

Viewing Time

The program will take up to one hour to complete.

Target Audience

This program is designed for primary care physicians.

Other health care professionals working with patients and their families may also find this program of interest.

Faculty Disclosure

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Faculty Disclosure

Thomas Roesler, MD has disclosed that he has published a book on this topic, *Medical Child Abuse: Beyond Munchausen Syndrome by Proxy*. American Academy of Pediatrics Press, Elk Grove Village, IL, 2008.

During this educational activity **Dr. Roesler** will not be discussing the use of any commercial or investigational product not approved for any purpose by the FDA.

Medical Child Abuse

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Medical Child Abuse

A lecture about the spectrum of presentations of a child receiving unnecessary and harmful or potentially harmful medical treatment at the instigation of a parent or caretaker.

Program Objectives

Upon completion of this program, participants should be able to:

- Define Medical Child Abuse (MCA)
- Appreciate a spectrum of presentations of MCA
- Compare MCA with other forms of child maltreatment
- Outline a treatment strategy for MCA

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Receiving CME Credit

To receive CME credit you must view the entire program and complete the evaluation form at the end.

MEDICAL CHILD ABUSE-- Beyond Munchausen Syndrome by Proxy



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Disclosure

- Drs. Roesler and Jenny have published a book on this topic, *Medical Child Abuse: Beyond Munchausen Syndrome by Proxy*. American Academy of Pediatrics Press, Elk Grove Village, IL, 2008.

We advocate abandoning the term
“Munchausen syndrome by proxy”
from the medical vocabulary.

MEDICAL CHILD ABUSE

- (1) A child receiving unnecessary and harmful or potentially harmful medical care; and
- (2) A parent or caretaker is driving the system and causing the unnecessary care to occur, i.e. instigating the care.

MEDICAL CHILD ABUSE

- Definition: A child experiencing unnecessary and harmful or potentially harmful medical care at the instigation of a care taker

MALPRACTICE

- Harmful medical care instigated by the doctor
- Does not meet the community standard of care
- No one considers medical neglect to be caused by the doctor. It is understood that neglect is committed by caretakers.

Medical Child Abuse has
many features in common
with other forms of child
abuse and only a few
differences

Our object is to demystify
MSPB – to bring it back
into the mainstream of
child maltreatment
diagnosis and treatment

How is medical child abuse like other forms of child abuse?

- It presents in many different ways.
- Severity ranges from mild to severe.
- There is a threshold that constitutes abuse.
- It is not an illness but can result in illness.
- Perpetrators of the abuse can have many different motivations.
- Perpetrators often have experienced difficulties in their own childhood.

How is medical child abuse different from other abuse?

The medical care system is the instrument of the abuse.

Review of 115 cases referred to Child Protection Program at HCH and treated by the Hasbro Partial Hospital Program for concerns about MSBP

- 68 HPHP
- 13 Child Protection Program
- 16 Both
- 18 "Second Opinion" cases from other states

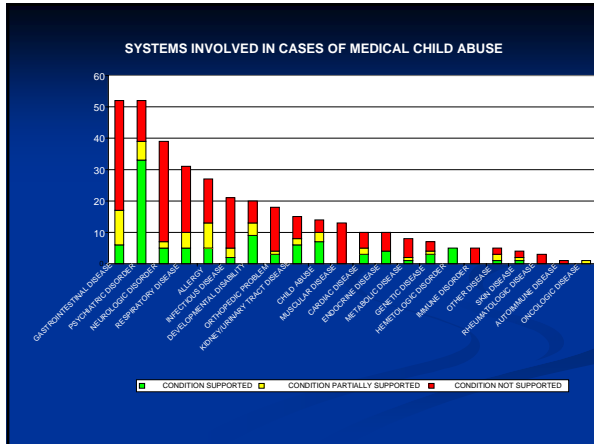
- 87/115 determined to be cases of medical child abuse (75.7%).
- 26% of children had no illness ever documented.
- 74% received care far in excess of the care required based on objective data

Types of unnecessary care received

- Unnecessary medical visits—81
- Unnecessary medications—74
- Unnecessary invasive tests—46
- Unnecessary minor surgery—33
- Unnecessary major surgery—21

