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INTRODUCTION

Abuse of the elderly is not a new phenomenon. Historians and sociologists have frequently refuted the myth that harmonious multi-generational family living was the norm (Hendes, 1987: 966). [1] In preindustrial Europe, it was common practice for rural peasants to retain the bulk of their property rights almost until the time of their death. Besides property rights, these rights included the right “of the elder parent to continue to sit at the family table or to use the front door of the house” (Rosenmayr, 1984). Before 1800 in England, “eighty percent of all persons 60 years of age and older were heading their own households” (Shanas, 1979) because there was a great tendency to preserve one’s own “well being.” In fact, at no time in western civilization was the multi-generational household the norm.

Among skilled artisans in the middle ages, elder craftsmen commanded respect, but only so long as they were able to produce or teach their craft. In their later years, many of the craftsmen had written guarantees of protection from their guild. The guarantees, perhaps the earliest forms of social security, clearly stated that the older person would be looked after if he needed care (Rosenmayr, 1984). The very fact that these provisions for old age were written leads one to suspect that these men were concerned about the treatment they might receive from members of their guild or from their children. One also suspects that elder abuse occurred even then in various forms.

More recently, the effects of industrialization and increased mobility have significantly modified the extended family (if it ever existed). Few older parents actually live with their children. During the 19th century, fewer than one in ten older women and fewer than one in 20 older men lived with their adult children. In the 1980s, less than 15 percent of older women and less than five percent of older men live with their children or with any other non-spousal relative.

REVIEW OF THE LITERATURE

Abuse of the elderly is difficult to detect because the problem is often obscure. It remains hidden because the victim frequently fears public exposure with its accompanying shame, embarrassment, and guilt over what has happened; because the victim sometimes fears retaliation or removal from the abode and placement in a nursing home; or because the victims are too passive or sick to remedy the situation. One author estimated that approximately 10 percent of Americans over the age of 65 are being or have been abused (Clark, 1981). This same author elsewhere in the study concluded that one in every 25 (or 4 percent) of elderly Americans (>1.1 million) are probably victims of abuse. At about the same time, the House Select Committee on Aging reported that there were approximately 100,000 abuse victims annually (U. S. House of Representatives, 1985). Others conclude that elder abuse occurs with about the same frequency as child abuse (cf. Kosberg, 1986; O’Brien, 1987). For example, Crouse et al. (1983) found that child abuse and elder abuse rates in Illinois were about equal.

As has been demonstrated, abuse statistics differ and clear estimates of the incidence of abuse are currently unavailable. However, while there is confusion about the extent of abuse, there is considerable agreement that abuse of the elderly is a serious problem that is increasing annually.

Probably the most difficult problem facing any public administrator or policy-maker confronting elder abuse or neglect is: “How can society best protect its vulnerable members within a
framework of individual freedom?’” (Crouse et al., 1983). The 40 states that have passed protective legislation to help victims of adult abuse, neglect, and exploitation have almost universally sought to place or maintain victims in the least restrictive environment. Yet, we know that has not always been successful as abuse is a recurring event. Three-fourths of all abuse cases are repeat offenses with some abuse being repeated for as long as 30 years.

Most often, the social policy response to abuse or neglect of the elderly has taken two forms — protective services legislation and mandatory reporting legislation (Kosberg, 1986). Currently, over 40 states use one or both of these two approaches. Protective services usually include the provision that both voluntary and involuntary services are to be given to the physically or mentally infirm older adult who has been abused, neglected or exploited (Faulkener, 1982). While protective services historically have helped to protect vulnerable adults from “abuse, maltreatment, self-destructive behavior, and other forms of adversity” (Ibid.), they also exacerbate existing legal difficulties. Problems such as the absence of due process safeguards and interference with protections against the invasion of the rights to privacy and self-determination often place the abused victim at the mercy of institutions whose goals may not match their own (Crouse et al., 1983).

For example, an underlying premise for most involuntary commitment, pares paiae (best interest premise), must be looked at very carefully in order to determine whose best interest is being safeguarded if a person is involuntarily committed (Ibid.). Furthermore, the problem of intervention in family situations presents even more complicated problems (Kosberg, 1986). Under circumstances of intervention, the rights of all who are involved need to be protected.

