J Med Humanit (2006) 27:135–149
DOI 10.1007/s10912-006-9014-9

ORIGINAL PAPER

Playing Patient, Playing Doctor: Munchausen Syndrome, Clinical S/M, and Ruptures of Medical Power

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Published online: 1 July 2006
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Abstract This article deploys sadomasochism as a framework for understanding medical practice on an institutional level. By examining the case of the factitious illness Munchausen syndrome, this article analyzes the operations of power in the doctor-patient relationship through the trope of role-playing. Because Munchausen syndrome causes a disruption to the dyadic relationship between physicians and patients, a lens of sadomasochism highlights dynamics of power in medical practice that are often obscured in everyday practice. Specifically, this article illustrates how classification and diagnosis are concrete manifestations of the mobilization of medical power.

Keywords Munchausen syndrome · Doctor-patient relationship · Sadomasochism · Classification · Power

> "Whereas the usual imposter assumes the role of affluence or power (i.e., the physician), the Munchausen becomes the object; rather than impersonating the doctor, he becomes the patient. Although this appears to be an apparent reversal of the desired objective, the same result may actually be accomplished since by fooling the doctors he has become their master. Then, when his impersonation is finally revealed and the drama concluded, the anxiety released is directed against the doctor."[1]

Considering it is not uncommon for sadomasochistic sexual players to adopt the roles of doctor and patient, it is surprising that there has been so little work using sadomasochism models to theorize medical practice. To begin filling that void, this article analyzes medical power, integrating theories of sadomasochism through the case of "Munchausen syndrome"–an illness characterized by undisclosed, self-induced physical injuries comprised solely of behavioral symptoms, such as wandering from hospital to hospital, fluctuating symptomatology, and dramatic medical histories. Patients have generated illnesses from innocuous

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[1] Heym, "The Imposter Patient," 160.

factitious fevers to the more invasive swallowing of foreign objects that require equally (or more) invasive treatments such as surgery. Not just "faking" it, patients actually produce the symptoms that they describe to doctors. It is assumed that patients with Munchausen syndrome are seeking interactions with the medical community, yet their reasons for doing so are unknown. Because Munchausen patients' illnesses are simulated (although often embodied through self-infliction), an element of role-playing maps onto the medical interaction. More importantly, because this illness is, according to the medical literature, a clear disruption to the dyadic relationship between physicians and patients, Munchausen syndrome and a lens of sadomasochism serve as a productive means to analyze the dynamics of power in medical practice.[2]

Specifically, Munchausen syndrome involves individuals playing the patient, and sadomasochism is a way of understanding the relationship with physicians that results. Rather than adopting a framework of inflexible binaries (i.e., sadist vs. masochist) to operationalize sadomasochism, I conceptualize it as a spectrum of behavior that is always already part of the medical interaction. This viewpoint assumes that sadomasochism is a dynamic institutional behavior and an enactment of structural power inequalities. By illustrating the ways in which Munchausen patients play sick and the ways in which physicians respond to ruptures in their authority, I contend, first, that these patients challenge the medical hierarchy and, second, that illness classification is one strategy that physicians employ to re-establish their authority. Furthermore, this analysis provides insight into power relations embedded in "normal" medical practice.

Reading medical practice as sadomasochistic

> "Rather than sadomasochism being merely the property of individuals, our culture itself is deeply oriented in a sadomasochistic direction. We are living in a society sadomasochistic in that it bombards us with experiences of domination and subordination far more regularly than it exposes us to sensations and inklings of freedom and reciprocity."[3]

To bring sadomasochism out of the individual realm and into the institutional is no easy task, considering the dearth of academic work on the subject. Most scholars who have theorized sadomasochism have done so from the perspective of s/m sexual practices.[4] In her book *Sadomasochism in Everyday Life: The Dynamics of Power and Powerlessness*, Lynn Chancer theorizes sadomasochism as a characteristic of modern capitalist institutions. Chancer does not discuss the institution of medicine in her work, but her framework is transposable to this realm. Building upon Chancer's understanding of sadomasochism, I argue that this power dynamic is mediated by the infrastructure of classification and diagnosis in medicine. This section will provide the framework for the specific case of Munchausen syndrome in medical practice.

[2] This observation comes from my review (Fisher 2002) of all the medical literature on Munchausen syndrome from 1951 (the year of the appearance of the original article) to 2000 (578 total publications).

[3] Chancer, *Sadomasochism in Everyday Life*, 2. Subsequent references to this work appear in the text.

[4] See, for example, RR Linden et al., *Against Sadomasochism* and M Thompson, *Leatherfolk*.

