Episode: *Ethics Talk: How to Avoid Hyper-medicalization and Iatrogenic Child Abuse*

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[mellow theme music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff.

Perhaps the most well-known type of medical child abuse is the result of factitious disorder imposed on another, or as it's previously and more commonly known, Munchausen syndrome by proxy. When a caregiver such as a parent misleads clinicians about the health state of a child, that child will be at risk for harms incurred by medically unnecessary interventions. But even in cases less dramatic than Munchausen cases, medicalization routinized in the norms of clinical practice places children at risk not only of iatrogenic harm, but of medical child abuse. Just having a diagnosis can draw hyperfocus or exaggerate need for intervention where there might not be any, and children with clinically complex needs are particularly at risk of experiencing harms of health care overuse and hypervigilance that undermine quality of life. Just as clinicians need to carefully meet their ethical and legal obligations as mandatory reporters of suspected child abuse, they should also cultivate a healthy index of suspicion about when overmedicalization could place children at risk of iatrogenic harms.

Joining us to discuss medical child abuse, overlooked sites of pediatric neglect, and how clinicians can best carry out their responsibilities as mandatory reporters are Dr Andrea Asnes, Professor of Pediatrics, Director of Resident and Fellow Wellbeing, and Director of the Yale Programs for Safety, Advocacy, and Healing; and Dr Sundes Kazmir, attending physician and Assistant Professor of Pediatrics at Yale University School of Medicine. Dr Asnes, Dr Kazmir, thank you so much for being on the podcast with me. [music fades out]

DR ANDREA ASNES: Thanks for having us.

DR SUNDES KAZMIR: Thank you, Tim.

HOFF: So, Dr Asnes, you problematize overmedicalization and distinguish medical child abuse from other kinds of child abuse. So, would you please help our listeners consider how clinicians can exacerbate abuse and neglect that they might see come into the clinics?

ASNES: Yeah, I'd be happy to. I think most forms of aberrant parental behavior, in my opinion, follow along a spectrum, and even non-abusive parents may see their children through a medicalizing lens. In other words, if a child is distressed, they may quickly think, "Oh, are they sick? Are they in pain?" And that way of thinking about children may be completely within the spectrum of normal parenting, although it may differ from another parent who might think of an emotional cause for a child's concern rather than a medical one. When parents present their children to medical care with a concern for sickness or illness when there's not actual sickness or illness, there is a potential in that frame of overmedicalization for medical providers to respond and treat children who are not sick as sick, thereby kind of perpetuating an inappropriate frame for understanding their children's communication.

HOFF: So, how can clinicians avoid taking that tendency toward medicalization that might start with a concerned parent and running with it, leading to various forms of iatrogenic child abuse?

ASNES: Well, one thing I counsel providers who are brought children who are presented as perhaps sick when they may not be is to have a healthy curiosity and to respond to that sort of inner voice when they think they're being asked to see a child as sick, when that child is maybe not as sick as they are billed to be. In other words, to pay attention if a parent is repeatedly bringing a child with concerns that seem out of proportion to the way the child appears in terms of their health, to express curiosity about that, not to let it go, to ask, maybe to understand more from the parent, gather some more objective data. Like, for example, if a child, if a physician or another medical provider is being told that a child has persistent fevers, and there's no evidence that the child is otherwise unwell, maybe ask to see the child when they actually have a fever. This doesn't have to be confrontational. It's a matter of saying, "When I see your child, they look really well. You're telling me that there's a lot of sickness at home. It might be helpful for me to evaluate when he's actually sick. Could we arrange that?" It doesn't have to be a big showdown.

HOFF: Hmm. And since there might not be the continuity of care where one clinician is seeing these patients over and over again, how would the best course of action for documenting these concerns be so that you're not necessarily blaming parents or patients or leading to that dramatic showdown? What's the best way to flag that for other clinicians?

ASNES: It's an excellent question, and I think the best way to flag it is to express that same curiosity in the chart. In other words, "Mother or father presents child for this many times with the complaint of vomiting. Child is well on exam. I'm perplexed by the lack of correlation between what I'm seeing with the child and what I'm hearing." There's probably a more formal medical way of saying that, but to document the disconnect between what's being reported and what's being seen and curiosity about why that might be, and plans to assess when the child is actually sick. Or there can be other, more documentation of what's actually going on objectively.

