We evaluated physicians' responses to state elder abuse reporting statutes. Most statutes require reporting without providing for adequate investigation and service delivery. The Alabama Protective Services Act of 1976 is typical. Survey responses by Alabama physicians suggest that they have reservations about their ability to diagnose abuse, the operation of the law, and their willingness to report abuse. It appears that, in Alabama, mandatory reporting by itself is counterproductive because the statute fails to provide for adequate investigation and service delivery or to command knowledgeable compliance.

Key Words: Elder neglect, Adult protective services, Legislation

Physicians' Mandatory Reporting of Elder Abuse†

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Elder abuse has largely been a hidden problem in American society (Steuer & Austin, 1980; U.S. House of Representatives Select Committee on Aging, 1980). Many dependent elderly people routinely see physicians as their primary health care providers, and they have the trust of their clients. As such, they are in a position to treat and report abuse victims. However, physicians are often reluctant to acknowledge that abuse has occurred because they are responsible for treating and reporting abuse victims, refuse to acknowledge that abuse has occurred (American Medical Association [AMA] Council on Scientific Affairs, 1987; Hickey & Douglas, 1981a). Only in the 1970s and 1980s have investigators begun to peel back the layers of obscurity surrounding elder abuse. Initial concern about elder abuse began to peel back the layers of obscurity surrounding elder abuse. Initial concern about elder abuse arose largely as an offshoot of ongoing inquiries into child abuse, spouse abuse, and general domestic violence (Block & Sinnott, 1979; Crouse et al., 1981; Hickey & Douglas, 1981a, 1981b; Lau & Kosberg, 1979; O'Malley et al., 1979; Steinmetz, 1978, 1981). The profile of the abuse or neglect victim drawn from this research is of an extremely elderly (over 75), isolated female with mental or physical disabilities living with an adult child (usually the daughter) who is at a great deal of stress. This profile remains the dominant one and has largely shaped the public response to abuse (U.S. House of Representatives, Select Committee on Aging, 1980, 1981, 1985), despite the fact that subsequent researchers have cast some doubt on its accuracy (Pillemer & Finkelhor, 1988).

The most common legislative response at the federal and state level has been mandatory reporting legislation (Clark-Daniels et al., in press; Kosberg, 1986). Such legislation usually has been justified as a means of uncovering unreported cases of abuse (Faulkner, 1982). A mandatory reporting statute should be focused on three phases of the case discovery process: reporting, investigation, and service delivery (Quinn & Tomita, 1986). In reality, many statutes emphasize reporting and investigation only.

Closer scrutiny of the structure of adult abuse-reporting statutes is needed to assess their efficacy. An effective reporting component must include several elements. First, the statute should make explicit the population that the law seeks to protect (Fulmer & O'Malley, 1987; Salend et al., 1984). Second, the statute ought to provide clear definitions of the behaviors prohibited to make determinations of incidence possible (Crystal, 1986; Faulkner, 1982; Hudson, 1986; Katz, 1979–1980; Pedrick-Cornell & Gelles, 1982; Salend et al., 1984). Third, statutes should clearly define the reporting population covered under the provisions (Crystal, 1986; Salend et al., 1984). Fourth, the statute should provide justification for the selected population and the mandatory reporting requirement. Fifth, the statute should guarantee immunity from prosecution for the reporting individual. Finally, the statute should provide that any information gathered is confidential and may not be accessed by unauthorized individuals or organizations. The clear purpose of the reporting provisions

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should be to clarify who is to report what acts under what conditions.

These requirements rarely may be met. The increased interest in elder abuse over the last decade has prompted a proliferation of definitions with respect to "intentionality, outcome, physical versus nonphysical treatment, acts of omission versus acts of commission, and the range of acts considered abusive ..." (Pedrick-Cornell & Gelles, 1982). This disarray has carried over into protective services legislation, resulting in significant variation in definitions of abuse and neglect across political jurisdictions (American Public Welfare Association (APWA) & National Association of State Units on Aging (NASUA), 1986; Salend et al., 1984).

In addition, many statutes mandate reporting by various classes of professionals likely to encounter cases of abuse. Such requirements may actually inhibit reporting by providing vague definitions of the reporting population or by mandating notification by a population with significant disincentives to report. When specifically about mandated reporters is absent, the impetus for potentially affected individuals and organizations is to define the population narrowly enough to exclude themselves, whereas the motivation for the administering agency is to adopt the most expansive definition possible. Time and resources can be wasted determining the proper focus of the mandate.

