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<th>Viewing Time</th>
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<td>The program will take up to one hour to complete.</td>
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<th>Target Audience</th>
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<td>This program is designed for primary care physicians.</td>
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<td>Other health care professionals working with patients and their families may also find this program of interest.</td>
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<th>Faculty Disclosure</th>
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<td>It is the policy of Children’s Hospitals and Clinics of Minnesota to ensure balance, independence, objectivity, and scientific rigor in all its educational programs. Our faculty have been asked to disclose to our program audience any real or apparent conflicts of interest related to the content of their presentation. They have also been requested to let you know when any product mentioned in their presentation is not labeled for the use under discussion or is still under investigation.</td>
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<td>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.</td>
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| **Thomas Roesler, MD**  
Associate Professor of Child and Family Psychiatry, Brown Medical School; Director, Hasbro Partial Hospital Program, Providence, Rhode Island |

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<td><em>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.</em></td>
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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

Disclaimer

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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

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%
SYSTEMS INVOLVED IN CASES OF MEDICAL CHILD ABUSE

Evolution of the concept of child maltreatment

Evolution of the concept of child maltreatment

Evolution of the concept of child maltreatment

Evolution of the concept of child maltreatment

Evolution of the concept of child maltreatment
Neglect

Battered Child Syndrome (1962)

Physical Abuse (1972)

Abusive Head Trauma (1999)

Uncommon Manifestations of BCS (1975)

Physical Abuse


Neglect

Battered Child Syndrome (BCS) (1962)

Sexual Abuse (1971)

Uncommon Manifestations of BCS (1975)

Physical Abuse


Neglect

Battered Child Syndrome (BCS) (1962)

Sexual Abuse (1971)

Munchausen Syndrome by Proxy (1977)

Medical Child Abuse (1992)


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.


--Human bites

--Non-accidental poisoning

--Withholding water causing hypernatremia
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.

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 wheelchair 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.

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.”

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
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- Involve outside agencies to monitor care
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Comments and Questions

Thanks for viewing this presentation!

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