Fabricated or Induced Illness/Perplexing Presentations

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1. Definition

Fabricated or Induced Illness is a clinical situation where a child is, or is very likely to be harmed due to parents'/carers' behaviour and action, or lack of action such as not giving required medication but claiming to have done so. Such actions are carried out in order to convince doctors that the child's state of physical and/or mental health or neurodevelopment is impaired (or more impaired than is actually the case). It is a relatively rare but potentially lethal form of abuse.

Concerns will be raised for a small number of children when it is considered that the health or development of a child is likely to be significantly impaired or further impaired by the actions of a carer or carers having fabricated or induced illness. The presence of alerting signs where the actual state of the child's physical/mental health is not yet clear but there is no perceived risk of immediate serious harm to the child's physical health or life may be evidence of a 'Perplexing Presentation'.

Perplexing presentations indicate possible harm due to fabricated or induced illness which can only be resolved by establishing the actual state of health of the child. Not every perplexing presentation is an early warning sign of fabricated illness, but professionals need to be aware of the presence of discrepancies between reported signs and symptoms of illness and implausible descriptions of illnesses and the presentation of the child and independent observations of the child.

It is important that the focus is on the outcomes or impact on the child's health and development and not initially on attempts to diagnose the parent or carer.

The range of symptoms and body systems involved in the spectrum of fabricated or induced illness are extremely wide.

Investigation of Fabricated and Induced Illness and assessment of significant harm to a child falls under statutory and the Legal framework within the Safeguarding Together Guidance (2019) and the Safeguarding Act 2018.

2. Risks

There are four main ways of the carer fabricating or inducing illness in a child:

- Fabrication of signs and symptoms, including fabrication of past medical history;
- Fabrication of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluids;
- Exaggeration of symptoms/real problems. This may lead to unnecessary investigations, treatment and/or special equipment being provided;
- Induction of illness by a variety of means.

The above four methods are not mutually exclusive.

Harm to the child may be caused through unnecessary or invasive medical treatment, which may be harmful and possibly dangerous, based on symptoms that are falsely described or deliberately manufactured by the carer, and lack independent corroboration.

Concern may be raised at the possibility of a child suffering significant harm as a result of having illness fabricated or induced by their carer.

3. Indicators

- Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering; or
- Physical examination and results of medical investigations do not explain reported symptoms and signs; or
- There is an inexplicably poor response to prescribed medication and other treatment; or
- New symptoms are reported on resolution of previous ones; or

- Reported symptoms and found signs are not observed in the absence of the carer; or
- Over time the child is repeatedly presented with a range of symptoms to different professionals in a variety of settings; or
- The child's normal, daily life activities, such as attending school, are being curtailed beyond that which might be expected from any known medical disorder from which the child is known to suffer;
- Excessive use of any medical website or alternative opinions.

There may be a number of explanations for these circumstances and each requires careful consideration and review.

Concerns may also be raised by other professionals who are working with the child and/or parents/carers who may notice discrepancies between reported and observed medical conditions, such as the incidence of fits.

Professionals who have identified concerns about a child's health should discuss these with the child's GP or consultant paediatrician responsible for the child's care.

4. Protection and Action to be Taken

Where there is a suspicion of FII, practitioners should consider this guidance carefully when fulfilling their role in assessing and investigating their concerns effectively. In addition to the usual child protection procedures there are also additional issues to be considered in relation to children whereby fabricated or induced illness is suspected.

The Significant Harm Threshold will have been met and a referral should always be made and child protection enquiries commenced when a possible explanation for the signs and symptoms is that they have been fabricated or induced by the parent or carer and, as a consequence, the child's health or development is likely to be impaired.

In situations where the child may be at immediate risk of serious harm through an induced illness an immediate referral to the Initial Response Team, Children and Families Division should be made in accordance with the **Referrals Procedure**. See also **Section (46) Child Protection Enquiries Procedure**. Consent is not required to make this referral.

Following the referral, Children and Family Services should decide within one working day what response is necessary. Lead responsibility for action to safeguard and promote the child's welfare lies with the Children and Families Division.

