Health Care Professionals' Perspectives on Barriers to Elder Abuse Detection and Reporting in Primary Care Settings

Amy N. Schmeidel BA [a], Jeanette M. Daly RN, PhD [b], Marcy E.
Rosenbaum PhD [b], Gretchen A. Schmuch MSW [b] & Gerald J. Jogerst
MD [b]

[a] Carver College of Medicine, University of Iowa, Iowa City, Iowa,
USA

[b] Department of Family Medicine, University of Iowa, Iowa City,
Iowa, USA
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AMY N. SCHMEIDEL, BA
Carver College of Medicine, University of Iowa, Iowa City, Iowa, USA

JEANETTE M. DALY, RN, PhD, MARCY E. ROSENBAUM, PhD,
GRETCHEN A. SCHMUCH, MSW, and GERALD J. JOGERST, MD
Department of Family Medicine, University of Iowa, Iowa City, Iowa, USA

The purpose of this study was to explore health care professionals' perspectives on elder abuse to achieve a better understanding of the problems of reporting and to generate ideas for improving the detection and reporting process. Through a mailed survey, nurses, physicians, and social workers were invited to participate in an interview. Nine nurses, 8 physicians, and 6 social workers were interviewed, and thematic analysis was used to identify the following core themes: preconceptions, assessment, interpretation, systems, and knowledge and education. Participants suggested a reorganization of the external reporting system. More frequent and pragmatic education is necessary to strengthen practical knowledge about elder abuse.

KEYWORDS elder abuse, elder mistreatment, primary care, reporting

INTRODUCTION

In the United States, mandatory reporting laws for health care professionals exist in 44 states and the District of Columbia (Daly, Jogerst, Brinig, &

Dawson, 2003). Guidelines from the American Medical Association note that a physician may be the only person outside the family that an elder sees regularly and is therefore in a key position to report elder abuse (Aravanis et al., 1993). However, many health care professionals attest to viewing cases of suspected elder abuse but fail to report them (Daly & Jogerst, 2005). One study revealed that physicians only report 2% of all suspected cases (Rosenblatt, Cho, & Durance, 1996). In the same study, social workers and mental health professionals reported 25% of case and nurses reported 26% of suspected cases, a substantially larger number than reported by physicians. Even so, it is suspected that only 1 in 5 cases of abuse is reported (National Center on Elder Abuse, 1998).

The reasons for lack of reporting have been identified by community health care providers and include clinicians reluctant to acknowledge abuse, lack of protocol to identify abuse, fear of liability, and limited number of services available to implement for abuse detection (Rathbone-McCuan & Voyles, 1982; Rodriguez, Wallace, Woolf, & Mangione, 2006; Wei & Herbers, 2004). Reasons for lack of case detection decisions by health care professionals include lack of knowledge about elder abuse; its prevalence, signs, and symptoms; risk factors; and information about perpetrators (McCreadie, Bennett, Gilthorpe, Houghton, & Tinker, 2000; McCreadie, Bennett, & Tinker, 1998; Taylor, Bachuwa, Evans, & Jackson-Johnson, 2006).

While laws require reporting regardless of mitigating circumstances, most health care professionals consider the broader context of the patient before reporting, including patient autonomy and rights, patient–physician confidentiality, quality of life, and future patient–health care professional relationships. One study found that many physicians encounter three key realities when deciding to report; namely, they worry about future physician–patient rapport and trust, patient quality of life, and physician control (Rodriguez, et al., 2006).

Various reasons exist for having unreported cases of elder abuse, such as a lack of trust in the reporting system, difficulty in detecting abuse, and lack of time. Over 90% of emergency physicians felt that their state lacked the resources to meet the needs of victims (Jones, Veenstra, Seamon, & Krohmer, 1997). Just 11% of Iowa family physicians thought there were sufficient resources to address elder abuse (Oswald, Jogerst, Daly, & Bentler, 2004). Although all adult protective services (APS) laws provide immunity from liability for those who report in good faith, some physicians cite that fear of liability keeps them from reporting except in cases of absolute evidence (Rodriguez, et al., 2006; Wei & Herbers, 2004). Unreported cases exist also, as many physicians may not even broach the subject with their patients; one study showed that over 60% of physicians had never asked their elderly patients about abuse (Kennedy, 2005).

Rodriguez and colleagues (2006) interviewed a convenience sample of 20 family and general internal medicine physicians to identify their

perspectives on mandated reporting of elder abuse. This study expands that work by examining the perspectives of other health care professionals, along with physicians, in primary care settings. Previous studies typically focus on the role of only physicians in reporting elder abuse, neglecting to fully reveal the multidisciplinary approach within health care systems. An elder patient may encounter many mandatory reporters in their clinical visits.

