



THE AGA KHAN UNIVERSITY

eCommons@AKU

---

Department of Emergency Medicine

Medical College, Pakistan

---

12-15-2015

## Community emergency medicine: Benefits and challenges of screening for elder abuse in the emergency department of a developing country

Muhammad Akbar Baig  
*Aga Khan University*, muhammad.baig@aku.edu

Asad Mian  
*Aga Khan University*, asad.mian@aku.edu

Erfaan Hussain  
*Aga Khan University*, erfah.hussain@aku.edu

Shahan Waheed  
*Aga Khan University*, shahan.waheed@aku.edu

Follow this and additional works at: [https://ecommons.aku.edu/pakistan\\_fhs\\_mc\\_emerg\\_med](https://ecommons.aku.edu/pakistan_fhs_mc_emerg_med)



Part of the [Emergency Medicine Commons](#), and the [Human Rights Law Commons](#)

---

### Recommended Citation

Baig, M. A., Mian, A., Hussain, E., Waheed, S. (2015). Community emergency medicine: Benefits and challenges of screening for elder abuse in the emergency department of a developing country. *World Journal of Emergency Medicine*, 6(4), 261-264.

Available at: [https://ecommons.aku.edu/pakistan\\_fhs\\_mc\\_emerg\\_med/103](https://ecommons.aku.edu/pakistan_fhs_mc_emerg_med/103)

## Editorial

# Community emergency medicine: Benefits and challenges of screening for elder abuse in the emergency department of a developing country

Muhammad Akbar Baig<sup>1</sup>, Asad Mian<sup>2</sup>, Erfaan Hussain<sup>3</sup>, Shahan Waheed<sup>1</sup>

<sup>1</sup> Department of Emergency Medicine, Aga Khan University Hospital, Karachi, Sindh 74800, Pakistan

<sup>2</sup> Departments of Emergency Medicine, Aga Khan University Hospital, Pediatrics & Child Health Stadium Road, Karachi, Sindh 74800, Pakistan

<sup>3</sup> Adult Critical Care Services, Aga Khan University Hospital, Karachi, Sindh 74800, Pakistan

**Corresponding Author:** Muhammad Akbar Baig, Email: [dr\\_akbar2007@hotmail.com](mailto:dr_akbar2007@hotmail.com)

World J Emerg Med 2015;6(4):261–264  
DOI: 10.5847/wjem.j.1920–8642.2015.04.002

As people live longer and fewer babies are born, the elderly became the fastest and largest growing population of the world, expected to increase further from 86 million in 2005 to 394 million in 2050 worldwide. Older patients represent a large bulk of the population arriving in emergency departments (EDs) all over the world.<sup>[1]</sup> They use hospitals more frequently than younger patients, have more hospital admissions from the ED and more prolonged hospital stays.<sup>[2]</sup> Elder abuse is defined as a single, or repeated, act which causes harm or distress to an older person and it can occur within any relationship where there is an expectation of trust from the elder person's perspective.<sup>[3,4]</sup> The ED setting is a particularly important environment being the first point of contact with formal services for the abused elderly population.<sup>[5]</sup> Careful consideration is demanded when older people attend the ED, with particular attention paid to assessment of subjective and objective data in terms of manifestations and potential indicators of abuse. There are no reliable elder abuse and neglect prevalence and incidence figures from Pakistan. There is also a lack of specific healthcare institutions and reporting systems for dealing with elder abuse in the country. In the present article we will be discussing the factors responsible for the ED presentation of elder abuse, reasons why such abuse is not reported and communication strategies that could be applied in screening for elder abuse.

A few of population-based studies in Pakistan suggest that between 4% and 6% of elderly people have experienced

some form of abuse in their home. As per a recent WHO report, elderly people are at risk of abuse in institutions such as hospitals, nursing homes and other long-term care facilities. Abusive acts in institutions include physically restraining the patients and depriving them of their dignity and choice regarding daily affairs.<sup>[6]</sup> The current demographic profile of Pakistan demonstrates the total population at 196 million, among which the elderly population, aged over 65 years, constitute 4.3% (3 million males versus 4 million females). The overall population pyramid is broad in the middle with the highest figure (62.3%) reflecting 15–64 years of age.<sup>[3]</sup> Old age has not posed a significant problem for Pakistan as yet where a value based, joint family system presumably prevails. However, with changes in societal norms, coping capacities among family members are now being challenged, and more often results in unwarranted behavior towards the older family members. It is likely that in Pakistan, these acts occur in the privacy of homes and therefore there is not much awareness regarding the existence of elder abuse.