Deeply connected with both capitalism and patriarchy, Chancer argues that sadomasochism is built into the highly stratified structures of contemporary life:

> The external, objective relations of capitalism are hierarchical, imposed coercively, and, most relevant to S/M's potential development, characterized by extreme mutual dependency that takes different forms depending on whether one has been situated in the worker's or in the capitalist's position (34).

These hierarchies about which she writes are often gendered: institutionally, men often assume the position of domination and women of subordination.[5] And like patriarchy, sadomasochism can be difficult to identify within complex infrastructures. As one means of making sadomasochism more visible, Chancer developed four criteria that form her "Sadomasochistic Dynamic": 1.) "excessive attachment exists for both parties," 2.) "interaction has a repetitive and ritualistic character," 3.) "dialectical form of interaction," and 4.) "individuals (or groups) positioned masochistically face severe consequences should they question, talk about, or challenge the power of those individuals (or groups) who are structurally more powerful" (3–5).

The first criterion – "excessive attachment exists for both parties" – entails something of a value judgment in determining what is excessive, rather than appropriate or reasonable. To determine this level, I will first describe the attachment between physicians and patients in medical practice. The medicalization of everyday life has created dependency on the medical profession in matters that had previously been outside of the medical realm, like birth and death. Paul Starr examines how this dependency was crafted by physicians beginning in the late nineteenth century as a means of establishing their cultural authority. He argues that the success of physicians' professionalization efforts has manifested in the ability of the medical establishment to define reality regarding health and illness.[6] This dependency continues today as most people in Western cultures are socialized to believe that they need the services of doctors and access to medical technological fixes to maintain or recover their health throughout their lives.

In addition to subscribing to the same beliefs and dependencies on medicine, physicians do also depend upon their patients. In his classic book *Medical Nemesis*, Ivan Illich critiques physicians' belief in the "myth" of medical progress. He argues that this myth is perpetuated by Western doctors who "deploy themselves as they like,... [and] gather where the climate is healthy, where the water is clean, and where people are employed and can pay for their services."[7] Another analysis of this attachment posits egotism as an aspect of the doctor-patient relationship:

> There is something flattering for a doctor in having patients. A patient is the "subject" of a doctor, as a medieval commoner was the subject of a king. The more subjects the more powerful the king. This is why we doctors prefer Charcot's model of hysteric as a sick person– our subject– on whom we can work. The fact that we rarely do them any good, and that we actually encourage the playing of the manipulative games somehow escapes us.[8]

[5] Chancer is very careful to point out that sadomasochism is *not* inherently gendered. That is to say, she stresses that patriarchy has influenced the gendering of institutional hierarchies, *not* that essential differences between men and women have caused this division.

[6] Starr, *The Social Transformation of American Medicine*.

[7] Illich, *Medical Nemesis*, 22.

[8] Nash, "Problems of Deception," 141.

Even if one does not want to go so far as to deconstruct the advances that have been celebrated in medicine, it is clear that medicine is, in large part, a service profession. The technologies and therapies are meant to be applied to human patients, and regardless of profit or even reputation, physicians rely on patients for their profession to have purpose.

But do these characteristics of the doctor-patient relationship imply an "excessive attachment"? Certainly the relationship is one of interdependency, but does it go beyond what is reasonable? I believe that on the institutional and frequently on the individual level, this relationship is excessive. I premise this on the idea that there is much to lose both for the physician and for the patient if the rules of the medical interaction are transgressed. There is a profound investment in the doctor-patient relationship for both members of the dyad. For the physician, there is a conflict of professional roles in balancing the scientific and the interpersonal aspects of medicine. For the patient, there is a similar conflict in balancing detachment from and experience of the illness. Because of this struggle to maintain a balance of these roles, there is inherently more at stake in this relationship than there is between many other service providers and consumers. The case of Munchausen syndrome will further illustrate this below.

The second criterion – "interaction has a repetitive and ritualistic character" – of Chancer's *sadomasochistic dynamic* is fairly straightforward to operationalize in medicine. Based on spatial and discursive norms, the practice of medicine standardizes care through the use of repetition and ritual. Although there are differences that exist among specialities in medicine, these rituals are part of the socialization of physicians and of patients.[9] While the "etiquette" of medical interaction is not explicit, Young argues that there is a complex "choreography" that governs the behavior of medical participants. From the waiting room to the examination room, operating room, and morgue, Young illustrates how each space is defined by rituals of (un)dressing, querying, and objectification.[10] In each domain of medical practice, there are "rules" governing what should occur in each space and how physicians and patients should interact.