The purpose of this study was to explore health care professionals' (nurses, physicians, and social workers) perspectives on elder abuse to achieve a better understanding of the problems of detecting and reporting elder abuse. Then, ideas for improving the process can be generated. Specifically, this exploratory study sought to identify the barriers to elder abuse reporting and how perceptions of barriers vary depending on health care discipline. This qualitative approach using in-depth interviews is appropriate for exploring a complex domain that is not fully understood, in this case perspectives on and barriers to mandatory reporting of elder abuse, and is meant to be hypothesis-generating rather than hypothesis testing.

METHODS

The methods for this project were approved by the Institutional Review Board of the University of Iowa. Methods will be described for subject recruitment, instrument, interviews, and qualitative analyses.

Subject Recruitment

A combined convenience and purposive sample of nurses, physicians, and social workers was sought (Marshall, 1996). All family physician names were obtained from the Iowa Board of Medical Examiners, and all nurse names were obtained from the Iowa Board of Nursing. All family physicians were selected from two adjoining counties in Iowa to receive the mailing. The counties selected were convenient for the interviewer to have close proximity for the interviews. All nurses employed in an office setting, except those employed at student health centers, as research assistants, or in pediatric specialties, were selected from the same two counties in Iowa. An office social worker (GS) provided a list of social worker names from one of these two counties.

A cover letter with the list of interview questions was sent to all eligible 155 physicians, 221 nurses, and 19 social workers. Included in the envelope was a form to complete and return in a postage-paid envelope indicating that the respondent would participate in the study interview. Returning a completed form indicated consent to participate. Contact information was provided on the form. After receipt of acceptance to participate, a researcher

contacted the respondent and set up a time and place for interview. Sixty envelopes (43 from physicians, 17 from nurses) were returned as undeliverable. Six persons reported they felt unqualified or lacked time to participate. No further attempts were made to engage nonrespondents after the initial invitation letter, as a sufficient sample size had been obtained.

Data Collection

An interview guide developed by Rodriguez and colleagues (2006) was used for this study. The guide had 13 open-ended interview questions (see Appendix) and was developed from literature review and expert input. The questions were developed for physicians and were modified for nurses and social workers by replacing "physician" with "nurse" and "social worker." Demographic information was not collected from the subjects because of the topic. A respondent could indicate they were aware of an elder abuse incident and had not reported it, which would be against the law in Iowa.

One interviewer (AS) was trained in ethnographic techniques by an investigator (MR), and she conducted all interviews. The interviewer held three practice sessions with two nurses and a physician prior to data collection and was critiqued by the three. The interviews were conducted in the respondent's or interviewer's office. At the beginning of the interview, the respondents were reminded not to indicate who they were or the names of any of the abuse victims. Interviews lasted from 10 to 60 minutes depending on the participants clinical experience with elder abuse, were all tape-recorded, and transcribed verbatim.

Qualitative Analysis

A multistep process of thematic analysis was used to identify the core themes that represent the perceptions of nurses, physicians, and social workers about barriers to elder abuse reporting (Crabtree & Miller, 1999; Rice & Ezzy, 1999). All transcriptions were entered in N'Vivo (QSR International, Victoria, Australia), a qualitative software program that allows for coding and systematic searching of interview data. The analysis team was made up of a family physician geriatrician (GJ), a nurse researcher (JD), a social worker (GS), a medical student who served as primary investigator and interviewer for the study (AS), and an anthropologist who oversaw the qualitative analysis of the data (MR). To develop a preliminary codebook, each team member carefully read a sample of transcripts from all professions and assigned descriptive codes to segments of text. Team members met to reach consensus on codes and the interviewer applied these codes to the transcripts of responses of all persons interviewed. A second coding step entailed members of the research

team representing each profession (nurse, physician, social worker) interactively reading through interview transcripts from subjects in their profession. Members of the research team developed discipline specific coding schemes and then met to reach consensus on overarching categories of barriers to elder abuse reporting that would capture individual differences and allow for generalizability of the perceptions of all practitioners. Codes were then grouped into these five primary categories and were analyzed by profession to reveal difference and similarities in discipline specific statements related to each of the five categories (see Table 1).

RESULTS

Nine nurses, eight physicians, and six social workers participated in interviews, resulting in a total of 23 participants. Nurse and physician participants worked in hospital-based outpatient clinics and stand-alone physician clinics. Social workers were employed in hospital-based outpatient clinics, a tertiary care hospital, an elder services organization, and a nursing home.

