Organizational Munchhausen-by-Proxy Syndrome:
A Psychoanalytic Case Study of Bristol Royal Infirmary

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ABSTRACT

Over a five year period in the 1990’s, thirty to thirty-five more babies died after open heart surgery at Bristol Royal Infirmary in the UK than might be expected had the Pediatric Cardiology Unit been up to the standard of care at other British hospitals. Drawing on psychoanalysis, this article introduces a theoretical framework of Organizational Munchhausen-By-Proxy Syndrome (OMBPS), identifying four features central to this disaster: collusive relationships based on fantasy, a reluctance to confront, an obsession with control, and a fixation on authority. Thus, the study contributes to organizational theory, disaster research, and the field of system psychodynamics.

Keywords: Organizational Munchhausen-by-Proxy Syndrome (OMBPS), system psychodynamics, organizational disaster, psychoanalysis, culture

INTRODUCTION

On January 10, 1995 eighteen-month old Joshua Loveday arrived at Bristol Royal Infirmary (BRI) in the United Kingdom to meet with a cardiac surgeon. Joshua was suffering from a rare congenital heart deformity called Transposition of the Great Arteries in which his heart’s aorta and pulmonary arteries were reversed, connected to the wrong sides of his heart. As a result of this misplacement, oxygen-rich blood circulated back to Joshua’s lungs rather than to his body while un-oxygenated blood circulated throughout his body, often turning him blue (Kennedy, 2001).
To rectify young Joshua’s problem, his surgeon recommended a relatively new procedure called an *Arterial Switch Operation*. During this open heart surgery, Joshua’s heart would be stopped and his body sustained by a heart-lung bypass machine so his heart’s arteries could be ‘switched’ to the correct side. Although risky, the operation was an imperative for Joshua’s life expectancy was less than seven months without the procedure (Liebman, Cullum, and Belloc, 1969). If the surgery was successful, he had a 90% chance of living an active life into adulthood, an excellent reason to accept the risk and attempt the switch operation (Martins and Castela, 2008).

It was a difficult and demanding medical procedure. Since the arteries of Joshua’s small heart were only about one millimeter in diameter this delicate operation demanded extensive surgical skill, recent practice, and coordinated teamwork to complete successfully. Because it was often impossible to predict exactly what the team would encounter once inside, doctors had to work together and think on their feet, making decisions quickly so as not to delay the operation and increase the patient’s risks.

Unbeknownst to Joshua’s parents, an emergency meeting had been called within Bristol’s Pediatric Cardiology Unit (PCU) the day before the operation. Although doctors all agreed that the switch procedure was warranted, some felt Joshua might be better served at a different hospital; one with more experience conducting this unusual operation and a better track record of success (BBC, 1998). Yet, despite the concerns, the surgery proceeded as scheduled.
Joshua Loveday died after eight hours on the operating table. In response, BRI stopped conducting the difficult and risky switch operation and opened an inquiry. It was determined that compared with other hospitals between 1990 and 1995, thirty to thirty-five more babies died after open heart surgery at Bristol than might be expected had the PCU been up to the standard of care at other British hospitals (Kennedy, 2001: 4). So why then did Joshua’s operation go forward?

The following system psychodynamics analysis will make clear that although doctors’ possessed the technical skills required to conduct Joshua’s operation, there was a lack of leadership and a breakdown in teamwork throughout the National Health Service (NHS), in general, and in Bristol’s PCU, in particular, in the period preceding this disaster. To explore this breakdown, the sequence of the article is as follows. First, drawing on ideas from psychoanalysis and its application to social and organizational dynamics, I outline the theoretical framework of Organizational Munchhausen-by-Proxy Syndrome (OMBPS). Following this, I argue that just such a culture developed at BRI over a seven year incubation period culminating with Joshua’s death in 1995. During this time, OMBPS dynamics undermined leadership and sabotaged teamwork, creating a dysfunctional environment which corrupted logical decision-making, escalated risk-taking, and contributed to the death of dozens of babies. This is followed by a conclusion.

