Elder abuse: do general practitioners know or care?

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ORIGINAL ARTICLE

SUMMARY

A pilot survey in Tower Hamlets, London, indicated that many general practitioners (GPs) might not be recognizing abuse of elderly patients through lack of training. The survey was replicated on a large scale in Birmingham, to allow further analysis.

561 Birmingham GPs were mailed questionnaires and responses from 291 were analysed, providing data from 95% of the practices. The findings were similar to those in Tower Hamlets: just under half had diagnosed elder abuse in the previous year. Regression analysis of the combined data-sets (*n*=363) indicated that the strongest factor predicting GP diagnosis of abuse was knowledge of 5 or more risk situations (odds ratio 6.77, 95% confidence interval 4.19, 10.93).

The findings of these surveys suggest that research-based education and training would help GPs to become better at identifying and managing elder abuse.

INTRODUCTION

It is ten years since the British Geriatrics Society publicly acknowledged the increasing problem of elder abuse. In 1989, the Society predicted the need for general practitioners 'to play a key role in recognising and acting on . . . factors leading to the abuse of elderly people within caring situations'[1]. Current estimates of prevalence, based on surveys in the UK and overseas, indicate a rate of around 5% for all types of abuse in the community for people over the age of 65, financial and verbal abuse being the most common[2]. Smaller case studies suggest that the rate in households where a patient has dementia may be substantially higher[3]. The understanding of risk of abuse has advanced from early concentration on the characteristics of the abused person to a wider consideration of his or her household situation and the characteristics of those with whom he or she is most closely connected[4]. There is wide agreement that medical practitioners in general, and the primary health care team in particular, have an important role in identifying and preventing abuse. Little is known,

however, of the extent to which the medical profession knows and understands the problem[5].

In 1997, three of us conducted a pilot study in Tower Hamlets, London, to determine whether general practitioners (GPs) reported diagnoses of abuse and identified patients at risk. We also looked at how prepared they were in managing abuse[6]. Of those who responded (73 of 107), 49% reported diagnosing abuse of an older patient in the previous twelve months. 84% reported having a patient in at least one situation (of twenty possible) which might place an older person at risk of abuse; 37% reported knowing patients in five or more such situations. 70% felt they needed further education on dealing with elder abuse; just 45% had attended a training course or had read around the subject. The results suggested that (*a*) neither recognition of elder abuse nor recognition of risk situations for abuse was universal and (*b*) general practitioners felt inadequately prepared on the subject.

This earlier study had three important limitations. First, Tower Hamlets, with its distinctive pattern of social deprivation, might be atypical in terms of GPs' knowledge and experience of the matter. Second, one of the study authors (GB) is a consultant geriatrician in the area with a well-established interest in elder abuse and professional links with some of the respondents. Third, the data-set was too small to permit examination of confounding variables. For example, an association was found between the amount of home visiting by GPs and the diagnosis of abuse. A possible explanation was that GPs with more older patients visit more; thus, regression techniques,

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applied to a large data-set, are required to disentangle the relationships[7].

In 1998, the Birmingham Medical Audit Advisory Group (MAAG) provided the opportunity to replicate the study with a survey of all 561 general practitioners in Birmingham. Previous Birmingham MAAG programmes had engendered successful responses from GP practices[8–10].

METHOD

All 561 GP principals in Birmingham were mailed the self-completion questionnaire, with up to three reminders, and the returns were collated by Birmingham MAAG. 300 replies were received, which provided 291 completed questionnaires for analysis (after we had excluded one GP on long-term sick leave and three on maternity leave); this response rate of 54% represented 95% of practices. Comparison of respondents and non-respondents indicated no particular differences in terms of size of practice, number of partners, city area, ethnic background or experience in general practice. Although female GPs were slightly over-represented, the proportion responding was the same as the national distribution. The age distribution of respondents also matched national figures.

Elder abuse was defined as harmful or distressing behaviour to an older person (aged 65+) by someone whom he or she should be able to trust—e.g. a family member or a paid carer. Five types of abuse were distinguished: physical (violence or aggression); psychological (typically persistent verbal abuse); sexual; financial; and neglect (repeated deprivation of assistance with daily living). Twenty risk situations, relating to all five types of risk, in which it would be reasonable for GPs to suspect abuse, were derived from reviews of research and clinical knowledge[11,12]. These risk situations either concerned older patients at an excess risk of being abused (e.g. because

of being demented and left alone all day, or living in a household where too much alcohol is drunk) or focused on other individuals who constitute a risk for the older person with whom they are living (e.g. because they get angry about the burden of caring).

Respondents were asked whether in the previous year they had had an older patient who was subject to any of the five types of abuse (diagnosis of abuse) and whether they had a patient in any of the twenty risk situations (knowledge of risk situation). Diagnosis of abuse and knowledge of risk situations amongst respondent GPs were examined separately and constituted the dependent variables. Independent variables covered:

- Demographic characteristics of GPs (age, gender, self-reported ethnic background, length of time as a GP)
- Practice characteristics (number of partners, number of older people on list)
- Home visiting (number of daytime home visits in preceding fortnight)
- GP education and training (courses, specific reading, knowledge of local guidelines on abuse)

Of the twenty risk situations, five were excluded from any subsequent analyses because of poor response. Four questions relating to financial abuse were dismissed as not useful because of the very high number of 'don't knows'. The one question on sexual abuse was also excluded since this accounted for a very small number of cases.