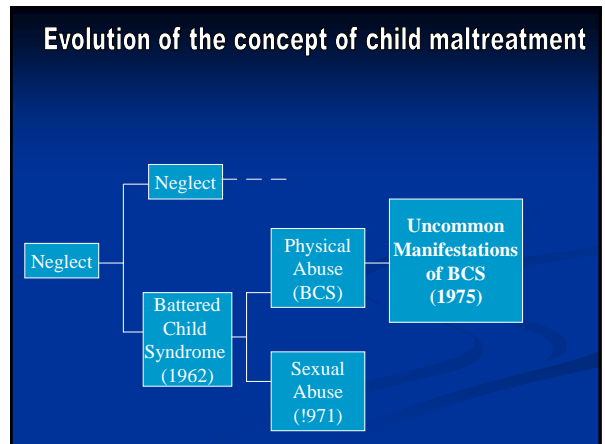
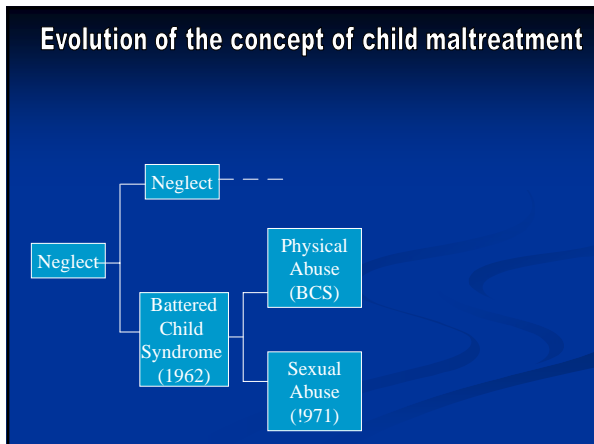
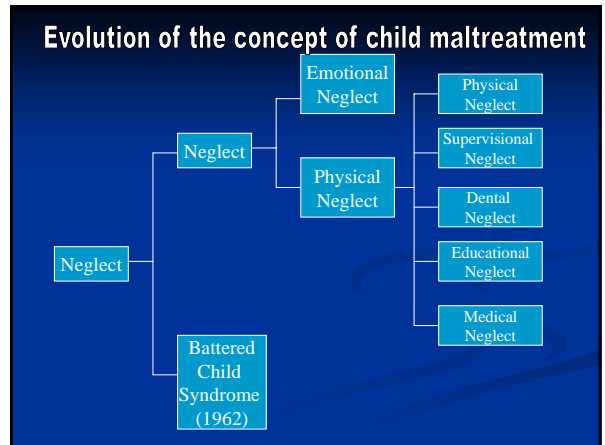
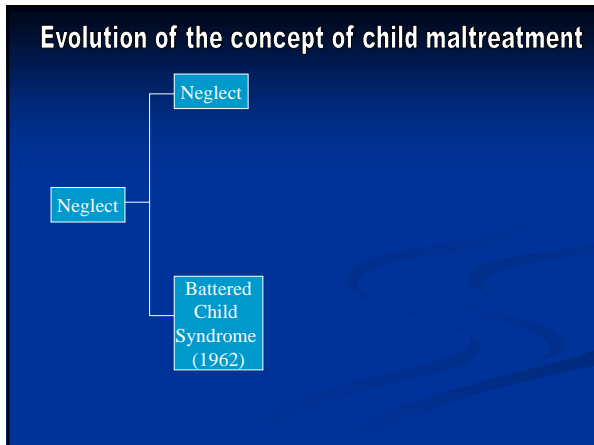
Type of MCA

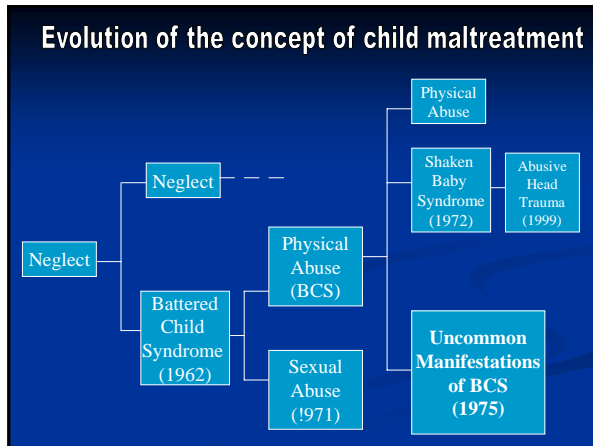
- Exaggerated symptoms 89.7%
- Fabricated illness 73.6%
- Induced illness in the child 26.4%