Physicians assume that part of the medical ritual is for patients to disclose truthfully all relevant information about their condition. Within the roles of doctor and patient, information becomes linked to dominance. Patients submit to physicians' care and expertise by recounting their ailments; physicians gain authority in each medical interaction through their ability to effectively interpret and act upon these stories. Physicians may be prone to repetition or patterns within their individual practices, but the rituals are largely systemic and depend upon the patients.

The last two criteria of the *sadomasochistic dynamic* are, in many respects, the most consequential for discussing how medicine can be considered sadomasochistic. Chancer's third item – "dialectical form of interaction" – is particularly important for this analysis because it places sadomasochism on a spectrum, instead of relying on binary categories. Rather than labeling physicians as sadists and their patients as masochists, a dynamic model of sadomasochism allows the analysis to escape discrete inflexible categories for boundary shifts and inversions. Chancer explains:

> . . . each position has the potential for transformation into its opposite: the sadist has a constant potential for masochism, even if generally not realized or realizable by conscious intentionality; the masochist has an analogous potential for sadism. Each faces the possibility and perpetual risk of turning into the other, an observation that,

[9] See B Good and M-JD Good, "Learning Medicine" and C Amirault, "Pseudologica Fantastica."

[10] Young, *Presence in the Flesh*.

> if valid, has enormous ramifications for questions of how and whether personal and political changes are realizable in the form intended by their myriad architects (4).

The most obvious example of this type of transformation is when the doctor becomes a patient.[11] In these cases, there is generally a narrative of revelation and often of repentance for their professional insensitivities. In addition, strategies of empowering patients can also have an effect on shifting the relationship between patients and their physicians. The women's health movement is one example of cultural values shifting toward more patients' rights. Due to these patients' movements of the past fifty years, the doctor-patient relationship has slowly become less paternalistic with empowering benefits for all patients.[12]

Furthermore, Chancer's focus on a "dialectical form of interaction" is a useful concept because it takes the emphasis off the individual and allows an examination of the behavior of institutions and the practices engendered by them. Applying this to my analysis, individual physicians do not have to be particularly sadistic, nor individual patients masochistic, for there to be a sadomasochistic dynamic at play in the medical system. It also means that physicians may be located in a sadistic position vis-à-vis patients, but they may also be relatively subordinated (masochistic) in relation to insurance companies. As the groups analyzed shift, so too will the form of interaction between the parties.

Chancer adds an additional note that examining group dynamics from a historical perspective tends to reveal that as groups rise to power, they adopt equally oppressive structures as did their predecessors: "Sadomasochism thus penetrates to the core of our social psychology, threatening to repeat itself *until its underlying motivations are understood and begin to be consciously acknowledged*" (5, my italics). In this sense, I interpret Chancer's definition of sadomasochism as related to Gramsci's concept of hegemony.[13] Power remains relatively stable within the institution of medicine because patients have effectively internalized its values and norms through their interactions with physicians. Because individuals subscribe to the ideology of the medical system, individuals who seek medical treatment consent (now often explicitly) to the authority of physicians and the institution of medicine more generally. In this way, power within the doctor-patient dyad does not manifest as direct domination. Rather, power is more diffuse, materializing in the practices of objectification of the body. In a more Foucauldian vein, individuals' surveillance of their own and others' bodies through the lens of medicine constitutes power dynamics.[14]

In spite of the subtleties in the operation of power, the last of Chancer's criteria is perhaps the most central for defining sadomasochism as a specific manifestation of power relations. She describes its characteristics in the following way:

> Our sadomasochistic dynamic is in evidence if the question of whether the masochists must pay for their rebellion can only be answered in the affirmative. Under those circumstances where 'conditions' come to exist, sadomasochism begins to develop either on an individual/microcosmic or on a societal and more macrocosmic plane (6).[15]

[11] See H Mandel and H Spiro, *When Doctors Get Sick* and EE Rosenbaum, *A Taste of My Own Medicine*.

[12] Schiebinger, *Has Feminism Changed Science?*

[13] Gramsci, *Prison Notebooks*.

[14] See both M Foucault, *Discipline and Punish* and *The History of Sexuality: Volume I*.

[15] Chancer uses the term "conditions" here to describe the responses from those in power to those challenging their authority.

