Primary Care Physicians and Elder Abuse: Current Attitudes and Practices

Deborah B. Wagenaar, DO, MS; Rachel Rosenbaum, DO, MS, RD; Connie Page, PhD; and Sandra Herman, PhD

Context: While estimates suggest that between 1.4% and 5.4% of older adults experience abuse, only 1 of 14 cases of elder abuse or neglect is ever reported to authorities. It is critical for clinicians to be aware of elder abuse in order to improve primary care.

Objective: To understand Michigan primary care physicians’ knowledge of and reporting practices for elder abuse, including the type of elder abuse education they received, the nature of their clinical practice, and the barriers that prevent them from reporting elder abuse.

Methods: A 17-item survey was mailed to 855 primary care physicians in Michigan in 2 waves between October 2007 and December 2007.

Results: Of the 855 surveys mailed, 222 were returned for a response rate of 26%. The majority of physicians (131 [67%] of 197 physicians) believed that their training about elder abuse was not very adequate or not adequate at all. Physicians with fewer than 10 hours of training were more likely to rate their training as not adequate when compared to those who had more than 10 hours of clinical training ($\chi^2=64.340, P<.001$). Whether abuse was reported was highly correlated with whether it was suspected ($\chi^2=26.195, P<.001$). Those physicians who reported receiving formal training on the topic of elder abuse in residency programs and those who reported participating in CME activities while in practice were less likely to identify not recognizing abuse at time of patient visits as a barrier to reporting.

Conclusion: Recognizing the subtle signs of elder abuse continues to be a barrier for physicians who treat older adult patients. However, education may improve primary care physicians’ ability to detect and recognize elder abuse.

Estimates suggest that between 1.4% and 5.4% of older adults experience abuse, a problem that has worsened since it was first highlighted in the early 1970s. Because older adults are expected to account for 1 of every 5 US individuals by 2030, it is critical for clinicians to be aware of elder abuse in order to improve geriatric primary care.

Between 1 and 2 million adults in the United States experience abuse annually. In the National Elder Mistreatment Study, 1-year prevalence rates for adults older than 65 years were 4.6% for emotional abuse, 1.6% for physical abuse, 5.1% for potential neglect, and 5.2% for financial abuse. Older adults who have been abused have poorer survival when compared with those who have not been abused.

The term elder abuse is comprehensive and may refer to abuse, neglect, exploitation, or abandonment of an older adult by someone who is not identified as a stranger. Abuse can be physical (ie, willful act with intent of pain or injury) or psychological (ie, verbal act resulting in mental anguish). Neglect is the failure to fulfill a caretaking obligation and may be described as intentional neglect (ie, willful failure to provide care), unintentional neglect (ie, nonwillful failure to provide care) or self-neglect (ie, conduct that threatens an individual’s own safety). Financial exploitation is defined as theft or confiscation of property or assets.

Although no federal statute exists specifically to prevent the mistreatment of older adults, individual states have enacted statutes to protect the elderly. Most states require mandatory reporting by professionals including physicians, psychologists, nurses, law enforcement officials, and clergy. Physicians are in an especially critical role with regard to the safety of elderly patients because physicians are likely to have frequent contact with older adults as they manage medical problems. In addition, physicians are often taken into confidence by older adults, who respect their authority and confidentiality. Given these facts, it is of concern that only 1 of 14 cases of elder abuse or neglect is ever reported to authorities.

From the Department of Psychiatry (Dr Wagenaar), the Department of Statistics and Probability (Dr Page), and the Center for Statistical Training and Consulting (Dr Herman) at Michigan State University and the Michigan State University College of Osteopathic Medicine (Dr Rosenbaum), both in East Lansing.

Financial Disclosure: Funding for this survey project was provided in full by a grant from the Blue Cross Blue Shield Foundation of Michigan.