It should be noted that Fabricated or Induced illness may also involve commission of a crime and therefore the Isle of Man Constabulary should be involved from the onset of the referral being made.

The Paediatric Consultant who is the lead health professional, will remain key throughout the enquiry and assessment period along with other health professionals who have responsibility for the child's health and decisions pertaining to it.

When there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm as a result of Fabricated or Induced Illness a Strategy Meeting should be convened. Experienced and skilled professionals who have knowledge of perplexing presentation/Fabricated and Induced Illness should meet together to agree the way forward.

The decision to commence a Section 46 Enquiry may be made at the point of referral and that will enable the IRT to make enquiries before the strategy meeting is convened. The strategy meeting will then determine based on the information shared if the threshold is met for significant harm and S 46 investigation. The Strategy discussion should, agree:

- How the enquiry should be carried out and what information is required about the child and family and how the information should be obtained and recorded;
- Who will carry out what actions, by when and for what purpose, in particular the planning of possible further paediatric assessment;
- Who will carry out what actions, by when and for what purpose, in particular the planning of possible further paediatric assessment;
- The needs of the parent or carer;
- Whether the child needs constant professional observation, and, if so whether the carer should be present;

- The designation of a medical clinician to oversee and co-ordinate the medical treatment of the child and control the number of specialists and hospital staff the child may be seeing;

- Who should be responsible for collating the medical records of all family members, including children who may have died or no longer live with the family.

- At what point we advise the parents or carer whilst we are gathering information as this information may place the child at additional risk.

Children who have had illness fabricated or induced require coordinated help from a range of agencies, including legal services, given that there may be a need to initiate Care Proceedings or the urgent removal of the child.

Joint working is essential, and all agencies and professionals should:

- Be alert to potential indicators of illness being fabricated or induced in a child;
- Be alert to the risk of harm which individual abusers may pose to children in whom illness is being fabricated or induced;
- Share and help to analyse information so that a NARRATES (S46) assessment can be completed taking account of the children's needs and circumstances. Including crucial information about the child's health and attendances with the GP and the hospital, with particular emphasis placed upon potential health diagnoses during the course of the assessment period;
- Contribute to whatever actions and services are required to safeguard and promote the child's welfare;
- Assist in providing relevant evidence in any criminal or civil proceedings.

Consultation with peers or colleagues in other agencies is an important part of the process of making sense of the underlying reasons for these signs and symptoms. The characteristics of fabricated or induced illness are that there is a lack of the usual corroboration of findings with signs or symptoms or, in circumstances of diagnosed illness, lack of the usual response to effective treatment. It is this puzzling discrepancy which alerts the medical staff to possible harm being caused to the child.

The signs and symptoms require careful medical evaluation for a range of possible diagnoses.

Normally, the doctor would tell the parent/s that s/he has not found the explanation for the signs and symptoms and record the parental response.

Where there are concerns about possible fabricated or induced illness, the signs and symptoms require careful medical evaluation for a range of possible diagnoses by a paediatrician.

Where, following a set of medical tests being completed, a reason cannot be found for the reported or observed signs and symptoms of illness, further specialist advice and tests may be required.

Normally the consultant paediatrician will tell the parent(s) that they do not have an explanation for the signs and symptoms.

Parents should be kept informed of further medical assessments/ investigations/tests required and of the findings but at no time should concerns about the reasons for the child's signs and symptoms be shared with parents if this information would jeopardise the child's safety and compromise the child protection process and/or any criminal investigation.

The outcome and findings of the NARRATES (S46) enquiries may determine various actions:

- At any time during the investigation or at the conclusion of the NARRATES there is medical or other evidence to indicate that a child's life is at risk or there is a likelihood of serious immediate harm, then statutory powers should be considered to secure the immediate safety of the child. If this is necessary then consideration should be given as to whether it is necessary to safeguard other children within the household. Urgent legal advice should be sought before any arrangements are progressed;
- Where concerns are substantiated and the child is considered to be at risk of continuing significant harm then consideration should be given to convening an Initial Child Protection Conference – see Child Protection Conference Procedure;
- Should the concerns be unsubstantiated and where medical tests reveal a medical condition which explains the child's signs and symptoms then child protection action will not be necessary.

