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Authors

Vega, Sarah
Nienow, Shalon M
Huang, Maria Z
et al.

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Medical Child Welfare Task Force: A Multidisciplinary Approach to Identifying Medical Child Abuse

Sarah Vega, MD[b,c], Shalon M.Nienow, MD[b,c], Maria Z. Huang, MD[a,c], Laurie Bernard Stover, MD[a,c]

Affiliations: [a] Pediatric Hospital Medicine Division, Rady Children's Hospital, San Diego, CA 92123; [b] Child Abuse Pediatrics Division, Rady Children's Hospital, San Diego, CA 92123; [c] Department of Pediatrics, University of California, San Diego, CA 92103

Address correspondence to:

Laurie Bernard Stover, MD, 3020 Children's Way, Mail Code 5064, San Diego, CA, 92123.

(858) 966-5841

lbernard@rchsd.org

Short Title: Identifying Medical Child Abuse in a Children's Hospital

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Abbreviations:

MCA: Medical Child Abuse
CMO: Chief Medical Officer
EMR: Electronic Medical Record
CAP: Child Abuse Pediatrician
CPS: Child Protective Services

Article Summary This article describes the successful implementation of a multidisciplinary team designed to improve the institutional approach to Medical Child Abuse.

Contributors' Statement Page

Drs Bernard-Stover, Nienow, and Huang conceptualized and operationalized the Medical Child Welfare Task Force, collected data on its performance, and reviewed and revised the manuscript.

Dr. Vega drafted the initial manuscript and critically reviewed and revised the manuscript.

All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

Abstract

Medical Child Abuse is a complex form of maltreatment with powerful and long-lasting impacts on the overall health of affected children. The complexity of this condition renders it challenging for clinicians to recognize its presence and intervene appropriately. The failure of medical systems to identify and de-escalate care in this form of maltreatment can result in grievous patient harm. While the medical literature provides limited guidance on how to address these multifaceted cases, several studies advocate for a multidisciplinary approach. Following a severe and chronic case of Medical Child Abuse at our institution, deficits in response became clear within our own hospital system. In reaction to these gaps, the Medical Child Welfare Task Force was developed in order to formalize education and multidisciplinary collaboration around Medical Child Abuse. The support of institutional leadership and the involvement of multiple medical disciplines that commonly encounter these patients was vital to the implementation and long-term success of the endeavor. To facilitate case identification, education was provided to clinicians in a variety of forums. Moreover, we leveraged the electronic medical record to streamline our ability to monitor cases of Medical Child Abuse and communicate the concerns and plan of care to other providers both within and outside of our health system. A post-implementation survey determined that the establishment of a multidisciplinary team increased provider comfort and skill in identifying and managing cases of suspected Medical Child Abuse.

Introduction

Medical Child Abuse (MCA) is a complex form of maltreatment in which caregivers exaggerate, fabricate, or induce a child's symptoms resulting in unnecessary and potentially harmful medical care.[1] Other potential terms for this type of child maltreatment include Munchausen syndrome by proxy, factitious disorder by proxy, factitious disorder imposed on another, caregiver fabricated illness and pediatric condition falsification. Although definitional inconsistency and poor recognition of this condition prohibit an accurate awareness of its prevalence, there is a strong consensus that MCA causes serious harm and is associated with significant morbidity and mortality.[1-3]

Few conditions are as difficult to diagnose and manage as MCA. Often, the signs and symptoms reported by a caregiver are not present on exam nor corroborated by objective studies. When induced or fabricated, symptoms may fluctuate and be inconsistent with normal physiology.[4] In pediatrics, clinicians rely on a caregiver's report of the patient's symptoms; for MCA to be uncovered, providers must first acknowledge that not all historians are accurate or truthful. Approximately 30% of children suffering from MCA have been reported to possess true underlying medical diagnoses which leads to difficulty in distinguishing legitimate medical concerns from those that are fabricated.[3] Older children, having been told repeatedly that they are ill, may come to believe this, and engage in illness fabrication behaviors.[5] All of these

components lead well-intentioned clinicians to provide erroneous diagnoses and unnecessary interventions.