Address correspondence to Deborah B. Wagenaar, DO, MS, Department of Psychiatry, A 231 E Fee Hall, Michigan State University, East Lansing, MI 48824-1020.

E-mail: wagenaar@msu.edu

Submitted October 14, 2009; revision received June 16, 2010; accepted July 2, 2010.
Results of studies suggest that physician involvement in the reporting of elder abuse is lacking. In a survey of emergency room physicians, only 31% were aware of a written protocol for elder abuse and most were unfamiliar with the reporting mandates for elder abuse in their state. Surprisingly, only 2% of all elder abuse reports are generated by physicians, despite statewide mandates that are present in most states. In one survey, two-thirds of residency programs did not place a major emphasis on training about elder abuse.

Reasons for underreporting of elder abuse and for physicians’ lack of knowledge about reporting statutes are not fully clear. Proposed barriers to reporting have included physicians’ concerns about being wrong, disturbing the patient-physician relationship, confidentiality, and lack of ample proof to make a report. In addition, reporting elder abuse to local or state authorities may take additional time and resources from busy primary care physicians. Jones et al found that 92% of physicians surveyed did not believe that their states had sufficient resources to meet the needs of elderly victims; this belief could contribute to reporting apathy.

How can clinicians more actively address elder abuse? Some efforts have used the Minimum Data Set for Home Care assessment to identify risk factors for abuse including brittle support (problems with the primary caregiver), loneliness, and conflict with family or friends. The presence of these risk factors might encourage primary care physicians to screen for elder abuse. In addition, efforts continue in the development of brief, rapid screening tools for detecting elder abuse in primary care. The US Preventive Services Task Force has also studied elder abuse, noting that trials demonstrating screening instrument use and validity are limited.

Given these facts, we sought to understand Michigan primary care physicians’ knowledge of and reporting practices for elder abuse, including the type of elder abuse education they received, the nature of their clinical practice, and the barriers that prevent them from reporting elder abuse.

Methods
Survey Development
A focus group of experts in primary care, elder abuse, and survey development was convened to offer content expertise in the creation of this survey. Members of the focus group represented the fields of medicine, education, and statistics. We also used a focus group while conducting an earlier survey (Appendix). Demographic items included specialty, age, years in practice, practice location, and practice setting. We also asked participants to identify the specialty and the location of the residency program they completed. Questions about completed hours and perceived adequacy of training about elder abuse during participants’ residency followed. Participants were asked to identify the types of elder abuse education they received within the past 5 years, as well as types of elder abuse continuing medical education (CME) activities that they believed would be beneficial for the future. Subsequent items inquired about the prevalence of elder abuse in the participants’ practices, the number of elderly abuse cases the participants had reported, and perceived barriers to reporting elder abuse.

Data Analysis
Distributions for all variables were examined for errors in coding and distributional properties. Dichotomized variables were created for the following items: adequacy of residency training about elder abuse (not adequate/adequate); participation in CME on elder abuse (no/yes); presence of patients experiencing abuse in practice (no/yes); patient abuse reported to Adult Protective Services (APS) (no/yes); use of at least one category of support staff to report abuse (no/yes); and identification of at least one barrier to reporting (no/yes).

Counts were created for questions with more than one answer, including the questions on past and future CME activities.
opportunities; types of support staff used to report abuse; and number of barriers identified. The 14 possible answers to the question about barriers to reporting elderly abuse were divided into 3 categories: victim, office, and external. The number cited for each type of barrier was computed.

The χ² analyses were used to assess the degree of association between categorical variables. One-way analyses of variance were used to assess mean difference on continuous dependent variables (number of types of CME opportunities, number of patients suspected of having been abused, number of patients reported as having been abused, and number of barriers identified) among groups based on the categorical independent variables (specialty, location, setting [eg, hospital, ambulatory care centers, nursing home], education in elder abuse, and adequacy of training). Correlational analyses were used to assess the degree of association between 2 continuous variables.