**METHODOLOGY**

A system psychodynamics approach applies psychoanalytic thinking, integrating individual psychology, group study, and systemic examination as a way to uncover
collective emotions and psychological behavior within organizations (Fraher, 2004b: 65). Much goes on beneath the surface in organizations. This methodology allows us to excavate, revealing the deeper features of organizational life, even those aspects that initially appear perfectly straightforward and ordinary. We accomplish this by examining not so much individuals’ behaviors, but rather the meaning of behaviors as a collective, and the hidden motives behind these actions. Like psychoanalysis itself, adopting a system psychodynamics approach often provides metaphors which helpfully bring certain traits into relief that might otherwise be unrecognizable (Gabriel, 1999).

System psychodynamics has been used effectively by a growing number of researchers (French and Vince, 1999; Hirshhorn, 1988; Gould, Stapley and Stein, 2001) to access organizational anxieties and understand social dynamics within the wider system. However, there have been criticisms of this approach. Jacques (1952), an early proponent of applied psychoanalytic study, ultimately abandoned the approach, calling it dysfunctional. Others noted how these methods can be suspect because they are not open to empirical validation.

Nevertheless, precedents for a psycho-dynamically informed analysis of organizational dysfunction are numerous. They include studies of such organizations as Enron (Stein, 2007a), Long Term Capital Management (Stein, 2003), and National Aeronautics and Space Administration (Schwartz, 1987, 1989; Feldman, 2004). And high-risk fields like aviation (Fraher, 2004b, 2005, 2011a, 2011b), coal mining (Jacques, 1952), firefighting (Weick, 1995), law enforcement (Fraher, 2011a), mountain climbing (Elmes and Barry 1999, Kayes 2004; Tempest, Starkey and Ennew, 2007), oil
refinement (Hirschhorn and Young, 1993), and nursing (Menzies, 1959). Drawing on a variety of psychodynamic concepts, these studies depicted the organizations studied as perverse (Long, 2008), envious (Stein, 2000), narcissistic (Elmes and Barry 1999; Stein, 2003), greedy (Long, 2008), resentful (Hirschhorn, 1997), toxic (Stein, 2007b), and manic (Stein 2011; Fraher, Unpublished).

Taking inspiration from this body of work, I apply a medical term called *Munchausen-By-Proxy Syndrome* (MBPS) to the broader organizational culture at Bristol, the PCU, and the NHS as a system. *Munchausen* was first used by a British physician in 1951 when he applied the term to people who fabricate ailments in order to gain attention, sympathy, nurturance and, through their illness, control over others. In 1977 Meadow introduced a variation, *Munchausen-By-Proxy Syndrome* (MBPS), in which a caregiver systematically concocts stories about another person’s health, like a child or elder parent—even intentionally making them sick—as a way to gain access to power within the healthcare system.

Since then MBPS has been studied extensively (Parnell, 1998; Rosenberg, 1987; Wilczynski, 1995). Yet there is little unified agreement on the defining characteristics. Particularly lacking is an understanding of “why certain caretakers put their vulnerable children at risk for pain, medical complications, and occasionally death” (Roger, 2004: 229). Although most models center on pathogenic explanations allied with psychodynamic thought, criminological and adaptational diagnoses have not been eliminated (230).

Only recently has the MBPS concept been applied to organizations (Fraher, 2011a). This article expands this application, advancing in more detail the theoretical
framework of Organizational Munchausen-By-Proxy Syndrome (OMBPS) articulated in an earlier analysis of this case. The essay’s originality lies in the identification of four central features found in both MBPS and OMBPS: collusive relationships based on fantasy, a reluctance to confront, an obsession with control, and a fixation on authority.

Psychoanalyst Wilfred Bion (1961) described how individuals often become unconsciously caught up in different group processes, assuming certain truths not found in evidence, as way to avoid the discomfort of group life. In this manner, group members collude to deny reality as a way to manage organizational anxieties (Lipgar and Pines, 2003). Expanding this concept, Wells (1985) used the term ‘collusive lattice’ to describe how individual group members tacitly agree to accept unconscious roles as a way to defend the entire group from anxiety. These processes usually involve a ‘fantasy’—a product of the imagination or picture of the organization in the mind—which distorts reality.

Therefore, we find that central to OMBS is an unconscious group dynamic that draws people in to roles that deny reality in favor of a more appealing fantasy, as a way to defend the group from the anxiety truth would bring. To explore the prevalence of this pattern, let us initially examine their occurrence within MBPS, and then apply the concepts to OMBPS later in this article.

