Physicians’ and Nurses’ Responses to Abuse of the Elderly: 
A Comparative Study of Two Surveys in Alabama

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ABSTRACT. A survey of Alabama physicians in the fields of internal medicine, family practice and general practice and a survey of nurses in the areas of home health and community health care were conducted in 1987 and 1988 concerning elder abuse and Alabama's thirteen-year-old mandatory reporting/protective services law. The authors found that physicians did not understand the law but nurses did. Physicians’ attitudes toward the law were ambivalent. Nurses had more negative attitudes toward the law. These attitudes appeared to be based on poor response by authorities to earlier reports.

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THE DILEMMA OF REPORTING

Many of our elderly are neglected or abused. The magnitude of the problem varies depending on which research is cited. Clark estimated that approximately 10% of those in the United States who were over 65 were or have been abused (Clark, 1981). The House Select Committee on Aging, reported that there were approximately 100,000 elderly victims of abuse per year (U.S. House of Representatives, 1985). Still others found that child abuse and elder abuse occur at about the same rate (Crouse, Cobb, Harris, Kopecky, and Poertner, 1983; Kosberg, 1986; O'Brien, 1987).

No matter what the actual rate of abuse (or neglect) is, any cases of abuse or neglect are too many. Because of the problems of adult abuse or neglect, 49 states have implemented legislation to protect adults over the age of 18 who need protection. The state laws usually provide for either protective services or require mandatory reporting of abuse and neglect (Kosberg, 1986). Where protective services are provided, there are sometimes limited services available to the physically or mentally infirm adult who has been neglected, abused, or exploited (Faulkner, 1982; Kosberg, 1986). The narrow range of available services often makes the proper disposition of cases difficult.

The second type of legislation, mandatory reporting of elder abuse or neglect, requires that health care or other professionals report cases of suspected abuse to designated authorities. But there is little standardization of “the criteria for emerging intervention and the protecting of due process rights” across states (Kosberg, 1986). In fact, mandatory reporting has been criticized as an “inexpensive (but showy) way for the state to deal with the problem and, thus, demonstrat(ing) an effort . . . that will not cost a great amount of state revenue” (Kosberg, 1986).

A further problem with existing laws has been the lack of due process protection provided by the law. Alabama, Florida and South Carolina are particularly negligent in this area. Such laws tend to focus on involuntary protective placement of persons who are unable or unwilling to consent in emergency situations. A person’s lack of capacity is not made an issue in either protective services or mandatory reporting laws. Yet, capacity is perhaps the most important criteria because capacity can determine the ability to care for oneself or, at the very least, to understand what procedures are taking place on one’s behalf (Crouse et al., 1983).

However, more immediate problems exist. The mandatory reporters are either unaware of the laws in their states or choose to disregard them. For example, a survey of physicians in Michigan and North Carolina found that 70% of physicians were unaware of elder abuse reporting requirements, even though about 25% of these physicians had previously encountered a case of elder abuse (O’Brien, 1986).

Another problem is whether the current laws protect the elderly or whether these laws should be strengthened. If mandatory reporters do not know or ignore the requirements of their respective state laws and few services are available, are there realistic answers? Several authors suggest that the laws concerning assault and negligence were already in place in 1985 but are not fully enforced (c.f., Cox, 1985). It has been further suggested that if states actively enforced these laws, the states would be successful in controlling the problems of both child and adult abuse.

To the contrary, many states have found that not all those suffering from neglect or abuse can be protected. Alabama’s response to curbing abuse, neglect, and exploitation has been a law which includes mandatory reporting and offers protective services for all over the age of 18. However, the services are restricted to those who are unable to care for themselves.

THE ALABAMA LAW

In Alabama, Act No. 780 was enacted in 1977 to protect all persons over the age of 18 who were in need of protective services. The Act requires the reporting by “practitioners of the healing arts” of all cases of abuse, neglect, and exploitation. These cases are to be reported to the county offices of the Department of Human Resources (DHR). The definition of “practitioners of the healing arts” is unclear. There is a penalty of $500 or six months in jail for not reporting suspected cases of abuse. Ironically, there is also a $500 penalty for being found guilty of abusing any adult in Ala-
Once a report of abuse or neglect is made, DHR is mandated to investigate within 72 hours of the initial report.

