Overmedicalization

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Presentation Objectives

1. Define
2. Review risks
3. Discuss spectrum of presentations
4. Multi-disciplinary management approach

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Overmedicalization (OM)

Delivery of unnecessary and potentially harmful medical care that results from the interactions and reciprocal relationships between:

- patient
- caregiver
- provider/health system

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Overmedicalization (OM)

- Characteristic behaviors of caregivers:
  - Over-focus on the child's medical conditions (or potential medical problems)
  - Tendency to live in a mindset of "crisis management"
  - Tendency to allow medical concerns/anxieties to obstruct good quality of life of the child, ignore child's strengths, downplay or limit child's functionality
- Fixated on a "Biomedical model"

Children with Medical Complexity (CMC)

Heterogeneous

High needs

Fragile

Functional limitations

High resource utilization

Often limited family support

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SYSTEMS INVOLVED IN CASES OF MEDICAL CHILD ABUSE

60
50
40
30
20
10
0

GASTROINTESTINAL DISEASE
PSYCHIATRIC DISORDER
NEUROLOGIC DISORDER
RESPIRATORY DISEASE
ALLERGY
INFECTIOUS DISEASE
DEVELOPMENTAL DISABILITY
ORTHOPEDIC PROBLEM
KIDNEY/URINARY TRACT DISEASE
CHILD ABUSE
MUSCULAR DISEASE
CARDIAC DISEASE
ENDOCRINE DISEASE
METABOLIC DISEASE
GENETIC DISEASE
HEMETOLOGIC DISORDER
IMMUNE DISORDER
OTHER DISEASE
SKIN DISEASE
RHEUMATOLOGIC DISEASE
AUTOIMMUNE DISEASE
ONCOLOGIC DISEASE

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CONDITION SUPPORTED
CONDITION PARTIALLY SUPPORTED
CONDITION NOT SUPPORTED

Factitious Disorder Imposed on Another

Diagnostic and Statistical Manual, fifth edition
Code 300.196 (International Classification of Diseases-10 code F68)

Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another; associated with identified deception

- The individual presents another individual (victim) to others as ill, impaired, or injured. The perpetrator, not the victim, receives the diagnosis
- The deceptive behavior is evident even in the absence of obvious external rewards
- The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder

Case Examples: Patient 1

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Patient 1

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Patient 1

- Process of acquiring the cumulative level of interventions took about 10 years
- De-medicalizing took less than 6 months
- Ultimately, no medical diagnoses of significance, but significant mental health consequences

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Patient 1 -- Reflections

- Age of child is critical – when they are young they cannot self-report
- Was crucial to "pay attention" to the inpatient team that flagged the discrepant reporting vs. observations
- Would not have uncovered the physical and emotional abuse history if child had not been removed from the home

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Potential Contributing Factors

Vague medical conditions

Parental anxiety

Vulnerable child syndrome

Psychogenic illness/somatization disorder of the child

Secondary gain

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Risks

- Inability of child to self-report
- Reliance on info from a single reporter (without substantiation by other family, community members)
- Over reliance on subjective information (without backup from tests, imaging)
- Minimizing role of stress and mental health (includes past trauma, life adversity, experiences)

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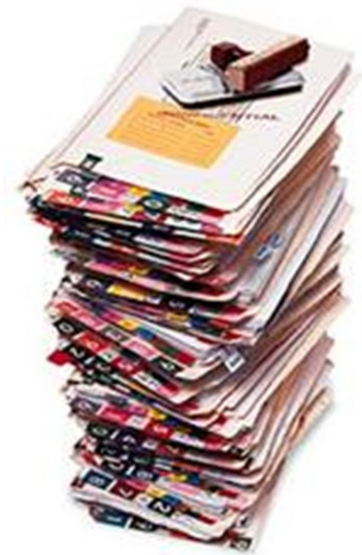
Warning Signs

- Persistent illness for which a cause can not be found
  - often involves repeated hospitalizations & evaluations
- Unusual symptoms that don't make clinical sense
- Fails interventions that "should" work
- Differential diagnosis of increasingly rare diseases
- Symptoms occur only in presence of a single caregiver



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Why is this so hard to diagnose?

- Hard to imagine
- We focus on the WHY harm occurred rather than WHAT
- Medical child abuse is a breakdown of the normal doctor-patient relationship!

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Why is this so hard to diagnose?

- Don’t want to miss a treatable disorder in a child
- Physicians are not accustomed to caregivers lying
- Dependence on verbal medical history provided by parents
- Physician may not want to admit to being stumped
- Increased medical sub-specialization may diffuse sense of responsibility
- Pursuing concerns is time consuming & overwhelming
- Doubts about whether outcomes of child protection process will help
- Cognitive bias
- “The road to h*** is paved with good intentions.”

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The medical system is the instrument of abuse.

"Without doctors
there would be no medical child abuse."

- Roesler & Jenny, 2009

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Proposed Management

- Move from “Overmedicalization” to “Appropriate Medicalization”
- Multidisciplinary effort – including outside providers, community
  - Provider agreement
  - Tight communication
- Careful charting and documentation
- De-escalation of care – “diagnostic pause”
- Centralizing care access (ideally through the PCP)
- Behavioral health intervention

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“Informing session”

Give the “good news”

State case clearly and simply

Be supportive, not accusatory

Focus on wellbeing of child, ability to change

Be prepared for rage, belligerence, denial

Plan with the family

Patient 2

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Patient 2

- Maternal anxiety, many parental somatic complaints
- Immediate concerns about discrepancies between mother's reports and child's observed functioning
- Enrolled in new school
- Hospital admission after maternal report of lethargy and extreme weakness, but physical exam normal
- Child Protection Team staffing

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Patient 2 – Management Plan

- Limiting additional specialty care
- Reducing current interventions
- All intervention goes through PCP
- Observing for improvement/compliance by parent
- Ongoing psychology therapy a “must”

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Patient 2

- Successful conversation with mother reflecting observed wellness of child in special school setting
  - Achieved several milestones
  - Able to verify/observe pattern of pain/dysfunction

Transitioned to regular school

Patient 2 -- Reflections

- Care plan requires ongoing work with all care teams to partner with parents to reduce medical interventions and encourage normal activities and school attendance.
- This is a very common scenario, and very difficult as providers to know when to "raise the flag"
- Team discussions VERY helpful
- Very low threshold to disclose to parents if reporting to county would be the only other good option; can always report if parent flees to other care or refuses to follow medical advice.
- Mental healthcare for parent re: anxiety is the way forward (we think!)

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THANK YOU

QUESTIONS?

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University of Colorado Anschutz Medical Campus

Children's Hospital

References

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