Under current circumstances, one wonders if due process is truly being maintained. A study in Los Angeles by the National Senior Citizens Law Center (1975) demonstrated that “in over 1,000 guardianship and conservatorship cases, the only persons present at 84 percent of the hearings were the judge, the petitioner, and the petitioner’s attorney!” (cited by Crouse et al., 1983). Apparently, procedural requirements do not dictate that the person about to be committed or placed under guardianship or his/her representative needs to be present for such determination. Have the rights of that person been protected? It is not possible to be certain that any rights have been safeguarded through such proceedings.

Several states, including Alabama, Florida, and South Carolina, have been cited for their lack of due process protections while other states have been praised for well-developed due process requirements. Oklahoma, Tennessee, North Carolina, and Virginia have due process stipulations which work to safeguard the rights of elderly citizens. The protective laws of Alabama and Tennessee do not have well-defined guidelines for procedural requirements when there is need for emergency care. In fact, both laws 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 of these laws. Yet, capacity is perhaps the most important criteria because capacity can determine if the person can care for himself or, at the very least, understand what procedures are taking place on his behalf.

By a broad interpretation of the laws in Alabama and Tennessee, one can conceive of circumstances in which a competent person who refuses care could be subject to involuntary placement without even notification of the hearing! In Alabama, this commitment could continue for 10 days with no guarantee that the problem would be resolved in the best interests of the elderly person (Bloom, Farren, and Villamore, 1981, as cited by Crouse et al., 1983). In other words, due process and all other rights are abrogated, at least on a temporary basis, if there is an emergency situation. More clearly stated procedures within the law would protect the rights of the elderly person.

The second type of legislation, mandatory reporting of elder abuse, generally requires health care professionals to report cases of suspected abuse to appropriate authorities. However, there is little standardization of “…the criteria for emerging intervention and the protecting of due process rights…” across states (Kosberg, 1986). Kosberg (1986) points out that usually “legislation provides [for] legal action against anyone who,
knowing of elder abuse, fails to report it.” But there are few, if any, due process protections for the abused persons.

Mandatory reporting has been criticized because of both its ineffectiveness in producing evidence of elder abuse and its failure to protect the personal liberties of the abuse victim (Salend et al., 1984; Faulkener, 1982). This type of legislation has also been criticized as an “ineffective [but showy] way for the state to deal with the problem and, thus, demonstrating an effort to deal with a problem that will not cost a great amount of state revenue” (Kosberg, 1986). Additional and more invasive interventions may be required because of the original reporting requirement and intervention. This intervention may even lead to institutionalization (Crouse et al., 1983). But, mandatory reporting has also been praised because it can raise the public and professional awareness to the “benefits which ... intervention can provide for vulnerable elderly persons” (Ibid.). This ambivalence toward mandatory reporting arises in virtually every state where such reporting is required.

As expected, there are as many different laws as there are states, even though the laws tend to follow the two patterns of mandatory reporting and protective services legislation discussed above. Differences in the laws and their implementation can be explicated by examining their application in the southern states. In North Carolina, the state provides overall leadership but the administration of the law is left to county departments of social services. In Florida, a human rights advocacy committee must be notified in the case of any report of abuse, but the Department of Health and Rehabilitation Services alone administers the law. Georgia’s law “mandates local health departments, mental health clinics and other agencies to fully cooperate with the Department of Human Resources” (Crouse et al., 1983). In cases of abuse, while South Carolina requires local welfare authorities to investigate and offer any services deemed necessary, the law, however, is criticized for possible civil rights violations because authorities may involuntarily provide protective placement of a person for up to 90 days (Ibid.) whenever violence has occurred.

Conceptually, there should be adequate resources within the community which can be mobilized to deal with the problem of elder abuse from both the perspective of the abused and the abuser (Kosberg, 1986). Clearly, this is not always the case. Where services are sparse, as in rural and low-income areas, reporting systems often frustrate abuse reporters and social service workers (Ibid.). Further intervention, such as institutionalization, may be required because of the lack of needed services.

However, more immediate problems exist. One such problem is the lack of awareness of the law and the law’s obligatory requirements that certain groups report cases of elder abuse. O’Brien (1985) surveyed physicians in Michigan and North Carolina and found that 70 percent of physicians were unaware of elder abuse reporting requirements, even though about 25 percent of these physicians had previously encountered a case of elder abuse.

Another problem concerns whether the laws which are meant to protect the elderly should be strengthened or whether the current laws are sufficient. If additional laws are needed, what is the role of the federal government to help states accomplish this task? If physicians do not know the requirements of their respective state laws and few services are available in many communities to prevent recurrence of abuse, what realistically can the federal government accomplish? Some have stated that the laws concerning assault and negligence are already in place and that these laws will protect the elderly as well as they protect anyone else (Cox, 1985).