**Munchhausen-by-Proxy Syndrome (MBPS)**

First, although individual actors do behave in conscious ways, MBPS is grounded in a collusive fantasy which draws family, medical professionals and outsiders into the unconscious dysfunctional dynamics. And, while MBPS is more common in mothers, fathers often act as passive colluders either through physical absence or emotional
distance. Physicians collude as well becoming drawn into the MBPS fantasy through a complicated need to be perceived as caring, helpful, and concerned, and their own hubris to solve the difficult case and be seen as competent amongst their peers.

Second, outsiders and other medical professionals collude too. For instance, they often do not question or confront, rarely contacting the father to gain more insight, clarify the mother’s stories, or investigate the situation. Third, MBPS mothers display an obsession with control and a fixation on authority. A critical motivation behind MBPS is an overwhelming need to be in a relationship with physicians and medical institutions in order to feel important and in control. The child becomes just an ‘object,’ used to gain access to authority figures and maintain connection to power.

Far from appearing strange, MBPS mothers may seem intelligent, articulate and caring: A fantasy of the ideal mother. Well educated about medical conditions, they often work within the healthcare field. Yet, incongruently, they can lack basic social skills, display inappropriate emotions and be simply “too intense” to deal with (Schreier and Libow, 1993: 87). Obsessed with obtaining medical treatment, these doctor-addicts are not interested in hearing medical advice. They are only interested in getting an authority figure to take action. When one doctor denies them the attention they need, they obsessively seek treatment with another medical professional or at a different facility (Gregory, 2003).

Extending this model to organizational culture, we find similar characteristics present within BRI and the PCU: collusive relationships based on fantasy, a reluctance to confront, an obsession with control, and a fixation on authority. Although enacted by individuals, the underlying motivations and collective dysfunction were almost always
unconscious. Yet, these dynamics nonetheless combined to create an undertow of hyperactivity as a way to vent organizational anxieties, and like MPBS itself, an abundance of information doctors were unable to make sense of.

FINDINGS

The Drift Towards Failure

Turner (1976: 381) was one of the first researchers to evaluate organizational decision-making, noting disasters do not typically occur spontaneously but rather “incubate” over time. Similarly, Dekker (2005: 18) argued that apparently safe systems can “drift into failure” during “the banality” of everyday life, “a slow, incremental movement of systems operations toward the edge of their safety envelope.” Applying this thinking, I argue that between 1988 when the switch operation was first begun at BRI and Joshua’s death in 1995, there were five complex systemic factors incubating as the safety system slowly drifted towards failure.

First, there was weak regulatory oversight during the NHS’s restructuring and transition to ‘Trust’ status (Paton, 2008). Second, as a result of this restructuring, a new generation of managers entered the leadership ranks from outside the healthcare field. Hired under renewable contracts, there was strong incentive to produce fast results in a short period of time, often at the expense of long-term planning and safety (Jones, 2006). These first two factors contributed to creation of the third and fourth factors incubating at Bristol: An inordinately long surgical learning curve was permitted to allow cardiac surgeons time to perfect the switch operation. And, as fatalities increased, a dysfunctional organizational culture emerged which made it difficult for pediatric cardiology surgical teams to communicate effectively or work together productively.
Finally, management changes within intensive care units during this period also impacted team performance heightening competitive tensions. In the 1980s, surgeons generally assumed primary responsibility for their patient’s post-operative care. In the early 1990s, a shift occurred as anesthetists became more fully involved in patient care. This created tensions between many surgeons and anesthesiologists, who were known to “have an antagonistic relationship that may have a negative impact on patient care” (Helmreich, and Musson, 2000: 391-2).

Researchers defined this professional interface as one of surgeon as customer, and anesthesiologist as service provider; not necessarily the optimal collaborative environment (Belli, Lacour-Gayet, Serraf, Alkhulaifi, Touchot, Bruniaux, and Bogner, 1994; Helmreich and Musson, 2000; Makary, Sexton, Freischlag, Holzmueller, Millman, Rowen, and Pronovost, 2006). As one Bristol anesthetist noted, there is a “legendary” rivalry “between surgery and anaesthesia” and the dynamic still “exists” today: “Surgeons do not like to be told what to do by anaesthetists and anaesthetists do not like to be told what to do by surgeons” (Kennedy, 2001: Bolsin interview: 132).