Screening is a concept from epidemiology and has become a central focus in public health care systems.<sup>[7]</sup> Screening for elder abuse has some merit due to its covert nature and because older people rarely self-report.<sup>[8]</sup> However, there have been arguments that the use of a specific screening tool may not be appropriate in elder abuse due to its complexity and the fact that the problem does not follow a traditional disease trajectory typical of epidemiology.<sup>[9]</sup>

Despite such challenges, a plethora of qualitative and quantitative tools have been developed for the society at large. Some screening tools are not realistic in the ED due to the length of time needed to complete them or their lack of psychometric support. For example, the Indicators of Abuse (IOA) screen<sup>[10]</sup> takes 2 to 3 hours to complete and has been shown to be weak in alerting to financial abuse.<sup>[11]</sup> Similarly, the American Medical Association Diagnostic and Treatment Guidelines on Elder Abuse and Neglect<sup>[12]</sup> are lengthy and do not discriminate well in terms of potential abuse and non-abuse.<sup>[13]</sup>

The Elder Assessment Instrument (EAI)<sup>[14]</sup> has been used in different clinical areas<sup>[15]</sup> and takes approximately 12–15 minutes to complete. In a study of 501 older people in an ED, the EAI showed some promising results in terms of validity and reliability, but it is victim-focused and does not capture an assessment of the caregiver or perpetrator.<sup>[16]</sup> More recently, the Elder Abuse Suspicion Index (EASI) was developed by Yaffe et al. The EASI is a six-question, brief assessment tool which takes approximately two minutes to complete, and therefore it is attractive for busy EDs. Evaluations with general practitioners in Canada have been positive, with 95.8% of physicians indicating that the questions were "very easy" or "somewhat easy". The EASI has also been evaluated by the WHO in eight countries.<sup>[17]</sup> Results indicate ease of completion and ability to focus on multiple types of abuse, but it only focuses on the older person and not the caregiver. The WHO noted that cultural transferability may require refining of the language used in the tool, which, like all screening tools, means that linguistic suitability and piloting is essential before using in different countries.

Injuries inconsistent with the typical history of such presentations should alert suspicion of elder abuse. This is particularly important, as presenting problems may be solely but erroneously attributed to the narrative from the older person or their accompanying relative/other<sup>[18]</sup> or attributed to age-related decline.<sup>[19]</sup> The function of the ED service in the context of elder abuse is not only to address the presenting problem, but also to screen for possible abuse, particularly when the presenting reality does not match the reported narrative. Unfortunately, most emergency physicians have not been trained in specific geriatric approaches, and many reports being uncomfortable when dealing with older patients.<sup>[20]</sup> The identification of elder abuse is hampered by issues of confusion regarding discriminating signs of abuse with age-related physical and mental decline, family privacy,

abuse being a taboo topic and the fact that ED facilities are busy environments where the staff are under time and increasing work restraints.

Successful communication with elderly people is an essential step for them to disclose information concerning abuse. As per the basic principles of Communication Privacy and Management Theory of Sandra Petronio, elder people own and control their private information and have their personal privacy rules.<sup>[21]</sup> Approaches to healthcare delivery should involve recognition of the person, respecting him or her and ultimately valuing their life, experiences and narratives. Such sensitive care has yielded positive results.<sup>[22]</sup> The disclosure of private information and the rule based theory are necessary adjuncts that can be employed while interviewing patients presenting with abuse.<sup>[21,23]</sup> Careful consideration should be taken when interviewing the older person as disclosure may be hugely compromised with the presence of a family member, who may be the perpetrator. It is also useful to interview the accompanying relative separately to elicit cause of presentation to the ED, which may deviate from the older person's account. In the context of a relative refusing to leave, it should be noted and the older person should be facilitated to answer the questions rather than communication being dominated by the relative/other person. In all communication, a non-judgmental, direct approach is essential to establish background and build a comprehensive picture.<sup>[24]</sup> Particular attention should be given to verbal and non-verbal cues, such as the older person or the perpetrator being evasive, the family member refusing to leave the older person alone or being aggressive or angry towards the older person or staff. It is important to remember that anyone can be a perpetrator of abuse and any older person can be an abuse victim.