If reporting is concentrated on a specific population such as physicians, other problems arise. For example, although medical facilities are among the most frequently used facilities in cases of elder mistreatment, physicians are frequently uninformed about abuse, neglect, and exploitation (Hickey & Douglass, 1981b; O'Brien, 1987). The focus on office-based treatment of specific complaints by most physicians often does not provide a proper environment within which to identify and treat cases of abuse and neglect. Moreover, some researchers have suggested that physicians have few formal methods for detecting abuse and are often unaware of state laws concerning elder mistreatment (O'Brien, 1987). Clear definitions and specific designation of reporters must be supplemented by awareness among reporters of their responsibilities under the law and by the absence of perceived external barriers to reporting, such as professional-client privilege.

Reporting requirements alone are insufficient. To be effective and to encourage repeat reporters, elder abuse reports must be investigated promptly and thoroughly. To do so, the investigating agency needs sufficient organizational slack to carry out its mandate (Quinn & Tomita, 1986). Legislation should designate the responsible investigative agency and specify time and documentation demands for investigation. Immediacy of investigation is crucial to the success of intervention. Unfortunately, many states require immediate investigation, but fail to provide adequate funding or manpower to carry out the investigatory function (Quinn & Tomita, 1986).

Although shortcomings in the reporting and investigation requirements of state statutes are serious, strengthening these requirements should at least improve case discovery. A more significant failing is in the area of service provision. To require mandatory reporting without providing adequate funding for supportive social services places an unreasonable burden on social service agencies (Crystal, 1986; Faulkner, 1982; Fulmer & O'Malley, 1987; Palincsar & Cobb, 1982; Quinn & Tomita, 1986; Salend et al., 1984). Because many states fail to specify adequate linkages between reporting and services for elderly persons, the agencies are left with a draconian choice between no intervention and institutionalization. Given the first alternative, serious abuse and neglect is likely to continue or even to escalate. On the other hand, intervention that offers few in-home services can lead to a solution (institutionalization) perceived by many elderly persons to be worse than ongoing abuse.

Adequacy of service options should be supported by a definition of the circumstances under which the involuntary provision of services can occur. The law should assume that the elderly person is competent and is entitled to due process (Crouse et al., 1981; Crystal, 1986; Faulkner, 1982; Katz, 1979-1980; Palincsar & Cobb, 1982). This is especially true if, in the reporting statute, the principle of parens patriae (by which the state assumes the burden of protecting legally incompetent individuals) is emphasized. Unfortunately, the same presumption of incompetence that is applied to minors is frequently carried over into elder mistreatment statutes. Judgments of incompetence may be made with few legal protections and may simply be based on the victim's age (Faulkner, 1982; Katz, 1979-1980; Quinn & Tomita, 1986; Regan, 1983). Although requirements that the state exercise the least restrictive option afford some built-in protection for the elderly person, the failure of some states to provide adequate resources for services makes the exercise of this option extraordinarily difficult to carry out in practice.

Ideally, mandatory reporting laws seek to combine clear definitions, well-informed reporters, adequate services, and legal protection to achieve a balanced solution to the problem of abuse. In practice, many state abuse laws have weak definitions, vague identification of reporters, and inadequate justification of mandatory reporting, and are backed by inadequate commitment of resources for investigation and service delivery. The laws, in fact, are symbolic. They exist to express state legislative commitment to the goals of case discovery and protective services without requiring disbursement of substantial state resources. As a result, state and county social service agencies are forced to operate under severe financial restrictions. In many of these states, the least restrictive option is translated as no intervention at all. Over time, inadequate agency response discourages both abuse victims and reporters from contacting the agency.

The purpose of this study was to examine the operation of elder abuse laws in a single state. The Alabama Adult Protective Services Program provides an excellent case study. Created by the Adult Protec
ceptive Services Act of 1976, the program provides protection to adults who are judged incapable of providing for themselves (State of Alabama, Department of Human Resources, 1987). Proscribed behaviors include abuse (physical injury, psychological abuse, willful deprivation of services), neglect (unintentional deprivation of services, self-neglect), and exploitation (misappropriation or misuse of resources). All "practitioners of the healing arts" are mandated to report if there is reasonable cause to believe abuse, neglect, or exploitation has occurred. Reports are made to the state or county Department of Human Resources or to the chief law enforcement officer in the jurisdiction. Reports are usually oral. Reporters are provided civil and criminal immunity for making a report, although they are not explicitly guaranteed anonymity. Failure to report a case of abuse or neglect is a misdemeanor subject to a maximum jail sentence of six months and/or a maximum fine of $500, a penalty identical to that for committing the abuse, neglect, or exploitation.