As a result of these five factors, PCU teams fragmented into professional cliques—surgeons became defensive, nurses became skeptical, and anesthetists became uneasy—undermining leadership, communication, and teamwork in operating room teams. Although there were signposts of this team performance breakdown along the way, which will be discussed in detail in the next section, hospital managers’ reluctance to exercise leadership, monitor doctors’ behaviors, improve hospital culture or prioritize quality of patient care stagnated systemic change efforts. As the Unit drifted
towards failure, several dysfunctional organizational dynamics emerged as people struggled to cope with the increasing anxieties and escalating risks.

Applying a theoretical framework of *Organizational Munchausen-By-Proxy Syndrome* (OMBPS), we can explore the nuances of these dynamics. Let us hypothesize: What if Bristol’s Pediatric Cardiology Unit was like a child being abused by its MBPS mother, neglected by its emotionally withdrawn father and ignored by medical professionals colluding in the dynamic? In other words, ‘what if’ anxieties and defenses within the BRI system-as-a-whole prompted anesthetists to take up a role similar to that of a MBPS mother and fixate on authority and control, cardiac surgeons to enact the role of the distant father, and NHS management to collude as non-confrontational medical professionals?

**Background—A Letter, a Study, and an Article**

In 1989, after yet another baby died during cardiac surgery at BRI, a concerned anesthetist confessed to a senior colleague that he suspected there was “a problem” within the PCU. The anesthetist was “absolutely distraught about” this baby’s death, the colleague recalled. He felt surgery at Bristol was taking too long and putting small babies at greater risk. But, the senior colleague quickly emphasized, this anesthetist was not very tactful or “introspective.” He could be volatile, lacked social skills, and “wanted to broadcast” his concerns to “the whole world” without necessarily “having the evidence to back it up.” So the colleague suggested the anesthetist collect hard data to support his hypothesis before speaking with anyone else (Kennedy, 2001: Prys-Robert interview: 4-5).
Yet, the anesthetist disregarded this advice, and sent a letter to Bristol’s Chief Executive, igniting a series of conflicts within the PCU. In retrospect, the anesthetist claimed his motivation for writing the letter was out of concern “for the safety of children that were dying unnecessarily” and the desire for an open, public review of the PCU’s performance (Kennedy, 2001: Bolsin interview: 111). Yet, he never used the word ‘safety’, never asked for ‘data’, never demanded an ‘open review’ or even mentioned ‘unnecessary deaths’ in the letter. Perhaps even more revealing about his motivations was his reflection that “the reason for bringing the Chief Executive in” was that “I was a member of the” PCU and surgical data “was not being given or shared with me” (56). This sounds more like he was unhappy with his service role as an anesthetist within the PCU’s surgical team and was using the volatile topic of child safety as way to attract attention, inflame emotions and retaliate against the surgeons for not involving him more proactively (108).

Although the CEO dismissed the letter as inconsequential, the anesthetist conceded his actions created disharmony and mistrust within the Unit. Surgeons were angry a fellow doctor voiced criticism outside the PCU. And anesthetists were dismayed that established avenues of communication had not been followed and feared they would all look bad with negative consequences for their working relationships with surgeons. As a result, the anesthetist recalled, he felt afraid and isolated (Kennedy, 2001: Bolsin interview: 113-114).

Yet, he continued on his quest, teaming up with an experienced medical researcher to secretly compile their own pediatric cardiology data in hopes of
formalizing the complaint. When the researcher wanted to inform the surgeons of their study, the anesthetist disagreed, arguing that talking with surgeons “would impede their task” (Kennedy, 2001: 139). In 1993 after collecting data sets on 233 children who had undergone open-heart surgery at BRI in 1991 and 1992 the anesthetist’s study was complete. Yet, it quickly became clear that the research was fundamentally flawed and largely unusable.

Nonetheless, if introduced correctly, the study still could have been a pivotal opportunity for the PCU to discuss ways to improve team performance and jointly consider the open review the anesthetist allegedly desired to investigate infant safety. And he had numerous opportunities to raise his concerns publically. Yet, strangely, the anesthetist chose to share his data informally, chatting in corridors, in the break room, in taxicabs or dropping by peoples’ offices unscheduled rather than raising his concerns in a formal way. For example, a fellow BRI anesthetist recalled discussing the research and advising him “to share the data with the surgeons”. He refused, she said, because “he thought this might limit his access” (Kennedy, 2001: 144).