Results
Demographics
Of the 855 surveys mailed, 222 were returned for a response rate of 26%. The largest number of respondents were physicians in family practice (100 [47%] of 214 physicians) (Table 1). Most physicians who responded were aged between 46 and 55 years (76 [36%] of 208 physicians) (Table 2). Years in practice were fairly evenly divided among all categories (Table 3).

Almost half of the respondents practiced in suburban settings (97 [46%] of 211 physicians), with fewer practicing in urban settings (70 [33%] of 211 physicians) and rural settings (41 [19%] of 211 physicians). The majority of respondents practiced in ambulatory care settings (119 [56%] of 211 physicians). Sixty-one (29%) of 211 survey respondents reported working in hospital-based practices, and substantially fewer respondents (7 [3%]) reported working in nursing home practices. Twenty five (12%) of 211 survey respondents endorsed the nonspecific “other” category for practice location.

Reported Training About Elder Abuse
More than half of the survey respondents (103 [51%] of 204 physicians) had no formal residency training in elder abuse detection. About one-third (77 [38%] of 204 physicians) reported undergoing 1 to 5 hours of training, while only 24 (12%) reported 6 or more hours of training in elder abuse (Table 4).

Survey responses showed an association between medical specialty and hours of training about elder abuse topics (P<.001). Physicians in internal medicine were most likely to report no training, whereas physicians in emergency medicine were most likely to report some training (Figure 1). The majority of physicians (131 [67%] of 197 physicians) believed that their training about elder abuse was “not very adequate” or “not adequate at all.” A small minority of respondents (13 [7%] of 197 physicians) thought that their elder abuse education was “very adequate.”

Most physicians who reported completing training about elder abuse cited “elder abuse reading materials” (84 [40%] of 210 physicians), “formal in-person lectures” (58 [28%] of 210 physicians), and “audio tapes/CD” (25 [12%] of 210 physicians) as types of activities completed. Newer learning technologies such as “on-line lecture” and “video/DVD” were much less popular with respondents (15 [7%] of 210 physicians). When the respondents were asked about how they would best like to have elder abuse information presented to them in the future, they consistently endorsed similar strate-

---

**Table 1**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family medicine</td>
<td>100 (47)</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>70 (33)</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>44 (21)</td>
</tr>
</tbody>
</table>

*Eight of the 222 physicians surveyed did not answer this survey question.
†Percentages do total 100 because of rounding.

**Table 2**

<table>
<thead>
<tr>
<th>Age, y</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>36-45</td>
<td>55 (26)</td>
</tr>
<tr>
<td>46-55</td>
<td>76 (37)</td>
</tr>
<tr>
<td>56-65</td>
<td>44 (21)</td>
</tr>
<tr>
<td>&gt;65</td>
<td>33 (16)</td>
</tr>
</tbody>
</table>

*Fourteen of the 222 physicians surveyed did not answer this survey question.

**Table 3**

<table>
<thead>
<tr>
<th>Years in Practice</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td>47 (22)</td>
</tr>
<tr>
<td>11-20</td>
<td>60 (28)</td>
</tr>
<tr>
<td>21-30</td>
<td>60 (28)</td>
</tr>
<tr>
<td>30</td>
<td>46 (22)</td>
</tr>
</tbody>
</table>

*Nine of the 222 physicians surveyed did not answer this survey question.
gies including elder abuse reading materials (84 [40%] of 210 physicians), formal in-person lectures (58 [28%] of 210 physicians), and audio tapes/CD (25 [12%] of 210 physicians) (Table 5).

Physicians who reported up to 10 hours of training were more likely to rate their training as either not very adequate or not adequate at all, compared with physicians who reported more than 10 hours of training ($\chi^2=64.340, P<.001$).