5. Issues

Whilst cases of fabricated or induced illness are relatively rare, the term encompasses a spectrum of behaviour which ranges from a genuine belief that the child is ill through to deliberately inducing symptoms by administering drugs

or other substances. At the extreme end it is fatal, or has life changing consequences for the child.

Contrary to normal professional relationships with parents, being challenged about suspicions from the start may scare off a parent thus making it more difficult to gain evidence. There may also be an unintended consequence in increasing the harmful behaviour in an attempt to be convincing.

Parents who harm their children this way may appear to be plausible, convincing and have developed a friendly relationship with practitioners before suspicions arise. They may also demonstrate a seemingly advanced and sophisticated medical knowledge which can make them difficult to challenge. Practitioners should demonstrate professional curiosity and challenge in an appropriate way and with coordination between the agencies.

Further Information

Safeguarding Children in Whom Illness is Fabricated or Induced (supplementary guidance to Working Together to Safeguard Children), HM Government (UK)

Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in Children Guidance, Royal College of Paediatricians and Child Health (UK) 2021

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For debate: Forty years of fabricated or induced illness (FII): where next for paediatricians? Paper 2: Management of perplexing presentations including FII

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INTRODUCTION

Perplexing medical presentations encompass many situations encountered by paediatricians, where a child is reported to have symptoms or disabilities that impact significantly on their everyday functioning, and yet thorough medical evaluation has not revealed an adequate and realistic medical explanation. Unlike in other medically unexplained symptoms (MUS), the parent(s) are reluctant to support a rehabilitative approach to the child and insist on continued investigations. The clinicians dealing with the child are, in addition, alert to the possibility that there may be an unusual and potentially harmful parent-child interaction that is causing or perpetuating the presentation.[1] If any of the professionals involved with the child becomes concerned that the child may be suffering (or at risk of) significant harm, and if that concern cannot be quickly and easily resolved, then under current safeguarding procedures a referral should be made to Children's Social Care. These will be managed under existing fabricated or induced illness (FII) guidelines and procedures. However, paediatricians recognise that there are many cases just below that threshold, where safeguarding does not provide a suitable framework for managing the child, and where there is room for a rehabilitative approach to be attempted before considering a safeguarding approach. These are cases where harm to the child is predominantly iatrogenic and avoidable. There may be a potential for some of these cases to progress to 'True' FII over time but they are not at that stage. We propose that the essence of the management of perplexing presentations (PP)/FII is to recognise these PP at an early stage. We suggest that early intervention may reduce the potential for iatrogenic harm, help to restore normal functioning and may reduce the need for safeguarding interventions. We also propose that current procedures may need to be revised to take account of the wider spectrum of cases being recognised as PP/FII and move away from a formulaic procedural response to all suspected FII cases.

ALERTING SIGNS

Alerting signs are suggestive, not indicative of FII. Their presence should initially be regarded as PP. It is the discrepancy between reports and observations, or presentations and requests for which there is not an obvious explanation, which suggests the possibility of PP or FII. The alerting signs listed below are now generally accepted:

- Symptoms not observed independently in their reported context.
- Symptoms not corroborated by the child.
- Reported symptoms or observed signs not explained by child's known medical condition.
- Physical examination and results of investigations do not explain reported symptoms or signs.
- Inexplicably poor response to medication or procedures.
- Repeated reporting of new symptoms.
- Frequent presentations, seeking opinions from multiple doctors but often with paradoxically poor compliance with medical advice and multiple failed appointments.
- Carer(s) insistent on more, clinically unwarranted, investigations, referrals, continuation of or new treatments.
- Restriction of child's daily life and activities that is not justified by any known disorder, possibly including the use of wheelchairs and other aids.

If one alerting sign is encountered, it is important to look for others. With each one, the question of associated harm to the child needs to be ascertained.