Since this law has been enacted, there has been an increase in the number of cases reported to DHR. For instance, in 1984, there were 4,171 cases of abuse, neglect or exploitation reported in the state. In 1985, 4,391 cases were reported and "approximately 7,211 adults received protective services...with a 'monthly average of 2,553 clients' receiving such services" (Alabama Department of Human Resources, 1986). There were over 5,200 cases of abuse reported in 1987. Through September 1988, over 7,200 reports had been received.

**THE PURPOSE OF THIS STUDY**

This research is part of an ongoing project to examine aspects of the understanding and attitudes of Alabama health care providers concerning important components of public policy toward elder abuse: understanding and diagnosis of elder abuse, neglect, and exploitation; knowledge of and attitudes toward the Alabama Adult Protective Services Act; and possible barriers to the willingness to report. If mandatory reporting serves a function, such as the discovery of new cases separate from the provision of services, the usefulness of that function will depend on a clear definition of abuse, neglect, and exploitation; a clear understanding of the law; and minimal barriers to reporting. The absence of these conditions renders mandatory reporting ineffectual at best, and harmful to the victim, at worst (Daniels, Baumhover, and Clark-Daniels, in press).

The initial study, conducted in 1987, covered Alabama physicians in the specialties most likely to encounter elder mistreatment: family practice, general practice, and internal medicine. It was found in that study that, while physicians had considerable awareness of abuse, these same physicians were not knowledgeable concerning the 1977 law or its operation. For those few who did know about the law, they identified considerable barriers to reporting (Clark-Daniels, 1988; Daniels, Clark-Daniels, Baumhover, 1988; Clark-Daniels, Baumhover and Daniels, in press; Daniels, Baumhover and Clark-Daniels, in press).

The second study, conducted in 1988, surveyed Alabama home health and community health care nurses. Nurses in these areas are among those most likely to be the first to encounter patients who have been abused or neglected. "This front line position is especially the case for nurses specializing in home health and community health care...[t]hese classifications frequently work with elderly patients, either in the patient's home or in nursing homes" (Clark-Daniels and Daniels, 1989).

**THE SAMPLES**

The research design for the physicians' study employed a stratified random sampling technique whereby all physicians in Alabama were identified and stratified by specialty and by three designations of city size (under 10,000 in population, between 10,000 and 49,999, and over 50,000). The population of physicians in Alabama was then matched by specialty and city size. A stratified random sample was drawn which represented all nine possible combinations equally. The survey was sent to 336 physicians during the summer of 1987.

For the nurses' study the entire population was surveyed rather than a sample. The research population for the nurses' study consisted of home health nurses and community health nurses. The listing of the entire population of 1,539 registered nurses and 304 licensed practical nurses in these specialties was provided by the Alabama Board of Nursing. A two-page mail questionnaire was sent to both groups in late July 1988. Only a handful (less than 10) of envelopes were returned as undeliverable, and only 4% of the respondents indicated that they were retired. By comparison, the Alabama Medical Association list of licensed physicians used in the previous study yielded a higher rate of undeliverable letters and a retirement rate of 20%.

Forty-seven percent (156 surveys) of the physicians' surveys were returned. Previous investigators have usually reported a response rate of less than 30% with surveys mailed to this population (cf., O'Brien, 1986). However, one-fifth of these surveys were from retired doctors. For most questions, the number of valid responses ranges from 118 to 121 (35% to 37%).

Of the 1,843 surveys sent to nurses, 581 (or 31.5%) were re-
turned. Of these responses, 462 were from registered nurses, 80 from licensed practical nurses, 16 from other occupations in the health care field, and 23 did not provide information about their occupation. The nurses did not make any distinction between home health and community health within their profession. The response rate for registered nurses was 30% and for licensed practical nurses, 26.3%. The 16 from other occupations and 23 who did not give an occupation comprise 2% of the original mailing and 6.7% of the returned responses.

The low response rate to both surveys does bias the conclusions to an undetermined degree. The respondents and non-respondents cannot be compared demographically because no state-wide demographic data are available for the practitioners in these fields. Strictly speaking, therefore, the conclusions of both studies should be limited to those who responded.

Some speculations about the direction of bias are possible in both studies. In particular, the nature of the study and previous research on the biases of mail questionnaires suggest that the physicians and nurses who responded to the survey are very likely to be those most interested in the topic. The nurses are more likely to be those who have reported abuse, neglect, or exploitation. As a result, the surveys probably overestimate the percentage of the nursing and physician populations who have seen and reported abuse and will generally not be useful in evaluating the extent of abuse. The possible bias with regard to the attitudes of physicians and nurses to the three main areas of the study is impossible to determine.