If prior laws actually protected the abused, there would be no need for additional legislation. However, over 40 states have found that abuse victims have not been protected under the prior laws. Alabama’s response to curbing abuse, neglect, and exploitation has been a law which includes mandatory reporting as well as protection of all infirm adults over 18 in need of protection. Because of this mandate, the largest county, Jefferson, recently added five social workers to handle cases of abuse. Collectively, they investigate about 100 reported cases each month. While two of these social workers suggested that their caseload was only the “tip of the iceberg,” it is interesting to note that the Birmingham Police Department (Jefferson County) does not keep records of reported cases of elder abuse
because "very few cases are ever reported" to the police department (Johnson, 1985).

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 of cases of abuse to the Department of Human Resources (county welfare department) by health care professionals. There is a penalty of $500 or six months in jail for not reporting suspected cases of abuse which, incidently, is the same penalty for being found guilty of abusing older people in Alabama. The Department of Human Resources is then required to investigate within 72 hours of the initial report.

Since this law has been enacted, there has been a large number of reported cases of elder abuse. 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).

PURPOSE OF THIS STUDY

It has been frequently reported that with increasing age come increasing visits to physicians (O'Brien, 1986). Based on the twin observations that physicians are the most likely non-family member to detect cases of abuse and neglect and that previously reported data suggest that physicians were largely ignorant of their respective state laws regarding elder abuse, this study attempted to examine physicians' knowledge and willingness to report elder abuse under current Alabama law.

The purpose of this study was threefold:

1. To examine physicians' knowledge and familiarity with the state law;
2. To ascertain physicians' willingness to report cases of abuse or neglect; and
3. To find what characteristics or attitudes physicians thought best described abused and neglected older persons.

While state law in Alabama requires health care professionals to report all cases of elder abuse to the proper authorities, it is believed that there is significant underreporting by Alabama physicians either because they ignore the law or they do not know about the law.

METHOD

The research design for this 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 in population, and cities over 50,000). Previous research suggests that the three specialties most likely to see elderly patients as primary care physicians were general practitioners, family practitioners, and internists (cf. O'Brien, 1986). Therefore, these classifications of physicians were used in this study. The population of physicians was then matched by specialty and city size. A stratified random sample was drawn which represented all nine possible combinations equally. All physicians in this study are board-certified.

An initial survey of 41 items was developed based on previous research studies and the Alabama Protective Services Act. The questionnaire contained items to identify demographic characteristics (such as age, race, years of practice), 14 bipolar adjective items designed to develop a systematic profile of an abused or a neglected person (current literature is strictly anecdotal), and questions concerning physicians' alertness to and handling of elder abuse cases, as well as their knowledge of the Alabama law.

A pre-test of the initial instrument was sent to 21 practicing physicians representing the three specialties in two urban areas of the state. Ten physicians responded to the pre-test. After some modifications, questionnaires and self-addressed, stamped envelopes were mailed to 325 physicians during the summer of 1987. Each questionnaire contained a cover letter
signed by the project co-directors explaining the purpose of the research. If the doctors did not respond within two weeks, reminder postcards were sent. A second survey was sent two weeks later to all doctors who failed to respond to the postcard.

The total number of questionnaires returned was 159, a 47 percent rate of return. Previous investigators have usually reported a response rate of less than 30 percent with surveys mailed to this population (O'Brien, 1986). Not all of these responses were from currently practicing physicians, however. One-fifth of the questionnaires returned were from retired doctors. The population was drawn from lists of board-certified physicians provided by the Alabama Medical Association. Some of the retired physicians filled in the questionnaire. All useable questionnaires which were returned (excluding three) were incorporated into the study for an N of 156. The three unusable questionnaires were from physicians in other specialties. Table 1 shows the number of returned questionnaires according to classification by location and by specialty. As can be seen all areas and specialties are represented.

