TOPIC IN REVIEW

The primary care of elder mistreatment

Case 1

Mrs. W. is an 85-year-old African American woman followed for hypertension, dementia, and peripheral vascular disease. She lives with her disabled daughter and unemployed son-in-law. Mrs. W. is dropped off at the entrance to the clinic by her chore worker for a scheduled visit with her doctor and is forced to walk 30 yards to the waiting room in her stockinged feet. She is left alone for the interview, during which she appears in pain but denies being mistreated. She tells the doctor, "I'm old and sick, but I won't die in any old age home!" The patient, wearing a soiled dress, is thin and has lost 9 pounds over the past 2 months. Physical examination reveals dry gangrene of the right second and third toes with cellulitis of the right foot. After she adamantly refuses hospitalization, her physician prescribes antibiotics and 100 tablets of acetaminophen with hydrocodone for pain. When the chore worker arrives to pick up the patient, she is hostile toward the clinic staff and claims the patient is faking pain to get attention.

A report is filed with Adult Protective Services (APS), and a home health referral is made to monitor the status of the gangrene and cellulitis. On her second visit, the nurse cannot find the bottle of acetaminophen-hydrocodone tablets. The physician prescribes a fentanyl patch to replace the lost narcotics, but the nurse observes that it is not being changed regularly, although the patient appears in constant pain. After the nurse confronts the daughter and threatens to call APS if Mrs. W.'s care does not improve, the son-in-law fires the home health agency because of the nurse's alleged rudeness and condescension. Four weeks later, Mrs. W. is admitted to the hospital with sepsis, and an emergency above-the-knee amputation of the right leg is performed. She dies a week after being discharged to a skilled nursing facility.

Definitions

Elder mistreatment involves the physical abuse, neglect, psychological abuse, or financial exploitation of an older adult. The lack of standardization in the definitions in the literature has carried over to the statutory definitions used by states to govern reporting and prosecution. Conceptually, physical abuse includes physical acts of violence, such as hitting and slapping, the infliction of injuries, unwanted sexual contact, as well as inappropriate physical or chemical restraint. Neglect refers to the failure of the primary caregiver to meet the care needs of a dependent adult, including the provision of food, adequate hydration, clothing, shelter, personal hygiene, and medical care. Psychological, or emotional, abuse entails actions that are designed to intimidate or inflict emotional harm, such as threats, denigrating statements, or the use of infantalizing language. Isolating and ignoring the elder also fall within the domain of emotional abuse. Financial exploitation involves the misappropriation of an elder's money or property for personal use or gain, whether through embezzlement, fraud, or outright theft. Self-neglect, the inability of an individual to perform essential self-care tasks, is considered by many authorities and states to be a special category of elder mistreatment.

Problems with statistics

Accurate statistics on the incidence and prevalence of elder mistreatment are lacking, in part because victims often are reluctant to reveal abuse out of shame, denial, self-blame, fear of reprisal, or a desire for privacy. The National Elder Abuse Incidence Study, using substantiated Adult Protective Services (APS) reports supplemented with case detection by community "sentinels," estimated a prevalence of 1.3% in 1996 among non-institutionalized persons over age 60.[1] This figure, which includes self-neglect, is far lower than previous estimates. Lachs et al estimated a 6.4% community prevalence of abuse,[2] based on 11 years of referrals of participants in the New Haven epidemiologic cohort to the Connecticut Ombudsman on Aging. Self-neglect was the most