The act requires the Alabama Department of Human Resources (DHR) to investigate cases of abuse or neglect and provide services. Complaints must be investigated within 72 hours. The act mandates the agency to provide services through existing public and private agencies, but provides no additional funding for these activities. The agency may petition the courts for protective legal action.

The passage of the act has produced a dramatic increase in the number of reported cases of abuse, neglect, and exploitation. In fiscal year 1978, the first full year of reporting, 477 cases were reported. By fiscal year 1987, the number of reported cases had risen to 5,220. This increase in reporting has not produced an increase in civil action against alleged perpetrators. Very few fines and jail sentences have been imposed for mistreatment and none for failure to report mistreatment.

The Alabama Protective Services Act of 1976 suffers many of the weaknesses of the typical mandatory reporting law, with few offsetting strengths. Weaknesses in reporting requirements are compounded by the necessity of relying on existing sources of funding to cover investigation and service delivery. Funding problems are magnified by the fact that DHR is funded from the state's general fund, which has no consistent source of revenue and is frequently the source of intense political infighting. As a result, DHR is chronically underfunded and understaffed in all divisions, including adult services. To further complicate the issue, the statute, which is based upon child abuse legislation, provides few legal protections for the abuse, neglect, or exploitation victim (Villmoare & Bergman, 1981).

Despite these apparent limitations in investigation and service delivery, the Alabama law has been in effect for over 11 years, during which time precedents and consensus may have overcome lack of clarity in the statute. Thus, the law may still serve as an effective means of case discovery if the reporting population holds consistent views about its scope and operation. If the law is serving this function, a survey of mandatory reporters in Alabama should reveal relatively clear definitions of abuse. Knowledge of the reporting population, understanding of the mechanisms of the law, and a willingness to report unencumbered by professional crosspressures. If, on the other hand, Alabama physicians are subject to the same barriers to reporting that O'Brien (1987) found among physicians in North Carolina and Michigan, responding physicians will display considerable confusion about definitions of abuse and reporting requirements and will exhibit considerable reluctance to report.

Methods

The Sample

To gather evidence on the effectiveness of the Adult Protective Services Law, the Center for the Study of Aging at the University of Alabama conducted a survey of licensed Alabama physicians during the summer of 1987. The purpose of this study was to examine physicians' knowledge of and familiarity with elder abuse and neglect, their understanding of the law, and their willingness to report cases of abuse and neglect.

In this study we used a stratified random sample across the three specialties most likely to regularly treat elderly patients (general practice, internal medicine, and family practice) and three city sizes (under 10,000, between 10,000 and 50,000, and over 50,000). We selected these specialties because they are the medical specialties most likely to treat elderly adults for general illnesses and injuries. Several elder abuse researchers have observed that physicians are likely to come into contact with cases of elder mistreatment during routine office visits or in the emergency room (Hickey, 1981b; O'Brien, 1987). Although the figure cannot be compared to other specialties, the typical physician in the sample reported that 44% of his or her patients were over 65. The breakdown by city size was based on the presumption that physicians operating in rural areas and small towns may have more personal ties with their patients and may be more reluctant to report. The completely crossed design produced nine different categories of respondent: a total sample of 336 was selected from the population of 2,512 physicians in the three specialties.

A total number of 156 questionnaires were returned, a 46% response rate. The response rate within stratification categories ranged from 43% to 57%. Because of a high proportion of retired physicians in the original universe, responses from active physicians commonly ranged from 118 to 125 (35% to 37%).

Whereas a low response rate is typical for mail questionnaires, the response for this survey, even taking into account the high proportion of retired physicians, is higher than the 30% response rate reported from a similar survey of physicians in Michigan and North Carolina (O'Brien, 1987). Even so, low response rate always affects the interpretation of the
conclusions and limits the generalizability of the results. In particular, the respondents in the survey probably reflect an overrepresentation of physicians who had a strong interest in the subject of elder abuse and neglect. As a result, the proportion of physicians reporting abuse cases may be overestimated. Moreover, physicians who are somewhat negative about the state's response to abuse may be motivated to reply more frequently than physicians who have received more satisfactory responses. Although the survey is probably not useful for estimating the incidence of abuse (especially because most abuse and neglect is not reported), it still should prove useful as a tool for determining the attitudes and knowledge of the subject population.

The Questionnaire

We developed the survey from the literature and from the Alabama Protective Services Act of 1976. The questionnaire contained demographic items, physician-generated profiles of the typical abused or neglected person, questions concerning physicians' alertness to elder abuse cases, and questions regarding their knowledge of the Alabama law.

