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Research Article

Identifying Elder Abuse in the Emergency Department: Results from a Structured Physician Survey in Canada

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Keywords

• Elder abuse; Elder mistreatment; Emergency medicine; Barriers; Resources; Education; Training

Abstract

Objectives: Seniors aged 65 years or older represent 16% of the Canadian population, and this number is expected to rise to more than 28% by 2061. Little research has been conducted on elder abuse in emergency medicine in Canada. Given the vulnerability of the senior population and the nature of elder abuse, emergency departments are a likely presenting setting. The objective of this research is to examine the depth of knowledge and approach to elder abuse by emergency physicians.

Methods: A structured survey was developed and distributed to 1,454 emergency physicians Canada-wide assessing knowledge and comfort level of management options.

Results: We found that 78% of emergency department physicians detected or suspected a case(s) of elder abuse in their career; 45% in the past 6 months. Further, 77% of respondents did not feel they were aware of community services available for victims of elder abuse and their families. In terms of resources, 81% of respondents did not feel there were sufficient resources available for the elderly. In terms of training, 43% of respondents had not completed training on elder abuse and 83% of respondents felt their training in elder abuse was insufficient.

Conclusion: Elder abuse is a relatively common presentation to the emergency department. With Canada's increasing elderly population, elder abuse is likely to increase. This research suggests there is progress to be made in emergency medicine training, policies and protocols at the national, provincial and institutional levels. While much remains to be done, this research represents an important initial step in the analysis and addressing of this important public health problem.

INTRODUCTION

While varying definitions exist, the World Health Organization (WHO) defines elder abuse as "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person" [1]. Consensus has arisen about the inclusion of five major types of elder abuse: 1) physical abuse, which are acts carried out with the intention to cause physical pain or injury; 2) psychological or verbal abuse, defined as acts carried out with the aim of causing emotional pain or injury; 3) sexual abuse, defined as non-consensual sexual contact; 4) financial exploitation, involves the misappropriation of an older person's money or property; and 5) neglect, or the failure of a designated caregiver to meet the needs of a dependent older person [2].

Elder abuse represents an important public health problem. Protecting our most vulnerable from both the physical and psychological morbidity that can result from elder abuse is both a moral and an ethical obligation. One 13-year follow-up study found that victims of elder abuse are twice as likely to die prematurely than are those who are not victims of elder abuse [3].

Globally, the burden of elder abuse is significant. One recent meta-analysis pooled prevalence estimates in 52 publications between 2002-2015 and found the global prevalence of elder abuse was 15.7%, or about 1 in 6 older adults. Using United Nations 2015 population estimates of 901 million people aged 60 years and older equates to 141 million victims of elder abuse annually [4]. In the Canadian context, most research suggests a stabl if not increasing, prevalence. Close to 10% of older adults in Canada experience abuse [4].

Estimates are likely an underestimation, as elder abuse is difficult to quantify due to data collection challenges, conflicting definitions and its nature as a hidden crime. It is estimated that only 1 in 24 cases of elder abuse is reported. This is likely because older people are often afraid to report cases of abuse to family, friends, or to the authorities [1].

The global population aged 60 years and older will more than double, from 900 million in 2015 to about two billion in 2050

[1]. In Canada, seniors aged 65 years or older compose 16% of the population; a percentage that will continue to increase (6). This group is projected to represent between 23% and 25% of the population by 2036 and between 24% and 28% by 2061 [7].

Some studies conclude that Canada's aging population will increase elderly patient use of emergency departments, and comprise 35% to 60% of all visits [8]. Emergency departments provide vital health care to Canada's elderly, often serving as entry points to hospitalization and long-term care and providing after-hours care to seniors unable to access a primary care provider [9]. Despite Canada's elderly population and the increased likelihood of seniors to present at the emergency department, very little data exists on the identification and knowledge of elder abuse by emergency department physicians.

This issue has been investigated in the United States, though not recently. In 1997, a questionnaire was sent out to 3,000 members of the American College of Emergency Physicians (ACEP) in the United States. The questions asked about physicians' comfort with their ability to recognize victims of elder abuse. Results showed that emergency department physicians did not think that a clear-cut definition of abuse existed. Only 25% of respondents were able to recall education regarding elder abuse during their medical residency. Responding physicians also believed that resources on elder abuse were insufficient [10].

