

Periodic health examination, 1994 update: 4. Secondary prevention of elder abuse and mistreatment

Canadian Task Force on the Periodic Health Examination

Objective: To provide recommendations for family physicians on the detection, assessment and management of abuse or mistreatment in patients over 65 years of age.

Options: Detection of elder abuse by history and examination or by specific protocols; intervention through mandatory reporting, removing the victim from the situation or acting as an advocate for the patient.

Outcomes: Termination of abusive situation and prevention of further abuse.

Evidence: A MEDLINE search was conducted with the use of medical subject headings "elder abuse" and "epidemiology" for articles published from January 1980 to October 1992 and headings "elder abuse" and "clinical trials" for articles published from January 1980 to February 1994. Standard references and review articles and their bibliographies were scrutinized, and experts were consulted.

Values: The evidence-based methods and values of the Canadian Task Force on the Periodic Health Examination were used. Since senior citizens are among the most disadvantaged people in Canadian society, prevention of abuse and promotion of their autonomy were the highest values selected.

Benefits, harms and costs: The principal benefits are cessation and prevention of abuse. Potential harms include the loss of a personal residence, the erosion of an established family structure and the loss of autonomy for the victim.

Recommendations: There is poor evidence to include case finding for elder abuse in or exclude it from the periodic health examination. However, it is prudent for physicians to be alert for indications of elder abuse and, if such abuse is discovered, to take measures to prevent further abuse.

Chairman: Dr. Richard Goldbloom, professor, Department of Pediatrics, Dalhousie University, Halifax, NS. **Vice-chairman:** Dr. Renaldo N. Battista, director, Division of Clinical Epidemiology, Montreal General Hospital, Montreal, Que. **Members:** Drs. Geoffrey Anderson, assistant professor, Department of Health Services Research and Development, University of British Columbia, Vancouver, BC; Marie-Dominique Beaulieu, associate professor, Department of Family Medicine, University of Montreal, Montreal, Que.; R. Wayne Elford, professor and chairman of research, Department of Family Medicine, University of Calgary, Calgary, Alta.; John W. Feightner, professor and research director, Department of Family Medicine, McMaster University, Hamilton, Ont.; William Feldman, professor of pediatrics, University of Toronto and head, Division of General Pediatrics, Hospital for Sick Children, Toronto, Ont.; Alexander G. Logan, professor, Faculty of Medicine, University of Toronto, Toronto, Ont.; Brenda Morrison, professor, Department of Health Care and Epidemiology, University of British Columbia, Vancouver, BC; David Offord, professor, Department of Psychiatry, McMaster University, Hamilton, Ont.; Christopher Patterson (**principal author**), professor and head, Division of Geriatric Medicine, McMaster University, Hamilton, Ont.; Walter O. Spitzer, professor and chairman, Department of Epidemiology and Biostatistics, McGill University, Montreal, Que.; and Elaine Wang, assistant professor, Department of Pediatrics, Faculty of Medicine, University of Toronto, Toronto, Ont. **Resource people:** Dr. Philip Mickelson, medical consultant, health standards, Health Services Directorate, Health Canada, Ottawa, Ont.; Ms. Jennifer Dingle, coordinator, Canadian Task Force on the Periodic Health Examination, Department of Pediatrics, Dalhousie University, Halifax, NS

Copies of this and other task force reports are available from the Health Services Directorate, Health Programs and Services Branch, Health Canada, Tunney's Pasture, Ottawa, ON K1A 1B4. The collected recommendations of the task force are available in the Canadian Guide to Clinical Preventive Health Care at a cost of \$69.95 (Canadian orders) or \$90.95 US (foreign orders) from Canada Communication Group—Publishing, Ottawa, ON K1A 0S9; tel (819) 956-4800, fax (819) 994-1498 or (800) 565-7757 for Visa or MasterCard orders.

Validation: These recommendations differ from those of the American Medical Association (AMA) because of differences in legislation between Canada and the United States. The AMA recommends incorporating routine questions on elder abuse and neglect into daily practice. There is insufficient evidence to support this recommendation in Canada.

Sponsor: These guidelines were developed and endorsed by the task force, which is funded by Health Canada. The principal author (C.P.) was partially supported by the Educational

Centre for Aging and Health, McMaster University, Hamilton, Ont.