Another colleague experienced with statistics, recalled he was sitting at his desk one day when the anesthetist wandered in and handed him the data. “What do you think of these?” he said vaguely. There was “a huge amount of information”, the data was “pretty raw” and had “no summary,” he recalled. It was “quite difficult to interpret” and needed “a lot more processing to make it intelligible” or useful in any “presentable manner” (Kennedy, 2001: Pryn interview: 129-30). Another doctor, Clinical Director of Cardiac Services, agreed with this assessment and immediately called the data’s
validity into question, directing the anesthetist to recheck his figures and get back to him. Yet, the anesthetist never returned.

Instead the anesthetist met with a medical reporter for a satirical magazine, and provided information for a series of articles which embarrassingly referred to BRI as “The Killing Fields”. When confronted, the anesthetist initially denied being the magazine’s source, yet later confessed that he did provide the information because “I needed action” (Kennedy, 2001: Bolsin interview: 53). As one might expect, this had detrimental impact on teamwork within the PCU, in particular on surgeons’ willingness to share information with their anesthetist colleagues.

But this did not dampen the anesthetist’s quest. He shared his research data with a senior medical officer at the Department of Health, who urged him in writing to speak directly with his colleagues and voice his concerns through the proper communication channels established within his organization. He did not. Then, five months later he approached a different Department of Health official in a taxicab, handing him a brown envelope containing his study data. This official immediately tried to return the envelop without opening it and, like his colleague, explained that there were well recognized mechanisms by which disputes could be resolved and urged he use them. But the anesthetist did not. And the pattern continued.

In fact, the anesthetist visited dozens of medical professionals to share his raw and inaccurate data. At times, he would be waiting for feedback from one person while continuing to reach out to others, asking them to take action on his behalf. When given advice, he rarely followed it, choosing instead to approach someone new. Most
importantly, he never shared his research with either of BRI’s pediatric cardiology surgeons. As a result, it seems clear that although the anesthetist claimed to be looking for resolution, the manner in which he chose to share his concerns ensured there would be none. He acted like a MBPS mother, enjoying his role as the central character in his own self-created drama, refusing any advice which might lead to a solution.

A final opportunity to break the chain-of-events which preceded Joshua’s death occurred the night before his surgery when nine Bristol doctors—cardiologists, anesthetists and surgeons—met to discuss the operation scheduled for the next day. The general feeling expressed was that there was no clinical reason for deferring the surgery. Joshua’s condition merited an immediate intervention and his cardiologist considered any further delay inappropriate. Apparently anticipating this response, the anesthetist shared that he had already contacted the Department of Health to alert them about the upcoming operation, shocking his colleagues.

From an outside point of view, it seems clear that the pressure of the emergency meeting, calls to the Department of Health, media coverage depicting Bristol as the “The Killing Fields,” and the general lack of teamwork and collegiality within the Unit, ought to have prompted a pause before Joshua’s surgery. Clearly this was not an ideal environment in which to proceed with an inherently risky and complicated medical procedure. Although there may not have been a clinical reason to delay the operation, there were many social reasons. Why did this go unrecognized?

I suspect that the Bristol PCU had learned to tolerate so much tension, turmoil and outside distractions over the years, few people recognized that waiting a few days
to let things settle down was a viable option. Joshua’s condition was not going to worsen significantly during that period. Yet, as Joshua’s surgeon noted, “When I am in the operating theatre, I am very focused” nothing bothers me, “I am a different person”. Even when challenged, he adamantly testified that there was no way he was distracted by the stress and anxiety of the Unit’s problems (Kennedy, 2001: Dhasmana interview: 78).

This denial may not be all that unusual. Numerous medical studies reported that healthcare professionals routinely refuse to acknowledge the impact of outside stressors on their job performance (Belli, Lacour-Gayet, Serraf, Alkhulaifi, Touchot, Bruniaux, and Bogner, 1994; Helmreich and Merritt, 1998). For instance, 70% of surgeons deny the effect of fatigue on their job performance compared with only 26% of airline pilots; 82% of doctors believed a true professional can leave personal problems behind when working, and 76% believe their decision-making during emergencies was as accurate as during routine operations (Sexton, Thomas, and Helmreich, 2000: 748).

Another recent study found that about a third of the anesthesiologists and about a quarter of the operating room teams studied “failed to ask for help, did not accept help when it was offered, or did not work together effectively in a crisis” (Groopman, 2005: 52).

