their consent.
[16] R.A. Fiatal, "Lights, Camera, Action: Video Surveillance and the Fourth Amendment," *FBI Law Enforcement Bulletin* 58 (1989): 23–30.
[17] See *Buchanan v. State*, 437 So. 2d 147 (Fla. Dist. Ct. Appl. 1983) and *State v. Abislaiman,* 437 So. 2d 181 (Fla. Dist. Ct. Appl. 1983).
[18] *Katz v. United States,* 390 N.W. at 361 (1967) (Harlan, J., concurring).
[19] Because hospitals can be characterized as both private and public spaces, unlike private residences, it may be easier for some to justify CVS in hospitals than in private homes.
[20] One could argue that CVS for MSBP is not all that ethically different from secret room searches of adult in-patients suspected of Munchausen Syndrome. Both raise questions about informed consent and privacy. There are, however, significant differences between the two types of cases. First, MSBP involves the competing interests of a child that must be balanced against an adult's privacy interests. This is not the case for MS, as no child is involved. Second, although room searches raise concerns about privacy and informed consent, unlike CVS, room searches don't involve the additional privacy concerns about what to do with video recordings once they have been made. Finally, CVS would simply be more effective than a room search in identifying MS or MSBP beyond a reasonable doubt. If room searches were used for MSBP, any evidence of child abuse would likely be only circumstantial, not the sort of direct, verifiable proof that can be obtained by CVS.

[21] D.P. Southall and M.P. Samuels, ''Ethical Use of Covert Videoing for Potentially Life Threatening Child Abuse: A Response to Drs Foreman and Farsides,'' *British Medical Journal* 307 (1993): 613–614.
[22] N. Shabde and A.W. Craft, ''Covert Video Surveillance: An Important Investigative Tool or a Breach of Trust?'' *Archives of Disabled Children* 81, no. 4 (1999): 291–294.

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