Table 4
Reported Hours of Residency Training on Elder Abuse Topics: Physician Responses to Elder Abuse Survey (n=204)*

<table>
<thead>
<tr>
<th>Hours of Training</th>
<th>No. (%)†</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>103 (51)</td>
</tr>
<tr>
<td>1-5</td>
<td>77 (38)</td>
</tr>
<tr>
<td>6 or more</td>
<td>24 (12)</td>
</tr>
</tbody>
</table>

*Eighteen of the 222 physicians surveyed did not answer this survey question. †Percentages do not total 100 because of rounding.

Physicians who reported up to 10 hours of training were more likely to rate their training as either not very adequate or not adequate at all, compared with physicians who reported more than 10 hours of training ($\chi^2=64.340, P<.001$). Hours of training and adequacy of training were positively related ($r=0.582$). However, physicians who reported 6 to 10 hours of training were most likely (193 [88.9%] of 217 physicians) to rate their training as “somewhat adequate” or “very adequate.”

Figure 1. Hours of residency training on elder abuse topics by medical specialty as reported by physicians who completed a survey on elder abuse.

Reporting Elder Abuse

The mean (standard deviation [SD]) percentage of older adult patients who experience abuse, as perceived by the survey respondents, was 3% (4.5%). The mean (SD) number of cases of elder abuse reported to APS per physician was 1.2 (1.9). Whether abuse was reported was highly correlated with whether it was suspected ($\chi^2=26.195, P<.001$). Physicians who reported completing no CME on elder abuse were also likely to report “did not recognize abuse at time of visit” as a barrier to reporting.

The use of ancillary health professionals to actually file an APS complaint could have an impact on whether elder abuse is reported. According to the responses, support staff in family practice offices was used substantially less often than was support staff in emergency medicine departments to report elder abuse (sum of squares=19.408, $df=2, P<.002$).

Emergency room physicians may have a more extensive network of support staff as a function of their hospital setting. More than one-fourth of survey respondents (63 [29%] of 218 physicians) reported not using any support staff to report elder abuse. Physicians who did report using support staff most frequently cited nurses (n=49 [23%]) and social workers (n=38 [86%]) as types of support staff used. Practice location also appeared to influence the type of support staff used to deal with elder abuse. Physicians in suburban locations, compared with physicians in urban or rural settings, appeared to
likely to check “yes” for “did not recognize abuse at time of visit” as a barrier to reporting. Additional efforts should be made at the state and federal level to provide elder abuse education in formats that physicians desire, such as journal articles, audiotapes, and formal lectures. Primary care disciplines should consider offering more education about elder abuse as part of member educational activities. As physicians become more adept at using online resources, additional consideration might be given to producing primary care–focused online CME materials that physicians could access as they desire.

The inability to recognize subtle signs of elder abuse continues to be a barrier for primary care physicians. It might be easier for physicians to develop alternate explanations for bruises or fractures than to entertain the notion that caregivers may have caused these injuries. Our survey results suggest that, for some groups of physicians, such as emergency room physicians, this is a compelling issue.

According to our survey, physicians in suburban locations feel they have more ancillary help in reporting elder abuse cases. Of concern is that more than 25% of all physicians have the greatest number of staff resources (Figure 2). Survey respondents from rural settings were half as likely to use nurses, social workers, or mental health professionals to help with elder abuse issues.

Family practitioners most frequently identified elder abuse as not being a significant problem for their patients (35 [57%] of 63 physicians) and poor cooperation from reporting agencies (21 [52%] of 41 physicians) as barriers to reporting. Internists were more likely to defer reporting to other specialties (eg, social work, nursing) (3 of 5 physicians). Thirteen [31%] of 44 emergency medicine physicians reported abuse involving subtle signs or minor injuries as a barrier.