Objectif : Fournir aux médecins de famille des recommandations sur le repérage, l'évaluation et le traitement des abus ou des mauvais traitements chez les patients de plus de 65 ans.

Options : Repérage de la violence faite aux aînés à l'aide de l'histoire de cas et d'un examen, ou en suivant des protocoles particuliers; production de rapports obligatoires, retrait de la victime de la situation de violence ou intervention de défense du patient.

Résultats : Élimination de la situation d'abus et prévention des abus ultérieurs.

Preuves : On a effectué une recherche dans MEDLINE en utilisant les sujets médicaux «elder abuse» et «epidemiology» dans le cas des articles publiés entre janvier 1980 et octobre 1992, et «elder abuse» et «clinical trials» dans celui des articles publiés entre janvier 1980 et février 1994. On a examiné des ouvrages de références standard, des articles de revue et leurs bibliographies, et consulté des experts.

Valeurs : On a utilisé les valeurs et les méthodes fondées sur les preuves du Groupe d'étude canadien sur l'examen médical périodique. Comme les aînés sont parmi les plus démunis de la société canadienne, les valeurs les plus élevées choisies ont été la prévention des abus et la promotion de l'autonomie des aînés.

Avantages, préjudices et coûts : Les principaux avantages sont l'élimination et la prévention des abus. Les préjudices possibles comprennent la perte d'une résidence personnelle, l'érosion d'une structure familiale établie et la perte d'autonomie pour les victimes.

Recommandations : Les preuves qui incitent à inclure à l'examen médical périodique des signes d'abus chez les aînés, ou à les en exclure, sont faibles. Il est toutefois prudent pour les médecins d'être à l'affût des signes d'abus faits aux aînés et, lorsqu'ils en découvrent, d'intervenir pour empêcher qu'ils se répètent.

Validation : Ces recommandations diffèrent de celles de l'American Medical Association (AMA) parce que les législations en vigueur au Canada et aux États-Unis sont différentes. L'AMA recommande d'intégrer à la pratique quotidienne des questions de routine sur les abus et les négligences dont sont victimes les aînés. Les preuves ne suffisent pas pour appuyer cette recommandation au Canada.

Commanditaire : Ces lignes directrices ont été mises au point et appuyées par le groupe d'étude, qui est financé par Santé Canada. Le principal auteur (C.P.) a été appuyé en partie par Centre d'éducation sur le vieillissement et la santé de l'Université McMaster à Hamilton (Ont.).

Family violence is endemic in Canada and the United States. Although spousal and child abuse have been recognized for many years, elder abuse has emerged as an important social and health issue only recently. Some of the underlying causes of such abuse are the vulnerability of elderly people, societal violence, poverty, stress and substance abuse.¹ Elderly people are often reluctant to accuse their caregivers of abuse or mistreatment, making detection notoriously difficult. Definitions vary widely, and consistent criteria are difficult to apply. Screening instruments and treatment protocols have been suggested; however, none of the screening instruments has been tested adequately in practice, and results of the application of protocols are lacking. The Criminal Code of Canada protects people from physical, sexual and financial abuse, but, again, elderly people are often reluctant to press charges against caregivers. Reporting of elder abuse is mandatory in Newfoundland, Nova Scotia and Prince Edward Island, and

in Ontario nursing homes since the Nursing Home Act was amended in 1987. Even when elder abuse is detected, satisfactory resolution is by no means the inevitable conclusion of intervention.

A MEDLINE search was conducted with the use of medical subject headings "elder abuse" and "epidemiology" for articles published from January 1980 to October 1992 and headings "elder abuse" and "clinical trials" for articles published from January 1980 to February 1994. Standard reference works and their bibliographies were reviewed. Other articles were identified from scrutiny of review articles. Experts in the field were consulted and asked to review manuscripts. The highest available level of evidence was used in making the recommendations. Prevention of abuse was selected as the highest value, which is consistent with the recommendations of other organizations. The article was reviewed by the entire task force before recommendations were final.

Definition

The simplest definition of elder abuse is "any act of commission or omission that results in harm to an elderly person."² However, there are many others.^{3,4} Elder abuse is distinguished from other crimes against elderly people by the perpetrator occupying a position of trust. Health Canada has developed the following definition of elder abuse and neglect:⁵

- *Physical abuse*: Assault, rough handling, sexual abuse or the withholding of physical necessities such as food or personal, hygienic or medical care.