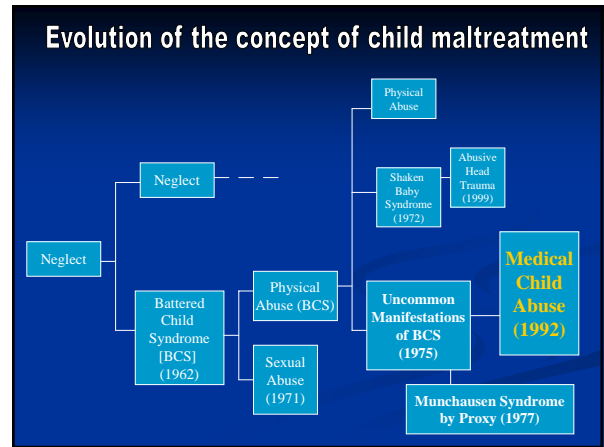
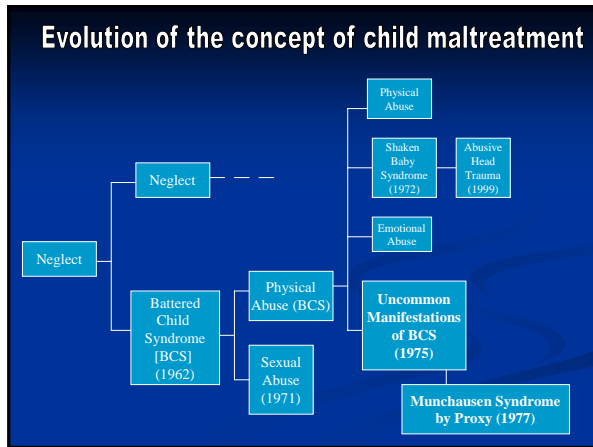
Evolution of the concept of child maltreatment

Neglect





- 1975 C. Henry Kempe: Uncommon manifestations of the battered child syndrome.
- --Human bites
- --Non-accidental poisoning
- --Withholding water causing hypernatremia



Why did we get sidetracked?

“None can doubt that these two children were abused, but the acts of abuse were so different in quality, periodicity, and planning from the more usual non-accidental injury of childhood that I am uneasy about classifying these sad cases as variants of non-accidental injury.”

Roy Meadow, 1977

- ### Why did we get sidetracked?
- Because physicians and medical personnel are the instrument of the abuse
 - This results in a need to explain how they got involved – distracting from what is happening to the child
 - We focused on the “why” to the detriment of understanding the “what” and how we can stop it.

What about lying

- People lie to their doctors about lots of things
- Eg. Drug seeking behavior, malingering, “I only eat 600 Kcal per day!”
- Geriatricians and psychiatrists do not always believe their patients but pediatricians almost always do (they are such nice people)

The rules for being a good patient

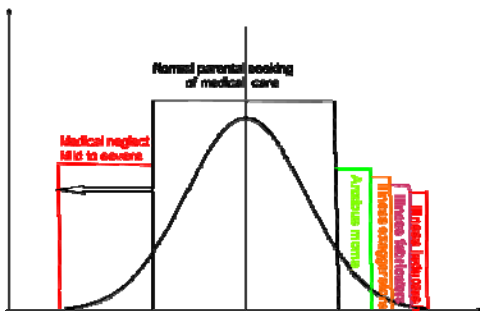
- Admit you are sick and need help
- With this admission you get permission to stay home from work or school
- In exchange for this privilege, you agree to cooperate in good faith in getting well
- You promise to return to normal activities as soon as the illness is over

Corollary to cooperating with treatment

- In agreeing to cooperate with treatment one also agrees to provide honest, accurate information to the treatment providers
- Treatment based on false information is seldom appropriate or helpful

MEDICAL CHILD ABUSE IS A RESULT OF A BREAKDOWN IN THE DOCTOR/ PATIENT RELATIONSHIP

Continuum of care seeking behaviors



Spectrum of Treatments, least to most intrusive

- Counseling in office setting
- Refer parent for therapy/medication
- Family counseling
- Involve outside agencies to monitor care
- Partial hospital program
- Inpatient trial of separation from parents
- Report to child protective services
- Remove child from parent
- Criminal prosecution/incarceration

Hasbro Partial Hospital Program

- Day hospital treatment for medically ill, psychologically ill children.
- Treatment is FAMILY SYSTEMS THEORY focused.
- Treatment is collaborative and multidisciplinary.
- Ideal model for treating MCA.

Cases that illustrate the use of “Medical Child Abuse”

Case 1.

