Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Strengthening Our Intuition About Elder Abuse

Timothy F. Platts-Mills, MD, MSc*; Karen Hurka-Richardson, RN, NP

*Corresponding Author. E-mail: tplattsm@med.unc.edu, Twitter: @TimPlattsMills.

0196-0644/$-see front matter

https://doi.org/10.1016/j.annemergmed.2020.05.016

A **podcast** for this article is available at www.annemergmed.com.

SEE RELATED ARTICLE, P. 266.

Intuition does not come to an unprepared mind.
—Albert Einstein

[Ann Emerg Med. 2020;76:277-279.]

During the past 2 decades, the field of geriatric emergency medicine has grown from a handful of clinical researchers mostly in the United States to a global multidisciplinary subspecialty with active growth in policy and advocacy, clinical practice, and research. A few notable steps along the way include the publication of the geriatric emergency department (ED) guidelines,[1] the development of the Geriatric Emergency Department Accreditation Program (now with greater than 100 accredited EDs),[2] the founding of geriatric emergency medicine sections within European academic medicine societies,[3,4] and federal funding of geriatric emergency medicine research networks.[5]

In some ways, the development of geriatric emergency medicine was inevitable. Older adults account for more than 20 million ED visits annually in the United States,[6] and even if your department doesn't have a geriatric ED, you, your colleagues, and your administrators are likely well aware of both the pleasures and the challenges of caring for older adults. Examples of the latter include subtle presentations of serious illness, the difficulty of finding a safe disposition for patients with minor injury or illness but for whom going home is no longer safe, the high prevalence of nonmedical problems that affect health outcomes, and the importance of assessing cognition, physical function, and goals of care.[7-11] The disproportionate effect of the coronavirus disease 2019 pandemic on older adults[12] has shifted EDs in areas of high viral prevalence even farther toward needing specialized care for older adults. The pandemic has also highlighted this population's unique vulnerabilities.

Of the many vulnerabilities faced by older adults, one of the most serious yet least often recognized is predation or neglect by other people. Before the coronavirus pandemic, elder abuse was already a common problem. In the United States, the prevalence of elder abuse during the past year in community-dwelling older adults was estimated to be 10%, and is substantially higher in institutionalized elders.[13,14] A recent review of elder abuse prevalence from 52 studies in 28 countries found a pooled estimate of 16%.[15] Victims of elder abuse preferentially depend on EDs for care,[16] but there are no well-conducted ED prevalence studies, to our knowledge. We believe the prevalence of ongoing elder abuse that affects geriatric ED patients' well-being is at least 5%.[9,17]

Not surprisingly, the burden of the coronavirus pandemic has fallen hardest on those least prepared for it. Numerous sources have reported increases in the rates and severity of elder abuse in the community,[18] and of neglect or even complete abandonment of nursing home patients.[19,20] Reduced access to community resources, loss of income and housing, and increased substance abuse are likely contributing factors. If elder abuse were a mountain, that mountain is large, is right outside our doorsteps, and in the past few months has grown much bigger. It is also a mountain that we have failed to climb; arguably we haven't even established a proper base camp.

In this issue of *Annals*, Rosen et al[21] present the results of a carefully conducted study to identify physical patterns associated with elder abuse. The authors examined the records of successfully prosecuted cases and compared the patterns of physical injury in those cases with those of older adults who presented to the ED after an unintentional fall. The cases were matched according to age, sex, and community or institutional living. The results give us a grim picture of the physical findings of elder abuse. Injuries (mostly bruises, abrasions, and lacerations) of the head, face, neck, chest, abdomen, and back are substantially more common in older adults who are victims of elder abuse than in those who fall. Bruising around the eyes and cheeks is particularly specific for elder abuse. An older adult who presents with an isolated forearm fracture may have fallen or may have been pushed; it's worth asking a few questions to understand what happened. For patients with injuries of the face, head, or upper torso, you should ask more

questions. For all patients, you should pause for a moment and listen. In our experience, victims of elder abuse will disclose their story, but they need some assurance that the person they are speaking to wants to hear it.

The work by Rosen et al is successful for several reasons. First, they take a relatively small step forward by using careful methods, which in the long run gets the field farther than taking a big step with imperfect methods. Second, they make efforts to ensure a rigorous approach to case definitions. Defining whether elder abuse is present is a nontrivial challenge. Rosen et al solve this by using only successfully prosecuted cases in which the perpetrator has been convicted or pled guilty. This approach may not be possible for many ED-based studies, but it is an example of a strong case definition in a field in which there can be a lot of subjectivity. Third, they provide a clinically relevant comparator. Falls are a common reason for ED visits by older adults and result in a wide range of injuries. By comparing injuries resulting from elder abuse with those resulting from falls, they give emergency physicians information that they can use to differentiate between causes for the patients in front of them.