Descriptions of Elder Abuse

All professions reported emotional, financial, mental, neglect, physical, psychological, spousal, and verbal abuse as the kinds of abuse they may encounter. In addition, physicians reported isolation and sexual abuse. Social workers also mentioned self-neglect.

Nurses tended to describe the abuse rather than label it, such as you might find a patient with suspicious injuries, perhaps on the forearm, some bruising or burns, or a blackened eye. Physicians answered succinctly with labels, such as physical abuse or financial exploitation.

In contrast to nurses and physicians, social workers all focused on self-neglect.

Barriers to Elder Abuse Detection and Reporting

Analysis of participants' statements about barriers to detecting and reporting of elder abuse revealed five major categories under which the majority of statements could be grouped: professional orientation, assessment, interpretation, systems, and knowledge and education. The level of emphasis on each of these categories varied between each profession interviewed.

Professional Orientation

Nurses, physicians, and social workers each approach elder abuse with different values that they have developed over their years of practice. While individual experiences varied, trends emerged in the general disposition of

TABLE 1 Themes With Grouped Codings

Professional orientation	Knowledge/Education	Assessment	Interpretation	Systems
Upset patient/professional	Knowledge of abuse and law	Privacy from caregivers	Dependency/autonomy	Internal system barriers
Believe abuse is rare	Lack of adequate training	Clinical time	Quality of life	External system barriers
Believe others see abuse more	Misinformation about the law	Sensitivity to mistreatment	Gray areas in definitions	Reimbursement
Want to be certain of abuse	Misinformation about abuse	Continuity of care	Suspicion hard to interpret	Statutory barriers
Worry about patient relationship		Confidentiality		Assessment of agency
Uncertainty of whose job it is to report		Patient barriers (fear)		IDHS
Help needed to detect and report abuse		Practicality		
Personal values influence reporting		Other priorities besides abuse		
Might not report if no intent to harm				
Assume the best of patients				

groups of health care workers as they discussed their thoughts and approach to elder abuse.

Nurses expressed passion about caring for their patients and preventing and detecting elder abuse. Nurses reported wanting to look for other explanations than elder abuse to explain why their patients are not doing well. As one nurse said, "Concerns would be falls, which can be described as 'I tripped and fell down the stairs.' Does that raise a suspicion? Not typically." Nurses stated feeling uncomfortable asking about abuse, and were more task-oriented to getting things done quickly that they are assigned to do, such as taking vital signs and getting the medical record ready for the physician. One nurse explained this as:

> . . . (nurses) are more concerned about "do we have the questions answered, to get the billing correct, do we have the blood pressure down, do we have all of the stuff that we need," there is not a lot of skill sometimes from the people that are actually in a position to find out much more before the seven or twelve minutes that the physician has.

Nurses also looked to others to deal with abuse, noting that others were more likely to see it than they would in their practice. They thought that physicians and supervisors should be the ones dealing with the abuse and that they should always direct any suspicions to them. Part of this stemmed from misconceptions about the laws; some nurses believed that protocol within the clinic prevented nurses from looking into reporting abuse, believing instead that the physician should look into and report it: "No, I think just mainly getting social services involved and letting them take over, because that is their expertise and they will be able to get a hold of the situation." Most nurses thought they either should rarely or never report directly to the Iowa Department of Human Services (IDHS), the regulatory agency for receiving reports and investigating elder abuse. One even noted explicitly that her experiences have changed how she deals with something like abuse, that she is now less likely to report every suspicion and more likely to validate her concerns first. While nurses clearly stated that all they need is a suspicion, they were unwilling to accuse people without very strong suspicions and leave investigations into their suspicions to a physician or social worker.

> The doctor can do that, though, I don't know that my licensure really puts me that far. It makes me a mandatory reporter, but reporting what I see is one thing, but actually speaking directly to the person, that's totally different, unless, I was one-on-one with the patient. If the patient's telling me this stuff, then I'd say, "Ok, the doctor's going to be coming in, you need to talk this over with her."

Physicians reported elder abuse as an important issue that they don't encounter enough in their practice to actively concern themselves with. One of their greatest barriers in disposition was the set of priorities with which they are otherwise concerned. Because of their limited time schedules, they prioritize with what they feel most concerned and comfortable dealing.

> I mean they die of heart disease, they die of high blood pressure, of cancer. So you go with what's going to kill them most likely, which is those common diseases, and elder abuse is probably too common, but it doesn't kill 400,000 people a year like heart disease does. So subconsciously, and maybe even consciously, you tend to suppress those suspicions.