- 15 yo girl referred to CPS by primary care physician for MSBP.
- Had missed 1.5 years of school with chronic abdominal pain and headaches.
- CPS referred child to Hasbro PHP after being told by an MSBP expert that she would require a \$25,000 retainer to evaluate the records in the case.
- Admitted to Hasbro PHP for evaluation and treatment.

Case 1.

- Evaluation: Record review showed several missed appointments and NO UNNECESSARY MEDICAL CARE. Had an untreated STD (child refused treatment after telling mom she was not sexually active).
- Diagnosis: Not MCA, acting out teen, untreated pelvic inflammatory disease.
- Outcome: Successful STD and family treatment, child returned to school, CPS closed the case.

Case 2.

- 9 yo girl with congenital heart disease (transposition of the great vessels), surgically corrected at age 2 months. Cardiologist said her activity should only be restricted by her comfort level.
- Family made her a “cardiac cripple”—would not let her do any normal childhood activities.
- Her mother insisted she use a wheel chair when it was convenient for the family.
- Child was frequently absent from school for multiple complaints. Worked up for kidney disease, asthma, allergies, and bipolar disorder, all of which were negative.
- Primary care MD diagnosed MSBP.

Case 2.

- Treatment: Outpatient family therapy—originally referred to help the child be less “spoiled”.
- Diagnosis: MCA (child received much unneeded care, activity unnecessarily restricted).
- No report was made to CPS, outcome was good, unnecessary care stopped. Now child is a normally functioning adult with her own family.

Case 3.

- 7 yo girl admitted to hospital with severe, chronic vomiting.
- Nurses suspected mother giving child Ipecac—vomiting occurred after mom accompanied child to bathroom.
- Vomitus tested positive for Ipecac.
- Case reported to CPS, mother escorted out of hospital.
- One week later, we were called by Juvenile Court judge. Defense JD requested \$10,000 to hire psychologist to evaluate mother for MSBP.

Case 3.

- Child diagnosed with MCA, physical abuse and psychological abuse. We told judge that this was not MSBP, but it was child abuse, assault by intentional poisoning.
- Placed in long-term foster care. Parental rights have not yet been terminated. No criminal charges were filed.

Case 4.

- Patient originally seen at age 18 months.
- Referred to Child Protection Program—residents suspected MSBP.
- Child had seen a doctor 219 times. Had had 5 sets of PE tubes inserted, on chronic IVIG for immune deficit. Immune work up was normal.
- Chronic ear disease was based on mother's history rather than on physical findings.

Case 4.

- Child protection team contacted MDs who insisted he had an underlying disorder. CPT sent a letter to all providers stating concerns and documented absence of physical evidence in the record.
- Primary MD confronted Mom about too much medical care. Mom left the practice. MD did not call CPS.

Case 4.

- Fast forward 9 years. Child is 11 yo, still getting IVIG, many hospitalizations and medical visits.
- Now develops severe abdominal pain of unknown etiology, requiring extensive medical work-up.
- Referred to HPHP where we found his old CPT evaluation in the record.
- Child was totally well during the day in the HPHP, but at night, with his mother, would be doubled over with severe pain.
- Mother withdrew him from program because we were not being sensitive to the child's needs.

Case 4.

- HPHP referred case to CPS. Reviewed case at multidisciplinary team meeting, including primary care MD and case manager from his health insurer.
- All MDs agreed he didn't need IVIG.
- Primary care doctor informed Mom that care plan would change and he would no longer need IVIG or hospitalization/narcotic meds for pain, and that he should go to school.
- Mom took the boy to a chiropractor who diagnosed spinal misalignment. With treatment, his symptoms disappeared.
- CPS closed case; insurance company case manager continues to monitor health care usage. School was informed he needed MD note to miss school.

Treatment of child abuse:

- 1. Identify it
- 2. Stop it.
- 3. Provide for ongoing safety
- 4. Repair the damage (physical and psychological)
- 5. Have treatment occur in a way that best preserves the family.

1. IDENTIFY IT

- Think that it might be happening
- Practice good evidence based medicine
- We can't just be "empathic"

Identification of MCA in Primary Care

- Advantages and disadvantages of the primary care relationship.

Specialty care

- Ability to come at case from a new point of view
- Ability to do more tests

Child Abuse Experts

- Have the advantage of working within a multidisciplinary team.
- Expert at extensive reviews.
- Use your MDT to coordinate relationships between multiple sub-specialists.



How to do an expert evaluation

- Get all the records
- Make a table
- Look for patterns
- Cite evidence for “a child receiving unnecessary and harmful, or potentially harmful medical treatment at the instigation of the caretaker.”