THE INSTRUMENT

After the demographic section and a set of questions about the characteristics of the doctor's practice, a set of items concerning the expected profile of abused or neglected persons were asked. These consisted of dichotomous adjectives such as independent-dependent, poor-affluent or timid-bold. For the purpose of this study, the elderly were defined as those 65 years and older. There was no attempt to define abuse and neglect in this study as this might influence physicians' perceptions of their attributes. Instead, the researchers were interested in physicians' definitions of abused or neglected persons by asking them to select from paired lists of characteristics they would consider abuse or, in the next section, neglect. [2] Physicians also had an opportunity to assess the applicability of any pair of these traits. The last section asked the doctors to use a 5-point Likert scale from "Definitely Not True" to "Definitely True" to assess statements about physicians' knowledge and opinions of the law concerning protection of the elderly.

### TABLE 1
RESPONSES TO SURVEY STRATEFIED BY SPECIALTY AND CITY SIZE*

<table>
<thead>
<tr>
<th>Specialty</th>
<th>City Size-Population</th>
<th></th>
<th></th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 10,000</td>
<td>10,000</td>
<td>49,999</td>
<td>Over</td>
</tr>
<tr>
<td>Family Practice</td>
<td>16 (13)</td>
<td>15 (12)</td>
<td>17 (24)</td>
<td>48 (49)</td>
</tr>
<tr>
<td>General Practice</td>
<td>20 (16)</td>
<td>18 (10)</td>
<td>16 (10)</td>
<td>54 (36)</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>18 (6)</td>
<td>18 (15)</td>
<td>18 (50)</td>
<td>54 (71)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>54 (35)</td>
<td>51 (37)</td>
<td>51 (84)</td>
<td>156 (156)</td>
</tr>
</tbody>
</table>

* The left-hand figures are the actual number of responses in each cell of the stratified sample. Each cell contained a potential sample of 35 respondents. The figure in parentheses is the actual response weighted to reflect the true proportion of each specialization in the Alabama physicians' population.
Reported statistics are weighted to reflect the true proportion of doctors by city size within the three specialties in Alabama. The average age of the physicians answering the survey was 47.7 years with 85 percent male and ninety percent white. The average number of years in practice was 16.8 years. Eighty-two percent were in private practice, of which 56 percent were in a solo practice. Seventy-eight percent saw patients in the hospital, 75 percent saw patients in an emergency room, and 82 percent saw patients in a nursing home. They reported a large patient load as three-fourths saw more than 15 patients per day with 40 percent seeing more than 25 patients per day. 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 of elder abuse per physician was 1.2 cases within the past year alone.

Even though the elderly constitute only 12 percent of the population, forty-four percent of all patients seen in offices were over 65 years of age. This is consistent with a national survey 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 (Kellogg, 1983).

When physicians were asked what living situations were most likely to produce abuse of an elderly person, 20 percent reported that the abused person lived alone, 38 percent thought that the abused would live with a relative, 40 percent that the abused lived with someone other that a relative, and 12 percent that an abused person would live in a nursing home.Still, most physicians responded that the abused person lived with someone else, either a relative or a non-relative.

The profile of the person at risk is not very dissimilar from the anecdotal literature, although Crouse et al. (1983) argued that abuse was “more likely to be a characteristic of the abuser” rather than the fault of a specific attribute of an abused person. According to respondents, the elderly abused person was female, over 75, disabled, in poor health, disagreeable, widowed or divorced, dependent, confused, uneducated, poor, incompetent, and timid. Judging from the response pairs most often selected by the physicians, the most relevant dichotomies were ablebodied/disabled, good/poor health, independent/dependent, and confused/mentally alert.

The profile of the neglected person differs little from the portrait above. If neglected, physicians suggested that the elder person was most likely to be female, non-white, over 75 years of age, disabled, in poor health, disagreeable, demanding, widowed or divorced, dependent, confused, uneducated, poor, incompetent, and timid. The most relevant pairs in the neglect profile were ablebodied/disabled, good/poor health, confused/mentally alert, and demanding/easygoing. Most of the literature generally supports this profile.

According to the physicians’ reports these are profiles of persons who are very vulnerable. One could almost conclude that, if an elderly person is able to stand up for his or her rights, abuse would not happen. While this may be the case in many instances, it is equally clear that not all these traits need to be present for abuse or neglect to occur. One may be mentally alert but physically dependent and abuse can still occur.

In examining how physicians understand and interpret the mandatory reporting law, Alabama physicians appeared to be confused about the law and unsure how to handle cases of elder abuse. While they were correct in reporting (1) their legal responsibility to report elder abuse (79%), (2) that they were not the only professionals required to report elder abuse (82%), and (3) that suspected abuse victims did not need to consent before the physician filed a report (62%), over half (51%) reported that they were unsure if Alabama had standard procedures for dealing with elder abuse (it does) and three-fourths (76%) were unsure how to report abuse cases. Half (51%) were also unsure what state agency was responsible for receiving abuse reports and over one-third (34%) identified the wrong agency.