If there is suspected or confirmed elder abuse, standard referral procedures to appropriate services are critical<sup>[25]</sup> and reporting elder abuse in many states in the USA is mandatory.<sup>[26]</sup> Unfortunately, in Pakistan, we are yet to see a strong, capable and just law providing authority for protection of older people from abuse, and recourse once abuse is identified. Pakistan has accepted the United Nations conventions on human rights, but stands in its violation as many of the rights of the elderly are not provided. Steps need to be taken at the national level to raise concerns regarding this potential healthcare challenge.<sup>[27]</sup> An effort like the World Elder Abuse Awareness Day held recently in 2013 in Islamabad is a just cause for providing motivation in this regard. Since no comprehensive screening and communication

**Table 1.** Summary of key recommendations for identifying and tackling the issue of elder abuse presenting to the EDs of LMICs

---

Initiate qualitative and quantitative research on elder abuse to overcome knowledge gaps existing in LMICs
Introduce the subject of elder abuse in emergency medicine training curricula
Increase community awareness of elder abuse
Increase awareness legal, financial and societal rights among the elderly population
Engage healthcare and non-healthcare professionals to identify and respond to elder abuse
Coordinate multi-agency support by relevant services for older people experiencing abuse
Screen by emergency physicians for risk factors of elder abuse
Increase emergency physicians awareness of medical conditions and medication effects that can mimic abuse in older persons
Interview patients and caregivers separately when screening for elder abuse

---

approach exists for dealing with suspected elder abuse in patients presenting to the ED of low to middle income countries, we propose a list of recommendations that could be employed (Table 1).

In all cases, discussions should focus on the suggestion that the older person should consider an alternative, safe environment, preferably with the support of family and/or friends. Perhaps, certain arrangements can also be made with NGOs functioning in Pakistan to act in favor of elderly people for further abuse prevention once informed. Currently, there are various senior citizen establishments in Pakistan<sup>[28]</sup> which can serve as safe haven for sheltering elder abuse cases. All of this requires much needed attention from the government of Pakistan so it may provide necessary funding and resources, along with strict re-enforcement from legal agencies for providing swift justice whenever and wherever needed.

**Funding:** None.

**Ethical approval:** Not needed.

**Conflicts of interest:** The authors declare that there is no conflict of interest.

**Contributors:** Baig MA proposed the study. All authors contributed to the design and interpretation of the study, and approved the final manuscript.