DATE	PROVIDER	COMPLAINT	COMMENTS
10/9/88	Langston United ER	Fall and cut mouth	TRAUMA-1.5 cm laceration on mucosa of U. upper lip. No tooth involvement noted. No sutures necessary.
4/10/88	Langston United ER	Fall and hit head	TRAUMA-Fall from bike. Hit head. No loss of consciousness, dizziness or vomiting. Hit 2 superficial fracture wounds to middle of forehead. No other trauma. Rx: Wash cuts with soap and water.
6/16/88	TCH Neurology (Hendry)	Dermoid, L. nostril	SURGERY-History from mother of progressively enlarging mass on back of head causing pain. Preop D Dermoid of the L. nostril sinus. Preincision was excised. Postop Dx: Thickened pericardium of unknown etiology. Path Dx: Pseudoepithelioid nodule (subcutaneous granuloma annulare).
	TCH Ortho	Granuloma on foot	SURGERY-Soft tissue mass now causing discomfort with shoe wear. Extremal biopsies performed desam R foot. Dx: Granuloma annulare.
4/21/88	TCH Ortho	Post-op w/	All wounds are healed. No evidence of infection. Rx: Return 2-3 weeks, depending on tolerance.
7/1/88	TCH Ortho	Post-op w/	Normal course of reaction. Incision well healed. No drainage, pain, redness, or swelling without a limp.
9/15/88	TCH Ortho	Recurrent lump on foot	4 weeks post node removal to R foot. 1 month ago a physical therapist noted recurrence. He now refuses wear shoes while at school because of discomfort. Also limping. Definite nodularity is noted in it subcutaneous tissue. Not tender to palpation. ...to totally treat this properly, a relatively wide resection to be necessary. This will likely require skin coverage in the form of a graft or free tissue transfer. Rx: Refer to a plastic surgeon.
9/16/88	Albin (Plastics)	Granuloma annulare	Referred for full thickness excision. Evaluated in clinic. Surgery scheduled.
9/23/88	UM Derm (Wesson)	Letter to Dr. Chang (ortho)	"Lesions on R foot and R great toe represent granuloma annulare. I advise no further therapy at this time. The lesion on R foot represents a dermoid/dermatoma which is the recurring reaction after secondary to a old folliculitis. No therapy needs to be done for this lesion either."
12/10/88	Langston United ER	Cosmeticon	"Mother of child reports that every year of this time her son gets pink eye in both eyes. (Mother says he allergic to all antibiotics except Ceclor and Neosporin ophthalmic). NOTE: No allergies have ever been documented. UH Path eye. Rx: Neosporin ophthalmic drops.
12/17/88	Langston United ER	Reaction to erythromycin	Was placed on erythromycin eye drops incidentally by a local physician. Eyes became more red, after also clearing with Neosporin. Also, recently had cholelithiasis. NO EYE OR SKIN EXAM IS DOCUMENTED O THE GREAT. Dx: Erythromycin intolerance. Chicken pox. Rx: Stop erythromycin eye drops. Treated dx with codaine for chest and mouth pain. Neosporin ophthalmic ointment, see Dr Kandell next week. (No visit to Dr. Kandell documented before 1990).
1/16/89	TCH Neurology (Hendry)	Occipital nodule	SURGERY-Painful lump excised from occiput (back of skull). Path Dx: lump node with soft tissue no specific cellular hyperplasia.
2/18/89	Langston United ER	Bicycle accident	TRAUMA-Fall of bike. Lost consciousness for 30 seconds. Hit R forehead. Mother says has been a bit bit droopy, but is improving in orientation. Physical exam: Normal except for milk bruising on forehead. D Mild concussion. Facial bruise and abrasions. Rx: Red test and head injury checks.