There have been a variety of responses by medical practitioners to the manifestation of challenges to the medical system. For example, David Hess has written extensively about the challenge of alternative medicines to the mainstream medical system.[16] In particular, he has studied the ways in which alternative cancer therapies have been delegitimized at the national level (in terms of health care policy) and on the local level (in terms of physicians' responses to their patients' use of alternative therapies). Even though these alternative practices are gradually (and selectively) being integrated into Western medicine, the initial responses of physicians to these practices were characterized by rejection and power struggles.[17]

Although I find Chancer's criteria for her "sadomasochistic dynamic" very compelling, I also think that one more must be added to differentiate this dynamic from coercion. In spite of her analogies to sadomasochistic sex, Chancer has eliminated sadomasochism's pleasure/pain paradox in her translation of sadomasochism into the institutional realm. In my opinion, the key to the pleasure/pain paradox is rooted in medicine's tendency to involve some form of suffering in the process of creating benefits for the patient. Surgeries, conventional cancer therapies, and many diagnostic tests cause patients varying degrees of discomfort or pain in their attempts to cure the illness. Physicians too experience their own pleasure/pain paradox in the routine of their work; medicine is a profession with high status and good wages in exchange for extremely long hours, being on-call, and empathizing with hurt and/or dying patients and their families. I do not mean to suggest that either physicians or patients relish pain and discomfort, rather that there is an accepted parallel paradox in medicine that treatment may have to hurt.

The sadomasochistic dynamic of medicine produces the conditions of possibility in the medical interaction and structures potential acts of resistance and suppression. This dynamic manifests as a performance of power in the doctor-patient relationship. The next section will continue this exploration of the *sadomasochistic dynamic* by discussing how medical practitioners and patients are constrained and enabled by power differentials. The five criteria (Chancer's four, plus my addition) will serve as a way of analyzing how physicians confront and respond to what they perceive as "problem patients" in the case of Munchausen syndrome.

The sadomasochistic dynamic and Munchausen syndrome[18]

> "One wonders if modern medicine had not introduced its own problems with the Munchausen type of patient. With the tremendous resources invested in medical technology and, at times, the dehumanized approach to patient care, it is not surprising that our medical system should become a dynamic factor in this type of emotional disorder. Physicians and paramedical personnel should be aware of the role they may play in the sadomasochistic behavior of the patient with Munchausen's syndrome."[19]

Speculations about the medical or psychiatric etiology of Munchausen syndrome have varied significantly according to spatial and temporal changes and to medical specialty.[20] And yet, since the identification of Munchausen syndrome in 1951, doctors have seemed

[16] Hess, *Evaluating Alternative Cancer Therapies*.

[17] Hess, *Selecting Technology, Science, and Medicine*.

[18] Analyses of the Munchausen patients' interpretations of the sadomasochistic dynamic will be lamentably absent from this work because there are few existing patient narratives.

[19] Haddy, et al., "Munchausen's Syndrome," 197.

[20] Fisher, *Sociopatholigizing Patients*.

to acknowledge that physicians have (and/or medical practice) has a key role in the formation and manifestations of factitious illness. This is most clear in doctors' assumption that Munchausen syndrome behaviors are directed explicitly and intentionally towards physicians. For instance, in his founding article, Richard Asher wrote, "[Munchausen patients] may appear many times at the same hospital, hoping to meet a new doctor upon whom to practise their deception."[21] Although most physicians have written about Munchausen syndrome from the perspective of a persecuted innocent person, several authors[22] have discussed how medicine has actually encouraged these patients' behavior: "The illness is partly iatrogenic, for it requires more than one party to produce a sadomasochistic relationship."[23] Unfortunately, statements like this one have not been followed by discussion when they have appeared in the medical literature.

Munchausen syndrome exposes the basis for the "excessive attachment" between physicians and patients. This is not to say that this illness terminates attachment, rather Munchausen syndrome perverts the conditions of the attachment. For instance, it is important to note that most of the physicians' negative reactions stem from their sense that the element of trust in the doctor-patient relationship has been violated[24]: "By their deceits, Munchausen's patients destroy all the essential ingredients of a trusting relationship. Their habitual imposturing creates an atmosphere which is, on the contrary, coercive, and exploitative."[25]

Reading the state of the doctor-patient relationship through the deviations in medical practice, physicians are alarmed by Munchausen syndrome because it breaks some of the "rules" of medicine. Because Munchausen patients seem to have lied to their physicians about the causes of their illnesses and their medical histories and have, thereby, undermined the process of interpretation, physicians label them as deceitful and manipulative impostors.