Physicians thought that other physicians or health care workers were more likely to see abused and neglected patients. If they did see it, they wanted to let social workers investigate and deal with it since they were the "experts." In addition, they respected their patients and wanted to trust and work with their patient rather than bring an outside party into the relationship. They were hesitant to upset the patient or label something as abuse. Physicians were reluctant to be incorrect and looked for "high suspicion" and "enough information" in order to report. One physician said "doctors don't want to be wrong, they want to be 100% certain, and suspicion does not mean certainty."

Social workers highly valued the safety and care of the elder and were hesitant to talk to patients about abuse for fear of alienating caregivers and patients or bringing retaliation onto the patient. They also wanted sufficient evidence, for fear of identifying the wrong perpetrator, as well as to have a strong enough case to be accepted. If a family member who was neglecting seemed to be amenable to additional services, the social worker instead attempted to manage the situation themselves instead of referring to IDHS. When they didn't feel like there was enough evidence, they would personally try to gather more information before reporting, or else they didn't report it at all and attempted to improve the possible abusive situation themselves. One social worker described her approach as:

> So if you don't feel like something's going to happen, it might be easier to say, "Looks like things are very good right now, but can we make this better? Can we just figure out a way to get you into a safe place, and if you're going to end up in a nursing home anyway, why go through all the rigmarole of the antagonism of making a report?"

ASSESSMENT

Many found difficulty in detecting abuse even if they were asking questions and looking for the possibility of it. Assessment for elder abuse was a major practical barrier that many found difficult to overcome with the resources available to them. A lack of time was one of the most commonly mentioned problems; both nurses and physicians felt that they had so many other tasks to deal with that there wasn't enough time to address elder abuse. Nurses felt they only had enough time to be concerned with tasks and questions to get the patient prepared to see the physician as quickly as possible.

Physicians were more focused on known diseases or physical conditions that they could treat and with which they were more familiar. Both cited that they had to prioritize what could best fit into the limited time they had, and most often elder abuse didn't fall at the top of that priority list. In addition, physicians noted that elder abuse isn't a problem that you can quickly or cleanly ameliorate: "The trouble is, you just can't say, 'I'm going to order an EKG and a CBC, and I'm going to call a social worker because I think you're being abused.'" Many physicians believe that it is a "schedule buster." If they suspect the possibility of abuse, they don't have enough time to delve into the subject to gather sufficient evidence to support reporting.

> The assumption is that physicians are clueless and don't care . . . so physicians are bombarded by all these people who want us to do a better job, enthusiasts who have only that as their responsibility. Very little understanding of the realities of practice.

In another pragmatic sense, obtaining privacy was a problem for all three groups. Social workers seemed most comfortable asking caretakers and family to leave the room, whereas nurses and physicians noted that it was sometimes difficult to find privacy in every visit. Nurses noted, "And I think most of the time the doctor has them go out while the exam is going on, but while I'm interacting with the elderly person, that family member is in the room." Physicians thought it was fine to ask caretakers to leave, but didn't always follow through. They might ask different questions based on whether or not the caretaker was in the room, but few mentioned asking the caretaker to leave.

General lack of sensitivity in detecting abuse is another factor in assessment challenges. The reasons to suspect abuse are often well hidden. One social worker said,

> You only see what's in front of you and do you know that someone hasn't been bathed or had their clothes put on or they're taken care of

for the past month if they come to the office in their Sunday best smiling with their loving caregiver. You know, and then somebody goes into the home and finds the place is a shambles and the electricity doesn't work and the person's been freezing.

All groups thought that the clinic was a controlled environment that allowed caretakers and elders to clean up before coming in. Elders seldom admitted to being abused because of fear of reprisal or being placed in a nursing home. Rarely did abuse present itself with easy physical evidence; the most common cases of financial abuse and neglect are far harder to find signs of within the clinic. In addition, social workers thought that even when they did suspect abuse, it was difficult to obtain sufficient information to report it.

Tied in with sensitivity is the problem of continuity of care. Several nurses thought that it was almost impossible to detect abuse in a one-time setting unless there were very obvious signs. One nurse said, "I would have to have, for elder abuse, I'd have to see a pattern. Seeing them once wouldn't give me the feeling that I could report anything, unless you overheard." Social workers and physicians thought that seeing a person over time allowed you to understand their baseline and any deviations from it.