Although developing a mental picture of elder abuse is important, it is also important to be aware that physical elder abuse is present only in a minority of victims of elder abuse receiving care in the ED. In ED elder abuse screening studies conducted by our group in Chapel Hill, physical abuse accounted for approximately 18% of the elder abuse cases we identified; psychological abuse, neglect, and financial abuse were more common than physical abuse.[17] Although subtypes of elder abuse vary, depending on study setting, the above-mentioned global review found a prevalence of 12% for psychological abuse, 7% for financial abuse, 4% for neglect, 3% for physical abuse, and 1% for sexual abuse.[15] Not all elder abuse is equally severe, but victims of physical abuse are likely at particularly high risk for poor outcomes, and the work of Rosen et al provides much-needed insight into this important abuse subtype.

To develop our intuition about other types of elder abuse, more research is needed, and in the short term, emergency physicians will need to look beyond the medical literature. Having some sense of the worst cases can help physicians anticipate the kinds of cases that might present to the ED. For starters, you might consider the CNN special report "Sick, Dying, and Raped in America's Nursing Homes."[22] Needless to say, this is not a pleasant read, but it is important because it is common: in the past 2 decades there have been more than 16,000 complaints of sexual abuse in long-term care facilities and numerous nursing homes with repeated offenses. Mishandling of these cases by nursing home administrators is common. You might have thought that was the toughest read, but actually it's not. If you want to get really angry, try *The New Yorker* article "How the Elderly Lose Their Rights."[23] Even if you don't want to get angry, you should read this article, which describes coordinated activities in Las Vegas from approximately 2005 to 2015 by an entrepreneur and a judge to obtain guardianship of older adults and then institutionalize them and take over their assets. Although some of the culprits in the Las Vegas story went to jail, you can be sure that we have not seen the end of these or the many other forms of elder abuse, which is estimated to cost $36.5 billion in the United States annually.[24] Financial abuse may seem like it is beyond the scope of an emergency physician, but its victims are right in front of us all the time, and there is overlap between financial abuse and other forms of abuse.

There is a blurred line between developing intuition about a disease, which strengthens our clinical acumen, and forming stereotypes for the disease, which can limit us. This is as true for elder abuse as it is for myocardial infarctions. Our experience and the literature indicate that elder abuse is more common in women, but still occurs in men, and that prevalence varies little according to race, ethnicity, formal education, or financial resources. Uncut toenails, poor oral hygiene, uncared-for bedsores, and dirty undergarments should raise concerns but need to be distinguished from signs of poverty, which is not a risk factor. Similarly, we need to be careful about stereotyping the culprit. A son with a substance abuse disorder or a daughter's boyfriend may be a likely suspect in elder abuse, but we have also identified older ED patients who are being abused by their daughters, and one case of a disabled older adult being abused by her mother.

Seasoned emergency physicians have an intuition about common serious diseases. They have a sense for what these diseases usually look like, and a sense of the less common presentations. It is time for emergency physicians to build their intuition about elder abuse, and the pandemic has provided us with additional reason and opportunity to do so. Rosen et al have taken us a step forward, but further developing our intuition will require some additional preparation.

Supervising editor: David L. Schriger, MD, MPH. Specific detailed information about possible conflict of interest for individual editors is available at https://www.annemergmed.com/editors.

Author affiliations: From the Department of Emergency Medicine, University of North Carolina, Chapel Hill, NC.

Authorship: All authors attest to meeting the four ICMJE.org authorship criteria: (1) Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation

of data for the work; AND (2) Drafting the work or revising it critically for important intellectual content; AND (3) Final approval of the version to be published; AND (4) Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). Dr. Platts-Mills is the recipient of funding from The John A. Hartford Foundation and from the National Insititute of Justice (2015-IJ-CX-0022) to conduct research on screening for elder abuse in the emergency department.