The alerting signs and defining criteria for FII are evolving. Adult psychiatrists have been engaged in a similar debate around adults who present in this way. The International Classification of Disease, Eleventh Revision (ICD-11), anticipated in 2018, proposes criteria for 'bodily distress disorder' to replace somatoform disorders.[2 3] The new criteria avoid the potential pitfall of having to exclude physical disorders. We suggest that this approach could be adapted to reflect and redefine the dynamics of PP/FII, especially in cases of erroneous reporting.

Child illness: carer distress disorder (adapted from ICD-11 bodily distress disorder)

- Presence of child symptoms that are distressing to the carer.
- The carer's response to the symptoms appears excessive and disproportionate in relation to the nature, impact and progression of the child's symptoms or any confirmed physical illness in the child.
- Excessive carer attention is focused on these symptoms, manifested by repeated contact with doctors, including tests and treatments that may be unnecessary and harmful to the child.
- The carers' excessive responses to the child's symptoms are not alleviated by appropriate examination of the child, reassurance, tests or treatments where needed (however, tests and treatments should not usually be carried out purely to provide reassurance to the carer).
- The child's symptoms (whether reported by the carer or observed due to induced illness) are persistent or relapsing and remitting, and lead to significant functional impairment. There is a risk of harm caused either directly by the carer or indirectly by the doctor.
- The symptoms may be multiple and may vary over time. On the resolution of one symptom another may appear. Different children in the same family may be presented at different times.
- There may or may not be evidence of the carer causing or creating the child's illness through apparently deliberate action (if present this would always require statutory intervention).

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- The child may continue to exhibit emotional and physical consequences of the condition even after separation from the carer.

The intention is that these would be paediatric (or in some cases child psychiatric) criteria focused on the presented illness in the child, not a label to refer to the carer.

RESPONSE TO ALERTING SIGNS AND PERPLEXING PRESENTATIONS

Alerting signs that are accompanied by indicators of deception or possible induction of illness by the carer, or other significant harm, require a referral to children's social care according to safeguarding procedures.

Otherwise, at this point, the alerting signs can be more usefully considered as PP, rather than FII. It is the doctors or other professionals who are perplexed by the presentation. One doctor, usually a paediatrician, should take the lead as the responsible consultant for the child and agree this with any other doctors who are involved. The essence of the approach, which needs to be explained to the carers and child, is to establish as quickly as possible the child's *current* state of health and *all* involvement with health services. If possible, the child's history and current functioning needs to be ascertained from all carers, including the father who may not have been included. It is important to understand the primary carers' concerns, fears, hopes and explanations for the child's difficulties. It is also important to meet with the child, if possible on their own, to ascertain the child's beliefs, concerns and expectations about their state of health, and their mood. Information about siblings' state of health and how family life is affected by the child's difficulties is also important.

The child may be under the care of several doctors (including private consultations) and services. The provenance of all reported diagnoses should be verified and ideally all specialists should agree to regard the responsible consultant as the conduit for future communications. Parents are occasionally reluctant for this process of information gathering to take place. While the reasons for this need to be understood, it might be an additional alerting sign. General Medical Council (GMC) guidance in the UK is supportive of this approach.[4] A further important source of information about the child is the nursery/day care or school observations about the child's attendance, symptoms and functioning, and any events that are reported to have taken place there. Having collated all this information about the child and their functioning, medical uncertainty may remain about causes of the reported symptoms. A period of 'watchful waiting' may be appropriate if this is deemed safe, or further definitive and warranted investigations and opinions may be required.

A very useful way to proceed may be admitting the child (often for 2 weeks or over a period of time greater than the interval between reported episodes of concern, if they are not continuous) for close observation during which weight, intake of food and medication, bowel and bladder function, mobility, pain and other symptoms and hospital school attendance can be observed and monitored. The admission will need to be carefully planned to include what tests are to be undertaken and who will undertake daily ward reviews. The senior nursing staff should be explicitly briefed about any concerns and the reason for admission. All notes about the child must clearly state who observed or reported whatever is noted. As during normal school days, the parents would be expected to leave during school hours for school age children. The purpose of the admission, namely constant observation *of the child*, needs to be discussed with the carers and child. If agreement cannot be reached with the parents about an admission or the planned assessment is thwarted, referral to Children's Social Care for assistance may be required, not for suspected FII, but to enable the doctors to establish what is, and is not, wrong with the child.

