LETTER TO THE EDITOR

Can Burnout Among Child Abuse Clinicians be Caused by Doubt that They are Doing the Right Thing?

Niels Lynøe, MD, PhD¹; Anders Eriksson, MD, PhD²


In their interesting paper about the strong association between burnout among child abuse clinicians,¹ the authors discuss whether burnout might have similarities with staff working within emergency departments and pediatric palliative care. This can be a relevant comparison regarding job demands and burnout and it seems also reasonable that increased risk of secondary stress and burnout can be mitigated by hope and meaning in work. Moreover, we also agree with the authors’ conclusion that the concerned child abuse clinicians should be offered education in coping strategies in order to minimize burnout.¹

But perhaps the child abuse clinicians have additional problems when compared to other medical specialties and situations. More specifically, do child abuse clinicians sometimes ask themselves if they are always doing the right thing? This question applies above all to a certain kind of presumed child abuse, namely the very young infants (peak age 2 months) where abusive head trauma is suspected but where no external signs of trauma are present.² A systematic literature review disclosed that there is very low evidence of the diagnostic accuracy of the three findings, encephalopathy, subdural hemorrhage, and retinal hemorrhages (“the triad”), without external signs of trauma for predicting violent shaking.³ Nevertheless, in practice, child abuse clinicians in many countries continue using the triad, without external signs of trauma, to claim with a high degree of certainty that such an infant must have been shaken violently.⁴ Hence, we believe that a child abuse clinician might have a difficult time if he/she has given evidence as an expert indirectly or directly in a court of law and contributed to the conviction of a potentially innocent caregiver, to the removal of an infant from a caring family, and to the splitting of this family. Are such expert statements always in the infants’ best interest?

If in doubt, we believe that child abuse clinicians sooner or later will suffer from a responsibility crisis. For example, in triad cases without external signs of trauma, child abuse clinicians might begin to doubt that all medical conditions have been ruled out when concluding that the infant must have been shaken. Are there medical conditions that are not yet accepted that can bring about the isolated triad spontaneously? Is the evidence behind the abusive head trauma theories as robust as assumed? Are retinal hemorrhages really pathognomonic for traumatic shaking or are they nonspecific and secondary to an increased intracranial pressure? Are caregivers really always lying when they tell that nothing happened ahead of the infant’s symptoms of encephalopathy?

Child abuse clinicians might think that what they are doing is making a difference, but they might also begin to doubt that it always results in a good difference, perhaps even bad consequences, and hence a responsibility crisis, which in turn can bring about “emotional exhaustion, depersonalization, and reduced personal accomplishment”. In other words, can such doubt also result in moral distress and burnout? ❖

References

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In Response

On behalf of our co-authors we appreciate the thoughtful comments and remarks by Dr. Niels Lynoe and Dr. Anders Eriksson1 to our article2 on hope, secondary traumatic stress and burnout among child abuse clinicians. We agree that stress associated with potential uncertainty in testifying in a court of law would be a job demand that in the absence of adequate resources, that over time, would be a contributor to burnout. That being said, the robust empirical literature on hope as a psychological protective factor would suggest the hopeful child abuse clinician would develop pathways to compensate and overcome the barrier of uncertainty. For example, accessing additional resources and evidence in making the determination that would be shared during the court hearing. This empirical literature also demonstrates the hopeful individual is better able to manage distress and daily stress.3,4

Lynoe and Anders1 offer meaningful concerns for child abuse pediatrics that will likely influence their well-being, burnout, and ultimately quality of care. Nevertheless, these concerns are better served as empirical questions in future research. First, what is the prevalence of uncertainty experienced by child abuse clinicians in making a clinical diagnosis? Second, what is the association of this uncertainty to stress and burnout? Finally, does hope as a coping resource mitigate this potential job demand and burnout?

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References:
1. Lynoe N, Eriksson A. Can burnout among child abuse clinicians be caused by doubt that they are doing the right thing? Perm J 2020; 24;20.011. DOI: https://doi.org/10.7812/TPP/20.011