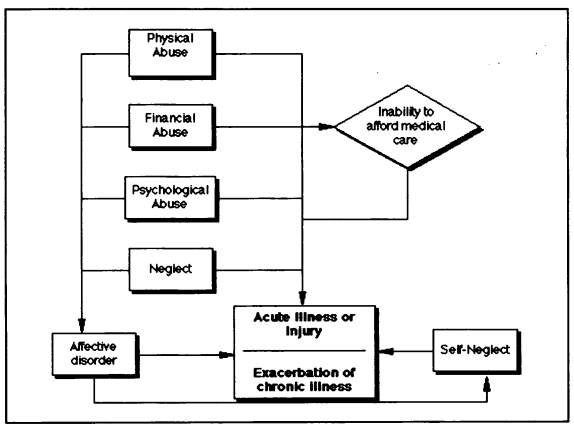

Figure 1 *Paradigm of the health effects of elder mistreatment*

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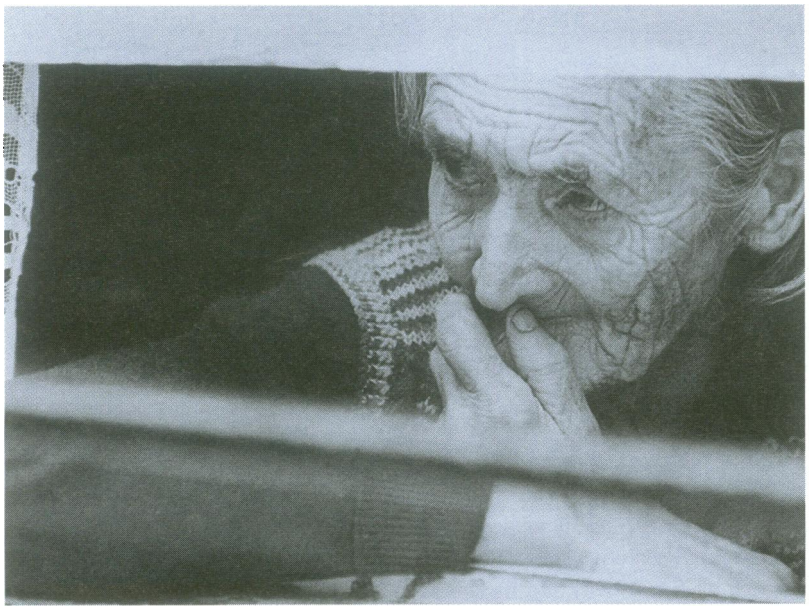
commonly reported type (73%), followed by neglect by others (17%). Cross-sectional surveys of elders determined that 3.2% to 4% have experienced some form of abuse (excluding self-neglect) after the age of 65. One-half to 2% of respondents acknowledged physical abuse, while 0.4% reported being neglected.[3,4] Data based on referrals to APS underestimate the true incidence, due to underdetection and underreporting. Surveys suffer from recall bias and the omission of data for the most dependent and cognitively impaired elders. It has been estimated that between 1.1 and 2.5 million older Americans annually experience mistreatment.[5,6]



Elders are vulnerable

Elder mistreatment as a chronic disease

Abuse, commonly in multiple forms, may occur chronically over months to years,[2,7] sometimes resulting in repeated medical crises.[8] The frequency and intensity of the abuse may escalate over time.[9] All forms of elder mistreatment directly or indirectly affect the health and health care of older patients. The injuries inflicted by physical abuse are the most obvious. Each form of abuse may contribute to anxiety, depression, or post-traumatic stress disorder. Fiduciary abuse may deprive the victim of the financial resources to afford medical services. Neglect may directly cause adverse health outcomes (e.g., dehydration, malnutrition); may lead to harmful delays in seeking medical care; or may lead to noncompliance with a prescribed plan of treatment, contributing to the exacerbation of chronic illness (Figure 1). The consequences of abuse and neglect also include excess hospitalizations and visits to the emergency department (ED). Lachs et al[8] found that 42 of 182 (23%) confirmed elder-abuse victims living in the greater New Haven, Conn, area had at least one visit to the ED attributable to abuse during a 5-year period. Twenty-four percent of their ED visits were injury-related; 22% of these injuries resulted in admission. Over 13 years of follow-up, older victims of elder mistreatment were shown to have a threefold greater risk of dying compared to unabused seniors, after adjustment for age, sociodemographic factors, and comorbidity.[10]

Physician recognition and reporting

The medical consequences of abuse make it likely that the victim will at some point come in contact with a physician. For the dependent elder, the scheduled visit to the primary care physician may be the only opportunity for abuse to be detected. Unfortunately, physicians all too often attribute the medical consequences of abuse to aging or underlying disease. In Michigan, between 1989 and 1993, only 2% of suspected elder-abuse cases were reported by physicians.[11] In a national survey of ED physicians, most doubted or were uncertain of their ability to recognize abuse as well as their state's ability to deal with it effectively once it was reported.[12]

Although all 50 states have adult protective service programs, each state has its own unique laws for reporting elder mistreatment. Health care providers are considered mandated reporters in all 43 states that have mandatory reporting laws. While suspected physical abuse must be reported in these states, the mandate for reporting other types of abuse varies.[13] Effective January 1, 1999, the State of California expanded the mandatory reporting of abuse of an elder to include abandonment, isolation, financial abuse, self-neglect, and neglect by others, in addition to physical abuse.[14] Most states provide reporters with immunity from criminal or civil liability, and the reporting is not deemed a legal breach of patient confidentiality. Failure to comply with mandatory reporting generally is considered a misdemeanor. California law now makes failure to report abuse that results in death or severe injury punishable by a fine of up to $5,000 and/or 1 year in a county jail.[14] It has been argued, from a legal perspective, that a clinician's failure to identify and report cases of obvious abuse and neglect could constitute both negligence and medical malpractice.[15]

Ethical and practical concerns about reporting

Although elder abuse laws are intended to protect vulnerable adults and punish abusers, they may conflict with the principles and practice of medicine, raising doubts among some clinicians about the appropriateness and feasibility of reporting.

