The Forensic Lens: Bringing Elder Neglect Into Focus in the Emergency Department

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We present 2 case studies of older patients who were brought to the emergency department (ED) in severely debilitated states. Both presented with severe malnutrition, contractures, and decubitus ulcers, and were nonverbal, with histories of dementia and end-stage disease. Their primary caregivers, adult children, were uncooperative with Adult Protective Services and disregarded treatment recommendations. Although both elders had signs suspicious for neglect, a comprehensive review revealed many layers of complexity. We use these cases to illustrate an approach to the assessment of possible elder neglect in ED settings and how to intervene to ensure patient safety. We begin with a discussion of the differences between willful, unintentional, and unsubstantiated neglect by a caregiver and then describe when to suspect neglect by evaluating the elder, interviewing the caregiver and first responders, assessing the caregiver's ability to meet the elder's needs, and, if possible, obtaining medical history and information about the home care environment. These cases illustrate the importance of careful documentation in cases of suspected neglect to assist investigative agencies, reduce the risk of further harm, and improve patient outcomes. [Ann Emerg Med. 2016;68:371-377.]

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INTRODUCTION

Case 1

Responding to a 911 call from Adult Protective Services, paramedics found Mr. K, aged 73 years, clothed in only a T-shirt and lying in the fetal position in a dimly lit bedroom in the back of his home. Paramedics observed that he was emaciated, filthy, and in pain. At the emergency department (ED), Mr. K was awake but disoriented, with generalized weakness, contractures, cachexia, hypoalbuminemia, and a body mass index of 15.6 kg/m^2, indicative of severe malnutrition. Records showed he had a history of Alzheimer's disease, alcoholism, tobacco use, diabetes, and chronic obstructive pulmonary disease. Early-stage pressure ulcers covered his left side. Test results for leukocytosis and hypercalcemia pointed to a finding that was confirmed by chest radiograph: a right lung mass measuring 12×8.5 cm was later determined to be non–small cell lung cancer that had metastasized to bone.

Mr. K's son lived in the home and was intoxicated when the paramedics arrived. He rejected recommendations for moving his father into a skilled nursing facility, insisting that his father's wishes were to live and die at home. Mr. K's inadequate dress, high pain level, malnutrition, and multiple decubitus ulcers, as well as his caregiver's lack of response to the gravity of his condition, were red flags for elder neglect.

Case 2

Mr. M, aged 85 years and with end-stage Parkinson's disease, was brought to the ED by his daughter, who lived in his home. He was nonverbal and presented with significantly deteriorated health, impaired physical and cognitive function, and multiple decubitus ulcers ranging from stages 1 to 3. Like Mr. K's son, Mr. M's daughter insisted that he be discharged back to her care and challenged the hospital's recommendation to place him in a skilled nursing facility. The physician believed that Mr. M required professional care and made a report to Adult Protective Services with suspicion of elder neglect. The same red flags were present: poor nutrition, contractures, pressure ulcers, and an uncooperative caregiver.

Elder Neglect

A seminal report by the National Research Council defined elder neglect as "failure by a caregiver to satisfy the elder's basic needs or protect the elder from harm."[1] Examples include failure to ensure the elder's physical safety, failure to help with personal care, and failure to prevent malnutrition or dehydration.[2] The American College of Emergency Physicians recommends that emergency personnel screen patients for elder mistreatment,[3] and laws mandate that health care providers report suspicions of neglect to Adult Protective Services in 49 states and the District of Columbia.[4]

Elder neglect can be difficult to diagnose. Symptoms are often confounded with end-of-life physiologic states,[5] and, unlike other forms of elder mistreatment such as physical or sexual abuse, neglect stems from an omission of care, as well as actions that inflict harm, such as physical restraints and social isolation. As these 2 cases demonstrate, patients may be unable to report poor-quality care because of cognitive impairment, advanced illness, or, ultimately, death.[2] Others may deny mistreatment for fear of angering or losing their caregiver.[6]

There are important distinctions between willful neglect, unintentional neglect, and subacute symptoms caused by an underlying illness that manifest as neglect despite a caregiver's best efforts. Examples of willful neglect are intentionally denying food, water, and medication, use of physical restraints, or isolating the elder, thereby withholding emotional stimulation and social interaction.[7] Some caregivers have underlying motives such as financial compensation, free housing, desire for power and control, and retaliation for dementia-related problem behaviors by the elder.[8] Other caregivers may have mental illness[9] or substance abuse disorders.

Conversely, unintentional neglect occurs when a caregiver lacks the necessary resources, strength, psychological stability, maturity, or skills to meet the elder's needs.[7] Physical or cognitive impairments, inadequate training (eg, wound care, administering injections), mistrust of the health care system, and limited support can also compromise care. In other situations, elders present with advanced geriatric conditions that are difficult to manage even by skilled professionals, including extreme frailty, loss of skin integrity, weight loss, and poor mental functioning. Even with optimal care, physiologic states may develop in dying persons that are not caused by willful or unintentional neglect.[10]

This complexity, coupled with lack of training in identifying mistreatment,[11-15] make it especially difficult for ED personnel to identify neglect, although they are often the first health care providers to interact with victims and caregivers. Victims often receive low levels of social support and infrequent primary care,[16] which are risk factors for ED use,[17] and some frail elders arrive to the ED by ambulance because of caregiver inability to transport them. Emergency physicians may feel trapped between doing too little—failing to identify neglect, not reporting, and increasing risk of further harm—and doing too much—accusing a caregiver of neglect, eroding trust, and inhibiting caregivers from providing care consistent with the patient's preferences.[18,19] Given the aging of the population, emergency physicians need to be prepared to balance their obligations to the patient by documenting findings, reporting suspicions, and referring to appropriate agencies.

THE FORENSIC LENS

The "forensic lens"[20] involves using medical expertise to answer questions pertaining to criminal justice and the law. It is intended to help investigators evaluate the entire clinical, social, and legal scenario when determining the cause of elder mistreatment. Objective documentation of the signs of neglect is helpful to neglect investigators, who may subpoena health records if the case is referred for prosecution. Although emergency providers are unlikely to be involved in the entire investigation process, viewing patients and their medical presentations through a forensic lens will help providers assess the possibility of neglect and improve patient outcomes.

Evaluating the Elder

All older patients presenting to the ED with signs suspicious for neglect should be interviewed privately at some point during the evaluation. If the patient is unable to answer questions, like Mr. K and Mr. M, individuals who have knowledge of the patient (eg, caregivers, family members, home care workers, primary care physician) may be able to provide information. We recommend starting with general questions about care at home, followed by more specific questions about neglect.[21]

Observation of a patient's behavior is critically important at the ED encounter, particularly when the patient cannot communicate. If the patient is alert, nonverbal clues such as changes in demeanor or guarded body language in the presence of the caregiver could indicate fear and anxiety. The physician should note general appearance (cleanliness, hygiene, and dress) and state of nutrition and hydration. Specific attention should be paid to dental hygiene, contractures, decubitus ulcers, bruises, untreated injuries, and elongated toenails.[21] Whenever possible, the provider should take photographs of pressure ulcers and other injuries and document their locations, color, and size on a body map (a drawing of the injuries on a body diagram). Severe weight loss and pressure ulcers may be signs of neglect but can also be markers of end-stage disease. The context in which they develop is important.

Some laboratory findings can be useful in determining whether neglect has occurred. Hypernatremia (sodium level >145 mM), elevated blood area nitrogen:creatinine ratio (>20), and elevated hemoglobin and hematocrit levels suggest dehydration. Other markers of malnutrition are anemia, low serum albumin level (<3.5 g/dL), low