Other studies found that perceptions of teamwork differ significantly by operating room role. Although surgeons rated their own operating room teamwork highly 85% of the time, nurses only rated them highly 48% of the time. Meanwhile all groups rated their own professional group’s teamwork highly, making breakdowns perennially someone else’s problem (Makary et al, 2006). Perhaps most disturbing is that one-third
of intensive care responders did not acknowledge that they made errors while more than half reported it was difficult to discuss mistakes in their organization or ask for help. Reasons given to account for this poor teamwork were personal reputation (76%), threat of malpractice (71%), high societal expectations (68%), fear of disciplinary action by licensing boards (64%), job security (63%), and the egos of teammates (60%) (Sexton et al, 2000: 748). This denial makes the environment ripe for collusive fantasies like the omnipotence of surgeons or second-class status of other professionals like nurses or anesthesiologists.

Applying OMBPS

To understand MBPS, organizationally speaking, I draw further parallels between the dynamics of MBPS and those within the PCU in the following section. There are a number of similarities. Like a MBPS mother, the anesthetist sought out one medical professional after another, over twenty-five in total, to share his confusing and inaccurate data about the PCU’s performance, the symptoms of his ‘sick’ child. He lied and manipulated to suit his needs, while simultaneously depicting himself as the victim, misunderstood, isolated, and powerless. Similar to an MBPS mother, he claimed his actions were solely motivated out of concern for children’s health. Yet, when he was advised numerous times to clarify his research results and then use the proper channels of communication to openly discuss his concerns, he never did. In fact several months before Joshua’s death, he had another perfect opportunity.

Three BRI doctors invited the anesthetist to dinner with the aim of surfacing his concerns about pediatric cardiology services and clearing the air within the Unit. Yet, the anesthetist did not speak up. He explained, he would have “contributed to a debate”
if someone else started it but “I did not want to raise the issue” myself. Instead, he said, he wanted others to take action. “That was why I was going through every other route possible to press alarm bells to get somebody to come and deal with the issue,” he emphasized (Kennedy, 2001: Bolsin interview: 180-2). Similar to the MBPS mother, the anesthetist seemed to revel in the spotlight and the power he gained by manipulating others in authority to take action based on his information. As long as the PCU stayed sick, the anesthetist retained his central role as whistleblower, providing important information to other doctors and the outside medical community.

Like many MBPS mothers, the anesthetist reported feeling uninformed, treated unfairly, rejected, and forced into a support role by his profession vis-à-vis the powerful cardiac surgeons. He believed he had more to offer and was outraged, for example, when Unit surgeons and cardiologists provided information in application for Trust status without consulting him, prompting his first letter to the CEO. While MBPS mothers are typically critical of the hospital’s treatment of their child, they often talk in laudatory terms about the physician himself. This is an important part of the MBPS fantasy, preying on the doctor’s narcissism. Similarly, the anesthetist was known to describe Joshua’s surgeon as a deeply caring, hardworking doctor who could be found at all times day and night serving the needs of his patients. In fact, the anesthetist called him “the best paediatric cardiac surgeon in the South West region” (8). He also noted that the medical director was pleasant, easy to work with, “had a lot of experience within the Health Service” and “was a very good manager” (89).

It is difficult to reconcile these competing images and the purpose they served organizationally but the MBPS model once again proves helpful. Like the anesthetist,
MBPS mothers often work within the healthcare field identifying with doctors as an idealized parent, allowing them to deny their own intense dependency needs. Yet they find themselves in a perplexing bind: While they need doctors to project their unresolved ego needs upon, they simultaneously devalue the very people they seek nurturance from. Therefore, although MBPS mothers crave attention, they are unable to accept the care they do receive as genuine, leaving them trapped in a hopelessly escalating cycle of frustration (Schreier and Libow, 1993: 87).

Similarly, the anesthetist seemed to need to both idealize Joshua’s doctor as ‘the best surgeon’ and the medical director as ‘the best manager’ to satisfy his dependency needs while also demonizing them for their role in children “dying unnecessarily”. He simultaneously craved attention from the outside medical community, yet could not accept that people were interested and listening. This perplexing double-bind led the anesthetist to act out, becoming overly emotional and highly frustrated at times. Although numerous colleagues urged him to calm down, think before he acts, use appropriate communications channels and talk with the surgeons directly, it seems he could not because he did not want to risk facts intruding into his fragile fantasy. If the surgeons remained ‘all bad’ in his fantasy, then the anesthetist remained ‘all good’ in his intentions and actions, innocent of participating in babies’ deaths.