Moreover, patients are not supposed to simulate or self-inflict injuries. By altering the conditions of illness, these patients challenge the construction of illness more generally. Munchausen syndrome is disruptive to physicians' authority *specifically* because it defies diagnosis. Individuals with Munchausen syndrome are, in the view of the physicians, role-playing at being patients. And yet, the problem with this game is that it reveals that physicians too are always already role-playing. In confronting the possibility of factitious illness, physicians must somehow create an artificial distinction between what is "real" and what is "fake" illness. In *Simulacra and Simulation*, Baudrillard presented the trouble caused by simulation in medicine:

> To dissimulate is to pretend not to have what one has. To simulate is to feign to have what one doesn't have. One implies a presence the other an absence. But it is more complicated than that because simulating is not pretending: "Whoever fakes an illness can simply stay in bed and make everyone believe he is ill. Whoever simulates an illness produces in himself some of the symptoms" (Littré). Therefore, pretending, or dissimulating, leaves the principle of reality intact: the difference is always clear, it is simply masked, whereas simulation threatens the difference between the "true" and the "false," the "real" and the "imaginary." Is the simulator sick or not, given that he produces "true" symptoms? Objectively one cannot treat him as being either ill or not

[21] Asher, "Munchausen's Syndrome," 339.

[22] See, for example, Haddy, et al.; DO Quest and SE Hyler, "Neurosurgical Munchausen's Syndrome"; DJ Vail, "Munchausen Returns."

[23] Spiro, "Chronic Factitious Illness," 574.

[24] See, for example, TP Duffy, "The Red Baron" and S Vaisrub, "Editorial: The Immortal Baron."

[25] Kass, "Identification of Persons with Munchausen's Syndrome," 197.

> ill. Psychology and medicine stop at the point, forestalled by the illness's henceforth undiscoverable truth. For if any symptom can be 'produced,' and can no longer be taken as a fact of nature, then every illness can be considered as simulatable and simulated, and medicine loses its meaning since it only knows how to treat 'real' illnesses according to their objective causes.[26]

The calling into question of the "reality" of illness, while certainly not consciously performed by each physician encountering a Munchausen patient, is what designates as consequential this shift away from the status quo of medical practice and ritual. If Munchausen syndrome were merely "fake," physicians would be able to dismiss these patients. The element of simulation complicates the diagnosis process by calling its legitimacy into question.

Karmen MacKendrick describes sadomasochism as power relations that "vex" the distinctions between fantasy and reality or between the "real" and the "performative."[27] Although I find her argument quite persuasive for s/m sex, I think that the relationship between these terms becomes more complicated when viewing sadomasochism as an institutional characteristic. Thinking through the example of Munchausen syndrome, the distinctions between "real" and "performative" illnesses are not "vexed" *until* physicians suspect the Munchausen simulation of illness. This is to say, role-playing in and of itself does not vex medicine.

Furthermore, physicians must continue to treat the simulated conditions because they are "real" in the sense that they have physical manifestations on/in the body of patients. The physicality of the simulations and the serial nature of the illness invoke the paradox of pleasure/pain. The Munchausen patients must continue to injure themselves if they wish to continue getting medical attention. The diagnosis and treatment of Munchausen syndrome only becomes slippery because the factitiousness of the physical symptoms has generally eluded physicians due to the illnesses' very "realness." These are the conditions in which dislocations in the distinction between real and performative suddenly challenge the authority of physicians.

Through the subversion of the power structure, physicians' identities are transformed in their relationship to the Munchausen patients:

> The physicians' responses to this type of patient are of interest. He [*sic*] is confronted with a difficult patient and the bonds of the doctor-patient relationship become supplanted by suspicion. Even when the patient's deceit becomes evident, the physician is reluctant to assume the role of adversary. The patient is treated with a mixture of bemusement, bewilderment, contempt, and anger. The patient's success in subverting and sabotaging the well-meaning physicians' efforts becomes a source of shame and embarrassment for the physicians. Whether or not these feelings are admitted, these are one of the few types of patients who kindle aversion, fear, despair, or downright malice in their doctors.[28]

Shifts in sadomasochistic power relations often cause shifts in identity.[29] That identity displacement occurs from the Munchausen interaction evinces a disruption in power relations and a transformation in the attachment between the doctor and patient: "That doctors are so frequently deceived by these patients is a reflection on the doctors' role: a role that does not

[26] Baudrilliard, *Simulacra and Simulation*, 3.

[27] MacKendrick, *Counterpleasures*.

[28] Quest and Hyler, 413.

[29] Hart, *Between the Body and the Flesh*.

allow naturally for cynicism and skepticism."[30] The possibility of Munchausen syndrome calls on doctors to doubt the stories told by their patients and to doubt themselves.