The ACEP drafted a policy resource and education paper entitled "Recognition and Management of Elder Abuse" [11]. Currently, no such policy exists for Canadian emergency physicians. Accordingly, the objective of this current survey was to examine the depth of knowledge and approach to elder abuse by emergency physicians in Canada. This undertaking, while not exhaustive, represents an important initial step in creating a landscape of information on this important public health issue.

STUDY DESIGN

We set out to examine the depth of knowledge and approach to elder abuse by emergency department physicians in Canada. To do so, a survey and delivery method were developed based on the 1997 ACEP survey.

This survey was comprised of 27 questions and distributed to 1,454 emergency physicians across Canada who were members of the Canadian Association of Emergency Physicians during the survey period (January – February 2016).

The survey was pre-tested in the emergency department of the Ross Memorial Hospital in Lindsay, Ontario.

RESULTS

Of the 1,454 surveys delivered, responses were received from 125 emergency physicians: a response rate of 8.5%.

As shown in Table 1, overall the responses were fairly age- and gender-balanced. There were similar response rates from physicians in FRCPC Emergency Medicine (a Royal College specialty training stream) and CCFP Emergency Medicine (a family medicine training stream) tracks. Responses were received from a wide range of years of practice and there was a fair balance between tertiary and academic centres. We received input from physicians in many communities, however responses were strongly weighted geographically towards Ontario.

Table 1: Profile of Respondents

Characteristic	% Sample	Characteristic	% Sample
Age		Years of Active Practice	
20-30	12%	Current training	10%
31-40	27%	1-5 years	24%
41-50	27%	6-10 years	10%
51-60	24%	11-15 years	13%
60+	9%	16-20 years	9%
Prefer not to say	2%	20+ years	32%
Gender		No response	2%
Male	56%	Type of hospital	
Female	40%	Community	42%
Prefer not to say	4%	Tertiary (academic)	56%
Province*		Other	2%
Newfoundland and Labrador	1%	Community Size**	
Northwest Territories	1%	Over 1 million	31%
British Columbia	12%	500,000 – 1 million	19%
Alberta	8%	100,000 – 500,000	17%
Saskatchewan	2%	50,000 – 100,000	15%
Manitoba	6%	10,000 – 50,000	13%
Ontario	54%	5,000 – 10,000	3%
Quebec	5%	1,000 – 5,000	1%
Nova Scotia	10%	Under 1000	0%
Professional Qualifications			
Family Medicine Resident	3%		
Emergency Medicine Resident	10%		
FRCPC Emergency Medicine	30%		
CCFP Emergency Medicine	40%		
CCFP	14%		
Other	4%		

*No responses were received from emergency physicians in New Brunswick, Prince Edward Island, Yukon, Nunavut.
**One respondent answered "Don't know" in response to community size.

Of the emergency department physicians that responded to the survey, over 85% perceived elder abuse to occur at least "sometimes."

In assessing prevalence, 78% of respondent physicians suspected a case of elder abuse during their career; 73% in the past 5 years and 45% within the previous 12 months (Table 2).

Respondents identified that the most common type of elder abuse they encountered in their practices was neglect followed

Table 2: Suspected Abuse among Emergency Physicians	
"Have you seen a suspected case of elder abuse in your career?"	
Yes	78%
No	17%
Unsure	0%
No answer	5%
"Have you seen a suspected case of elder abuse in the past 12 months?"	
Yes	45%
No	27%
Unsure	8%
No answer	20%
"Have you seen a suspected case of elder abuse in the past 5 years?"	
Yes	73%
No	4%
Unsure	4%
No answer	19%

by financial abuse. The majority of responding physicians (60%) suspected cases occurred in the home.

In terms of reporting, responding physicians "always" or "often" asked patients direct questions less than half the time (44%) they expected abuse. The majority (64%) of respondents had not reported the elder abuse that they had suspected. However, 83% of respondents felt it was a physician's responsibility to report suspected abuse (Table 3).

The majority of respondents felt they knew how to report suspected cases of domestic (68%) and institutional (63%) elder abuse. However, over 50% of responding physicians stated their emergency department did not have a written protocol to address elder abuse, while 39% were "unsure" whether a written protocol existed (Table 4).

Of all respondents, 77% did not feel they were aware of the community services available for victims of elder abuse and their families (Table 5). In terms of resources, 81% of respondents did not feel there were sufficient resources available for elderly victims of abuse (Figure 1). Finally, 35% of respondents had not completed training on elder abuse and 83% of responding emergency department physicians felt their training in elder abuse was insufficient (Figure 2).