Failure of the medical system to appropriately recognize, intervene, and de-escalate care in this form of maltreatment can lead to significant patient harm**.** While the medical literature provides limited guidance on how to address these complex cases, several studies including a clinical report published by the American Academy of Pediatrics support a multidisciplinary approach.[4,6-7] In this way, relevant disciplines work together to gather information, formulate a concerted response, and maintain the health and safety of the child. Other benefits highlighted by these studies include early recognition of signs and symptoms, direct observation of the patient and their healthcare utilization, and the establishment of interdisciplinary networks within hospitals.[7] These findings suggest that a collaborative and multi-faceted approach is important in mitigating the detrimental impact of MCA.

Following a severe and long-standing case of MCA within our healthcare system, our institution recognized the need for a multidisciplinary approach moving forward. This sentinel case revealed that clinicians had difficulty recognizing MCA and those who were concerned for MCA were unsure how to report their concerns to colleagues or how to document them in the medical record. Those who recognized MCA also struggled with how to manage and de-escalate care. In response to these gaps at our institution, the Medical Child Welfare Task Force (hereinafter “Task Force”) was conceived. The overarching goal of this multidisciplinary effort was to assist with the evaluation of cases concerning for MCA and to support medical decision making and de-escalation of care when necessary. This case study describes the creation of the Task Force to formalize education and multidisciplinary collaboration around MCA.

Program Objectives

- To review and monitor healthcare utilization for children with concerns for MCA at a pediatric tertiary health care integrated delivery network
- To empower and provide support to clinicians in the evaluation and management of children with overutilization and/or suspected MCA
- To enhance communication among healthcare providers so as to provide consistent, appropriate medical care and de-escalation of unnecessary care to children with MCA

Methods and Process

Initial Landscape and Stakeholders

A sentinel case of a child with MCA at our large, free-standing children's hospital prompted a root cause analysis which uncovered the need to improve our approach to such cases. This case presented a unique challenge as the patient had a long-standing history at our institution and had developed close relationships with the medical team. As such, when the child was diagnosed with MCA, several providers expressed guilt and anger over the delay in diagnosis despite previous red flags. They struggled with where to place culpability.

An external Child Abuse Pediatrician (CAP) with national recognition for expertise in MCA was consulted, with the goal of reviewing our practice and defining opportunities for improvement. After a comprehensive case review, the following deficits were apparent: (1) inadequate recognition of MCA and how to manage it once identified, leading to reticence to diagnose; (2) insufficient collaboration and communication between outpatient medical team

members regarding medically complex patients; and (3) absence of an effective, efficient way to communicate and track cases in the electronic medical record (EMR).

Once we were equipped with this information, key stakeholders were engaged in the process including our institution's General Counsel, the Chief Medical Officer (CMO), and representatives from Child Abuse Pediatrics, Hospital Medicine, Palliative Medicine, Gastroenterology, Social Work, and Bioethics. Due to the complexity of MCA which often involves several medical disciplines and subspecialties, along with our review of the currently available literature, a multidisciplinary Task Force was considered the optimal means by which to comprehensively address improvements needed in our current practice. All original committee members had a specific interest in MCA and the ability to consistently attend meetings. From the committee's induction, we chose to include members of the Gastroenterology team as our institutional experience and the medical literature supported that most children diagnosed with MCA encounter this subspecialty during the course of their medical care.[7] We invited other subspecialties who commonly encounter children with MCA, such as Neurology, Surgery, and Metabolic on an ad hoc basis. Representatives from Hospital Medicine and Child Abuse Pediatrics provided co-leadership for the taskforce. We hypothesized that this collaborative relationship comprised of expertise in child maltreatment and complex care pediatrics would foster the Task Force's success.

Task Force Programmatic Development

The Task Force's primary objective is to identify and perform comprehensive reviews of suspected cases of MCA at our institution and to assist with healthcare de-escalation strategies and/or protective interventions when appropriate. Our institution is a pediatric tertiary healthcare

integrated delivery network comprised of specialty and primary care practices, inpatient and emergency departments, a level I pediatric trauma center and a child advocacy center.

To facilitate case identification, education regarding MCA was provided to clinicians at committee meetings, educational meetings, and via didactics directed at commonly affected services. A component of this education included recognition of indicators of potential MCA as detailed in Table 1[1,4,6]. The Task Force then leveraged the EMR to create a Dashboard intended to aid in monitoring healthcare utilization for patients identified with or at risk of MCA. The Dashboard resides within the EMR. Only Task Force members are granted access and the information contained within the Dashboard is not visible in the patient portal. Within the Dashboard, characteristics of each case are documented to include demographic information (patient's medical record number, name, date of birth, age, and sex); case referral date, last review date and status; the number of healthcare visits, procedures, subspecialists involved, and patient portal messages; and a free text area for clinical and social updates. Once cases of concern are identified, they are manually added to the patient list. The dashboard domains then auto populate. Additionally, the Dashboard was set up to automatically notify the Task Force of all case-related inpatient admissions.