**Comment**

More than half of the survey respondents reported no formal training in elder abuse. Based on our survey results, education makes a difference in a primary care physicians’ ability to detect and recognize signs and symptoms of elder abuse. Those physicians who reported undergoing formal training in elder abuse during their residency programs or who participated in CME activities within the past 5 years were less likely to check “yes” for “did not recognize abuse at time of visit” as a barrier to reporting. Additional efforts should be made at the state and federal level to provide elder abuse education in formats that physicians desire, such as journal articles, audiotapes, and formal lectures. Primary care disciplines should consider offering more education about elder abuse as part of member educational activities. As physicians become more adept at using online resources, additional consideration might be given to producing primary care–focused online CME materials that physicians could access as they desire.
in rural settings reported that they did not use support staff in dealing with elder abuse. What help is then provided to an abused elder living in a rural setting? One answer may be that, in rural settings, elder abuse is more often addressed informally by the community and less frequently by physicians. For example, informal family networks may help with caregiving or dealing with abuse. In addition, it is unclear whether rural physicians do not report elder abuse at all or if they simply do not use support staff when reporting abuse. Further studies of elder abuse that take into account treatment location may further elucidate health service needs issues and regional differences in treatment approach.

The findings from our survey suggest that, to reach primary care physicians with additional information and support about elder abuse, we may need to take a flexible, variable approach that is dependant on the needs of the primary care specialty. For example, family physicians most frequently endorsed inadequate community resources as a barrier to responding to identified cases, leading us to believe that perhaps a greater connection with APS and community resources to provide support may be most meaningful to these family practice physicians. On the other hand, internists more often cited deferring elder abuse reporting to other specialties. Providing ongoing, effective CME activities for internists that focus on screening and physician responsibility may be most effective for them. Finally, emergency department physicians might benefit most from seminars and educational materials that address subtle signs of elder abuse. Providing specialty-specific information about detection and treatment of elder abuse could more effectively impact clinical care.

One element that is critical for the improvement of elder abuse detection and treatment is victim advocacy. Older adults without obvious physical evidence of abuse may be unwilling to talk about the abuse they have experienced at the hands of caregivers, because they are fearful of retaliation or abandonment. Educating primary care physicians on how to ask about elder abuse in an open-ended, non-threatening manner is critical to providing an atmosphere of safety. Additional surveys should be performed or clinical observations made to clarify further if and how physicians ask about abuse if the abuse is not obvious to them. In addition, public information and advocacy campaigns on elder abuse would also be helpful to educate the community about the dangers of elder abuse and the importance of early detection.

A number of limitations exist with this survey. We recognize that our physician response rate is low but not uncharacteristic for physician-based surveys. Low physician response rates may impact the generalizability of this study. However, these rates are not unusual for practicing primary care physicians. In addition, physicians’ responses were subject to recall bias with respect to number of CME hours focused on elder abuse. This survey is limited to Michigan physicians; we had respondents from all settings (rural, urban, suburban) and hope that our results might generalize to other settings. National surveys on this topic are warranted in order to support the generalizability of these results.

Our study points out the need for future research on elder abuse detection and reporting in primary care. Other studies may want to more fully explore the role of support staff and why physicians choose to use or not use them. In addition, future research calls for epidemiologic approach to studying detection rates and how physicians’ attitudes impact their actual ability to detect and triage elder abuse cases. Little is known about the differences between suspected and actually reported elder abuse cases; information about these differences is also important for future research.

Conclusion

As our older adult population increases, we must find ways to more effectively identify elder abuse. Physician education is one critical component of this task. Education in the form of clear, effective literature, as well as CME lectures that are accessible and interesting continue to be critical for primary care physicians. In addition, providing additional community resources and financial support to treatment programs and public education is necessary to improve the quality of life for our abused elders. A multifaceted approach is vitally important to correct the problem of elder abuse.

References


2. The National Center on Elder Abuse at The American Public Human Services Association, in Collaboration with Westat Inc. The National Elder Abuse Inci-
7. of elder mistreatment.
8. should do.