DISCUSSION

Canada is facing an increasingly aging population that presents to emergency departments more often and with more complex illnesses than other age group. This study suggests that elder abuse is commonly suspected in Canadian emergency departments and highlights gaps in combatting this pervasive social problem.

Numerous similarities exist in the results from with the previous 1997 survey of emergency physicians in the United States and this current Canadian research. Both point to the fact that emergency departments are insufficiently resourced to manage suspected cases of elder abuse. In the U.S. study, 31% of emergency physicians confirmed having a written protocol to report elder abuse whereas this Canadian data suggests that only 2% of respondents reported there was such a protocol.

Table 3: Elder Abuse Reporting by Emergency Physicians	
"When you suspect mistreatment, how often do you ask ED patients direct questions about it?"	
Always	15%
Often	28%
Sometimes	22%
Rarely	11%
Never	3%
No response	20%
"Have you reported suspected abuse to authorities?"	
Yes	28%
No	64%
No response	8%
"Do you feel it should be a physician's responsibility to report suspected cases of abuse?"	
Yes	83%
No	10%
No response	6%

Table 4: Written Protocols for Reporting Elder Mistreatment.	
"Does your emergency department have a written protocol for the reporting of elder mistreatment?"	
Yes	2%
No	53%
Unsure	39%
No response	6%

Table 5: Familiarity with Community Services	
"Are you familiar with the types of community services available for victims of elder mistreatment and their families?"	
Yes	16%
No	77%
No response	6%

Table 6: Signs and Symptoms of Elder Abuse
Bruising in unusual locations (not over bony prominences; on lateral arms, face, or back; larger than 5 cm)
Burns in patterns inconsistent with unintentional injury or with the explanation provided (e.g., stocking or glove pattern, suggesting forced immersion)
Decubitus ulcers, unless the result of unavoidable decline
Dehydration, fecal impaction
Evidence of sexual abuse
Intraoral soft tissue injuries
Malnutrition, medically unexplained weight loss
Missing medications
Patterned injuries such as hand slap or bite marks; ligature marks or scars around wrists, ankles, or neck suggesting inappropriate restraint
Poor control of medical problems despite a reasonable medical plan and access to medication
Subconjunctival or vitreous ophthalmic hemorrhage
Traumatic alopecia or scalp swelling
Unexplained fractures
Unusual delay in seeking medical attention for injuries
Urine burns (similar to severe diaper rash), dirty clothing, or other signs of inattention to hygiene

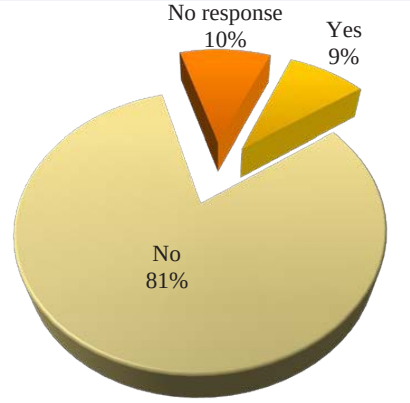

Figure 1 "Responses to: Are there sufficient resources available for elderly victims of abuse?".

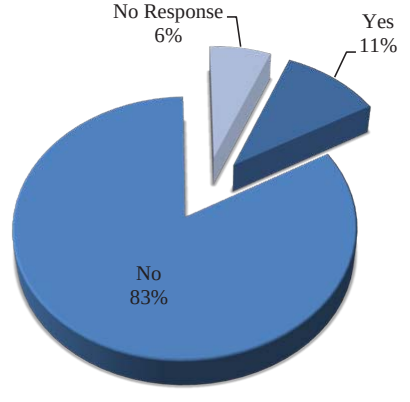

Figure 2 Responses to: "Do you think your training in elder abuse has been sufficient?".

Respondents in both studies indicated insufficient training on elder abuse. Only 25% of respondents recalled educational content pertaining to elder mistreatment during their emergency medicine residencies in the United States while 83% of Canadian respondents in this current research felt their training in elder abuse was insufficient. In addition respondents in both studies, 92% in the United States and 81% in Canada, agreed that there were insufficient resources available to address the issue adequately.