Collation of all this information will require at least one meeting to enable all professionals to freely express their observations and concerns about the child and their illness, and reach agreement about the child's current health/ill-health and treatment needs. The responsible consultant should give careful consideration as to how to involve the child and carers in this process.

RESOLVING PERPLEXING PRESENTATIONS

There may be one of several outcomes following this comprehensive process of gaining full information about the child's current state of health.

- The child may be found to have a previously unrecognised condition that can then be treated appropriately and the child and family enabled to cope optimally with this condition.
- Rarely, during the process of observation, explicit deception or evidence of illness induction becomes apparent. In this case, a safeguarding referral should be made following local procedures.
- Most commonly, however, there is no clear evidence of illness induction or deception and the child's reported symptoms and signs are either absent or persist but remain unexplained. There may be good clinical evidence for the *absence of* an illness that explains these symptoms. However, unlike MUS where the child is 'owner' and main complainant of the reported symptoms, in PP the caregiver is the main narrator of the child's difficulties. Caregivers often perceive the professionals' approach to the child's difficulties as binary—either physical/organic or psychological and 'in the child's mind'. Caregivers in PP tend to strenuously resist the latter. The aim of resolving these PP is to *change tack*. This requires halting iatrogenic harm to the child by further unnecessary investigations and treatment, restoring the child's daily life to optimal normality (allowing for any confirmed health problem) and enabling the child to develop a more reality-based understanding or her/his state of health (box 1).

Box 1 Approach to perplexing presentations

- Consult a colleague/named doctor
- Verify child's *current* state of health
  - Obtain history/observations from *all* carers (including father)
  - Collate all current medical/health involvement and treatment
  - Establish provenance of reported diagnoses
  - Carry out further *definitive, warranted* investigations
  - Inpatient admission for direct observation of child may be required
- Document child's current functioning (school, mobility, aids)
- Seek parents' views explanations, fears, hopes for child's difficulties
- Seek child's views—illness beliefs, anxieties, mood
- Explore family functioning and effect of child's difficulties on
  - Siblings, and their health
  - Family life and interactions

Professional consensus

The first stage in the restorative process is to gain the agreement in a consensus meeting of all professionals concerned,

including the general practitioner (GP), that this is the way to proceed. Failure to reach consensus is not uncommon, and may reflect a professional's commitment to either the particular family or to a particular diagnosis. A restorative programme cannot be successful if a professional continues to support the family's preference for a purely biomedical explanation of the child's difficulties, and so a professional referee may be needed. Consensus may be further undermined by the involvement of new doctors from different hospitals and specialities. It is important that partial feedback is not given to the parents before the definitive consensus meeting.

Explanation to the family

The lead doctor together with a colleague meet with parents and explain the current medical formulation of the child's problem. This will include what diagnoses are objectively present and what impairments this causes. There are likely to be other symptoms or impairments that are not medically explained and the doctor should explain that some genuine symptoms, such as chronic pain, often have no organic diagnosis, although the doctor may be able to interpret the child's symptoms in other terms. While not disputing the child's symptoms, for example, pain, the doctor may explain that this is not life threatening, does not need urgent treatment and that further opinions and investigations would be counter-productive and harmful. The aetiology is not a binary one—either organic or physical. Rather, organic, psychological and family factors may all be contributory. The doctor can acknowledge that this is a departure from the previous medical approach to the child, which may not be welcome if the parents have been very anxious or had strongly held beliefs about their child's state of health. This approach could also create a 'gap' in the parents' life, previously 'filled' by the child's perceived ill-health. Help to the child and family will be offered to function better alongside symptoms. Once the parents agree to this plan, it can be given to the child, age-appropriately. If in the course of the assessment there are concerns that this approach might lead the parent(s) to induce illness in the child in an effort to convince doctors of the seriousness of the child's reported symptoms, then the threshold for making a safeguarding referral has been reached and the child probably needs to be in a safe place such as an inpatient admission.