More drastically, the presence of the "false" story has often transformed the physician from an investigator to a detective. Although the difference between these terms may seem innocuous, the distinction is extraordinary in medical practice. The usual role of the physician is to investigate physical symptoms as part of the process of diagnosis and treatment. The physicians' detective work, on the other hand, is precipitated by a desire to obtain what they see as the "true" medical history that has been denied them by the patient. In the process of being deceived, the doctors sense that their authority over knowledge in the medical encounter has been sabotaged. Without knowing the facts about Munchausen patients, physicians cannot regain their domination over the patients and over "the truth," and so physicians have invested a great deal of energy into tracking and tracing the past and future movements of their patients:

> Rarely in medicine does the past medical history play such a prominent role in the diagnosis (stealing the show, as it were, from the chief complaint). Physician and patient become the defendants of these two elements; the patient struggles to minimize or efface completely his past history and to aggrandize the present illness, while the physician assumes the task of archaeologist, literally digging up the buried facts of the past medical history, until the sheer weight of the excavated material dominates over the presenting complaint in the whole picture... After surgery or investigation, the patient unmasks his deception; here he can demonstrate overtly his superiority and simultaneously cause the doctors and himself further pain. He has regained control and, once again master of his own fate, he leaves the hospital, righteous and defiant.[31]

A particularly interesting example of this phenomenon is found in the writings of Pallis and Bamji from the Munchausen syndrome literature. In their first publication, they authored a factitious obituary for Stewart McIlroy (or any of his eight first names and twenty-two surnames) whom they had aggressively traced for four years, the "longest followed-up patient with Munchausen's syndrome." Having lost track of McIlroy, they decided to publish his "obituary" as one way of soliciting potential information about his whereabouts. This rheumatologist and neurologist use colorful descriptions that betray their obsession with the patient:

> His scarred abdomen, meanwhile, remained a monument to current investigative enthusiasm, if not to modern powers of discrimination. ... The number of ordinary *x*-ray examinations and blood tests must run into hundreds if not thousands. His survival story bears testimony to the resilience of the human frame and to the relative safety of our hospitals. ... We hope this obituary is premature. It was once said that old patients with Munchausen's syndrome were like old soldiers: they never died but just faded away. Stewart McIlroy taught many lessons to those who were deceived, not least being the lesson that we are not always the astute physicians we should like to believe.[32]

One year later, a second publication followed to report that McIlroy was alive and still an active Munchausen case. Evidently their first publication received enormous coverage in

[30] Sale and Kalucy, Munchausen's Syndrome, 525.

[31] Manolis and Sanjana, "Cardiopathia Fantastica," 528.

[32] CA Pallis and AN Bamji, "McIlroy Was Here," 973, 974, 975.

the popular press, and much of this second article speculated about why this patient was so interesting to the public:

> Within the profession, was it that there was a grudging admiration for a worthy opponent, for the man who kept winning against all odds? *Outside it, is there a national – nay, international – gratification when the carefully nurtured mystique of medical expertise is itself systematically eroded by a mere consumer, and an amateur to boot?* There is an unspoken feeling that doctors would be infallible and much lay criticism was voiced that so many had proved so credulous. Beneath the veneer of condemnation, is there widespread sympathy for McIlroy – as undoubtedly still lingers for the train robbers? In an era of mediocrity (and of theatrical recession) is the sheer technical competence of the feat silently applauded?
>
> And could there be other, even less mentionable, motives? Does the average person (and even the average subeditor) experience an ambivalent shudder as he or she thinks of being at the receiving end of 48 lumbar punctures? *How much sadomasochism underpins public interest in the McIlroy myth?* 'Heroic' behaviour on this scale, clearly engenders much morbid fascination, as shown by the many letters we have received.[33]

Bamji and Pallis' report ended by urging the press to leave McIlroy alone and leave him to the medical establishment.[34]

In spite of the simulatedness of the illnesses and the destabilizing effects on the doctor-patient relationship, the McIlroy case should illustrate that Munchausen syndrome does not, by any means, destroy the attachment that exists between physicians and patients. And yet, by altering the power relations and breaking the rules of practice, Munchausen syndrome not only makes visible the dialectical form of interaction between patients and physicians, but it also requires action for physicians to reclaim their authority. The next section will address further how physicians attempt to mend the ruptures caused by their "problem patients" and regain their dominance in the doctor-patient relationship.