- *Psychosocial abuse*: Verbal assault, social isolation, lack of affection or denial of the person's participation in decisions affecting his or her life.

- *Financial abuse*: The misuse of money or property, including fraud or use of funds for purposes contrary to the needs, interests or desires of the elderly person.

- *Neglect*: In active neglect the caregiver consciously fails to meet the needs of the elderly person; in passive neglect the caregiver does not intend to injure the dependent person. Neglect can lead to any of the three types of abuse.

Other categories of abuse have been proposed such as violation of rights and medical abuse, which would include inappropriate treatment, excessive use of restraints and withholding of treatment.⁶ Abuse may be intentional or unintentional.

Stones⁷ recently reported data from 364 senior citizens and 208 professionals who work with them that showed that the perception of abuse differs between older and younger people. For example, older people considered spitting, which is not an offence, as abusive as hitting and sexual violation, which are crimes. Furthermore, older people regarded a request to an impoverished senior citizen for financial help as more abusive than stealing something which the person values.⁷

Prevalence in the community

There have been three rigorous studies⁸⁻¹⁰ of the prevalence of elder abuse in the community.

In a stratified random sample of 342 people over 65 years of age living in the community in New Jersey, 1% admitted they had experienced some form of abuse.⁸ In half of the victims the abuse was financial; physical abuse was the least reported form of maltreatment. In a stratified random sample of more than 2000 elderly people living in the community in the Boston metropolitan area, interviewed by telephone or in person, the prevalence of all types of abuse was 3.2% (95% confidence interval [CI] 2.5% to 3.9%).⁹ Of the people interviewed 2% had experienced physical violence, 1.1% long-term verbal aggression, 0.4% neglect and a small number of others had suffered several types of abuse.

Podnieks¹⁰ conducted a cross-Canada telephone sur-

vey of a randomized sample of 2000 elderly persons living in private homes. The respondents were asked whether they had been abused by family members or other caregivers since the age of 65. About 4% (95% CI 2.5% to 5.5%) of respondents had experienced some form of maltreatment. The forms of abuse suffered by respondents were material abuse, including financial abuse and property exploitation (2.5%), long-term verbal abuse (1.4%), family violence (0.5%) and neglect (0.4%). The risk profiles of victims and abusers showed several important characteristics. For material abuse, men and women were equally likely to be victims, the victims tended to live alone, and the perpetrators tended to be distant relatives or nonrelatives. Long-term verbal abuse tended to occur between spouses, with men and women equally affected. Victims of such abuse generally functioned independently but tended to blame themselves. Physical violence was most likely to occur between spouses. Men were more likely than women to be victims, but the violence perpetrated by men tended to be more severe than that inflicted by women. Approximately 25% of abused elderly people reported that they needed medical attention as a result of the violence.

The prevalence of abuse found in this study (4% of all senior citizens living in private homes) translates into an estimated 98 000 elderly Canadians. Similarly, the US House of Representatives Select Committee on Aging estimated that 4% of that nation's elderly population is abused, according to its own survey and a review of other studies.¹¹ Other estimates have been as high as 10%.¹² In many cases abuse is long-term, repeated or both. In one study 58% of elderly people abused had suffered previous incidents of abuse.¹³ O'Malley and associates¹⁴ found that repeated abuse had occurred in 70% of cases they studied.

Prevalence in institutions

Although mistreatment of patients residing in institutions and other iatrogenic problems are frequently reported, the true prevalence of abuse in institutions is unknown. In the only rigorous study of nursing homes, a random sample of staff in 31 nursing homes in New Hampshire (577 nurses and nursing aides) was interviewed.¹⁵ Of those interviewed 36% had witnessed physical abuse of residents in the preceding year. The most common forms of abuse were excessive use of restraints (witnessed by 21% of staff); pushing, grabbing, shoving or pinching (17%); and slapping or hitting (15%). Psychologic abuse was observed by 81% of the staff: 70% had witnessed a staff member yelling at a patient in anger, 50% had seen someone insulting or swearing at a patient and 23% had seen a patient isolated inappropriately. Excessive use of restraints is particularly common. An analysis of 56 detailed complaints to an Ontario advocacy group revealed that nearly half involved sufficient grounds for laying criminal charges of theft, assault

or failure to provide adequate medical attention.¹⁶ The analysis showed that staff in most nursing homes were untrained and that homes were understaffed. A small survey of residents in public and private nursing homes in Quebec revealed that staff did not usually regard incidents of mistreatment as abusive; rather, they interpreted residents' complaints as a reaction to their loss of autonomy, powerlessness, monotony and isolation.¹⁷