With obvious trepidation on the part of some PCU doctors, secret telephone calls to the Department of Health, and escalating stress and political pressures, we are still left wondering why Joshua’s operation went forward? To understand this we must now examine how the pediatric cardiology surgeons enacted roles as the absent and neglectful fathers in the MBPS organizational drama. Although it is clear that the
anesthetist never directly shared his data or his concerns with the surgeons, it is difficult to understand why they remained so aloof. They were either too busy or emotionally distant to get fully involved in the anesthetist’s ‘motherly’ activities or the health of their ‘sick child,’ the PCU. Apparently, like the MBPS family dynamic, where it is nearly incomprehensible that fathers do not suspect something unusual is occurring, it is hard to reconcile the surgeons’ inaction.

Yet we know of the surgeons’ eagerness to perfect their surgical skills and bring Bristol into the forefront as a leading pediatric cardiac surgery center. It is possible that these personal goals motivated them not to ask questions and to pursue their individual agendas at the expense of the general good, particularly the babies; for example, not fully disclosing the risks of Joshua’s operation to his parents. The narcissism and denial required by the surgeons to turn a ‘blind eye’ to this organizational undercurrent seems a conscious attempt to disguise a paradoxical reality all too evident—that no length of learning curve would have allowed surgeons to perfect the challenging switch operation. The operation would always be risky and babies with this rare birth defect will most likely die. Joshua’s statistical chance of survival without an operation was only about 11%. This was what remained unspeakable.

Although surgeons were certainly aware of the mortality rates, the wider system—through parents, managers, other healthcare professionals and the community—colluded to deny the risk and instead placed increasing pressure on the surgeons, whose narcissism fueled a fantasy of their omnipotence. The purpose of this dysfunction was to develop a diversion to serve as an organizational defense, avoiding the pain that facing reality would cause. For instance, the pain of accepting that many
babies died during the risky pediatric cardiology procedures to facilitate a learning curve and doctors cannot cure everybody.

Yet, perhaps we have been asking the wrong question. Perhaps the question is not why did Joshua die, but why was Joshua’s death—among all the other fatalities at Bristol over this seven year period—the proverbial ‘straw that broke the camel’s back’? It is clear that anxieties associated with the risky pediatric cardiac surgeries activated certain defenses within BRI and the PCU. Although the surgeons seemed to reconcile the statistical odds of babies dying by using their learning curve metaphor others, like the anesthetist, were agitated by the reality that many of these sick babies would die without surgery and might very well die with it. Unable to accept this uncomfortable reality, the organization activated the anesthetist, among others, to create a complicated organizational undertow that slowly built up over the years until it was nearly impossible for the surgical team to perform effectively. Preying upon the surgeon’s sense of omnipotence, these organizational dynamics led the doctors to increasingly ignore the escalating impact of outside stressors and press forward with the surgeries in an effort to play savior one more time.

This coexisting organizational dynamic—where the fantasy that doctors could save all babies and the reality that many babies might nonetheless die—might have continued for several more years except for one fact: The hospital had just hired a new experienced pediatric cardiac surgeon and hospital facilities were being upgraded. Although these improvements might seem to be exactly what the anesthetist wanted all along, like an MBPS mother, these changes could potentially impact his previous power
as Unit whistleblower and might instead leave him feeling unneeded and unwanted as the negative repercussions of his actions took full effect.

Finally, and perhaps most disturbing, the anesthetist seemed oblivious to the social impact of his actions on others and the detrimental result for team performance. Even after the letters, article, phone calls, and Joshua’s death one supervisor recalled, the anesthetist voiced “no objection to working with any of the cardiac surgeons.” In fact he seemed quite happy to continue in his previous operating room role, ignoring the ramifications of his previous actions and the fact that the relationship between surgeon and anesthetist in the operating room “at critical times is of paramount importance. If there is tension and difficulty, then there is a risk of increasing mortality” (Kennedy, 2001: Monk interview: 42).