Rehabilitation

An active rehabilitation programme entails a multidisciplinary physical, psychosocial and education approach. Hospital, GP and community health services—possibly including physiotherapy and occupational therapy, psychology, child and adolescent mental health and education professionals will need to work together. Goals should be clearly defined and achievable, for example, reducing or stopping unnecessary medication, increasing range of foods in the child's diet and, where relevant, returning to full oral food intake, a graded mobilisation plan and re-establishing phased school attendance and community activities.

An integral part of a successful programme of change is the psychosocial work with the child and family:

- The child and the family, including siblings, need to be helped to construct a narrative explanation for the improvement in the child, which the child can tell to her/his peers. Such a narrative needs to be truthful and non-judgemental, acknowledging the carer's erroneous beliefs about the child's state of health, alongside the evidence of the child's actual health.
- The child will need support to adjust to a state of (better) health, and use adaptive coping strategies to deal with symptoms such as pain and reduce the child's anxieties about her/his health.
- The parents will require support in adapting to the change in their child.

Follow-up

It will be necessary to follow-up the child to ensure that the progress gained in the rehabilitation programme is sustained and the difficulties in this or in other children do not recur. This falls to primary health and education to ensure that there are alerts in place should there be a recurrence of concerns.

WHAT IF?

As described above, illness induction and evident deception by parents are clear indicators of likely FII and require referral to Children's Social Care. What differentiates PP from fabricated illness is the parental positive response to the proposed medical change of direction—from investigation to rehabilitation. However, some parents wish to persist in their quest for more investigations and diagnoses, seek further medical opinions, decline or do not participate in the rehabilitation process. They find difficulty in enabling their child to function and cope better with any health difficulties which the child may have and are likely to continue to be motivated by the underlying needs described earlier. This is now a persistent and unresolved PP and the child is at risk of harm. A referral to child protective services is indicated and the family will be informed about this.

NATURE OF THE REFERRAL

Within the Children Act (1989), the threshold for significant harm can be either *ill-treatment*—actually causing or likely to cause harm to the child, or *impairment* of child's health and functioning *attributable to* the care given or not given to the child. If the child is referred on the grounds of FII, evidence is usually sought of ill-treatment, namely the caregiver's erroneous reporting, deception or illness induction. However, this may be very difficult to prove particularly when, as is often the case, there is no clear evidence of actual intention to deceive. The alternative and preferable approach is to refer the child on the basis of the *impairment* of the child's *current* functioning, which is attributable to the parents' unwillingness or inability to participate and allow their child to benefit from the change in direction towards rehabilitation. There will be clear evidence to support this contention. Symptoms may not have been observed independently, a situation of res ipsa loquitur ('the thing speaks for itself'). Emotional abuse and/or medical neglect may be more appropriate causes of concern.

For Children's Social Care to respond appropriately, a clear referral from health is required. This includes:

- A statement of verified diagnoses with a clear explanation of their functional implications for the child ('so what').
- A description of the:
  - Parents' reports of the child's difficulties;
  - Independent observations of the child's actual functioning and symptoms (eg, reported symptoms/signs were absent when the child was directly observed);
  - Information given to parents about diagnoses and their implications;
  - Help offered to the parents and child to improve the child's functioning;
  - Parents' response.
- An explanation of the harm to the child.

A PROTECTION PLAN: THE CHILD'S NEEDS

Doctors, often GPs, will inevitably continue to respond to parents' reports of their child's symptoms and these children therefore require protection from doctors. The parent(s) or carer(s) are now recognised as unreliable informants. The children therefore need to be taken to doctors only by reliable informants, who may be the father or other carer if they have gained a clear insight into the problem. In some cases, this might require providing the child with an alternative carer. The child needs to be provided with the rehabilitation plan described above. Attention will also need to be given to parent-child/family interactions, help offered to the parents to fulfil the child's needs and the parents are likely to require help with their own unmet needs. This may include referral to adult mental health services, who are particularly helpful in providing a diagnosis and an understanding of the carer's motivation; a prognosis and the carer's likely capacity to change; an indication of the required treatment and providing treatment, which is often a slow process to effect change.