VIOLATION OF PATIENT CONFIDENTIALITY

Mandatory reporting potentially violates physician-patient trust and confidentiality and threatens the thera-

peutic alliance between the physician and the caregiver-abuser. A feared consequence is that the patient will change doctors, losing not only continuity of care but also a physician who, by being alert to the situation, might have more success in working with the family to eliminate abuse and achieve the therapeutic goals of the relationship.

VIOLATION OF THE PRINCIPLE, "DO NO HARM"

Once the report is filed, the physician may lose control over the events that follow. Although APS generally subscribe to the principles of freedom over safety, self-determination, and maintenance of the family,[16] the outcome of an APS investigation may be contrary to the patient's desires (e.g., institutionalization). The investigation itself may heighten tension between the victim and abuser, as well as generating resentment of the doctor.

IMBALANCE BETWEEN MANDATE AND PUBLIC FUNDING

The filing of a report does not guarantee either that a satisfactory solution to the abusive situation will be found or that the report will prompt an investigation. For example, the number of staff assigned to APS programs in California declined by 35% between 1990 and 1998. By 1998, fewer than 20% of counties were able to respond to all APS reports, and 45% could not provide longitudinal case management of APS cases.[17] The frustration of not seeing any benefit to the patient after an APS report has been filed is one of the most persuasive arguments against physician reporting.

Despite these concerns, the filing of a report with APS remains the single best way to stop elder mistreatment. Most clinicians do not have the training—or the time—to interview and counsel the victim and alleged abuser, and few can muster the resources offered by most APS. Improperly conducted investigations may harm the chances of stopping the abuse, and place the patient at greater risk. The success of an APS referral depends, in part, on the quality of the information provided and the willingness of the physician to work with APS during the investigation and interventions.

The physician's role in managing elder mistreatment

The primary care of elder mistreatment requires an awareness of its prevalence, risk factors, and clues (Tables 1 and 2). Evaluating a patient's risk for abuse starts with an understanding of the patient's degree of dependence, which is best done through a systematic assessment of the patient's functional and cognitive status. Early research concentrated on the dependency of the elder and caregiver stress as the principal risk factors. Subsequent research has found that the functional dependency of the older adult may be less important than the dependency of the abuser on the elder (e.g., for housing or financial support), especially if the abuser is an adult son or daughter of the elder. Abusers are more likely to have past or present psychiatric problems, a history of alcohol or drug abuse,[9,18] and underlying personality disorders.[19] Elderly men and women are equally likely to be mistreated.[20] As shown in Table 2, there may be clues to the possibility of elder mistreatment.

Case 2

A 72-year-old woman with moderately severe dementia, uncontrolled diabetes, and uncontrolled hypertension lives with her husband, who is suspected of being an alcoholic. The patient always comes to her appointments with 1 of her 2 daughters, who live nearby, but never with her husband. She is always dishevelled, with evidence of urinary incontinence, and her glycosylated hemoglobin is 12. The daughters claim to visit their mother daily, but consistently have failed to bring in her blood glucose monitoring record so that her insulin can be adjusted. Their reports of the mother's diet indicate that previous dietary counseling has been fruitless. The daughters are reluctant to admit that their father is an alcoholic but acknowledge purchasing liquor for their parents. The physician tells the daughters that because they clearly need more help caring for their mother's medical problems, she will send a referral to a county social worker and public health nurse (i.e., APS) to see if they can come up with a new plan, even though home health already is involved.

Table 1 *Risk factors for elder mistreatment in the community setting. (Adapted from Jones et al[24])*

Excessive dependency of the elder for activities of daily living
Resentment by caregiver for giving too much, getting back too little
The stressed-out caregiver
Poor premorbid quality of the relationship, external stressors (job, family, finances), lack of social support, emotional burden, depression, increasing care needs of a demented relative
History of family violence (child or spousal abuse)
Psychopathology in the caregiver
Substance abuse, sociopathic personality, financial exploitation of elder
Caregiver dependence on elder
Housing, financial support
Sociocultural/environmental
Inadequate housing
Resentment and anger from elder over decline in stature within family
Demanding personality of elder
Cultural sanctions against seeking help outside family

Table 2 *Clues for possible elder mistreatment. (Adapted from Kleinschmidt[25] and Lachs & Pillemer.[21])*