KAZMIR: And I think with what Andy said, just really attributing the sources. So, is the symptom report from the parents? I think sometimes reading this documentation after the fact, it might just, the note might report a symptom, but it's unclear is that per parent report? Was that observed by the clinician? So, I think being very direct about the sources of information as well and what is objectively clinically known from the documentation versus by parent report or caregiver report.

HOFF: Hmm. Mmhmm.

ASNES: Right.

HOFF: Yeah, yeah. So, that leads to kind of another question, and this may also just boil down to expressing that same level of curiosity. But imagine a clinician is looking through a patient's chart for more information about whatever the patient is being brought in for. What are some ways to potentially see overmedicalization in process and sort of catch it before it gets too far? Are there things that clinicians should look out for that might be the start of overmedicalization?

ASNES: Well, overmedicalization is what happens when a child is interpreted to be sick and isn't, or a physician participates in escalation of care inappropriately. I think if that's happening, sometimes a clue is that there are diagnoses in the chart for which there's no obvious source. So, you read a list of problems that are associated with a child. They have asthma, they have allergies, they have this, they have that. But it's impossible to find where that came from other

than parental report. So, this is one of the barriers to recognition is that we don't start with doubt when we meet parents of children as pediatricians. We assume that parents are coming to us in good faith. And it's quite time consuming to go back through a chart to find out the actual source of that diagnosis. But that's often what first tips people off is that there are multiple diagnoses in the chart for which there isn't an obvious source other than parental report.

HOFF: So, this month's issue deals a lot with sites of pediatric neglect and abuse that happen outside of health care systems, where patients are brought in, children are brought in already having undergone abuse or neglect or trauma of some kind. How should clinicians and organizational leaders identify sites of pediatric neglect and abuse within health care systems? And what should they do to make sure that health care sites are places of healing?

KAZMIR: I think, thinking about your prior question too about maybe signs of overmedicalization or things that might alert a clinician, I think something that stands out to me about these cases is that they're often marked by very fragmented care. Sometimes there are multiple specialists involved, and I think I've seen that the more, sort of the more cooks there are in the kitchen, so to speak, the less communication there is directly between clinicians. So, that's something that I've thought about with these cases is more opportunities for multidisciplinary discussion, particularly when multiple different specialties are involved. Because I think sometimes how these can get perpetuated is a parent kind of reporting what the result is from a specialist or what was relayed by them, but there hasn't been a direct communication necessarily from the specialists involved in the care. I don't know if, Andy, you have anything to add or if you agree with that?

ASNES: I completely agree with that. I think that's very well said. And I think that there's a tension in the children's hospital or in the outpatient clinic between wanting to satisfy parents and provide them with care that they appreciate and they value, like, honestly, customer satisfaction or patient satisfaction—which is actually a metric to which many physicians are held accountable—and also, paying attention to what may not be medically necessary. So, I feel for those providers who are pressured to order tests and treatments by families that believe they want them, that the children should have them, but also have to protect from unnecessary care that could be, in fact, harmful. So, managing that, being able to recognize, "Am I doing this because the parent is asking me to, and I hope to please them and satisfy them, or is this really necessary?" That can often mean a frame shift for us when we're, again, usually approached in good faith and want to have our families leave satisfied customers. It's not unusual to feel that way, but it can be tested in this setting and can actually challenge the provision of safe care as a result.

HOFF: Mmhmm, mmhmm. Looping back to the idea of sort of fragmented care, what's the best way to potentially address that? Is it just a matter of care coordination with case managers, or is there something that individual clinicians can or should be doing to unify that fragmentation? What might be the best next steps there?

KAZMIR: I think there could be a couple of different strategies. I definitely love the kind of case management care coordinator suggestion because I think, you know, I think the other is reinforcing the primary care provider as the medical home of the child. I think some of the child abuse pediatricians who have written on this topic have also talked about reducing or even eliminating lateral referrals from specialist to specialist and reinforcing the idea of a medical home and really a clinician who is aware of and overseeing the medical care. Because I think when there's a breakdown in that is then when we can start to see some of this fragmentation and then a subsequent lack of communication between providers or care that may be even

among different institutions. But if things are kind of centered back through a primary medical home pediatrician or within an institution, a care coordinator, someone who has that overarching picture, I think that that could be a strategy to address that issue.