THE SURVEY

The survey instrument used in the nurses’ study is an adaptation and an expansion of the survey used for the physician study. The key difference between the two instruments is the focus of the nurses’ instrument on the reporting of elder abuse, neglect, and exploitation, and the reasons for not reporting. Both surveys contain demographic items (age, sex, race) and characteristics of practice (occupation, years in practice, retirement status, patient load, proportion of senior citizens among patients). The nurses were also queried concerning the identification and reporting of elder mis-

RESULTS OF THE STUDY

In the physicians’ study the reported statistics were weighted to reflect the true proportion of doctors by city size within the three specialties in Alabama. The average age of physician-respondent was 47.7. The typical nurse in the sample had a median age of 39. Eighty-five percent of the physicians were white and 90% were male. Ninety percent of the nurses were white and 90% were female. Most of the nurses were registered nurses (83%); this percentage matched the true proportion in the research universe. The average number of years the physicians had practiced was 16.8 years and the average nurse had worked for 7 years in her profession. Table 1 presents a summary of the reported demographics.

The physicians reported a large patient load; three-fourths saw more than 15 patients per day with 40% seeing more than 25 patients per day. Most home health and community health nurses in the sample saw relatively few patients per day; the median was 7. This low figure did disguise considerable variation because the number of patients ranged from a low of 0 to a high of 300.

Even though the elderly constitute only 12% of the population, 44% of all patients seen in physicians’ offices were over 65 years of treatment. Questions were developed in three areas: the understanding and diagnosis of abuse, the knowledge of the Alabama law, and the willingness to report abuse. Physicians were not asked questions regarding whether they had reported abuse; the authors were concerned about violations of doctor-patient confidentiality. In retrospect, these concerns may have been overestimated.

The second page of both surveys contained statements about understanding or knowledge of abuse, opinions of the law concerning protection of the elderly, and willingness to report. This section of the survey asked the health care givers to use a 5-point Likert scale from “Definitely Not True” to “Definitely True” to assess a series of statements. There were 23 statements on the physicians’ survey and 31 statements on the nurses’ survey. There are 19 comparable questions, and these will be discussed in this paper. For the purposes of this analysis, the scales are collapsed into three-point scales, Not True, Unsure, and True.
This is consistent with a national survey by Kellogg (cited in O'Brien, 1987) which reported that those 65 and over see physicians at a rate of 1.41 visits for each visit by someone under 65 years of age. The average nurse reported a caseload of which approximately 61% were over 65.

Thirty-eight percent of the physicians stated that they had seen cases of elder abuse in their practice in the past year. The average number of cases per physician was 1.2 within the preceding twelve months. Seventy-three percent of the nurses had seen abuse. The median cases seen by nurses in the past year was 2 and during an entire career, 4. Sixty-one percent of the nurses indicated that they had reported abuse cases; this figure was slightly lower than the figure for identified abuse. The median reported cases of abuse in the past year was 1, and in their entire career, 3. There are no comparable data available on physician-reported cases of abuse.

Physicians are likely to suggest that other professionals have a responsibility to report, but 76% of the physicians were unsure how to report abuse. In addition, when confronted with a statement identifying the Department of Health as the responsible agency, 84.9% responded that they were unsure or that it was the correct agency. In fact, the correct agency for reporting abuse, neglect and exploitation is the Alabama Department of Human Resources (DHR).

The nurses did not suffer from the same confusion. The nurses were given a choice of agencies and asked to which agency they reported abuse, neglect, and exploitation. Eighty-five percent of the nurses knew that the Alabama DHR was the appropriate investigating agency, 11% of the nurses reported to the Department of Public Health, and 10% reported to a physician. No other single source accounted for as many as 5% of the reports. However, the majority of the nurses (53%) were generally dissatisfied with the response to the report. Only 27% expressed relatively complete satisfaction.