Multiple regression analysis was used to explore the impact of combined variables on GPs' diagnosis of abuse and knowledge of risk among their patients. Diagnosis of abuse was explored with both the inclusion and the exclusion of knowledge of five or more risk situations as an additional explanatory factor. Because of the hierarchical structure of the data, namely multiple GPs grouped by

Table 1 **General practitioner's knowledge and experience of elder abuse: results from Birmingham, 1998, and Tower Hamlets 1996**

Experience	Birmingham n=291	Tower Hamlets n=73
Diagnosed abuse of an older patient in the previous twelve months:	45%	49%
Physical abuse	17%	14%
Psychological abuse	25%	36%
Neglect	21%	25%
Had patients in five or more risk situations for abuse of an older person	40%	37%
Had no patients in risk situations for abuse of an older person	15%	16%
Has attended a training course about elder abuse	14%	16%
Has either attended a training course or done some reading about elder abuse	39%	45%
Would find training or education helpful	72%	70%
Was aware of local guidelines on elder abuse	19%	15%

Table 2 **General practitioner knowledge of 15 risk situations for physical abuse, psychological abuse and neglect**

GP experience	Birmingham n=291	Tower Hamlets n=73
Had an older patient in the previous twelve months:		
With dementia who is left alone all day	44%	25%
Who is living in a household where too much alcohol is drunk	43%	41%
With dementia who is violent towards carer	38%	40%
Who is living with an adult with severe personality problems	25%	23%
Who is concerned about the challenging behaviour of adult son or daughter	24%	19%
With a long history of domestic violence either as victim or as perpetrator	11%	15%
Who repeatedly turns up at accident and emergency departments without GP involvement	11%	5%
With a *paid* carer who fails to meet properly the needs of the older person for daily care	10%	14%
With bruising that is not satisfactorily explained	6%	4%
With a *paid* carer who is aggressive towards the older person	5%	5%
Had a patient in the previous twelve months who was a carer of an older person and who:		
Has personal problems (e.g. psychological, alcohol, anger)	52%	52%
Gets very angry about the burden of caring	42%	49%
Is unable to meet properly the needs of the older person for daily care	40%	36%
Behaves aggressively towards an older person with dementia	14%	21%
Over or under medicates the older person	13%	12%

practices, the data were examined for any significant multilevel effects. None was found and multilevel analyses yielded near identical results to single-level analyses. The final model treated knowledge of five or more risk situations as an independent variable, with the prediction that the diagnosis of abuse would increase with the greater recognition of risk situations.

RESULTS

Survey results are shown in Table 1. Responses of Birmingham GPs were remarkably similar to those of their colleagues in Tower Hamlets. Less than half of general practitioners in either area reported diagnosing a case of elder abuse within the preceding twelve months. At the same time, less than half said they had undergone any training or had done any reading on the subject. Over 70% reported that they would welcome education about elder abuse, having been specifically asked, and many respondents gave their views on how this might be delivered.

Table 2 shows the proportions of GPs who reported that they were aware of patients living in situations which would constitute reasonable grounds for them to hold a *suspicion* of abuse. The situations most commonly identified related to dementia, problems of the carer and alcohol. Nearly half the GPs in both areas reported the number of risk situations involving their patients as two or less; nearly one in seven said they knew of none.

These results were then analysed to see whether any of the independent variables (i.e. GP and practice characteristics, home visiting, training and reading about elder abuse) were significant in predicting diagnosis of abuse. The multiple regression technique allowed the impact of each variable to be considered while the remaining variables were held constant. In Birmingham, none of the independent variables predicted diagnosis of abuse. In Tower Hamlets, two variables were significant. One was 'other reading' about elder abuse (reading other than training material, medical texts, Department of Health Guidance, and Action on Elder Abuse pamphlets) with an odds ratio (OR) of 4.16 (95% confidence interval [CI] 1.39, 12.45), indicating that those GPs who read around the subject were over four times more likely to diagnose at least one case of elder abuse. The second significant variable was 500 or more older patients on a GP's list compared with less than 500. This had an OR of 3.33 (95% CI 1.00, 11.23), indicating greater likelihood of diagnosis amongst GPs with 500 or more patients on their lists. The wide range of the confidence intervals for both statistics reflects the small size of the data-sets.