Re-appropriating power: Physicians' reactions against Munchausen syndrome

> "Any society, to be stable, needs certified deviance... By being assigned a name and a role, eerie, upsetting freaks are tamed, become predictable exceptions who can be pampered, avoided, repressed, or expelled."[35]

In the previous section, I briefly discussed one of the ways that physicians reclaim their power after it has been destabilized through Munchausen interactions. By becoming a detective, physicians construct the "truth" of the patient and they reassert their own and medicine's authority through medical knowledge. Detective work, however common, tends to be an individual reaction of particular physicians. In this section, I will develop the analysis of sadomasochism in medicine by discussing the role of institutional infrastructures in

[33] AN Bamji and CA Pallis, "McIlroy, the Media, and the Macabre," 641-2.

[34] Other examples of this detective work can be found in Le Coz et al. 1997 and in Asher 1951.

[35] Ilich, 117.

maintaining power structures. In the case of Munchausen syndrome, the medical establishment responded institutionally to factitious illnesses though classification. Naming served as a political act with symbolic and material effects.[36]

One of the primary components of the repetitive and ritualistic practices in medicine is the process of diagnosis and prognosis. Based on the classification of diseases, the practice of diagnosis establishes one of the key power differentials between physicians and patients. Diagnosing illness subordinates individuals' expert knowledge of their *own* bodies to physicians' technologically-mediated knowledge of bodies.

Expert medical knowledge of illness organizes the rules of medical practice. Through its composition of illness categories and treatment recommendations, the medical nosology, in large part, frames how physicians should investigate illness. Although classification is largely a symbolic infrastructure, the process of diagnosis translates the symbolic pathology into material bodies. More specifically, the patients' role is to describe their physical complaints truthfully and submit to medical examination and testing. The physicians, on the other hand, follow the standardized classification of diseases in order to decide what tests should be done and what diagnoses can be made. The act of labeling the patient's illness as a standard disease entity materializes and legitimizes the condition within medicine while it simultaneously legitimizes the expertise and power of physicians in relation to their patients.

Munchausen syndrome has been said to make such normal medical investigations into defensive ones:

> The reflexes of the doctor are such that he [*sic*] is immediately on the defensive, doing a routine work-up, plus [other tests]. . . Once the physicians is through with his defensive examination, the [Munchausen] patient is ready with another set of complaints, calling for more defensive action, and in this way keeping the physician off balance.[37]

Because Munchausen patients do not disclose the "true" nature of their illness, the diagnostic tests indicated by the symptoms often return with negative or puzzling results. In response, physicians must order additional tests that incorporate any new symptoms the patients present. This process is often extremely time-consuming and expensive. Accordingly, when the patients' deceptions are revealed, physicians are generally angry and frustrated. One physician suggested with some irony, "Indeed, the very impostureship involves the hostile duping of the physicians. Perhaps physicians are ill disposed to respond charitably to such an assault on medical omnipotence and omniscience."[38]

These interactions between Munchausen patients and physicians can be even more frustrating for doctors because the motives of the patients are so unclear. The affective responses of the physicians can frequently be characterized as, "'Save us from being duped' seemed more often to be the attitude than 'Save these patients from their disease.'"[39] Although the stance of these physicians may seem unsympathetic, most treatment attempts have been extremely unsuccessful during the past fifty years. Thus, it is hardly surprising that when physicians cannot *change* the challenging behavior of Munchausen patients, they want to

[36] GC Bowker and SL Star 1999.

[37] DJ Vail, "Munchausen Returns," 320.

[38] Spiro, 577.

[39] Case Records of the Massachusetts General Hospital, 113.

avoid these interactions altogether. Two physicians have summarized this position toward Munchausen patients – or "the doctor's thorn" – as follows:

> Attempts to deal with these difficult patients have uniformly met with defeat. The doctor becomes provoked to anger, communicates this to the patient and in general feels relieved when the patient signs out AMA [against medical advice].[40]

When Richard Asher published his 1951 article that created an illness categorization for these patients, physicians submitted letters to *The Lancet* expressing their gratitude to Asher for aiding the diagnosis of their "problem patients" and expressing their surprise that it had not been named sooner.[41] This act of creating "Munchausen syndrome" as a specific medical illness re-admitted the patients back into the medical classification system by offering physicians a diagnosis for what was before simply a frustrating hoax. The physicians' personal destabilization effected by the Munchausen patients could be institutionally managed by resubordinating the patients by means of a standardized nosological label.