As can be noted in Table 2, physicians and nurses were uncertain about the availability of published guidelines from their professional associations (the American Medical Association has published guidelines; the nursing association does not). Despite this, over 60% of the respondents to both surveys believed that experienced medical professionals could detect abuse. The majority of the physicians (52.1%) believed that the largest number of incidents of

<table>
<thead>
<tr>
<th>Average Age (in years)</th>
<th>Physicians</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Sex:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>90%</td>
<td>2%</td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>98%</td>
</tr>
<tr>
<td>Average number of years in profession</td>
<td>16.8</td>
<td>7</td>
</tr>
<tr>
<td>Average number of patients seen per day</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>Percent of patients over 65 seen per day</td>
<td>44%</td>
<td>61%</td>
</tr>
<tr>
<td>Percent who have seen cases of elder abuse in the past year</td>
<td>38%</td>
<td>53.2%</td>
</tr>
<tr>
<td>Median number of cases of elder abuse seen in past year</td>
<td>1.2</td>
<td>2</td>
</tr>
<tr>
<td>Median number of cases of elder abuse seen in career</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Percent who have reported cases of elder abuse in past year</td>
<td>35.8%</td>
<td>58.5%</td>
</tr>
<tr>
<td>Median number of cases of elder abuse reported in the past year</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Median number of cases of elder abuse reported over entire career</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Know how to report cases of elder abuse</td>
<td>24%</td>
<td>85%</td>
</tr>
</tbody>
</table>

*These data are not available from the physicians survey.

Table 3

Understanding the Alabama Protective Services Act

<table>
<thead>
<tr>
<th>Questions</th>
<th>Physicians</th>
<th>Not True</th>
<th>Unsure</th>
<th>True</th>
</tr>
</thead>
<tbody>
<tr>
<td>All health care providers in Alabama have a legal responsibility to report elder abuse.</td>
<td>Physicians</td>
<td>5.9%</td>
<td>13.3%</td>
<td>80.8%</td>
</tr>
<tr>
<td>Only physicians are required to report abuse of the elderly.</td>
<td>Nurses</td>
<td>9.2%</td>
<td>5.2%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Anonymity will be guaranteed to any health care provider who reports cases of elder abuse.</td>
<td>Physicians</td>
<td>20.2%</td>
<td>48.7%</td>
<td>31.1%</td>
</tr>
<tr>
<td>There are standard procedures for dealing with elder abuse.</td>
<td>Nurses</td>
<td>25.2%</td>
<td>33.7%</td>
<td>41.1%</td>
</tr>
<tr>
<td>I am protected from litigation if I report unfounded cases of elder abuse.</td>
<td>Physicians</td>
<td>16.0%</td>
<td>48.7%</td>
<td>35.3%</td>
</tr>
<tr>
<td>In Alabama, there is a potential fine if elder abuse is not reported to the authorities.</td>
<td>Physicians</td>
<td>18.5%</td>
<td>73.1%</td>
<td>8.4%</td>
</tr>
<tr>
<td>The abuse victim must consent before a report of abuse is made.</td>
<td>Nurses</td>
<td>10.1%</td>
<td>64.9%</td>
<td>25.0%</td>
</tr>
</tbody>
</table>


for dealing with elder abuse. DHR and the law do give guidelines on the transmittal of reports but not on how to deal with abuse, neglect, and exploitation. Presumably, DHR will take over when a case is reported, and the physician or nurse will be relieved of this duty.

On other aspects of the law, physicians were unclear and the nurses demonstrated significant confusion or animosity. For example, most respondents were uncertain (physicians 48.7%; nurses 33.7%) or believed that their anonymity would be guaranteed if they reported cases of abuse (physicians 31.1%; nurses 41.1%). The law itself is not clear on this point. Almost one half of the physicians and over half the nurses were unsure that they were protected from litigation if they reported cases of elder abuse. The law protects the reporter from any litigation.

The uncertainty that the physicians and nurses displayed pertaining to the legal aspects of elder abuse was matched by their concern over factors influencing willingness to report. As has been demon-
resented in Table 3, these professionals accepted the responsibility to report; however, as shown in Table 4, they preferred not to handle the cases themselves (physicians 79.0%; nurses 87.3%). Both physicians and nurses also expressed a wide range of concerns about barriers to reporting. They were sharply split on the necessity for certainty before reporting abuse. Approximately 40% of the doctors and 55% of the nurses did not believe that the reporter must be certain, whereas 20.1% of the physicians and 35% of the nurses did. Because all are protected from litigation if a report is made, the reporter need not be absolutely certain before making a report.