INTERPRETATION

While the laws surrounding elder abuse try to make it clear what constitutes elder abuse and who the law protects, interpreting and implementing the law in clinical practice proved to be more difficult for most nurses, physicians, and social workers. One social worker argued, "It's not like we have universal agreement on what is abuse and what is violence in this society at all . . . I think that's part of what plays into this is that whole area of 'What is abuse?' We don't agree." Nurses were most concerned with discerning whether something they observed actually adds up to elder abuse, or whether it was merely poor care decisions by caretakers: "If you really did know someone well or felt like you understood their situation and you were on the fence, it might be reasonable in some cases to wait until the next time that you see them." Cases of abuse that were not clearly evident created challenges for others as well. One physician said,

> I think this is where it gets pretty complicated, because we're trying to determine probably from what is a continuum into a dichotomous state, which is suspicion: yes, no. And what do you do with all those gray areas in between? That makes it very hard.

In these cases health care providers often approach the patient and family as needing more resources rather than viewing the case as purposeful abuse or neglect. One social worker said,

> I think for the reason that if you don't feel like something's going to happen, it's easier just to take whatever you can do in your own hands and try and fix it, and not in the light of elder abuse, just in the light of someone who has care needs that haven't been met that you can help them meet.

The physicians' reasons for this seem to stem from personal values related to patient autonomy and respect, whereas social workers used their experience with the reporting system to IDHS as a gauge to determine whether something was "reportable" or not: "I know for a lot of social workers, you just choose not to report because if you report, nothing's going to be done."

Social workers wanted a large body of evidence available before they decide to make a report to IDHS. While they acknowledge that many cases of elder abuse are not obvious, their knowledge of the law and the reporting system made them confident in their suspicion when reporting. However, even when they feel they have well-documented abuse and dependence, many cases still were not accepted by IDHS. As said by one social worker, "If we reported every case like that, that would be huge. And I don't see IDHS taking those cases." Their line of what is abuse and what they can take care of themselves tends to be drawn not on personal values, but on what the system will accept and substantiate.

One of the other difficult issues for physicians and social workers was interpreting whether the patient who was being abused or neglected was a dependent adult. For an investigation to be conducted in Iowa, the alleged victim has to be dependent. A social worker noted the struggling with this determination, "Whether a person chooses to live that way and they're just making those choices, or whether they actually have impaired decision-making and can't make those choices." Physicians were strong advocates of personal autonomy, but also did not want their patients to be hurt. While many contrasted elder abuse with child abuse, they expressed that it was far more difficult determining dependence in an elder than in a child. For example, one physician said, "There often is question whether a 90-year-old is totally dependent. It's not always black and white in elders, whereas the existence of dependence is very black and white in children." Determination of dependences factored into decisions of whether to report or to work with the elder to improve their own care. Every social worker said that dependence was an important consideration for them when reporting. Unlike determining whether abuse was occurring, social workers typically relied on physician expertise to help make the final determination of dependence.

SYSTEM

There were two major systems discussed in the interviews: the internal system of responsibility within a clinic or hospital and the external system of reporting to IDHS. Most nurses seemed generally unaware of exact protocols for reporting elder abuse in their clinic, and some thought they didn't exist. They preferred to refer suspected abuse to the physician and/or to the social worker. Nurses also seemed generally unaware of the possibility of dealing with the reporting system external to their clinic. While some claimed suspicions of abuse, only one described actually calling and reporting to DHS in another state.

Physicians generally thought it best to report in their system to a social worker, but wished the internal system was easier to navigate. They preferred for the social worker to take over for them and tell them how best to proceed: "It's not 'call this number and we'll be right down,' it's 'this is what you should ask, and this is how you should investigate,' and the trouble is, we don't have time to ask that or investigate that." Some physicians acknowledged that part of this came from lack of payment or compensation for the long time requirements that come with reporting. Most physicians' knowledge of reporting to IDHS came from hearsay that the system was frustrating. One who had tried to report was of the opinion that IDHS seems to be underfunded and overworked, and he'd had frustrating results from reporting.

Social workers were by far the most dextrous at navigating both internal clinical and external IDHS systems. They thought that often physicians or nurses wanted the social worker to report for them. One commented that this was a poor choice; even though there might be a team approach to investigating the suspected abuse internally, everyone should take the burden upon themselves to report the abuse so that there are checks within the system to ensure cases get reported.

> I will say there have been a couple cases where I have known that there's been a report made, with patient's that I've seen, that I did not think it was a dependent adult, but somebody else felt they were and made a report. Which is, in a way, the system working.

Because they had the most experience with reporting, social workers knew in detail the problems they encountered with reporting to IDHS. All except one social worker found the process "frustrating." Because of how the reporting system is legislated in Iowa, social workers often found that most of their reported cases of abuse were not even accepted by IDHS for investigation: "I'm not aware that they have accepted more than one report in our county this year." Some social workers blamed the law as too prohibitive.