Downloaded From: http://jaoa.org/pdfaccess.ashx?url=/data/journals/jaoa/932117/ on 07/13/2018
Elder Abuse Survey

For the purposes of this survey, elder abuse is defined as physical, sexual, emotional, verbal abuse and/or neglect, abandonment, financial/material exploitation or self neglect of individuals age 65+.

DEMOGRAPHICS:

Please indicate your specialty: (check one)
- Family practice
- Internal medicine
- Other: _______________________________

What is your age range? (check one)
- 25-35 years
- 36-45 years
- 46-55 years
- 56-65 years
- >65 years

How long have you been in practice? (check one)
- 0-10 years
- 11-20 years
- 21-30 years
- 31-40 years
- >40 years

Where is your practice located? (check one)
- Urban
- Suburban
- Rural
- Other _______________________________

What type of setting do you currently practice in? (check one)
- Hospital based
- Ambulatory
- Nursing home
- Other: _______________________________

LEARNING ACTIVITIES:

From which residency program did you graduate? _______________________________

Please estimate how many hours of training (clinical, lectures, etc…) you had on elder abuse during your residency? (check one)
- none
- 1-5 hours
- 6-10 hours
- >10 hours

How adequate was your residency training in elder abuse? (check one)
- Very adequate
- Somewhat adequate
- Adequate
- Not very adequate
- Not adequate at all

In the past 5 years, have you completed any of the following elder abuse educational activities? (check as many as apply)
- yes no On-line lecture
- yes no Formal in-person lecture
- yes no Video/DVD
- yes no Audio tapes/CD
- yes no Small group case reviews
- yes no Elder abuse reading materials
- yes no None

In the future, what type of CME activity on elder abuse would be beneficial to you? (check as many as apply)
- On-line lecture
- Formal in-person lecture
- Video/DVD
- Audio tapes/CD
- Small group case reviews
- Elder abuse reading materials
- None needed

(continued)
**Clinical Contact:**

What percentage of your patients are 65 years of age or older? __________________________

Of the patients you see 65 years and older, what percentage would you say are experiencing abuse? __________________________

How many patients 65 years and older did you report to Adult Protective Services last year for Elder Abuse concerns? __________________________ (number of patients)

What types of issues stop you from reporting elder abuse in your practice? (check as many as apply)

- [ ] yes [ ] no Victim denied abuse
- [ ] yes [ ] no Unclear if case fits criteria of abuse
- [ ] yes [ ] no Abuse involved subtle signs or minor injuries
- [ ] yes [ ] no Did not recognize abuse at time of visit
- [ ] yes [ ] no I do not think elder abuse is a significant problem for my patients
- [ ] yes [ ] no Time constraints
- [ ] yes [ ] no No support staff available to assist
- [ ] yes [ ] no Medical malpractice concerns
- [ ] yes [ ] no HIPAA confidentiality concerns
- [ ] yes [ ] no Not part of my specialty
- [ ] yes [ ] no Inadequate community resources to respond to identified cases
- [ ] yes [ ] no Poor cooperation from reporting agency
- [ ] yes [ ] no I defer reporting to other specialties (social work, nursing, other)

Do you utilize any of the following support staff in reporting elder abuse? (check as many as apply)

- [ ] yes [ ] no Nursing
- [ ] yes [ ] no Clerical staff
- [ ] yes [ ] no Social work
- [ ] yes [ ] no Mental health specialist
- [ ] yes [ ] no Other: __________________________

What are the consequences for not reporting elder abuse in the state of Michigan? (check as many as apply)

- [ ] yes [ ] no Fines
- [ ] yes [ ] no License sanctions
- [ ] yes [ ] no Malpractice actions
- [ ] yes [ ] no Civil liability (liability under tort law)
- [ ] yes [ ] no No consequences exist

If you have questions about this survey or wish to contact the authors, please contact Deb Wagenaar, DO, MS, at 517-432-2994; wagenaar@msu.edu; or A231 E Fee Hall, Michigan State University, East Lansing, MI, 48824.