General
• Caregiver of cognitively impaired elder absent for appointment
• Failure of caregiver to visit patient in hospital
• Reluctance to answer questions about a suspicious physical finding or illness
• Implausible or vague explanations for injuries given by caregiver or patient
• A history of "doctor hopping"
• Tension or indifference between caregiver and patient
Suspicious physical signs
• Multiple bruises or bruises at different stages of healing
• Bruises in unusual locations
• Pattern injuries (injuries in the shape of the object used to inflict them, such as bite marks, cigarette burns)
• Evidence of old injuries not previously documented or radiographic evidence of old, misaligned fractures
• Broken nose, teeth
• Subtherapeutic levels of drugs
• Patient lacking his or her eyeglasses, dentures, or hearing aid
Caregiver
• Poor knowledge of patient's medical problems
• Excessive concern about costs
• Attempts to dominate medical interview
• Verbal abuse or hostility toward elder or health care provider during encounter
• Evidence of substance abuse or mental health problems
• Evidence of financial dependence on elder
The abused elder
• Fearfulness toward caregiver
• Flinching or reluctance to make eye contact
• Diagnosis of dementia with history of disruptive behavior
• In demented person, unexplained resistance to, or fear of, physical touch, removing clothes, toileting, bathing of private parts
• Depression, anxiety, insomnia

Physician assessment of elder mistreatment

An emphasis on the diagnosis and treatment of the health consequences of mistreatment offers a less threatening approach and may help the physician retain the patient's and suspected abuser's trust while interventions are tried. If abuse is suspected, the patient and caregiver must be interviewed alone in order to elicit uninhibited disclosure and to identify inconsistencies between the two accounts.[21] The clinician should avoid confrontation and blame, while appearing sympathetic to the suspected abuser's perceived burden of caregiving. Table 3 lists examples of questions that may be used to elicit information about mistreatment.

To avoid the surprise and anger that the unexpected visit of an APS social worker might engender, the physician should tell the patient and caregiver that a referral will be made to APS. The law-enforcement implications of APS should be down-played, instead offering APS as an additional service to help the patient's medical problems.

If the patient or caregiver refuses the APS referral, clinicians should explain that they are bound to adhere to state regulations that were developed to help seniors who are not receiving the care they need—for whatever reason. These laws obligate the physician (in the case of mandated reporting) to notify APS.

Keeping the patient safe

The safety of the victim is the paramount consideration, and in certain circumstances, such as escalating physical violence, physicians should immediately contact law enforcement in addition to APS. Hospitalization may be the most expedient way to separate victim and abuser, although the medical necessity may be questioned by third-party payers. In most cases the decision-making capacity of the patient will determine the intervention. If the patient has decision-making capacity but refuses intervention, the patient has the right to remain in the abusive situation. In such cases, the physician should educate

the patient about the medical consequences of abuse and its tendency to increase in frequency and severity. The physician should counsel the patient to develop a safety plan, such as when to call 911 or installing a Lifeline™ emergency alert system. Often the patient who refuses intervention for abuse will accept more frequent monitoring of a specific medical condition. Increased oversight can take the form of more frequent appointments or home health and subspecialty consultations. To avoid biasing the consultant, requests should be framed in terms of a specific medical need. For example, a consultation request to a psychiatrist for evaluation of possible depression secondary to psychological abuse might include the statement, "Please evaluate for depression and, if found, please assess its etiology in light of a possible problematic relationship between Mrs. X and her husband." It is appropriate to mention that an APS referral has been made.

Role of the court

Although a patient may lack decision-making capacity, he or she still is considered legally competent until mental incompetence is determined by the court, which can then impose services. Most states have provisions to arrange guardianship, conservatorship, or financial management, as well as to remove cognitively incapacitated elders from the abusive environment against their will. Usually, forced removal requires a formal psychiatric assessment and the presence of imminent danger to the elder.

Table 4 *Guidelines for reporting to adult protective services*

Urgency of the referral
Likelihood of imminent harm
History
Description of the suspected abuse
The medical/psychiatric consequences of the mistreatment and their acuteness or seriousness.
A list of the patient's chronic illnesses and how they might have been affected.
Predicted impact of the abuse on future health
Likelihood of adverse effect
Anticipated time frame (days, weeks, months)
Pertinent physical findings
If physical abuse, include detailed descriptions of any injuries, using drawings and (if possible) photographs. (Forensic photography may be available in the some emergency departments)
Description of the patient's functional status and care needs
Assessed or estimated decision-making capacity of elder
Suspected abuser's relationship to the patient
Known or suspected risk factors for abuse (e.g., caregiver stress, substance abuse)
Other medical and community services currently being used by patient (e.g., name of home health agency)
When and how best to contact you