DATE	PROVIDER	COMPLAINT	COMMENTS
4/18/89	Pashley (ENT)	Chronic ear infections	According to mother, there was an attempt at removal of wax and/or tubes by use of a water pik. 7 audiogram was performed in Langston which seemed to reveal a conductive hearing loss. Mother can remember the name of the child's disease, but she thinks it is eosinophilic granuloma. There are multiple allergies documented to penicillin, erythromycin, and Keflex, but according to mother, child can take it dose Ceclor. He sneezes and sneezes breathes. On physical exam, he has hypertrophied tonsils and adenoids at retraction of the tympanic membranes. Needs tonsillectomy, adenoidectomy, and insertion of PE tubes.
4/24/89	TCH ENT (Pashley)	Recurrent otitis media	SURGERY-Recurrent OM, partial airway obstruction and tonsillitis. Rx: Adenoidectomy, tonsillectomy bilateral myringotomy with placement of PE tubes. Path Dx: No unusual viral and bacterial pathology.
5/26/89	Albin (Plastics)	Granuloma annulare	Mother says, "My Dad had some removed." Doctor says, "The mother has been told in the past that it will resolve spontaneously. Rx: Scheduled excision and grafting."
6/1/89	Pashley (ENT)	Post-op w/	Tubes in place and dry. Follow up in 3-4 months with hearing test.
7/10/89	TCH Plastics (Albin)	Granuloma annulare	SURGERY-Excision of multiple granuloma lesions with closure. R wrist, R dorsum of foot, R great toe lesions, R leg, L leg (2 lesions), L hip, R foot and toe required skin grafting at sites. Path Dx: Granuloma annulare.
7/21/89	Albin (Plastics)	Post-op w/	Wounds doing well. Skin grafts have taken. Mother interested in wound care. She is to change wraps every other day. Keep 3 days from walking too much. Follow up in 2 weeks.
7/31/89	Albin (Plastics)	Post-op w/	Missed appointment.
9/15/89	Albin (Plastics)	Post-op w/	Has 2 small draining areas on the large skin grafts on foot and prethral area. Rx: Warm soaks, bed rest, elevate foot.
10/6/89	Albin (Plastics)	Granuloma annulare	"Mom's niece had surgery for the same thing - grandfather had it and lost 3 toes and part of R hand. Send down at University Hospital." Physical exam shows new lesions and repeatedly traumatized anterior sh grafts. Rx: Shin guard to protect grafts. "Spoke with pathologist Gail Wulstein who will send his slide one or two soft tissue pathology experts in the country since (per mother of child) two relatives on a mother's side had very aggressive granuloma annulare in past."
10/27/89	Albin (Plastics)	Granuloma annulare	New lumps on R prethral area. Grafts healing well.
11/15/89	TCH Plastics (Albin)	Granuloma annulare	SURGERY-Excision of 8 recurrent sites of granuloma. Path Dx: Granuloma annulare.
12/1/89	Albin (Plastics)	Granuloma annulare	No recurrent lesions. New lesions on L knee, L ankle. Pathology report from Barnes Hospital shows granuloma annulare. There is a minority of patients who have a generalized form of this. Rx: "At a moment there is nothing to do but to continue managing these lesions. Schedule surgery."
1/5/90	TCH Plastics (Albin)	Granuloma annulare	SURGERY-Excision of 3 sites on L ankle. Path Dx: Granuloma annulare.
	TCH ENT (Pashley)	Recurrent otitis media	SURGERY-Tympanostomy and placement of PE tubes. Tympanosclerosis noted.

The spectrum of MCA

- Excessive parental anxiety
- Illness exaggeration
- Illness fabrication
- Illness induction

What about Covert Video Surveillance?

- Irrefutable evidence is nice but...
- Only addresses the smallest part of the problem
- Sets a standard to which no other aspect of child abuse investigation is held

2. Stopping it

- Similarities with other abuse treatment
- Differences – getting the doctors to agree
 - Recognizing that the doctor/patient treatment contract is broken and needs to be renegotiated

The informing session

- After the doctors agree
- Meet with the family to give the good news
- Be ready for a wide range of responses

Use of the Child Protection Team

- If you ain't got one, get one
- Educate the team
- The more people you have on board the easier it is to renegotiate the contract
- Be ready to "report"

Reporting Medical Child Abuse

- Most jurisdictions will be way behind you in awareness, still wanting to use "MSBP" and wanting to get an unnecessary psychological examination of the mother.

3. Providing for ongoing safety

- As with any form of child abuse, use the minimum intervention necessary to guarantee safety
- Examples:
 - Education, Persuasion, Enlightened choice

4. Repairing the damage

- It is preferable to treat both the physical and psychological effects simultaneously
- Treating the physical damage
 - Stop the unnecessary medical care
 - Start with the most lethal medical treatment
- Treating the psychological damage

Spectrum of Treatments, least to most intrusive

- Counseling in office setting
- Refer parent for therapy/medication
- Family counseling
- Involve outside agencies to monitor care
- Partial hospital program
- Inpatient trial of separation from parents
- Report to child protective services
- Remove child from parent
- Criminal prosecution/incarceration

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and
Questions**

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