THE CHRONOLOGY

It is always useful for the clinician to understand the child's journey through clinical services to their current position. At some point, certainly if formal safeguarding procedures are invoked, a detailed chronology is likely to be required., Initially, however, the emphasis in PP is on the child's current functioning and well-being.

When a chronology is constructed, for each documented presentation of the child to health services, it is important to state:

- The source of the information.
- Who reported the concerns.
- Whether the reported symptoms and signs were independently observed.
- What the medical findings were.
- Whether they explained the reported concerns.
- Whether they explained the functional impairment of the child.
- What treatment or management was offered.
- What the outcome was, including any safeguarding actions.
- Whether there has been frequent change of doctors, including due to geographical moves.
- The impact of these events on the child.

The chronology may well show previous episodes of reported ill-health of the child with repeated involvement of the medical profession in investigating and treating the child but with negative findings. While not evidence of current fabricated illness, it is very important as a past predictor of future repetitions, of which the child's current presentation may be one.

FUTURE RESEARCH

- The need for an understanding of the current UK situation regarding recognition and management of PP/FII is urgent and epidemiological studies are also needed. While the alerting signs have been widely disseminated, they have not been tested prospectively for specificity and sensitivity.
- The proposed pathway for managing PP/FII has been applied clinically successfully. However, the extent to which this can prevent harm to children, or progression to more damaging FII, remains untested systematically.
- At the harder end of the spectrum, the presenting features of illness induction also need to be clarified and updated.

CONCLUSIONS

If PP are to be tackled at an early stage, with the implicit (but currently unproven) hope that good early intervention will prevent escalation to more severe FII or illness induction, then doctors' behaviour has to change. The doctors' behaviours that are likely to lead to a de-escalation of PP/FII concerns will vary from case to case but should include:

- Considering the child's symptoms in the context of normal behaviour and physiology at the child's developmental age.
- Explaining when further information is required and how that will be gathered (eg, reports from teachers, discussion with GP).
- Explaining that some symptoms do not signify disease but may be how the body is working at that time.
- Explaining that treatment is not always required for medical conditions and that delay in treating would not pose a risk.
- Giving the carer a 'good news story' that their concerns, or the concerns of other doctors, may turn out to be unfounded or that the child may be 'recovering' from the problems.
- Explaining to the carer that tests and treatments are potentially harmful and that deferring investigations or second-phase referrals will not cause the child harm.
- Discussing what the child may be able to do and how they will return to normality after 'recovering' from the problem.
- These discussions need careful planning, particularly if there is concern about possible consequent illness induction.
- The doctor's records, communications and reports should be clear and factual and should not support any restriction of the child's activities unless clearly justified.
- If the child is presented to another doctor, the concerns should be explicit from the records and/or communicated directly by the previous doctor.

There are very few conditions where deferring investigation or treatment and adopting a watchful waiting approach is likely to put an apparently well child at risk of serious harm. The situation is obviously different if the child is overtly unwell, or if the parent is reporting potentially life-threatening problems such as apnoea. For other presentations, where clinical judgement suggests that serious underlying disorder is very improbable, a move towards a more restrained style of practice is to be encouraged and doctors should be supported in this.

Doctors need to develop the skills to manage these children without causing unnecessary harm, at an early stage in their medical history when formal child protection procedures are not yet indicated. It is likely that current professional guidance on FII will need to be reviewed and updated where necessary to take account of this trend. The threshold for statutory services intervention in family life remains when there is concern that a child may be at risk of significant harm, but we propose another layer of intervention that we hope will protect children from harm at an earlier stage.

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REFERENCES

1 RCPCH. *Child Protection Companion*. Second Edn, 2013.
2 Gureje O, Reed GM. Bodily distress disorder in ICD-11: problems and prospects. *World Psychiatry* 2016;15:291–2.
3 American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders*. Fifth Edn: American Psychiatric Publishing. ISBN 978-0-89042-555-8.
4 GMC. Protecting children and young people: the responsibilities of all doctors. 2012.