Physical Abuse of the Elderly: The Medical Director's Response

Solomon Liao, MD, and Laura Mosqueda, MD

Many people think of physical abuse when the term "elder abuse" is used. Although it ranks behind neglect and emotional abuse as the third most common form of abuse, physical abuse cases are some of the most heinous.[1] It is also the most common form of abuse that comes to medical attention.[2] Physical abuse may include pushing, striking, force feeding, improper use of physical restraints, and infliction of pain or the withholding of pain relief.[3] It is not uncommon for a person to be a victim of multiple types of abuse; thus, physical abuse should alert us to look for other types of abuse as well. Medical directors therefore must become proficient in identifying physical abuse in older adults, know the markers that raise suspicion for abuse, and lead their multidisciplinary team and/or agency in an effective approach to this problem.

As the leader of a multidisciplinary team, the medical director is well positioned to prevent and identify possible mistreatment. The medical director can make sure that the issue of abuse is openly discussed in team meetings. For example, if a home health nurse notices that a patient is having unusual and/or unexpected wounds the possibility of abuse may be raised by the medical director during a multidisciplinary team meeting. Other members of the team might then add their observations that serve to either increase or decrease the level of concern. In working toward recognition and prevention of abuse, the medical director has the authority to insist that more training and education on the topic of elder abuse is available for members of the interdisciplinary team.

In this article we will emphasize the role of the medical director in the home health care setting and focus on the issue of physical abuse in a board and care. The following discussion will be case-based to highlight the challenges as well as potential solutions when physical abuse is suspected.

University of California, Irvine, Elder Abuse Forensic Center, Orange, CA (S.L., L.M.).

Dr Liao's effort on this paper was partly supported by funds from the Division of State, Community, and Public Health (DSCPH), Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHSS) under grant number 1-K01-HP-00029. The information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should be any endorsement be inferred by the DSCPH, BHPr, HRSA, DHHS or the US government.

Address correspondence to Solomon Liao, MD, University of California, Irvine, and Elder Abuse Forensic Center, 101 The City Drive, Building 200, Room 835, Route 81, Orange, CA 92868. E-mail: ssliao@uci.edu

DOI: 10.1016/j.jamda.2006.12.009

CASE 1: Mr Jones

Mr Jones, a 71-year-old resident of a small board and care facility, is receiving home health care for his diabetic foot ulcer. He has a moderate vascular dementia and has a history of behavioral problems, including prominent sundowning. He has wandered off a couple of times, and this is of concern because the facility is not locked and has no formal security measures in place. He ambulates with the aid of a front-wheeled walker, although he often forgets to use it and recently has had more gait difficulty because of the peripheral neuropathy and his foot ulcer.

The home health nurse reported to the medical director at the routine weekly interdisciplinary meeting that the patient had 2 black eyes. When she questioned the board-and-care staff, they stated that on the weekend the patient wandered off, tripped, and fell face forward on the sidewalk. There is no incident report or any documentation of the event. The patient is unable to provide a reliable history. His nose is not broken nor are there any lesions, lacerations, abrasions, or other evidence of trauma to the nose. The nurse states that the periorbital ecchymosis is darker on the right than the left. The right eye has more shades of blue and green while the left is more yellow and red. The patient is on enteric-coated aspirin 325 mg a day but no other medications that interfere with clotting.

The home health team debates whether abuse occurrs and whether to file a report. The team social worker ardently believes that an Adult Protective Services (APS) report should be made. The home health nurse agrees that that this is a suspicious situation but believes that there is not enough information to make a report. She would like to monitor the patient more closely to see if any other incidents occurred. The nurse manager argues that because the bruises are of different colors, they are of different ages. She thinks that 2 separate incidents occurred, and therefore this must be abuse. The agency administrator becomes involved. She is concerned that filing an abuse report will anger the facility with whom the agency has had an excellent and long-standing relationship. She would like to discuss this with the agency attorney before any action is taken.