> What I mean by that is that if it's so stringent that there has to be a care-
> taker or if the definition of dependent is so stringent that adult protective
> services isn't taking referrals, then we have to do something about that to
> loosen that up or at least to have some kind of alternative so that person
> can still be brought into the system.

Social workers felt that there needed to be something else in place to bring
alleged victims into the system and obtain resources. When cases were
accepted, they were often not substantiated, even when social workers had
documented that abuse or neglect had occurred: "I feel like the neglect rises
to a level of self-neglect, but IDHS or the county hasn't agreed with that,
and felt like the situation almost needed to worsen before they could step
in or do anything."

Some blamed this on parts of the law being unclear, leading to different
interpretations by social workers and IDHS. Some explained that since IDHS
is under such tight funding restrictions, they choose to interpret reports
so that they don't have to investigate in order to stay within their bud-
get. Because of this, some social workers believed that IDHS should not
be responsible for investigating both child and adult abuse and advocate
bringing more resources toward investigating elder abuse.

> You're not going to get stronger laws, because IDHS is always going to
> argue against them, because a stronger law is going to be more people
> into the system, and that destroys their budget, and they can't do it, so
> they'll write fiscal notes all the time to block anything that's going to cost
> more money, even though it should help more people.

Even when abuse is substantiated, social workers generally did not
see changes occurring in those mistreated. The caretaker may be banned
from professionally practicing, but the caretaker can still privately take care
of family members. IDHS isn't regulated to obtain resources for the elder
unless they have permission to, and for some dependent adults they don't
receive that permission. If they do, they often do not have adequate funding
to obtain needed resources or to pay guardians and conservators. Unlike
child or domestic abuse, no institutional settings are available for placement.
Because there is not a clear remedy to these situations, many social workers
attempted to work inside the system, but often obtained far better results by
working outside it. As one social worker explained,

> What we want is to continue to follow up if those rejections occur,
> because that doesn't take away the fact that they're still living in an
> avarice situation. So we want to work outside that if we have to, and to
> answer your question then what we want to do, what we can do is go
> in and do an assessment to try to work with the person to set up the

services that they might benefit from, even if they are not a so-called "founded case" of dependent adult abuse.

They report what they think they might be able to be substantiated with well-documented evidence or a paper trail.

> I guess it's probably made me a little more argumentative, and when I call DHS, I feel like I have to have a really strong case and a lot of concrete evidence to provide them to insure that it gets accepted or to up the likelihood that it gets accepted. So I try to have all my information and to be able to defend it.

KNOWLEDGE AND EDUCATION

Overall, social workers were the most informed about the detection and reporting of elder abuse, likely because they had all undergone the process of trying to report cases. A few thought that education and awareness of elder abuse could be improved for clinicians. Nurses and physicians weren't nearly as comfortable with their knowledge of abuse as social workers. As one physician noted,

> I think because it's an infrequent thing that doctors think about, it falls away as far as things to remember. It's like any other medical issue, if you don't treat it or see it frequently, you're not going to remember how to treat it as much in the future.

While Iowa is currently the only state with required education for mandatory reporters of abuse every five years, most found this training inadequate and unpractical for approaching an elder with suspicion of abuse. Many would like more case-based pragmatic training that they could actually use. One physician said,

> What exactly do you say? I mean, the education tends to be very vague. "Well, if you suspect elder abuse, you should inquire about X, Y, Z," without using the exact words that you would use. So what we need is the exact words.

Nurses and physicians were typically unsure of a specific person or number to contact for reporting abuse and unsure how to proceed if abuse was suspected. Some physicians and nurses presented inaccuracies in their knowledge about elder abuse. Most physicians thought that elder abuse was rare. Most nurses were unaware of many of the laws surrounding confidentiality, anonymity, and personal liability for reporting, as well as who should

specifically be the one to report. One nurse voiced her uncertainty: "We're mandatory reporters, but I don't know what that includes. Something that they tell us here in the office, if that can be divulged. But if I am outside of the office, I wouldn't hesitate at all."

DISCUSSION

The purpose of this exploratory study was to elicit the perspectives of nurses, physicians, and social workers surrounding the detection and reporting of elder abuse in primary care settings. What emerged was a sequence of events that occur during elder abuse detection and reporting that detailed the barriers to reporting elder abuse: the professional orientation held even before entering a room with a possibly mistreated elder, the assessment of that elder for abuse, interpretation of the assessment, and reporting and managing the case of elder abuse both within internal institutional and external IDHS systems. An additional barrier to detection and reporting, cross-cutting the others, was the lack of knowledge and adequate education for assessing and addressing elder abuse and neglect.