Risk factors for abuse

Risk factors have been determined from profiles of victims of abuse seeking medical attention, cases of suspected abuse investigated by social-service agencies and cases of neglect (Table 1). Earlier identification of risk factors involved the victim, whereas recently more attention has been paid to factors in the environment and characteristics of the perpetrator.^{18,21,22} There are often signs that the elderly person's needs exceed or will soon exceed the caregiver's ability to meet them. The caregiver often expresses frustration in dealing with the situation and shows signs of stress. Increasing attention is being paid to the model of family violence as an underlying cause of elder abuse; when there is such a family dynamic between the abused person and the perpetrator, there is also an opportunity for intervention to alleviate stress for the caregiver and meet the elderly person's needs. However, community prevalence studies show

that older men are abused as frequently as older women and that spouses are more often perpetrators of abuse than children.³ Results of recent studies, particularly the Canadian survey by Podnieks,¹⁰ show that the profiles of the victim and perpetrator differ depending on the type of abuse (Table 2).

Natural history

Elder abuse rarely resolves spontaneously; it tends to escalate in the same way as spousal abuse. Abusive events tend to be repeated^{13,14} and will often continue unless there is a major change in the environment. Such a change may not occur because, in 25% to 75% of cases, victims or their families refuse help.^{14,23-25} The result may be serious illness, crisis, admission to an institution or death.

Detection manoeuvre

Detection of elder abuse is notoriously difficult, and it is often complicated by denial by the elderly person and his or her caregiver. The victim is often reluctant to admit that he or she is being abused for fear of abandonment, reprisal, admission to an institution, or as a result of embarrassment or shame. The caregiver is often reluctant to admit he or she has abused the elderly per-

Table 1: Risk factors for elder abuse^{3,18-20}

Situational factors

- Community
- Isolation
- Lack of money
- Lack of community resources for additional care
- Unsatisfactory living arrangements

Institutions

- Shortage of beds
- Surplus of patients
- Low staff-to-patient ratio
- Low rates of pay for staff
- Low educational level of staff
- Staff burnout

Characteristics of the victim

- Physical or emotional dependence on caregiver
- Lack of close family ties
- History of family violence
- Age over 75 years
- Recent deterioration in health

Characteristics of the perpetrator

- Stress caused by financial, marital or occupational factors
- Deterioration in health
- Bereavement
- Substance abuse
- Psychopathologic illness
- Related to victim
- Living with victim
- Long duration of care for victim (mean 9.5 years)

Table 2: Victim and perpetrator profiles in different types of abuse¹⁰

Type of abuse	Characteristics
Financial or property exploitation	Victim Unmarried Male or female (affected equally) Poor physical health Socially isolated Low morale
Long-term verbal abuse	Victim Usually married Male or female (affected equally) Perpetrator Usually a spouse
Physical violence	Victim Male (more frequently affected than women) Perpetrator Usually a spouse Alcohol abuser Has physical or emotional problems or both Often financially dependent on the victim
Neglect	Victim Usually female Has health conditions that limit activities

son, for obvious reasons, although in the appropriate circumstances (a private conversation with a nonjudgemental listener, preferably on home ground) caregivers are often willing to talk about difficulties and may be relieved to share their problems with somebody else.²⁶ Because of this denial, detection depends on identification of items in the history and physical findings that may suggest abuse. Although radiologic evidence of fractures without a satisfactory history of trauma may signal abuse, such fractures may occur in older people as a result of prolonged bedrest, with no abuse or trauma of any kind.²⁷ Examples of questions and observations that may be helpful in detecting abuse are given in Table 3.