What should the medical director do? What should the medical director recommend or say to each of the above team members? What options are available to the medical director?

DISCUSSION

Reporting Responsibility

Most states in the United States have laws that mandate health professionals to report elder abuse. The 13 states without such mandatory reporting laws permit health professionals

to report abuse and provide mechanisms for doing so.[4] Besides the legal mandate to report, health professionals have an ethical and moral obligation to report elder abuse.[5] Although the laws vary in details and specifications, they all provide protection from liability and anonymity for the reporting party. This liability protection applies as long as the report is made in good faith and protects the reporting party from civil action or retribution from their employer. However, the *failure* to make a report carries significant risk to health care professionals. Health care providers and agencies they work for can be and have been held criminally and civilly responsible for failing to report.

The decision to file an elder abuse report is based on clinical judgment, not on legal or administrative concerns. The threshold for reporting is one of "reasonable suspicion." Sometimes health care providers worry that they do not have proof of abuse and so they are hesitant to make a report. In fact, proof is not necessary to make a report, only a reasonable suspicion that abuse may have occurred. This relieves the health care provider from the burden of investigating or proving the possible abuse and puts this burden in the hands of APS, ombudsman, and/or law enforcement personnel.

Risks of Reporting

The concern of the administrator in this case about reporting is understandable. The good relationships and referral patterns that may take years to develop can be ruined with a report of possible mistreatment. Even if the report is made anonymously, for the facility to guess who made the report may not be difficult. The medical director and administrator must weigh this risk against the risk of ongoing abuse and our duty to protect vulnerable older adults. How comfortable is the health care team in sending more patients to a setting where there is a reasonable suspicion of abuse?

The medical director should work with the administrator to minimize the risk of offending the facility. Often, disclosing the reporting process to the facility may be the most effective way. Disclosure allows the health care professional to set the reporting in a positive context rather than an accusatory one. The health care provider can explain their legal responsibility and discuss the need for further evaluation by the appropriate agency. Disclosure engages the facility administration and staff as partners. Good-quality facilities will want to assist in the investigation, because they, too, are concerned about the welfare of their residents and want to ensure that no mistreatment is occurring. Disclosure may also play another important role: If there truly is an individual who has abused an older adult, it may serve notice that someone is looking more closely at the situation. Investigation and monitoring may deter ongoing and future abuse.

To Whom to Make the Report

In deciding with whom to file a report, the setting in which abuse occurs and the severity of abuse are the primary determinants. In most states, reports of abuse occurring in licensed care facilities such as skilled nursing homes, assisted livings, and board and cares, should be directed to the long-term care ombudsman. If abuse is suspected in any other setting such as the home or hospital, the report is directed to APS. When in doubt, the health care provider can call the receiving agency and simply ask if the report seems justified and if they are the correct agency to handle the concern. In the case of Mr Jones, the report should be made to the ombudsman rather than to APS because the possible abuse occurred in a facility.

The health care provider also has the option of reporting to the police, and this may be appropriate in circumstances such as sexual assault, the use of a weapon, or other situations that pose an immediate or severe danger. Simultaneous reports to APS or the ombudsman and to law enforcement may be beneficial. When in doubt about reporting to law enforcement, health professionals can call APS (or the ombudsman) first to discuss whether law enforcement should be contacted, or they can contact law enforcement directly.

Other agencies that may have jurisdiction include licensing agencies for the facility and state and federal agencies, such as the attorney general's office or Medicaid and Medicare fraud investigation.

Recognizing Signs of Physical Abuse

Physical abuse may or may not leave physical evidence in its wake. Injuries such as bruises, lacerations, and fractures may represent the outcome of physical abuse, but there may be no physical signs present if a person was not given his or her pain medication. There may be no physical evidence that a person was put in physical restraints as a form of punishment and that the restraints were purposefully made tight enough to cause pain but not to leave marks on the skin. In cases such as these there may be changes in behavior or mood instead of physical signs of abuse.