And yet, because the unwelcome set of behaviors that comprise Munchausen syndrome defy medical explanation in terms of standardized symptomatology and models of illness etiology, physicians continue to have difficulty in distinguishing exactly what this illness is and when to diagnose it:

> In a patient presenting with a multisystem disease, a physician has to stretch his [*sic*] imagination and use all his diagnostic skills. When the picture is truly bizarre and dramatic, one must consider factitious illness, remembering that, at times, a patient's imagination can really run wild and that patients have been known to outsmart their physician.[42]

The category of Munchausen syndrome, therefore, becomes a catch-all illness for those "bizarre and dramatic" cases that physicians have trouble diagnosing. Constructed of only behavioral symptoms, there are no clinical tests or quantified method to reach a diagnosis of Munchausen syndrome. This diagnosis allows much more interpretative flexibility than most other illnesses in the medical classification schema. What this enables is for physicians to feel vindicated that they figured out the troubling case and can provide closure through the label of a medical diagnosis.

More importantly, the inclusion of "Munchausen syndrome" as an illness redraws the boundaries of illness by circumscribing the behavior of these patients within medicine's domain. The label of Munchausen syndrome subsequently exerts power over the patients by maintaining and enforcing the hierarchy of medical expertise. As a consequence of a challenge to their authority, physicians impose medicalization of patients' behavior through classification techniques. Through this valenced nosology, the repercussions for these "problem patients" entangled in the sadomasochistic dynamic of medicine is that they are sociopathologized via Munchausen syndrome. It is important to note, however, that physicians' reassertion of authority is a surface remedy to their problem of dealing with factitious illnesses. The Munchausen patients will remain destabilizing as long as they maintain their power of action, mobility, and camouflage.

[40] RW Moore and K Ullman, "The Doctor's Thorn," 123.

[41] See E Frankel, "Munchausen's Syndrome"; JEH Stretton, "Munchausen's Syndrome"; B Williams, "Munchausen's Syndrome"; P Wingate, "Munchausen's Syndrome."

[42] AM Karnik, et al., "A Unique Case," 701.

Implications of sociopathologizing patients

> "Most physicians generally use an informal dichotomous classification which groups all somatic complaints into either 'the real,' or the other somewhat more murky, emotionally colored symptom complexes."[43]

Factitious illnesses have the potential to generate scientific self-doubt about medicine's own facticity that is concealed within the normal sadomasochistic dynamic of medicine. To sociopathologize the patients who catalyze these uncertainties is an effective way to fend off the effects they have upon medicine. In other words, if Munchausen patients are "sociopaths," then why should medicine take them seriously? And yet, the existence of Munchausen syndrome is problematic for medicine *both* as an undefined set of behaviors found in patients *and* as an illness construction. Although this double-bind seems paradoxical, it accounts for how physicians have added this category as a way of making sense of challenging experiences in medical practice, while they themselves simultaneously weaken the basis of medical classification based on specific etiology and physiological symptoms.

Without a physical or psychiatric cause of Munchausen syndrome, a certain level of discomfort with its classification will remain. Consequently, judging the deviance of these patients based on their nonconformity to the rules and rituals of the medical interaction, most physicians will agree that these patients must have some form of psychological pathology. After fifty years of inquiry, however, there have been as many studies declaring Munchausen patients have no psychiatric symptoms as there are cases in which patients have been found to have schizophrenia, borderline personality disorder, obsessive-compulsive disorder, psychodynamic problems, etc. combined. For example, two doctors observed,

> These patients are clearly masochistic to undergo the self-mutilation, foreign body ingestion, and other maneuvers necessary to create their factitious illness. Equally masochistic is the toleration of painful diagnostic procedures and repeated surgeries . . .. *Masochism alone doesn't explain the other aspects of this syndrome*. . . Other authors have described the sociopathic aspects of Munchausen's patients' personality. However, the literature concerning sociopathology is itself very confusing as to what is meant by sociopathy. Certainly, these patients are immature, impulsive, and appear to act upon feelings instead of experiencing feelings as such. *None of our cases have any record of antisocial or criminal activity; this would be against the diagnosis of sociopathy in these particular individuals*.[44]

In spite of the absence of evidence of sociopathy in these patients, the sociopathologizing label of Munchausen syndrome remains unchallenged as a diagnostic category. It is my contention that this contradiction remains ignored in medicine because sociopathologizing the patients enables the medical establishment to silence the challenges that these patients present in medical practice that is characterized by power asymmetry. The illness category, moreover, has helped to obscure its own constructedness by physicians and the sadomasochistic dialectic in medicine. The patients are not the only ones guilty of role-playing.

[43] T Nadelson, "The Munchausen Spectrum," 175.

[44] JO Cavenar and AA Maltbie, "Munchausen's Syndrome," 349-50.

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