Half of the physicians surveyed felt that it was not necessary to be absolutely certain that abuse had occurred before reporting abuse or neglect, while 41 percent believed that such certainty was a must before reporting. This dilemma is magnified by the physicians’ recognition that the abuse victim will probably deny that abuse had occurred, a response given by
70 percent of the physicians in the survey. Fifty-one percent of the physician-respondents stated that most cases of elder abuse only involved minor injuries or bruises.

Almost two-thirds (64%) were unsure if there are clear-cut definitions of elder abuse provided by the American Medical Association (there are not), one-third were not sure whether experienced physicians could accurately diagnose cases of elder abuse, and over half (52%) were unsure whether they were protected from litigation if they reported cases of abuse (they are). Finally, one-eighth percent knew that failure to report elder abuse results in a fine for physicians.

Physicians expressed a great deal of skepticism about the above reporting requirements and follow-up procedures. Only 20 percent felt that prompt action would be taken if physicians reported a case of elder abuse to the proper authorities, while over 40 percent felt that reporting the abuse would only make the abuser angrier. Only 30 percent said that their confidentiality would be maintained if they reported elder abuse.

Doctors were somewhat split on the question of whether involvement in abuse cases would result in lengthy court appearances. Fifty-one percent believed that lengthy appearances would not be likely while 33 percent believed that they would. Fifty-seven percent did not believe that the relationship between patient and doctor would be damaged by reporting abuse, but 61 percent felt that the family would suspect that the physician had been the one who had reported elder abuse.

Clearly, there is considerable confusion and ignorance about elder abuse legislation in Alabama. This confusion is not unique to either physicians or to the state. Even though the responding physicians were able to give a reasonably accurate profile of abused and neglected persons, they were unsure how to report abuse and what procedures were required. These data demonstrate that physicians, who are often the first non-family member to become aware of abuse and neglect, are not sure what to do when such cases arise. Misconceptions remain concerning the meaning of the law, the degree of local protection provided, and the degree of certainty required before abuse is reported.

CONCLUSION

As shown by these survey results, there is confusion about the protective services law in Alabama. As shown in other reports, this confusion is not unique to the state. It is not surprising that abuse is difficult to quantify even though physicians were able to give a reasonably accurate profile of an abused or neglected person when they were surveyed. Even though doctors believed that they had a legal responsibility to report abuse, they were unsure how to report the abuse. For this and a variety of other reasons, there is significant under-reporting in Alabama. This confusion brings up an interesting problem doctors must face: when to report abuse and how to report it.

The mandatory reporting feature of most state laws probably has increased the awareness of abuse and neglect for affected physicians. It is likely that more cases of abuse are being reported than ever before. However, it is not possible to measure the effectiveness of the law truly because unreported abuse of some magnitude still exists. Increases in reported cases may simply mean that more new cases of abuse are occurring that particular year than in previous years.

Thus, 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. But, if some definitive guidelines for recognizing abuse and neglect in adults were provided by the American Medical Association or other appropriate organization, most doctors would feel some comfort in having these guidelines available. To others, however, these guidelines may not make much difference as these physicians may continue to believe that they are best able to handle the situation by themselves.

There are still other difficulties for public administrators. The mandatory reporting law in Alabama and in many other states does not seem to give the necessary procedural guidelines which will actually protect the rights of elderly adults nor has the law been well publicized by the state, and nor is it well understood by physicians. This survey demonstrates repeatedly
that physicians who are required to report cases of abuse or neglect are not sure how or to whom to report such cases. The law in Alabama is now ten years old and misconceptions remain concerning the meaning of the law, the degree of legal protection provided, and the degree of certainty required before abuse is reported. Public administrators and human services workers could do considerably more to make the law known to caregivers in the state and to help doctors define the meaning of the law.

Moreover, older Americans often voice the fear of institutionalization and believe that the move to an institution is a prelude to death. But institutionalization may be a foregone conclusion for some since the protective services law requires intervention even when the only available policy response is placement in an institution.