When traumatic signs exist, the challenge is usually differentiating whether it was related to an innocent cause or to a suspicious cause, particularly when the patient has a dementing illness and is unable to give a reliable history. Is the hip fracture the result of a fall from tripping or did someone push the patient? Is the bruise the result of being hit with an object or bumping into furniture? Rarely is the physical finding by itself conclusive of the cause. The findings need to be interpreted in the overall context of the situation. Key contextual factors are functional and cognitive levels of the potential victim. For example, a cigarette burn on the hand of a severely demented patient who is unable to strike a match or work a lighter is highly suspicious for abuse. Similarly, a son who pushes his elderly mother to the floor knowing she has severe osteoporosis and an unsteady balance is committing physical abuse that can lead to grave bodily injury. In the case of Mr Jones, for example, the report of bilateral periorbital ecchymosis is inconsistent with the story the facility staff gave that the resident fell face forward, since trauma logically would have occurred first to the nose. Such inconsistency should raise suspicion and is sufficient for an abuse report to be filed so that further investigation can be done.

The location and pattern of traumatic injuries such as bruises, pressure sores, and fractures are important in assessing for abuse. A recent study of noninflicted bruises in the elderly shows that the age of a bruise cannot be determined based on its color.[6] This study showed that all the colors of a bruise can

Table 1. *Characteristics of Suspicious Physical Lesions*

Lesion in skin folds areas
Axilla, between buttocks, groin, under breast, popliteal fossa
Circumferential
Linear
Central clearing
Multiple locations with different stages of healing

be found from day 1 to day 14. The study also found that nearly all such innocent bruises occur on the extremities. Physical lesions (such as bruises, burns, or ulcers) found in skin folds should raise suspicion since these are not areas that usually incur trauma. Such fold areas include the axilla, under the breast, in the groin, between the buttocks, or in the popliteal fossa. The pattern of injuries may also be a useful clue in determining likelihood of abuse. Circumferential lesions, for example, are not commonly seen as the result of a fall but may be an indicator of a ligature or grab mark. Lesions that are linear, rectangular, or suggestive of other identifiable patterns may suggest that an item was used to cause the injury and that it was not due to a simple bump. Linearity of lesions suggest a man-made cause. Determining multiple traumatic events may be possible through the radiographic determination that fractures are at different phases of healing. Plain films, CAT scans, and multiple resonance imaging (MRI) should be ordered when underlying sequela of trauma, such as fractures, cerebral contusions, and subdural hematoma, may be possible. Table 1 lists a summary of factors in physical findings suspicious for abuse.

Risk Factors

An understanding of risk factors is more important to the prevention of future abuse than the recognition of current abuse. Patients with dementia and depression are more vulnerable to abuse.[7] People with these illnesses are the least capable of defending themselves and are the least likely to report abuse. Elders who exhibit abusive or provocative behavior themselves have also been found to be at risk for abuse.[8] Cognitive impairment and the need for assistance with activities of daily living have been citied as important risk factors for elder mistreatment.[9]

The caregiver's perception of his or her own stresses appears to be one of the main risk factors for abuse, and therefore caregiver stress should be a major focus of the team's assessment. The caregiver's individual perception of burden is probably more important than the "actual" burden of caregiving and may be the reason that studies have failed to find a direct relationship between abuse and the poor health and functional impairment of the patient or their dependence on the abuser.[10,11]

RECOMMENDATION

How does a medical director approach an elder abuse case such as Mr Jones'? The medical director's responsibility in a case like this falls into 2 categories: those to the patient and those to the health care team. The responsibilities to the patient include (1) ensuring the safety and protection of the patient, (2) preventing future abuse, and (3) providing a proper medical assessment and documentation. The responsibilities of the medical director to the team are heightened in elder abuse cases. These responsibilities include (1) achieving as much consensus as possible to ensure cohesion of the team, (2) providing education and guidance, and (3) meeting ethical and legal mandates.