We subsequently designed a process intended to guide clinicians with the next steps following case identification. Any provider with a concern for healthcare overutilization or MCA may consult with the on-call CAP to discuss the case and determine whether it should be reviewed by the Task Force. Initially, only inpatient cases were considered for review. Outpatient cases were subsequently added, largely dependent on the availability of Task Force members for medical record review. If selected for assessment by the Task Force, the case is discussed at the following

meeting. If not selected, evaluation follows the standard processes involved in a Child Abuse consultation.

Task Force meetings are 60 to 90 minutes long and occur every 1 to 2 months. All standing members attend each meeting as availability allows. During each meeting, the Task Force discusses new case referrals and active cases on the EMR Dashboard. For new cases, the team discusses and arrives at agreement on any necessary interventions. If the team decides that intervention is needed, Task Force members assist with arranging a second meeting to include all involved clinicians. During this meeting, the Task Force details the concerns, solicits input from the child's medical team and presents recommendations for intervention. Possible actions include but are not limited to adding the child to the EMR Dashboard for regular review of healthcare utilization, placing an alert in the EMR with a regularly updated "Emergency Care Plan", adding the diagnosis of "risk of harm due to overutilization of healthcare" to the child's problem list (marked "sensitive" in the EMR), consulting the CAP team, referral to Child Protective Services (CPS), guidance on EMR documentation and contacting providers at other medical centers where the child received care. After the group's discussion, the Task Force continues to act as a resource for involved providers.

Due to the recent advent of the 21st Century Cures Act, which mandates for increased patient access to medical records, providers are understandably hesitant to document their concern for MCA in the EMR as this may pose a significant risk to the child's health and safety. For this reason, providers often omit this information which causes it to be inaccessible to not only the family but also the child's other healthcare providers. The Task Force mitigates this predicament by advising providers to document their concerns for MCA in a discrete clinical note marked

"sensitive," which ensures that it will not be released through the patient portal or by the medical record department. Legislation supports this practice as it prevents harm to the patient while allowing caregivers access to other vital clinical information.[8]

Success of the Task Force has been measured by tracking the number of cases for whom intervention resulted in de-escalation of healthcare care and/or recovery of the patient as well as provider surveys evaluating the Task Force. Cases in which an MCA diagnosis is made often have CPS involvement. This is helpful in the initial stages of diagnosis confirmation where a removal of the parent from the bedside is necessary and subsequently results in a resolution of symptoms. CPS can also mandate therapeutic services for caregivers which is essential for treating the underling mental health issues that prompt the MCA behavior. Without such services caregivers that perpetuate MCA are unlikely to ever be able to safely maintain custody of children.

Outcomes

Cases

Since its initiation in 2019 to 2022, the Task Force has reviewed 44 cases. Although all members of the task force have the responsibility of reviewing cases, as per hospital procedure, any official diagnosis and/or documentation of abuse is made by the Child Abuse Pediatrician assigned. Overutilization is determined by the number of My Chart messages, subspecialties involved in the care of the patient, and number/frequency of patient visits. Medical Child Abuse is only diagnosed when harm is occurring to the patient by way of unnecessary and/or potentially

dangerous medical procedures being requested/performed. Of the current patients on the dashboard, 15 have been diagnosed with MCA (diagnosis rate of 34%) and 14 with overutilization. Six were evaluated and ruled out for MCA/overutilization and 9 are actively being monitored without a definitive diagnosis but are considered at-risk. Cases are closed if intervention has resolved the MCA and/or overutilization, if these diagnoses are ruled out, or if the child permanently leaves the health system.

Of the 44 cases, 22 received a CPS referral. For 7 cases, CPS intervened by removing the child from their caregiver's custody resulting in resolution of their reported symptoms and overall healthcare utilization. For the remaining 15 cases, CPS performed an investigation and assisted with monitoring of safety within the child's current home environment while the medical team instituted de-escalation. Six cases did not require a CPS referral as healthcare de-escalation was successfully instituted by the medical team without intervention.