As our study demonstrates, each group of health care providers has different perspectives on their role in the detection and reporting of elder abuse. Nurses tended to perceive elder abuse as uncommon and generally did not feel it was their role nor did they have time to assess patients for potential abuse. Rather, they relied on physicians to detect and report elder abuse. Physicians felt that other patient care issues, time limitations, and maintaining trust in the clinician–patient relationship outweighed the importance of detecting and pursuing suspected cases of elder abuse, and relied on social workers to approach these issues with patients. Social workers, although having the most knowledge and experience related to elder abuse, relied on nurses and physicians to detect potential abusive situations and to work with them in making appropriate referrals. While social workers were perceived by all groups as having a major role in reporting elder abuse, social workers reported major obstacles to reporting and achieving adequate results within the current system. All groups acknowledged the need for more and better education about elder abuse detection and reporting.

While previous studies have tended to focus solely on physicians, the current study's focus on three different groups of health care professionals revealed both common and divergent perceptions of elder abuse detection and reporting. Physician–patient relationship, increase and decrease in patient quality of life, and presence and loss of physician control were themes identified by primary care physicians answering the same questions as the participants in this study (Rodriguez et al., 2006). Even though concepts were labeled differently from this work and the earlier study, the

same issues were evident, such as discerning that abuse occurred, deciding when to report, hurting the provider–patient relationship if a report is made, deciding to provide increased services other than reporting (quality of life), and determining who should report. Similar themes also evolved in this study as noted in the earlier work about reporting: reluctant to acknowledge abuse, lack of knowledge about reporting laws, protocol for reporting, and limited funding for services (Rathbone-McCuan & Voyles, 1982). In a recent focus group study to develop and validate an instrument, nurses, physicians, and social workers involved with elder abuse appeared to have similar thoughts as the respondents in this study (Yaffe, Wolfson, & Lithwick, 2009). Nurses were practical and cognizant of time constraints in the clinic setting, physicians were holistic in their approach but were also constrained by practicality and time, and social workers were advocates for their clients.

While Iowa is currently the only state with mandatory training on dependent adult abuse, confusion still persists as to the actual law surrounding both abuse and mandatory reporting, especially by nurses. Differing institutional requirements and chains of command may contribute to this confusion. When asked what changes or improvements could be made, many people from all groups suggested more frequent and more practical education. While education is currently mandated every five years in Iowa for mandatory reporters of abuse, participants requested refreshers to be given as often as yearly. They also desired content on how to focus on specific cases and questions, as well as how to best respond.

It is possible that such education could be helpful in providing a better base of knowledge for people to address both assessment and interpretation of elder abuse. While the realities of a busy clinic cannot be changed, giving clinicians the tools to function in that clinic and better assess patients for elder abuse in the short amount of time they have may begin to address practicality problems. While not as obvious as physical ailments, elder abuse is far more prevalent and impactful on health than most clinicians recognized. Consistently screening and watching for elder abuse needs to be done in a realistic manner that fits into a clinical context. The difficulty arises in that asking about elder abuse cannot be a mere box checked off while a nurse reads questions off a computer. Rather, it must be a question sensitively attended to throughout the clinical evaluation both in a patient's responses and in their interactions with caregivers. Pragmatic education on how to address elder abuse in the clinic is essential and is a clearer, more easily implementable initial route for change than beginning to address other systemic concerns. To improve detection of elder abuse, a 6-item questionnaire, the Elder Abuse Suspicion Index, is available for use in primary care clinics (Yaffe, Wolfson, Lithwick, & Weiss, 2008). Its sensitivity is 0.47, specificity is 0.75, and takes less than 2 minutes to complete.

Proper case-based education also may begin to address some of the problems of interpretation encountered when addressing elder abuse by providing examples to which nurses, physicians, and social workers can compare their own personal experiences. Physicians and nurses who had experienced case-based education felt it was some of the most helpful for later actual possible abuse situations. Reviews of the continuing health care education interventions identify experiential, interactive, and case-based educational approaches as more likely resulting in provider behavior change than does relying solely on didactic lectures (Davis et al., 1999). Nonetheless, there is no absolute way to elucidate whether a particular patient actually meets the criteria for suspicion of abuse or neglect. Facts, values, and experience go into personally defining abuse, suspicion, and dependence for each individual health care professional. It is here, possibly, that the multidisciplinary team of all of these groups focused on addressing a specific case can be most beneficial by both aggregating evidence as well as multiple interpretations of the possible abuse. This may be especially valuable in dealing with typically more difficult cases of neglect, which constitute the highest proportion of abuse but cause the most speculation on dependence and personal autonomy.