## REFERENCES

- Mion LC, Palmer RM, Anetzberger GJ, Meldon SW. Establishing a casefinding and referral system for at-risk older individuals in the emergency department setting: the SIGNET model. *J Am Geriatr Soc* 2001; 49: 1379–1386.
- Active ageing: a policy framework. Geneva, World Health Organization, 2002 (WHO/NMH/NPH/02.8).
- Pakistan Demographic Profile 2014 Website: [http://www.indexmundi.com/pakistan/demographics\\_profile.html](http://www.indexmundi.com/pakistan/demographics_profile.html). Published August 23, 2014 Accessed November 15, 2014.
- Missing voices: views of older persons on elder abuse. Geneva, World Health Organization, 2002 (WHO/NMH/VIP/02.1; WHO/NMH/NPH/02.2).
- Tonks A, Bennett G. Elder abuse. *BMJ* 1999; 318: 278.
- WHO. Abuse of the Elderly 2002. Website: [www.who.int/violence\\_injury\\_prevention](http://www.who.int/violence_injury_prevention). Published July 14, 2009 Accessed November 15, 2014.
- Lachs MS, Pillemer K. Elder abuse. *Lancet* 2004; 364: 1263–1272.
- Reichenheim ME, Paixão CM Jr, Moraes CL. Reassessing the construct validity of a Brazilian version of the instrument Caregiver Abuse Screen (CASE) used to identify risk of domestic violence against the elderly. *J Epidemiol Community Health* 2009; 63: 878–883.
- Cohen M, Halevi-Levin S, Gagin R, Friedman G. Development of a screening tool for identifying elderly people at risk of abuse by their caregivers. *J Aging Health* 2006; 18: 660–685.
- World Health Organization, 2008. A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem Worldwide – Main Report. WHO, Geneva.
- American Medical Association, 1992: 2004. Diagnostic and Treatment Guidelines on Elder Abuse and Neglect. American Medical Association, Chicago, Illinois.
- Buri HM, Daly JM, Jogerst GJ. Elder abuse telephone screen reliability and validity. *J Elder Abuse Negl* 2009; 21: 58–73.
- Fulmer T, Street S, Carr K. Abuse of the elderly: screening and detection. *J Emerg Nurs* 1984; 10: 131–140.
- Fulmer T. Barriers to neglect and self-neglect research. *J Am Geriatr Soc* 2008; 56 Suppl 2: S241–243.
- Imbody B, Vandsburger E. Elder abuse and neglect: assessment tools, interventions and recommendations for effective service provision. *Educ Gerontol* 2011; 37: 634–650.
- British Geriatric Society. The older person in the accident and emergency department best practice guide. Website: [http://www.bgs.org.uk/Publications/Compendium/compend\\_3-2.htm](http://www.bgs.org.uk/Publications/Compendium/compend_3-2.htm). Published October 30, 2009 Updated December 28, 2012 Accessed November 15, 2014.
- Yaffe MJ, Wolfson C, Litwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: the Elder Abuse Suspicion Index (EASI). *J Elder Abuse Neglect* 2008; 20: 276–300.
- Bonnie RJ, Wallace R. Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America. The National Academy Press, Washington; 2003.
- Grief CL. Patterns of ED use and perceptions of the elderly regarding their emergency care: a synthesis of recent research. *J Emerg Nurs* 2003; 29: 122–126.
- Phelan A. The Discursive construction of elder abuse: Community Nurses' accounts. Unpublished PhD Thesis, UCD, Dublin; 2010.

- 21 Petronio S. Communication boundary management: a theoretical model of managing disclosure of private information between married couples. *Communication Theory* 1991; 1: 311–335.
- 22 Kitwood T. *Dementia Reconsidered: The Person Comes First*. Open University Press, Buckingham; 1997.
- 23 Sandra Petronio. Communication Privacy Management Theory. In: *Engaging Theories in Interpersonal Communication: Multiple Perspectives*, Leslie A. Baxter and Dawn O. Braithwaite (eds.), Sage, Thousand Oaks, CA, 2008; 309–322.
- 24 Humphries-Lynch S. Elder abuse: what to look for, how to intervene. *Am J Nurs* 1997; 97: 27–32.
- 25 Kingston P, Penhale B. Elder abuse and neglect: issues in the accident and emergency department. *Acc Emerg Nurs* 1995; 3: 122–128.
- 26 Hughes SL. Can bank tellers tell? – legal issues relating to banks reporting financial abuse of the elderly. American Bar Association, The Commission on Law & Aging & NCEA, Washington; 2003.
- 27 The Express Tribune. Website: <http://tribune.com.pk/story/883418/with-no-welfare-in-sight-the-elderly-prone-to-abuse/> Published: May 9th, 2015. Accessed: July 7th, 2015.
- 28 Pakistan NGOs Directory & Guide. Website: [http://www.ngos.org.pk/vulnerable/senior\\_citizens\\_pakistan.htm](http://www.ngos.org.pk/vulnerable/senior_citizens_pakistan.htm). Published: June 21st, 2013. Accessed: November 15th, 2014.

*Received February 21 2015*

*Accepted after revision June 16, 2015*