The section of the survey concerning the physicians' sensitivity to abuse and neglect and their experience with the Alabama law was organized to elicit responses in three important areas: understanding and diagnosis of abuse, mechanics and operation of the Adult Protective Services Act, and willingness to report. Physicians are among the first professionals who come into contact with cases of elder mistreatment, yet they are rarely the first to identify it (Crouse, et al., 1981; Hickey & Douglas, 1981b; O'Brien, 1986, 1987). To explore this dilemma, we included five statements concerning the existence of clear-cut professional definitions of abuse, the ability of the physician to diagnose cases of abuse, the most typical injuries, the impact of diagnostic-related groups (DRGs), and physicians' personal experiences with abuse.

Some researchers have suggested that physicians are often unaware of the legal responsibilities that mark their relationships with elderly patients. O'Brien (1986, 1987) found that the overwhelming majority (84%) of the physicians in his North Carolina and Michigan samples were largely uninformed about the existence of their states' mandatory reporting laws. To test Alabama physicians' understanding of the Adult Protective Services Act, we incorporated 11 statements pertaining to the legal responsibility of health care providers, the mechanisms and circumstances of reporting, the existence of standard procedures for dealing with cases, the degree of anonymity and legal protection guaranteed, and the type of legal liability for failure to report.

An equally important area of concern is the willingness of physicians to report. Although O'Brien (1986, 1987) discussed the role of denial by the patient in failure to report, factors that might increase health care providers' reluctance to notify authorities of cases of abuse, neglect, or exploitation are generally not addressed in a systematic way in the literature. To explore these phenomena, we inserted seven statements involving confidentiality, legal liability, family response to reporting, abuser response to reporting, patient-client privilege, and patient denial.

Physicians were asked to evaluate each of these statements regarding their knowledge and opinions of the protective services law using 5-point Likert scales ranging from "definitely not true" to "definitely true." For this analysis, the scales have been collapsed into three categories. The questions are grouped under their respective headings in Table 1 for ease of analysis.

Results

Physicians had mixed responses regarding the definition and diagnosis of elder mistreatment (see Table 1). On the one hand, over 60% believed that an experienced physician could accurately diagnose cases of abuse; yet, 77% expressed doubt or uncertainty about the availability of clear-cut definitions from the American Medical Association. Most physicians (52%) also believed that most incidents of abuse involved minor, nonreportable injuries. These cross-cutting responses are disturbing, considering that 58% of the physicians reported seeing abuse and an additional 9% were uncertain about seeing its occurrence.

Physicians also displayed considerable confusion with regard to their understanding and interpretation of the Alabama law. Whereas they recognized their legal responsibility to report elder abuse and knew that they were not the only mandatory reporters, over one-half reported that they were unsure if Alabama had standard procedures for dealing with abuse and three-fourths were unsure how to report abuse cases. Although the physicians were evenly split on the degree of certainty necessary to require a report, two-thirds did agree that the approval of the victim was not required prior to reporting. One-half were also unsure what state agency was responsible for receiving abuse reports and over one-third identified the wrong agency.

Physicians also expressed a great deal of skepticism about the reporting requirements and follow-up procedures of the law. Most doubted or were unsure of the anonymity of the report and their own legal immunity from prosecution for reporting. Only 20% felt that prompt action would be taken if physicians reported a case of elder abuse to the authorities.

Although most physicians (79%) did not feel they could handle abuse by themselves, considerable barriers to reporting abuse, neglect, and exploitation were revealed by the survey. Many physicians (36%) cited the possibility of lengthy court appearances. Strong majorities agreed that the victim would deny abuse and that the family would suspect the physician if a report were made. Arousing the anger of the abuser was cited by over 40% of the respondents. As a result, nearly one-half believed confidentiality could not be maintained. Despite these objections to
There are clear cut definitions of elder abuse given by the American Medical Association. An experienced physician can accurately diagnose cases of elder abuse. The largest number of incidents of elder abuse involve only minor, nonreportable injuries. Release of elderly patients from the hospital as a result of Medicare DRGs is a form of elder abuse. As a physician, I have seen cases of elder abuse in my practice.

Mechanisms and operation of the law
Physicians and other health care providers in Alabama have a legal responsibility to report elder abuse. A physician must be absolutely certain that abuse has occurred before reporting elder abuse. Only physicians are required to report abuse of the elderly. Anonymity will be guaranteed to any physician who reports cases of elder abuse. Prompt action will be taken if a physician reports a case of elder abuse to the Alabama State Department of Health. Physicians are required to report cases of elder abuse to the Alabama State Department of Health. There are standard procedures for dealing with cases of elder abuse in Alabama. Physicians are protected from litigation if they report unfounded cases of elder abuse. As a physician, I am unclear as to how to report cases of elder abuse to the proper authorities. In Alabama, there is a fine if identified elder abuse is not reported to the authorities.

