The role of the dermatologist in detecting elder abuse and neglect

Melissa J. Danesh, BS,[a] and Anne Lynn S. Chang, MD[b]
San Francisco and Redwood City, California

The National Research Council of the National Academies defines elder mistreatment as: (1) intentional actions that cause harm or create serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder; or (2) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm. Estimates of the prevalence of elder abuse have ranged from 2.2% to 18.4%. Dermatologists are uniquely positioned to identify and manage suspected cases of elder abuse given their expertise in distinguishing skin lesions of abuse from organic medical disease and their patient populations with strong elderly representation. This article discusses aspects of both the screening and management of elder abuse with particular relevance to dermatologists. Like physicians across medical specialties, dermatologists must be familiar with those aspects of elder abuse in screening, diagnosis, management, and reporting that are unique to their field and to those aspects that are applicable to all health care providers. (J Am Acad Dermatol 2015;73:285-93.)

Key words: abuse; adult protective services; elder abuse; elder mistreatment; elder neglect; geriatrics; screening tools; reporting elder abuse.

The National Research Council of the National Academies defines elder mistreatment as: (1) intentional actions that cause harm or create serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder; or (2) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm.[1] The reported prevalence of elder abuse varies among studies, likely because of inconsistencies in definitions, protocols, geography, or a combination of these.[2-4] However, estimates from studies of Western countries have ranged from 2.2% to 18.4%.[5-10] This may increase in coming decades as the geriatric population in the United States grows, from 14.8% of the population in 2015 to a projected 23.5% in 2060.[11] Perhaps most worrying is that the fastest growing group—individuals over 85 years of age—is expected to double over the next 30 years, and this group is the most vulnerable to elder abuse.[11-13] The importance of detecting and intervening in cases of elder abuse is heightened by the far-reaching health implications for victims: even after adjusting for chronic disease and functional status, the risk of death for individuals experiencing elder mistreatment is 3 times that of control subjects.[14] These issues should be handled with a sense of urgency because elder abuse is associated with increased rates of hospitalization[15] and the risk of death is significantly higher during the first year after hospitalization for a physical abuse injury.[16]

Abbreviations used:

AMA:	American Medical Association
EASI:	Elder Abuse Suspicion Index
USPSTF:	US Preventive Services Task Force

Dermatologists are uniquely positioned to identify and intervene in cases of elder abuse. Elderly adults visit dermatologists at higher rates than other age groups.[17] Bruising, burns, lacerations, traumatic alopecia, external genital trauma, malnutrition,

From the Departments of Dermatology at University of California, San Francisco School of Medicine,[a] and Stanford University School of Medicine, Redwood City.[b]
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Reprint requests: Anne Lynn S. Chang, MD, Department of Dermatology, Stanford University School of Medicine, 450 Broadway St, MC 5334, Redwood City, CA 94063. E-mail: alschang@stanford.edu.
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weight loss, and poor hygiene are all indications of abuse that are readily identifiable by dermatologists on routine skin examination.[18,19] By virtue of their training, dermatologists are particularly adept at identifying these lesions and distinguishing them from medical disease and accidental injury. Apart from the moral obligation that physicians owe their patients to help manage suspected elder abuse, they also possess a legal obligation in the United States to report confirmed cases to government officials. The dermatologist must be prepared to detect and report elder abuse.

Despite the importance of this preparation, little has been written on elder abuse for the dermatologist. Two recent review articles have surveyed the dermatologic manifestations of elder abuse.[18,19] But, neither of these articles, nor any other to our knowledge, offers a comprehensive approach for dermatologists to manage cases of suspected elder abuse. Moreover, no article has attempted to incorporate the controversial literature on screening for elder abuse into specific recommendations for the dermatologist. This article discusses aspects of both the screening and management of elder abuse with particular relevance to dermatologists. Although we aim to provide a comprehensive discussion, the intent of this review is to provide concise, practical information that will help dermatologists care for their elderly patients. Although some authors draw distinctions between "mistreatment" and "abuse"[20] we will use these terms inclusively and interchangeably.

CAPSULE SUMMARY

- Elder abuse is expected to increase among the rapidly aging population.
- This article provides a practical approach for the dermatologist to screen, diagnose, and manage cases of elder abuse.
- Incorporation of techniques in this article may lead to improved identification and management of elder abuse by dermatologists in clinical practice.

SCREENING

The literature on screening for elder abuse has been developed most thoroughly by family physicians and geriatricians. Many of their proposals, such as brief patient-reported screening instruments, are designed for busy outpatient clinics familiar to the dermatologist. Although dermatologists are not primary care providers such as family physicians or geriatricians, they are health care providers capable of providing similar forms of screening. Yet, dermatologists also possess specialized expertise that might make alternative forms of screening more appropriate: forms that emphasize detection of suspicious skin and mucosal lesions, which, if discovered, trigger further assessment. Such a model of specialty-specific screening would be comparable with the expectation that ophthalmologists assess for symptoms and signs of abuse in a senior with lens dislocation and orbital fractures,[21] or that orthopedists pursue further workup for suspected abuse after diagnosing multiple fractures consistent with trauma.[22,23] A third and final model of screening might simply ask the dermatologist to wear 2 hats: one as a health care provider who carries out generalized screening in busy outpatient clinics and the second as a specialist who goes 1 step further to specifically look for skin and mucosal abuse.

There are currently no uniformly accepted screening recommendations for the generalist or specialist. The US Preventive Services Task Force (USPSTF) found insufficient evidence for the accuracy of available screening questionnaires to identify elder abuse.[24] However, the American Medical Association (AMA) has recommended standardized routine inquiry by all practicing providers.[25] Similarly, the Joint Commission, National Center on Elder Abuse, and National Academy of Sciences all recommend routine screening for elder abuse.[1,26] Although few specialty fields have issued specific recommendations for elder abuse screening, the American Academy of Neurology recently came out in favor of it.[27]

The heterogeneity of screening recommendations stems, in part, from the lack of available evidence documenting improved clinical outcomes in individuals who are screened versus those who are not screened. The literature in dermatology is no exception. To our knowledge, there have been no studies in dermatology that examine the effects of screening for elder abuse. This lack of evidence and the absence of uniform recommendations by the USPSTF, AMA, and other organizations leaves the decision to screen on the good clinical judgment of the dermatologist.

If the dermatologist does decide to screen, we propose adopting a screening tool that is consistent with best practices in the primary care setting. A helpful 2004 review of these tools noted numerous limitations: lengthy protocols, lack of empirical data on specificity or sensitivity, and poor interrater agreement.[28] However, in 2008, Yaffe et al[29] developed and validated the Elder Abuse Suspicion Index (EASI) (Table I), a brief 6-item instrument for primary care physicians. The EASI is validated for seniors