Task Force Performance

In 2021, providers with high risk for encountering patients with MCA at our institution were surveyed (n = 136) to determine institutional satisfaction regarding collaboration with the Task Force. Respondents included clinicians across 10 medical subspecialties and the response rate was 72%. Survey participants were asked to evaluate the following areas: knowledge and confidence regarding the diagnosis and treatment of MCA before and after Task Force inception, awareness of the Task Force and indications for referral, whether they had referred to the Task Force, perceived benefit to provider and patients, and overall satisfaction with their experience. The results of this survey are detailed in Table 2. Eighty-seven percent of respondents reported

that they would benefit from more education and assistance surrounding recognition and management of MCA. Of those who interacted with the Task Force, 63% reported that their ability to recognize MCA improved and 78% reported that their ability to manage MCA improved. The overwhelming majority of respondents (97%) reported that the involvement of the Task Force was beneficial to very beneficial for them personally and their patients.

Lessons Learned

Through the Task Force's experiences within a large children's healthcare network, many lessons were learned. First, early and ongoing institutional support, including the highest levels of hospital leadership and legal counsel, has been integral to the Task Force's long-term success. It has been particularly critical during hospitalizations in which caregivers escalate complaints regarding requested studies and consultations that are not medically indicated. Executive leadership support has also been helpful in encouraging medical staff to prioritize Task Force meetings when invited. These endorsements affirmed the hospital's commitment to improving recognition and treatment of MCA with the goal of enhancing a child's health and overall well-being. This collaborative relationship additionally fostered an understanding of the institutional culture surrounding the diagnosis and management of MCA and informed the eventual composition of the Task Force.

Second, leveraging EMR tools facilitated the Task Force's ability to efficiently monitor cases of suspected or confirmed MCA. The Dashboard granted our team a central, secure location to document and review patient information and case updates. The formation of templated EMR messages, addition of "risk of harm due to overutilization of healthcare" to the problem list, and

a regularly updated “Emergency Care Plan” provided a standardized and efficient way of communicating MCA concerns and recommended interventions. Allocation of information technology resources was critical to the success of the committee. As availability of resources varies across institutions, this may represent a barrier to implementation elsewhere.

Furthermore, we learned the importance of promoting open communication among all healthcare providers engaged in a child’s care, both within and outside of our institution’s network. We learned that when providers participate in a multi-disciplinary meeting and listen to the differing experiences of their colleagues, they are often able to assess the big picture more accurately and become aware of details that may be omitted by caregivers. Providers can also be more frank during verbal conversations than in their written documentation. These open discussions lead to increased agreement among providers to a care plan, improved adherence to care plans, more consistent messaging to caregivers, and decreased dissension between providers. Through these efforts, the Task Force successfully supported a diverse group of medical providers in delivering evidence-based care to children and creating boundaries with families regarding medically unnecessary healthcare requests. We discovered a subset of providers who were skeptical of the approach to MCA and therefore resistant to the Task Force’s involvement. In these cases, communication by way of multidisciplinary meetings and one-on-one discussions proved vital in providing awareness regarding MCA concerns, explaining the rationale for the diagnosis and management, and discussing possible outcomes in the absence of intervention.

We also recognized that while intercession at any stage of MCA can benefit the child, early identification simplifies intervention and mitigates harm. Once the child has been subject to

several years of healthcare overutilization, de-escalation of care and rehabilitation becomes complicated by the number of medical interventions completed and the child's engagement in illness fabrication behaviors. Nevertheless, success can be achieved in long-standing cases of MCA when all providers are engaged and adhere to a consistent treatment plan. To this end, in an ongoing effort to prevent late case identification and encourage a joint response, continuing education has been provided at relevant meetings and conferences.

Lastly, we faced challenges surrounding the time providers need to perform comprehensive reviews of cases. Cases of MCA are generally complex and require a thorough review of the medical records, conversations with multiple providers and community partners, and detailed documentation. Often cases progress to legal intervention, therefore adding the additional time cost of medical expert testimony. The time commitment required to perform these tasks is often weeks to months and can occasionally span years. The lack of dedicated funding and/or protected time prevents the Task Force from expanding its comprehensive evaluations to a wider population of patients with potential MCA. The Task Force is limited in their scope to predominantly hospitalized patients. However, we have managed well without funding due to the passion and dedicated interest of our committee members who graciously offer their protected time to the Task Force's efforts. The authors argue that this uniquely vulnerable subset of patients requires a time commitment beyond the typical medically complex or abused/neglected patient. Ideally, we believe a provider should be funded on an hourly basis to perform a comprehensive chart review and draft a detailed report for the EMR, Task Force and CPS. Institutional budgetary constraints prevent us from obtaining approval for this model at our

institution. Potential sources of funding would differ by locale but may include proposed medical directorships, stipends for consultations and philanthropic support.