The abuse victim must consent before a report of abuse is made.

Willingness to report
A major reason for failure to report elder abuse by a physician is lengthy court appearances. As a physician, I can handle cases of elder abuse better myself than if I reported them to the authorities. Families of suspected victims will assume that the physician is the one who reported a case of elder abuse. Reporting abuse will only make the abuser angrier. If a physician reports a case of elder abuse, the doctor/patient relationship will be damaged. As a physician, I do not believe that confidentiality will be maintained if I report elder abuse. The abused victim will usually deny that they have been abused.

Entries are collapsed from the original 5-point scales.

Physicians with an extensive case load of patients over age 65 did display some significant differences from physicians with a smaller elderly case load on 8 of 23 statements. On the understanding and diagnosis of abuse, physicians with large elderly case loads were slightly more likely to believe that clear-cut definitions of abuse existed and that most abuse was not minor and nonreportable. With regard to the mechanics and operation of the law, physicians with older patients were more likely to believe that health care providers had a legal responsibility to report and that the responsibility was not limited to physicians; but they were also more likely to state that they were unsure about how to do so. For most of the statements, however, their positions differed little from the rest of the sample. Finally, with regard to willingness to report cases of abuse, physicians with elderly patients were more likely to believe that lengthy court appearances reduced reporting and that the abuse victim would deny abuse, although they were less likely to believe that their relationships with patients would be damaged by reporting. Again, the tau-b's for these relationships are relatively low, ranging from .14 to .20 in absolute terms. Thus, although they are significant, their substantive impact is less obvious.

Physicians who reported having seen cases of elder abuse in their practice tended to produce a more negative profile. Although they acknowledged their responsibility to report, they were significantly more prone to doubt the anonymity guarantee, to doubt their ability to diagnose abuse, to argue that there were no standard procedures for dealing with abuse, and to state they were unclear how to report. They were slightly more likely to believe that reporting would not damage the doctor/patient relationship and that the consent of the victim was not necessary before reporting abuse. Despite the consistency, the
statistical relationships, although significant, are small in magnitude.

Clearly, there is considerable confusion and ignorance about elder abuse legislation in Alabama. In the survey, physicians indicated that they were unsure how to report abuse and what procedures were required. Physicians, who are often the first nonfamily members to become aware of abuse and neglect, are not sure what to do when these cases arise. Misconceptions remain concerning the meaning of the law, the degree of legal protection provided, and the degree of certainty required before abuse is reported.

This confusion appears to be influenced by age and sex. The medical approach to the treatment of elder abuse appears to be in flux. The current trend in treatment of abuse has been away from the home and the family physician and toward more reliance on governmental intervention. Older physicians in Alabama tend to reflect the older tradition. Newer entrants to the medical profession are somewhat less confident in dealing with abuse on their own and are more willing to report. The contradiction is magnified if the physician has a large elderly case load. Although these physicians clearly have a stronger sense of responsibility to their elderly patients, their assessment of barriers to reporting is somewhat more negative. What is disturbing in these results is that physicians who have seen abuse in their practices hold more negative attitudes toward the system for reporting abuse. Contact with the victims may in some cases increase the physicians' disillusionment with current legislative remedies for abuse and neglect.

Conclusion

Many of the early researchers suggested that the United States was faced with an epidemic of elder abuse. The sense of urgency and the desire to be on record with a legislative response produced most of the impetus necessary for the passage of state mandatory reporting legislation. For many states, mandatory reporting was an ideal solution. The primary problem appeared to be one of case discovery. Making abuse illegal and requiring professionals to report such cases to the authorities committed the state to the fight against mistreatment without committing a significant portion of state resources. Most political decision-makers assumed that investigation and service delivery could be accomplished with available resources and services.

Unfortunately, many of the researchers since that time have concluded that mandatory reporting without adequate service delivery places the social worker in the position of choosing between no intervention and institutionalization. Neither solution is mandatory. Reporting statutes may actually worsen the likelihood that such statutes will remain an important mechanism in the process of case discovery, at least for the near future.

Under these circumstances, the best available alternatives would be better education of the mandatory reporters and a much closer and better-funded linkage between reporting, investigation, and service delivery, emphasizing the principle of least-restrictive intervention. The confusion of the physicians in the Alabama survey underscores the need for the first alternative. Unless the mandated population fulfills its responsibility willingly, mandatory reporting is neutralized. And unless identified cases are investigated expeditiously and provided with needed services, reporting will only lead to nonintervention or institutionalization. Only with a properly linked statute does elder mistreatment legislation become truly protective.
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