ASNES: Agree. And documentation. I think when there's a daunting electronic medical record that comes with every patient these days, and these patients can have really long ones because they've been multiply involved with many specialists, and that's fragmented, it's not that easy to put a note in the chart that really sticks out. But there are some tools within electronic medical records that can be used to call attention so that people can be alerted to, again, not necessarily an accusation, but really a concern. And I think taking advantage of that opportunity and learning how to use those tools, of course, putting it in the chart doesn't mean necessarily that everyone will see it. And I think also, there's an old-fashioned tool called the telephone that doesn't get used as often as it might. But if I'm looking at a chart and know that there's a diagnosis that would've come from a gastroenterologist, and there's a gastroenterologist involved, I think the threshold to pick up the phone and put in a call and say, "This child carries a diagnosis of X. I can't find any testing that explains to me where it came from. Can you help me understand?" That often is the first step that leads to an uncovering of what the actual problem is. And that actual direct conversation doesn't happen that often in our world but could happen more.

HOFF: As I'm sure that you both and most of our listeners know, an important part of clinicians' roles is as mandatory reporters of suspected abuse. As with many important tasks that clinicians are asked to do, however, training might not fully prepare them to execute their responsibilities with confidence. Since the consequences of reporting suspicion of abuse and neglect that is not actually abuse or neglect can be dire and are often inequitably experienced in families of color, how should clinicians be as sharp and sure as possible about helping identify neglect and abuse?

ASNES: Well, this is an opportunity for me to make a plug for our specialty of child abuse pediatrics, because this is one of our primary aims, is, I mean, obviously, we want to get it right. We don't want to miss cases that kids can be harmed. We're very devoted to avoiding unnecessary reports for children that don't need them to Child Protective Services. You said that very, very well. There is absolutely evidence for disparity in the setting of reporting. So, one way that your listeners may get help is to consult their local child abuse pediatrician who is charged with maintaining knowledge of the best available evidence to distinguish abuse from non-abuse or neglect from non-neglect and can help by applying that same evidence base continuously for patient after patient, which we believe will diminish disparity. Along those same lines, doing the same thing every time, irrespective of what the patient looks like or what their background is or where they live and what their zip code is, is also the clinician's best defense against disparity.

KAZMIR: Yeah, I agree. I was going to use the same opportunity to plug our team and our field. I think in our role as child abuse pediatricians, we work for hospitals, we work for medical schools. We are a distinct entity from Child Protective Services. As an agency, though, we also do work closely with them. And I think we've done a lot of work at our institution that calling our team is not the same as calling a report. And an appropriate kind of clinical question for our team can be, "Here is the clinical scenario. Does this meet a threshold for reporting? Or how do I better assess a concern?" Because I think to your point about bias and inequity, it's very well established both that families of color disproportionately face these investigations of these concerns, but conversely, also that in families with certain sort of socioeconomic attributes, abuse is likely to be missed. I think we really center that in our work: What is the objective

clinical picture? What are the symptoms? What are the findings? What is the history that's provided and can be a support to clinicians on the front line?

HOFF: And so, what should health professions students and trainees know about their roles in identifying potential cases of pediatric abuse and neglect?

KAZMIR: I think the main thing that I stress to trainees, whether it's pediatric residents or medical students who we lecture to that may end up not doing pediatrics at all but surgical subspecialties or other fields, is that everyone will encounter cases of child abuse and neglect. Andy may know the statistics better than I do, but I know one article mentioned that every clinician will see a case of medical child abuse at least once in their career. And probably there's a lot that goes missed or underdiagnosed that are more subtle clinical presentations. So, I think it's important to know that abuse and neglect exist, that it happens, that children will present to the hospital with these concerns, and that there are clinical teams such as ours and in our specialty and discipline who can help evaluate those considerations and determine next steps. [music returns]

HOFF: Dr Asnes and Dr Kazmir, thank you so much for your time on the podcast today. I really appreciate your insight and expertise.

ASNES: It was a pleasure.

KAZMIR: Thank you, Tim.o

HOFF: That's our episode for this month. Thanks to Drs Asnes and Kazmir for joining us. Music was by the Blue Dot Sessions. To read this month's full issue on child abuse and neglect for free, visit our site, JournalofEthics.org. Find us on Facebook and Twitter for all of our latest news and updates. And we'll be back next month with an episode on Medicalization in Public Health. Talk to you then.