The second model undertook the same analysis, but this time included knowledge of five or more risk situations as an independent variable. Again, in Birmingham, GPs', practice characteristics and home visiting were non-significant but 'other reading' was (OR=1.88, 95% CI 1.05, 3.37). However, even more significant in predicting a

Table 3 **Knowledge of risk situations and diagnosis of elder abuse in Tower Hamlets and Birmingham—combined regression analysis (*n*=363*)**

	Odds ratios (95% confidence interval)	
	Predicting knowledge of 5 or more risk situations	**Predicting diagnosis of abuse**
'Other reading' about elder abuse	1.99 (1.25, 3.17)	2.17 (1.30, 3.65)
Knowledge of 5 or more risk situations	—	6.77 (4.19, 10.93)

*Excluded one respondent who did not answer the question about diagnosis of abuse

diagnosis of abuse was knowledge of five or more risk situations (OR 5.82, 95% CI 3.43, 9.86). That is, Birmingham GPs with a knowledge of five or more risk situations among their patients were nearly six times more likely to have diagnosed a case of abuse (having considered all other potential confounding factors). This finding was paralleled in Tower Hamlets (OR 13.85, 95% CI 3.73, 51.45).

Knowledge of five or more risk situations was then treated as the dependent variable. In Birmingham, there were small but significant associations between knowledge and more home visiting (OR 1.32, 95% CI 1.02, 1.71 for each additional five visits weekly) and self-reported ethnic background of GP, with Indian GPs less likely than white GPs (OR 0.44, 95% CI 23, 0.87) and other ethnic group GPs less likely than white GPs (OR 0.37, 95% CI 0.12, 1.20) to have knowledge of five or more risk situations. In Tower Hamlets, GPs qualifying since 1980 were more likely to know of five or more risk situations (OR 3.18, 95% CI 1.07, 9.43) and 'other reading' continued to be significantly associated with knowledge of risk situations (OR 4.96, 95% CI 1.66, 14.85).

Table 3 shows analyses when the two data-sets are combined. The likelihood of reporting a diagnosis of elder abuse was increased by a factor of seven if GPs reported that they knew patients in five or more risk situations. If all variables are taken into account, the relationship which dominates the results is the one between knowledge of five or more risk situations and diagnosis of abuse. In other words, the more GPs know about the situational risks of their patients, the more likely they are to diagnose abuse (and *vice versa*).

DISCUSSION

The study is based on GP reporting and may underestimate or overestimate reality. Nevertheless, the similarity of the results in Birmingham to those in Tower Hamlets suggests that the questionnaire successfully captured GP perceptions and experiences. This similarity also goes some way to countering the 54% response rate in Birmingham, a disappointing one, particularly in view of previous response rates to studies in the city. One factor may be that responses were invited from individual practitioners rather than from a practice, when one practitioner with an interest in a subject is likely to canvas colleagues' opinions and complete a questionnaire on behalf of the whole practice. It is equally possible, particularly in view of some of the comments that we did receive ('I do not perceive it as an important problem in my practice'; 'I don't have time to look properly'; 'There is no point in identifying a problem unless there are going to be adequate resources for dealing with the problem') that the low response reflects lack of interest and understanding.

It is a truism that a doctor cannot diagnose a condition of whose existence he is unaware. The 55% of respondents who did not report a diagnosis of abuse in the previous year may not have had a case of abuse, but they may also have failed to recognize one or more. Existing prevalence data do not indicate how many cases of abuse GPs could expect to find among their older patients. It is also possible that some GPs did not concur with the research definition of abuse (given at the beginning of the questionnaire), which was neutral as to the intention and circumstances behind the behaviour. For the purposes of the research, abuse could result if a young carer persistently bullied an older person with dementia but also if the person with dementia persistently bullied an older carer. GPs, however, may define the first instance as abuse but the second as a behavioural problem. Further research is needed to understand these important distinctions in both reporting and diagnosing abuse.

It is noteworthy that few of our independent variables were significant. When the two data-sets were combined, factors that might have been expected to affect the diagnosis of abuse, such as the amount of home visiting or the number of older people on a GP's list, were not important. Similarly, they had little impact on GPs' knowledge of risk situations. The small number of risk situations reported by Indian and other ethnic minority GPs in Birmingham may reflect a lower prevalence in their practice populations, although the data from Tower Hamlets did not suggest this.

Although causal links between knowledge of risk and diagnosis of abuse could not be demonstrated, existing data support the proposition that knowledge of risk situations, and consequent greater awareness of the psychosocial circumstances of patients, facilitates diagnosis of abuse. While this may seem obvious, it began as a research hypothesis and the strength of the relationship was unexpected. Three implications can be extracted. First, training and education need to be grounded in research-based knowledge about risk. Second, knowledge of a risk situation justifies a *suspicion* of abuse and should engender further enquiry. Third, the list of risk situations was notable for its emphasis on psychosocial problems in older-person households. The number of GPs (15%) who reported no patients in any of these categories may reflect the extent to which these problems can go un-recognized[13].

Greater awareness of elder abuse might stimulate GPs to reconsider their role in relation to that of colleagues in primary and secondary care, as well as their response to current initiatives on adult protection[14]. We must also hope that, when the National Service Framework for Older People is published, it will address the question of abuse in full recognition of its connections with other social needs and interventions.

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