Furthermore, other services provided for elder adults are often sparse, particularly in rural areas. In rural areas, physicians may not know what is available beyond nursing homes and this can serve to frustrate those who are required to report abuse. Even though relocation to an institution may clearly obviate the need to report further abuse, it may not be the best solution for the victim. For instance, the home where the abuse occurred is often owned by the victim and the abuser may be living there in order to care for the victim. It would seem that the removal of the abuser would leave the elder person less vulnerable than the removal of the victim. This requires the development of alternative in-home services. The law offers no guidelines on this point.

Abuse and neglect of the elderly are a continuing problem that will not go away with the passage and implementation of new punitive laws. Mandatory reporting laws alone cannot prevent abuse or even reduce the problem. Laws tend to be punitive toward both the abuser and abused as well as toward the non-reporting physician. This is particularly difficult when the abuser is a family member, as is often the case. Currently, 80 percent of all social and economic support of the aged is derived from family members. Elderly persons depend on this support even if their family members are the ones committing the abuse. Furthermore, the elderly person needs this support and expects that this support will continue even if abuse occurs.

There is a clear need in our society to develop a set of typologies which will more fully explain the root causes of abuse. Currently, the same variables that describe abusive caregivers (adult female family members) and abused victims (75+ dependent females) also describe non-abusive relationships. One way to clarify discrete causal variables is through social and behavioral methods, not through punitive laws.

Attempts need to be made to lessen the stress placed on other family members when an elderly person needs financial, medical, and social support. Public policy could be redirected to support family members in their endeavors to care for elderly relatives rather than the current solution of supporting institutions for the elderly. Physicians would have other realistic alternatives besides institutionalization of the elderly. Community-based, long-term care programs, Medicaid waivers, and welfare agencies could allow funds to be paid directly to families who are willing to care for their elderly relatives. This paid care received by the elderly may provide for the continuation of or improvement in the lifestyles to which they were accustomed in the past. It is quite likely that the additional funding would lessen the stress within the family and result in less abuse of the elderly. This alone may sustain a better quality of life for elderly persons and thus prolong their lives.

Instead, public policy largely emphasizes reimbursement for placement in institutions which are viewed as places of death by elderly persons. Moreover, when financial support for family members has been suggested, there has historically been a negative reaction. Despite the fact that such familial support has been implemented in some locations over the last twenty years, conservative opposition has prevented its widespread use. Generally, such opposition has focused on the arguments that such aid represents yet another welfare program in a government already bloated with such programs and that aid to families undermine the family unit by destroying its ability to take care of itself.

But failure to implement creative solutions may lead to repetition of the blunders which followed the implementation of Medicare and Medicaid. These programs were simply imposed on the existing uncoordinated health care system with no
attempt to assess the long-term impacts which might be produced. The available evidence suggests that these two programs simply made hospitals and, especially, nursing homes richer without developing any new approaches to dealing with the problems of elder care. The development of family support funds, community-based, long-term care options, Medicaid waivered services programs, home health care agencies or other innovative programs occurred much later. As a result, Medicaid and Medicare contributed to the explosion of medical costs (a 500 percent increase in a 10-year period), thereby leading to the development of such cost-control measures as Diagnostic Related Groups (DRGs) and limits on new nursing home bed construction.

We are all growing older and most of us can live productive lives beyond what was available to our grandparents. Punitive laws can protect us to some extent, but also deprive us of control over our lives. Moreover, lack of guidance and coordination among the professions most likely to encounter elder abuse makes the application of existing law sporadic and arbitrary. The lack of knowledge of existing law and lack of a common frame of reference in dealing with elder abuse is clearly apparent among Alabama physicians and, most likely, among all physicians. What is needed now is a more comprehensive education program for professionals most likely to encounter abuse and the development of new, creative programs designed to meet the unique needs of a population which, ultimately, all of us will represent.

NOTES

1. This research was supported through a Bio-Medical Research Grant and a College of Community Health Sciences Research Grant from the University of Alabama. The opinions expressed in this article are solely those of the authors.

2. The pairs of semantic differentials used for both the abuse and neglect profiles are:

   Male/Female
   White/Non-white
   Under 75/Over 75
   Ablebodied/Disabled
   Good/Poor Health

   Disagreeable/Pleasant
   Demanding/Easygoing
   Widowed-Divorced/Married
   Independent/Dependent
   Confused/Mentally Alert
   Educated/Uneducated
   Poor/Affluent
   Competent/Incompetent
   Timid/Bold

3. Because physicians were asked to give dichotomous yes-no responses to each of these situations, the percentages add up to more than 100 percent.

REFERENCES