Conclusions

The evaluation and management of MCA is complex and requires ongoing vigilance and advocacy by the child's entire medical team. The establishment of a multidisciplinary team at our institution has advanced our approach to these cases by increasing provider comfort and skill in identifying and managing cases of suspected MCA and leveraging the power of the EMR to enhance multidisciplinary care and facilitate rehabilitation for victims of MCA. We hope that our experiences and discoveries prompt other pediatric institutions to undertake similar efforts and improve upon them.

Our future directions include expanding our educational endeavors to other clinicians and community partners as well as extending our capacity to evaluate outpatient cases by the recruitment of additional Task Force members. We aspire to develop a screening tool for MCA into the EMR that would facilitate case identification.

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Tables

Table 1 Indicators Suggestive of Medical Child Abuse

- History provided by caregiver does not match objective findings
- Information provided by caregiver does not match recorded medical documentation
- Patient has sought or received care at multiple medical institutions
- Caregiver insists on unnecessary and often invasive medical interventions
- Sibling(s) with unusual or unexplained illness or death
- Signs or symptoms reported by caregiver resolve when caregiver's access to child is restricted
- Signs and symptoms are only "seen" when in the care of a specific individual
- Caregiver does not express relief in response to being told that their child is improving or does not possess a particular medical condition
- Public solicitation of benefits, sympathy, or donations because of child's rare illness

Table 2. Results of Survey Distributed to Determine Institutional Satisfaction in Collaborating with the Task Force (n = 136)

Survey Prompt	Survey Choices	Number of respondents (%)
Please rank your level of knowledge regarding MCA.	Very Knowledgeable Knowledgeable Moderately Knowledgeable Slightly Knowledgeable Not Knowledgeable	4 (2.9) 44 (32.4)) 61 (44.9) 24 (17.6) 3 (2.2)
Please rank how confident you are in recognizing MCA in your patients.	Very Confident Confident Moderately Confident Slightly Confident Not Confident	5 (3.7) 26 (19.3) 62 (45.9) 35 (25.9) 7 (5.2)
Please rank how confident you are managing MCA in your patients.	Very Confident Confident Moderately Confident Slightly Confident Not Confident	2 (1.5) 8 (5.9) 28 (20.7) 44 (32.6) 53 (39.3)
Do you feel you would benefit from more education and assistance around the recognition and management of MCA?	Yes No Not sure	117 (86.7) 3 (2.2) 15 (11.1)
Have you had any extra training (beyond residency) specific to the diagnosis and management of MCA?	Yes No	27 (20.1) 107 (79.9)
Are you aware of the Task Force at our institution?	Yes No	57 (42.2) 78 (57.8)
Do you know what the indications are for a Task Force consult are?	Yes No	31 (23.0) 104 (77.0)
Have you ever referred a patient to the Task Force?	Yes No	28 (20.7) 107 (79.3)
After your interactions with the Task Force, did your ability to recognize MCA improve?	Improved Significantly Improved No change Decreased recognition/confused me Made me less able to recognize	5 (18.5) 12 (44.4) 10 (37.0) 0 (0) 0 (0)
After your interactions with the Task Force, did your ability to manage MCA change?	Improved Significantly Improved No change Decreased management/confused me Made me less able to manage	5 (18.5) 16 (59.3) 5 (18.5) 1 (3.7) 0 (0)
When considering your consultations with the Task Force, how beneficial do you this this committee has been to your patients?	Very beneficial Beneficial Moderately beneficial Slightly beneficial Not beneficial	22 (78.6) 5 (17.9) 1 (3.6) 0 (0) 0 (0)
Please rank your overall satisfaction with the service provided to you by the Task Force.	Very satisfied Satisfied Moderately Satisfied	20 (71.4) 7 (25.0) 1 (3.6)

	Slightly satisfied Not satisfied	0 (0) 0 (0)

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