Table 3 *Examples of questions to elicit information about mistreatment. (Adapted from Kleinschmidt[25] and Lachs & Pillemer.[21])*

General lead-in questions about the safety of the home environment and who provides help
Do you feel safe where you live?
Who helps you with the things that you have trouble doing yourself?
Who handles your checkbook, pays the bills?
Questions concerning physical abuse
Are you afraid of anyone at home?
Have you ever been slapped, punched, or kicked?
Have you ever been tied down or locked inside in your room or house against your will?
Questions about neglect
Are you made to wait a long time for food or medicine?
Have you been left alone for long periods?
When you need assistance, do you have trouble getting someone to help you?
Questions about psychological abuse
Are you yelled at?
Have you been threatened with punishment or placement in a nursing home?
Are you kept isolated from friends or other relatives?
Do you get the "silent treatment" at home?
Do you have frequent disagreements with your [principal caregiver]?
When you disagree, what happens?

Working with Adult Protective Services

Clinicians should have realistic expectations of their local APS. For example, not all state APS routinely assess the risk of future abuse,[13] and there is great variation between states in the criteria for providing involuntary protective services.[22] Because hospitals with emergency departments or outpatient clinics are required to provide mandatory education about elder mistreatment, they represent a logical mechanism by which APS representatives can inform community physicians about their services. In many communities, APS are unaccustomed to working closely with the primary-care physician. Until such collaboration is routine, physicians should specifically request to be kept informed.

Reporting

The first step in managing suspected mistreatment is to report the case to the appropriate protective services agency. In California, suspected mistreatment occurring in the community is reported to APS or law enforcement (in the case of criminal abuse), while mistreatment in the long-term care setting is reported to the local ombudsman. APS use the report to triage cases, and the content may guide the investigation and prosecution of abuse. Although most primary care clinicians are not accustomed to performing an evidentiary exam, it is important that the documentation be as complete as possible, since physical signs and symptoms recognized by the clinician may resolve before a forensic examiner (if available) can evaluate them. The reporting guidelines in Table 4 will help the clinician provide APS with critical information and promote effective collaboration.

Summary Points

- Elder mistreatment occurs commonly, may be chronic, and can adversely affect the health and health care of the older patient
- Primary care physicians can play a pivotal role in the diagnosis and management of abuse and neglect, by focusing on the medical conditions that they affect or cause
- Nearly all states require physicians to report suspected physical abuse to the local adult protective services program
- Successful management requires effective teamwork between the primary care clinician, APS, consultants, and a variety of community agencies

Working with other services

Although home health may be useful in assessing and managing the medical consequences of mistreatment, drawbacks include a restricted number of visits and, frequently, limited experience in dealing with elder mistreatment. Respite services should be considered in most cases of abuse and neglect. A referral to a chore worker service (a fee-for-service agency or state- or county-funded in-home support service) may alleviate the burden for the caregiver. Chore workers, however, who may receive low wages, minimal benefits, and little oversight, can also abuse vulnerable elders.

Conclusion

For the busy clinician, a geriatrician, usually working with an interdisciplinary team, may be better able to coordinate the time-consuming assessments that are integral to understanding the etiology of the mistreatment and its relationship to the patient's health care needs.[23] The social worker, who is usually part of the geriatric team, can help to maintain effective and essential communication between the primary care physician, consultants, APS, and other involved agencies. Geriatricians are not available in all communities, but in time, the geriatric team may play an integral role in elder-abuse management, in much the same way child protection centers now help pediatricians and child protective services in the area of child abuse.

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capsule

Life-threatening licorice. In March 1997, a 44-year-old women walked into the emergency department of a Swedish hospital and promptly had a series of life threatening ventricular tachycardias (*Journal of Internal Medicine* 1999; 245:307-10). Her serum potassium concentration was 2.3 mmol/l. After a bewildering variety of investigations—including cardiac ultrasound and endoscopy of her esophagus, duodenum, and colon—she admitted eating 40-70 grams of licorice every day for four months. The metabolic consequences of a surfeit of licorice are well known, but this is the first reported case of a resulting torsades de pointes tachycardia.

capsule

Add exercise to asthma therapy. Exercise training programs in children with asthma are controversial, but two small studies in *Thorax* add to the evidence supporting their use (1999; 45:196-200, 202-6). In the first, individually tailored swimming training improved fitness and reduced exercise induced bronchoconstriction in eight children; in the second, training on an exercise bicycle for two months had a short-term impact on participants' use of medication. One commentator warns, however, that the available evidence is still too weak to justify modifying conventional asthma treatments.