The external systematic structure and funding of the reporting system within the Iowa Department of Human Services was obviously a far-reaching and major systematic barrier that cannot be easily changed. The lack of documented reports makes it difficult to quantify the number of reported cases of abuse versus those accepted for investigation. Working together, the three disciplines rely on each other to maneuver the system and meet the requirements for reporting. Because of their role in most systems, social workers most often have far more expertise in reporting.

An obvious undercurrent was the abounding variety of items that hindered physicians, nurses, and social workers from reporting elder abuse. For example, a commonly held notion was the idea that strong suspicion, almost to the point of certainty, was needed to report elder abuse. Many identified in one thought that they would report any suspicion, but in another detailed how although they had been suspicious of elder abuse in a certain case, they didn't report because they lacked sufficient evidence. Most seemed to understand the general idea of the law; however, implementation and understanding of the definition of "suspicion" vacillated as each individual saw fit.

In contrast to the other health professionals, social workers recognized elder abuse as a common and important problem. Their general disposition to approaching elder abuse is based on what experience has taught them. Many questioned the structure of the external system and felt that it wasn't efficient or even capable of handling elder abuse. They questioned whether they should report elder abuse initially detected by someone else and whether IDHS should be the body to whom they report. They viewed the reporting system as stressful and frustrating, and this tainted how they handled their reports.

These results must be considered in the context of our study limitations. As an exploratory qualitative study, we interviewed only a limited number of health care providers about their perceptions of barriers to elder abuse detection and reporting. While our overall sample size was small, it was appropriate in order to fulfill our study purpose, which was to identify the range and complexity of issues and barriers perceived by different health care disciplines in relation to elder abuse and within the sample size range for similar exploratory qualitative studies (Rice & Ezzy, 1999). However, it may limit the generalizability of findings from this study to understanding barriers to elder abuse reporting for all groups of health care providers. Further investigation of the categories of barriers among a larger sample size would be necessary to determine the validity of our findings. Also, as noted, this open-ended interview study did not allow for quantification of respondents perceptions, but rather only the identification of salient themes in addressing issues of elder abuse in the clinical context. This study, however, does provide a clearer foundation that could be used to develop more objective questions and surveys that would allow for assessment of whether similar perceptions and barriers are present among a larger sample of health care providers.

In addition, our study is limited to the geographical sampling. All of those sampled were in a single Iowa Department of Human Services reporting site within Iowa. The results may not be indicative of reporting results and barriers at other sites and in other states, since there are no federal laws regarding domestic elder abuse reporting.

CONCLUSION

While not as obvious as diabetes or stroke, elder abuse and neglect can have deep and long-term effects on an older person's health. The impact by health care professionals in recognizing and reporting elder abuse and obtaining resources for those mistreated can be profound. While continuity in the external reporting system is needed, many changes also can be made within the clinical setting that may facilitate reporting elder mistreatment. More frequent and pragmatic education is necessary to strengthen practical knowledge about elder abuse in the minds of nurses and physicians. This education should stress maintaining personal responsibility and fulfilling one's personal role in reporting abuse within the use of an interdisciplinary medical team.

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APPENDIX

Open-Ended Interview Questions: Nurse

Instructions: Remember, during the interview, I will be taping our conversation. Please provide no information that would identify yourself or any of your patients. We are interested in understanding nurse's thoughts on addressing elder abuse in the outpatient clinical setting.

1. Please tell me about the kinds of elder abuse that a primary care nurse might encounter in the outpatient setting.
2. Please tell me about any patient situations (provide no names or patient identifiers) in which, for whatever reason, made you think that there may be risk of or probable elder abuse.
3. What might make you suspicious that a patient of yours was experiencing elder abuse?
4. What would you do if you become suspicious?
5. Is there anything else that a primary care nurse might consider doing once there is suspicion of elder abuse?
6. Under what conditions if any would you report abuse?
7. Under what circumstances if any would you consider only monitoring?
8. Why do you think that patients who have been victims of elder abuse might be reluctant to bring this up with their primary care nurses at regularly scheduled visits?
9. Why do you think nurses may not address the topic of elder abuse, even if suspected during regularly scheduled visits?
10. How do you feel about the law that requires nurses to report suspected elder abuse?
11. What do you think could be done in your practice to help improve the effectiveness of nurse efforts to address elder abuse?
12. What changes can be made to the clinic setting or environment that will help improve the effectiveness of nurse efforts to address elder abuse?
13. Is there anything else that we haven't talked about that you would like to say about improving nurse effectiveness in addressing elder abuse?