Our current study suggests that gaps exist related to education and resources for elder abuse assessment and management in some Canadian emergency departments. These gaps appear to be due to a number of factors including inadequacies of: research; training; awareness of community services; and continuing education. There is a recognized need for further resources to identify and respond to abuse or, at the very least, an appreciated lack of awareness among emergency department physicians of the resources available to them and patients in their communities. Further awareness and education for physicians through residency training and continuing medical education opportunities will be essential in adequately addressing elder abuse moving forward.

Importantly, this study identifies systemic gaps in identifying and addressing elder abuse in Canada's emergency departments. While reporting elder abuse to law enforcement can be contentious and rife with conflict with patient autonomy, trust and confidentiality, physicians have a professional and ethical obligation to ensure vulnerable patients are supported. Over 90% of respondents noted that there was no written protocol or they were unaware of one to respond to elder abuse in their emergency departments. The majority of respondents were unsure what community services were available. These findings underscore the importance of having established protocols and involving an interdisciplinary team to ensure victims of elder abuse are identified and provided with appropriate, timely care, assistance and advocacy.

Clearly, elder abuse represents an important public health issue. The emergency department setting is an ideal setting to detect elder abuse as visits are often unplanned and there is opportunity for the patient to be assessed by multiple health care professionals both of which make it more difficult to hide evidence of abuse. While no tool has been validated in the emergency department setting to identify abuse, the Elder Abuse Suspicion Index (EASI) has been validated in the primary care setting and can be used as a guide. The EASI is a short questionnaire comprised of five patient-answered items and one physician question. It has a sensitivity of 0.47 and specificity of 0.75. In addition, emergency department physicians can be vigilant in screening for physical signs of abuse such as unusual bruising, burns inconsistent with unintentional injury, dehydration, fecal impaction and malnutrition [12].

Given the prevalence of elder abuse and its presentation at emergency departments, physicians must remain vigilant for signs and symptoms, which can come in many forms.

There are no federal laws in Canada that make reporting of elder abuse mandatory and elder abuse is not identified in the Criminal Code as a crime. Accordingly, physicians do not have a duty to report a criminal offence related to elder abuse to the police. In fact, this would be considered a breach of confidentiality without consent from the patient or substitute decision-maker [13].

Each Canadian province and territory varies in its approach to how suspected elder abuse is handled [14]. Physicians may be required to report to a designated authority if elder abuse is suspected due to unlawful conduct, incompetent care or treatment, or neglect. In some provinces, this obligation may be triggered only when the patient is a resident of a care home or an in-patient at a public hospital [14].

In the United States, federal law does not specifically address elder abuse however all 50 states and the District of Columbia provide Adult Protective Services (APS) programs for victims [15]. APS is the federal program that receives mandatory reports of suspected abuse and is responsible for case investigations. Forty-nine states (New York is the exception) have mandatory reporting laws that require designated reporters, including physicians, to report any suspicion of abuse to APS, law enforcement, or a regulatory agency. An APS worker then visits the home and conducts an investigation with the goal of verifying or refuting the concern [2].

Physician awareness of elder abuse in the emergency department is critical to addressing this important issue. But perhaps more importantly these results underscore the need for coordination at the national level to address elder abuse in Canadian emergency departments. In 1999, the ACEP established a policy on elder abuse in the context of emergency medicine underscoring the importance of this issue. Having a coordinated strategy in Canada that provides guidance to emergency departments on establishing protocols, providing adequate training and coordinating an effective multidisciplinary response will be essential. As the Canadian population continues to age we must ensure that appropriate emergency department training and resources are allocated to address elder abuse with effective protocols in place.

Further exploration of elder abuse in the emergency department will be critical. These efforts may result in the creation of a consensus-based working document for Canadian emergency physicians. We will continue to focus on this goal.

Our study, by its preliminary nature, has several limitations. Our sample size approached only 9% and several geographical areas were not adequately sampled. This survey exclusively examined emergency department physicians' knowledge of and approaches to elder abuse in Canada. While many similarities may be inferred internationally, the scope of this study was limited to a national representation. Further, this survey was administered through the CAEP national distribution list. The list does not include all physicians practicing emergency medicine in Canada so is not a completely representative sample source. Finally, while a survey is often used as an initial fact finding instrument, it is by definition, structured and therefore cannot capture the richness and complexity of such a broad subject. We plan to conduct further semi-structured interviews with emergency physicians to try to understand better the nuances of elder abuse going forward.