The fact that the anesthetist “was happy shows no insight into the feelings of the surgeons” or awareness of his impact on Unit teamwork and surgical outcomes, the supervisor observed (Kennedy, 2001: Monk interview: 42). But it does show the anesthetist’s desperate need to remain connected to the surgeons. Joshua’s death became ‘the last straw’ because the anesthetist knew the upcoming organizational changes would cure the PCU’s illness, steal his spotlight and sever his special relationship with authority figures. Although we have discussed these dynamics as ‘individual’ behaviors, it is important once again to emphasize how these complex dynamics were interrelated, woven within the dysfunctional hospital culture over a long period of time.
Conclusion

The events surrounding the deaths of the Bristol babies became the subject of the longest medical inquiry in UK history. Written evidence from 577 witnesses, including 238 parents, medical records of over 1,800 children and 900,000 pages of documents were considered along with individual testimony taken over ninety-six days (Kennedy, 2001: 1). In sum, the inquiry found pediatric cardiac surgical services at Bristol were “frankly not up to the task” (7). Between 1988 and 1994, the mortality rate in open-heart surgery on children under one year of age at BRI was roughly double that of other hospitals. Rather than “a deterioration in standards,” the inquiry found a lack of leadership and teamwork along with “a failure to progress” in the surgical learning curve (4-5).

As the old NHS system transitioned to the new Trust status, there was confusion at a national level about who was responsible for monitoring quality. There was no protocol to introduce new surgical techniques or monitor surgeons’ proficiencies. As a result a gentlemen’s club culture grew at BRI where an imbalance of power put “too much control in the hands of too few individuals” during which “vulnerable children were not a priority” (Kennedy, 2001: 2). Although “Bristol was awash with data”, the inquiry concluded, it was “often partial, confusing and unclear” research with little information provided openly to parents or the general public (3).

As BRI transitioned into the new NHS system, cardiac surgery expanded and surgeons worked to improve the unit’s reputation by trying new procedures like repairing infants’ birth defects. Babies like Joshua were selected because they had a very high
mortality rate and little chance of living to adulthood without surgery (Kennedy, 2001: Dhasmana interview: 71). Yet, there were few guidelines, no set standards, and little supervision for these procedures. As one surgeon observed, doctors recognized “that whenever you start any new operation you are bound to have unfortunately high mortality.” Although no surgeon wants to admit “practicing” on his patients, he explained, “that is the definition of ‘learning curve’,” (Kennedy, 2001: Dhasmana interview: 42-3).

During the rocky transition to Trust status, a number of leadership challenges emerged. However, most new managers hailed from business not from healthcare, making supervision of doctors, hospital culture change, and quality of patient care areas they were reluctant to get involved with. As Bristol’s Chief Executive noted, the widespread understanding of the manager role was “to provide and coordinate the facilities which would allow [doctors] to exercise their clinical freedom,” not to try and influence their behaviors (Kennedy, 2001: 68).

This deference to authority, overreliance on doctor’s self-management, and reluctance to confront each other’s behaviors became a critical influence. Unfortunately, it is all too easy to see how this dynamic could happen again in other scenarios. As the government inquiry noted:

We must learn from the lessons of Bristol. Even today it is still not possible to say, categorically, that events similar to those which happened at Bristol could not happen again in the UK; indeed, are not happening at this moment (Taylor, 2001: 11.)
As a result, we find that Joshua Loveday’s death was actually the culmination of a complex interrelated systemic breakdown. Although it may be impossible to determine with certainty the underlying influences, actions, motivations and behaviors that contributed to these failures, team breakdown occurred often enough over the long- and short-term that creative explanations of the possible confluence of variables leading to this failure is warranted. One explanation has been offered here: a theoretical framework of *Organizational Munchausen-By-Proxy Syndrome*. Thus, this study contributes to organizational theory, disaster research, and the field of system psychodynamics. By examining this disaster from a systemic perspective, identifying leadership failures and teamwork breakdown, we can better access the unconscious dynamics and psychoanalytic influences that are often so influential in organizational dysfunction.

As the Bristol PCU drifted towards failure over a seven year incubation period, there were several opportunities to avert disaster. Yet, none were taken. I hope that our understanding of the destructiveness of these dynamics might in some way inform our leadership efforts in the future.
REFERENCES


BBC News. 8 June 1998. 'Our Rights Were Ignored'.


Schwartz, H. S. 1989. ‘Organizational Disaster and Organizational Decay: The Case of the National Aeronautics and Space Administration.’ *Industrial Crisis Quarterly*, 3: 319-34.