REFERENCES

1. Carpenter CR, Bromley M, Caterino JM, et al. Optimal older adult emergency care: introducing multidisciplinary geriatric emergency department guidelines from the American College of Emergency Physicians, American Geriatrics Society, Emergency Nurses Association, and Society for Academic Emergency Medicine. *J Am Geriatr Soc*. 2014;62:1360-1363.
2. Southerland LT, Lo AX, Biese K, et al. Concepts in practice: geriatric emergency departments. *Ann Emerg Med*. 2020;75:162-170.
3. European Society for Emergency Medicine. EUSEM Section of Geriatric Emergency Medicine (EuSGEM). Available at: https://eusem.org/sections-and-committees/sections/geriatric-section. Accessed August 2, 2020.
4. Mooijaart SP. Improving care of older patients in emergency medicine throughout Europe. European Geriatric Medicine Society (EuGMS). Available at: https://www.eugms.org/research-cooperation/special-interest-groups/geriatric-emergency-medicine.html. Accessed August 2, 2020.
5. Department of Health and Human Services. A Collaborative Network to Optimize Emergency Care of Older Adults with Alzheimer's Disease and Related Dementias (AD/ADRD) (R61/R33 Clinical Trials Optional). October 23, 2019. Available at: https://grants.nih.gov/grants/guide/rfa-files/RFA-AG-20-026.html. Accessed August 2, 2020.
6. Rui P, Kang K. National Hospital Ambulatory Medical Care Survey: 2015 Emergency Department Summary Tables. Available at: http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2015_ed_web_tables.pdf. Accessed August 3rd, 2020.
7. Shenvi CL, Platts-Mills TF. Managing the elderly emergency department patient. *Ann Emerg Med*. 2019;73:302-307.
8. Platts-Mills TF, Owens ST, McBride JM. A modern-day purgatory: older adults in the emergency department with nonoperative injuries. *J Am Geriatr Soc*. 2014;62:525-528.
9. Stevens TB, Richmond NL, Pereira GF, et al. Prevalence of nonmedical problems among older adults presenting to the emergency department. *Acad Emerg Med*. 2014;21:651-658.
10. Roedersheimer KM, Pereira GF, Jones CW, et al. Self-reported versus performance-based assessments of a simple mobility task among older adults in the emergency department. *Ann Emerg Med*. 2016;67:151-156.
11. Ouchi K, George N, Schuur JD, et al. Goals-of-care conversations for older adults with serious illness in the emergency department: challenges and opportunities. *Ann Emerg Med*. 2019;74:276-284.
12. Richardson S, Hirsch JS, Narasimhan M, et al. Presenting characteristics, comorbidities, and outcomes among 5700 patients hospitalized with COVID-19 in the New York City area. *JAMA*. 2020;323:2052-2059.
13. Acierno R, Hernandez MA, Amstadter AB, et al. Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: the National Elder Mistreatment Study. *Am J Public Health*. 2010;100:292-297.
14. Lachs MS, Teresi JA, Ramirez M, et al. The prevalence of resident-to-resident elder mistreatment in nursing homes. *Ann Intern Med*. 2016;165:229-236.
15. Yon Y, Mikton CR, Gassoumis ZD, et al. Elder abuse prevalence in community settings: a systematic review and meta-analysis. *Lancet Glob Health*. 2017;5:e147-e156.
16. Dong X, Simon MA, Evans D. Prospective study of the elder self-neglect and ED use in a community population. *Am J Emerg Med*. 2012;30:553-561.
17. Platts-Mills TF, Dayaa JA, Reeve BB, et al. Development of the Emergency Department Senior Abuse Identification (ED Senior AID) tool. *J Elder Abuse Negl*. 2018:1-24.
18. McKenna K. Coronavirus restrictions lead to rise in elder abuse cases, advocates say; April 28, 2020. Available at: https://www.abc.net.au/news/2020-04-29/coronavirus-queensland-elder-abuse/12188668. Accessed August 2, 2020.
19. Minder P, Peltier E. A deluged system leaves some elderly to die, rocking Spain's self-image. *New York Times*. March 25, 2020.
20. McAllister T. Abandoned by caretakers, 83 nursing home patients evacuated. *Patch*. 2020.
21. Rosen T, Lofaso VM, Bloemen EM, et al. Identifying injury patterns associated with physical elder abuse: analysis of legally adjudicated cases. *Ann Emerg Med*. 2020;76:266-276.
22. Ellis B, Hicken M. Sick, dying, and raped in America's nursing homes. *CNN*. Feb 22, 2017.
23. Aviv R. How the elderly lose their rights. October 9, 2017. Available at: https://www.newyorker.com/magazine/2017/10/09/how-the-elderly-lose-their-rights. Accessed August 2, 2020.
24. National Council on Aging. Elder abuse facts. Available at: https://www.ncoa.org/public-policy-action/elder-justice/elder-abuse-facts/. Accessed August 2, 2020.