CONCLUSION

Elder abuse is a relatively common presentation to the emergency department. With Canada's increasing elderly population, elder abuse is likely to increase. This study suggests there is progress to be made in emergency medicine training, policies and protocols at the national, provincial and institutional levels. Improvements in awareness, coordination of resources and the establishment of protocols will help emergency departments more effectively address elder abuse and help ensure this vulnerable population is protected.

APPENDIX A: SURVEY

1) DemographicsWhat is your age?

- 20-30
- 31-40
- 41-50
- 51-60
- 60+
- Prefer not to say

2) What is your gender?

- Female
- Male
- Prefer not to say

3) What is your most relevant professional qualification?

- Family Medicine Resident
- Emergency Medicine Resident
- FRCPC Emergency Medicine
- CCFP – Emergency Medicine
- CCFP
- Other – please specify:

4) Please identify your current province or territory of practice:

- British Columbia
- Alberta
- Saskatchewan
- Manitoba
- Ontario
- Quebec
- New Brunswick
- Nova Scotia
- Prince Edward Island
- Newfoundland
- Yukon
- Northwest Territories
- Nunavut

5) How many years have you been in active practice (excluding fellowships)?

- 1-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 20+ years
- N/A

6) Please select the type of hospital that most accurately describes the majority of your clinical activities:

- Tertiary (academic)
- Community

7) What is the community size in which you practice?

- Over 1 million
- 500,000 – 1 million

- 100,000 – 500,000
- 50, 000 – 100, 0000
- 10,000 – 50,000
- 5,000 – 10,000
- 1,000 – 5,000
- Under 1,000
- Don't know

Elder Abuse Prevalence, Reporting

Elder abuse is any action by someone in a relationship of trust that results in harm or distress to an older person. Neglect is a lack of action by that person in a relationship of trust with the same result. Commonly recognized types of elder abuse include physical, psychological and financial. Often, more than one type of abuse occurs at the same time. Abuse can be a single incident or a repeated pattern of behaviour.

8) How prevalent do you think elder abuse is in your community?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

9) Have you seen a suspected case of elder abuse in your career?

- Yes
- No
- Not sure

10) Have you seen a suspected case in the past 12 months?

- Yes
- No
- Not sure

11) Have you seen a suspected case in the past 5 years?

- Yes
- No

12) If so, approximately how many suspected cases of elder mistreatment have you evaluated in the preceding 5 years?

- 1-5
- 6-10
- 11-15
- 16-20
- 21-25
- 25+

13) Of the elder abuse you have seen what was the most frequent type?

- Financial abuse
- Psychological abuse
- Physical abuse
- Sexual abuse
- Neglect

14) Where did it take place?

- Home
- Institutional setting such as a nursing home or adult day care facility
- Not sure

15) When you suspect mistreatment, how often do you ask ED patients direct questions about it?

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

16) Do you feel it should be a physician's responsibility to report suspected cases of abuse?

- Yes
- No

17) Have you reported suspected abuse to authorities?

- Yes
- No

18) If no, why (select all the apply)?

- Patient declined disclosure
- Mistreatment involved minor injuries or subtle signs
- Victim denied mistreatment
- Unsure how to report suspected cases
- Unclear about definitions of abuse and neglect
- Did not recognize mistreatment at the time of the visit
- Unaware of provincial reporting laws
- Inadequate community resources to respond to identified cases
- Physician-patient confidentiality issues
- Mistreatment reported by other professionals (eg, police)
- Patient admitted to hospital or long-term care facility
- Did not want to get legally involved
- Patient's responsibility to report mistreatment
- Risks of liability
- Patient did not consent
- Mistreatment occurred in nursing home

19) Does your ED have a written protocol for the reporting of elder mistreatment?

- Yes

- No
- Not sure

20) Do you know your reporting requirements for suspected cases of domestic elder abuse/neglect?

- Yes
- No

21) Do you know to whom you should report suspected cases of institutional elder abuse/neglect?

- Yes
- No

Resources

22) Are you familiar with the types of community services available for victims of elder mistreatment and their families?

- Yes (please specify:)
- No

23) Do you feel there are sufficient resources available for elderly victims of abuse?

- Yes
- No

Training

24) What training have you completed on elder abuse?

- None
- Training during residency
- CME course(s)
- Recall reading a journal article or monograph on elder abuse, neglect, or a related topic
- Other, please specify:

25) Do you think your training in elder abuse has been sufficient?

- Yes
- No

26) Do you have specific recommendations on how to improve ED response to elder mistreatment?

27) Do you have any final comments or questions for the investigators?

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