In this case example, the physician would best serve the patient and the team by visiting the patient and performing a medical assessment. Recent geriatrics literature suggests that a physician visit can help confirm the presence or absence of abuse and identify unmet needs and new resources or solutions.[12,13] The history should include a thorough review of the patients's medications, medication compliance, the behavior of the patient, how staff and other residents respond to the patient, and any recent visitors. The physical exam should look for other evidence of abuse and neglect and an assessment of the patient's mental status. At the visit, if further work-up is deemed to be warranted, such as CAT scans and laboratories, the patient should be sent to the hospital. If there is a concern over the patient's safety, the patient can be admitted to a geropsychiatry unit or to the medical ward.

A report to the proper authorities should be made and the director or owner of the board and care informed. At a minimum, the ombudsman should be notified. If after the physician assessment, a crime is suspected, the police should be notified so that forensic pictures can be taken. The medical director should also notify the primary care physician of the findings and conclusions from the visit. A member of the health care team should also notify the family.

As the physician leader of the health care team, the medical director should provide education and guidance to the team. Such cases are opportunities to discuss the impact that the team can make in intervening and preventing abuse. They can be rewarding to a team that feels they have "made a difference" and bring them together rather than tearing the team apart. The physician should dispel misconceptions and misunderstandings about elder abuse and hold the team to the highest ethical and moral standards. The medical director should also be involved in the development of agency policies on how they should respond to suspected abuse. The physician should be involved in the training of staff at orientation or at in-services.

SUMMARY

Physical abuse of the elderly has significant consequences not only on patients and families but also on the health care team. It is not only a social or family problem but a medical problem that is often under-recognized and underreported. The medical director, as the physician leader of a multidisciplinary team, is well positioned to address abuse through proper assessment, reporting to the appropriate authorities, and if necessary, immediate action to protect the patient. The physician should provide education to the staff about abuse, and all health care professional should be aware of the potential markers of abuse.

REFERENCES

1. National Center on Elder Abuse. National Elder Abuse Incidence Study. Washington, DC: American Public Human Services Association, September 1998.
2. Lachs MS, Williams CS, O'Brien S, et al. ED use by older victims of family violence. Ann Emerg Med 1997;30:448–454.
3. Aravanis SC, Adelman RD, Breckman R, et al. American diagnostic and treatment guidelines on elder abuse and neglect. Arch Fam Med 1993; 2:371–388.
4. American Bar Association. State-by-State Mandatory Reporting Requirements: Sanctions for Failure to Report Elder Abuse. Available at: http://www.abanet.org/media/factbooks/eldt2.html. Accessed November 6,2005.
5. Bergeron LR, Gray B. Ethical dilemmas of reporting suspected elder abuse. Soc Work 2003;48:96–105.
6. Mosqueda L, Burnight K, Liao S. The lifecycle of bruises in older adults. J Am Geriatr Soc 2005;53:1339–1343.
7. Dyer CB, Pavlik VN, Murphy KP, Hyman DJ. The high prevalence of depression and dementia in elder abuse or neglect. J Am Geriatr Soc 2000;48:205–208.
8. Costa AJ. Elder abuse. Prim Care 1993;20:375–389.
9. Paveza GJ, Cohen D, Eisdorfer C, et al. Severe family violence and Alzheimer's disease: prevalence and risk factors. Gerontologist 1992;32: 493–497.
10. Homer AC, Gilleard C. Abuse of elderly people by their caregivers. BMJ 1990; 301(6765):1359–1362.
11. Brody EM. "Women in the middle" and family help to older people. Gerontologist 1981;21:471–480.
12. Heath JM, Kobylarz FA, Brown M, Castaño S. Interventions from home-based geriatric assessments of Adult Protective Service clients suffering elder mistreatment. J Am Geriatr Soc 2005;53:1538–1542.
13. Mosqueda L, Burnight K, Liao S, Kemp B. Advancing the field of elder abuse: A new model for integration of social and medical services. Gerontologist 2004;44:703–708.