Thirty-six percent of the doctors and 60% of the nurses cited lengthy court appearances as a major factor in failing to report abuse. The likelihood of a lengthy court appearance is minimized because the reporter is protected under the law. Forty-two percent of the physicians and 72.4% of the nurses agreed that reporting abuse makes the abuser angrier. Both professions were in agreement that abuse victims would generally deny abuse and over 64% of all respondents assumed that the family would find out who reported the abuse. However, physicians (80%) and nurses (79%) did not believe or were unsure if prompt action would be taken once any report is made. DHR is mandated to make an investigation of a report within 72 hours. Ninety-two percent of the physicians and 75% of the nurses were either unsure or did not believe that there was a fine for not reporting abuse. In fact, there is a $500.00 fine for not reporting abuse, the same as the civil fine for abusing someone. The only area where they expressed some positive attitudes was the majority’s belief that reporting would not damage their professional relationship with the patient.

Clearly, there is considerable confusion and ignorance about elder abuse legislation in Alabama. This confusion is not unique to physicians and nurses or to the state. Although both professions were fairly certain of their ability to detect abuse, they were unsure about important aspects of the law and displayed considerable disillusionment with the effectiveness of reporting. These data demonstrate that physicians and nurses, who are often among the first nonfamily members to become aware of abuse and neglect, are occasionally unsure of what to do when cases arise. Misconceptions remain concerning the meaning of the law, the level of local protection provided, and the degree of certainty required before abuse is reported.

**CONCLUSIONS**

Mandatory reporting has been the public policy of choice for most states scrambling to respond to increased publicity about elder abuse and neglect. This response is most effective when linked with adequate investigations and well-funded services. Unfortunately, many states, including Alabama, have placed the burden of these components on existing personnel and funding. Such short-sightedness distorts the impact of mandatory reporting statutes.

Still, mandatory reporting might be an effective means of case...
discovery if all participants had clear definitions of abuse, a clear understanding of the law, and few barriers to reporting. As demonstrated by the survey results, these conditions do not hold in Alabama. More ominously, nurses, who have the most knowledge of the law, have the most clearly negative responses. Nurses are more likely to correctly report abuse; yet, nurses were more concerned than physicians with lengthy court appearances or making the abuser angrier.

Nurses clearly are not complacent toward the law. While the nurses know how to report and to whom to report, they are reluctant to use the law. The nurses study contained an open-ended question asking the major reasons for not reporting. Several nurses reported that a lack of compliance by the responsible authorities to prior reports was a main reason for not reporting abuse. Several other nurses wrote long letters in the comments section of the survey. These letters were heart-rending and basically said much the same thing, that the authorities were not responsive to their reporting, so why should they report?

The mandatory reporting law in Alabama only works as well as those who implement the law. First, all physicians need to be made aware of the law and its provisions. Second, nurses must be assured that reports will be followed up. Until that time, human services workers may never be given the opportunity to deal with any but the worst cases of abuse or neglect because these cases are so obvious and demand immediate attention. DHR also has a responsibility to be responsive to reports of abuse, neglect, and exploitation. If some county DHR offices ignore reports of abuse or are not adhering to the mandates of the law (i.e., 72-hour investigation time, providing protective services for the abused person, and some type of intervention between the abuser and abused) then the physicians and nurses cannot be expected to comply to the fullest extent of the law. Abuse will not go away by itself and, in effect, the law is rendered useless because it is ignored by many who are required to report and by those who are required to follow up these reports.

One of the key weaknesses of the law is in the area of services. The nurses in the survey were uniform in their belief that social services for the elder abuse victim in Alabama are inadequate. This lack of services is particularly damaging, as it imposes a draconian choice on DHR social workers: institutionalization or no intervention. In some cases institutionalization is not even an option. When a patient is on Medicaid and is not sponsored, many open nursing home beds are not available to these patients. It is essential that the state provide additional sponsorship for these Medicaid patients.

It is time to revise the current law in such a way that more abused, neglected, and exploited victims may be helped. The law, as it is now in place in Alabama, is not protecting all who are abused. In part, this is a problem of too little money to investigate and provide services for those who have been abused. There also needs to be definitive guidelines that can be followed when a report is made. The law needs to be reformulated such that more money is provided for needed services and additional workers who can investigate reports of abuse.

NOTES

1. Workers at the Department of Human Resources have assumed that mandatory reporters include doctors and nurses. However, the Alabama State Board of Nursing asserts that they are not included under the “practitioners of the healing arts” banner, and, therefore, nurses are not required to report abuse or neglect.
2. A preliminary sampling of the nurses found that the typical nurse had seen 2 cases in the past year and 7 in his/her entire career. This seems to indicate that those with a greater intensity of interest in the topic of elder abuse returned their questionnaires earlier.
3. These percentages do not add up to 100% because some nurses responded that they reported to more than one source.

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