Several measures to identify elder abuse have been developed. These are generally checklists of indications of possible neglect or abuse and characteristics of the caregiver.^{22,30} They have been developed in a variety of settings, including acute care hospitals, emergency departments and social-service agencies. Assessment of many of the items on such checklists depends on professional judgement instead of objective data. Seven instruments were reviewed by Sengstock and Hwalek.³⁰ These checklists contained few items that measure types of abuse other than physical. They did not address the distinction between effects of disease and potential abuse, and few had been empirically tested.³⁰

Table 3: Questions for patients and indications useful in detecting elder abuse in the periodic health examination²⁸⁻³¹

Suggested questions

Has anyone at home ever hurt you?
Has anyone ever made you do things you did not want to do?
Are you afraid of anyone at home?
Has anyone ever failed to help you take care of yourself when you needed help?
Have you signed any documents that you didn't understand?

Physical examination

Physical injuries, especially those near the mouth, face and eyes, and in areas normally covered by clothing, and those consistent with the shape of a weapon
Alopecia and hemorrhage beneath the scalp (possibly caused by hair pulling)
Bruises, burns and human bite marks
Wasting, dehydration and decubitus ulcers (bed sores)
Paranoia, fear, depression, withdrawal, anger, infantile behaviour, agitation or low self-esteem
Fearful interaction with caregiver

Physician visit

Conflicting histories from patient and caregiver
History inconsistent with type or degree of injury
Vague explanation of injury
Denial of obvious injury
Bizarre explanation
Long delay between injury and seeking of treatment
History of being "accident prone"
History of "doctor hopping"
Caregiver indicates stress or low tolerance for victim

One exception is the Elder Assessment Instrument, which was used to assess all persons 70 years of age or more in an emergency department in Boston.³² This measure showed significant differences between the scores of those not abused and those subsequently investigated by the assessment team and found to have evidence of abuse. The instrument, developed in a medical setting with a wide variety of professionals, documents inadequate care that may be abusive. However, at present no validated questionnaire or checklist has been adequately tested in a primary care setting for use as a screening measure.³³

Intervention

Decisions about how and when to intervene in elder abuse and neglect are among the most difficult faced by service providers. The causes of abuse are complex, and little is known about causes and risk factors in each particular case. Legal and ethical issues add to this complexity. On the one hand the elderly person must be protected from harm; on the other hand his or her autonomy in making decisions must be respected.

Reporting of abuse is mandatory in Newfoundland, Nova Scotia and Prince Edward Island. In the United States, where reporting of elder abuse is required by law in all 50 states, compliance with reporting is poor,^{34,35} and there has been little effect on detection or reporting by physicians. One study found that physicians tend to overlook elderly victims of domestic violence.³⁶ Physicians rarely brought cases of elder abuse to the attention of other professionals who could have assisted the victims.^{14,36,37} Physicians surveyed in Alabama were generally unfamiliar with the mechanics and operation of the state mandatory-reporting statute.³⁵ It has been estimated that only 1 in 14 cases of mistreatment of an elderly person is reported to a public agency.³¹ An ethical analysis of mandatory reporting showed that there are conflicts among the goals of maintaining confidentiality, doing potential good and preventing potential harm.³⁸ Hence, there is no evidence that mandatory reporting is effective in improving the treatment of elder abuse.

Because of the complexity of elder abuse a team approach has been recommended.^{1,39} The aims of intervention are to protect the victim and prevent further abuse. The three models usually adopted are the spousal-abuse, advocacy and adult-protection models. In the spousal-abuse model the victim is removed from the abusive situation until the conflict is resolved and the victim is empowered to take appropriate action. However, this model may not meet the needs of victims, particularly those who own the property where they live and are reluctant to move out, even temporarily. In one study in Connecticut 60% of abuse victims who were admitted to hospital for short-term medical care remained in an institution permanently.⁴⁰ In the advocacy model a neutral person helps the victim, mainly by assisting him or

her to find and use community services. The advocate informs the victim of his or her rights and options. This model has the least potential for violation of the rights of the individual. The adult-protection model is exemplified by the mandatory reporting of abuse; it has the greatest potential for violation of rights. Furthermore, it has not proven effective in the jurisdictions where it has been introduced.⁴¹ Each model involves recognition of the problem, provision of information, assessment of the victim's decision-making capacity and aid in making choices (Table 4). However, the advocacy model is generally the most appropriate.

Table 4: Management of elder abuse

Detection and risk assessment

Determine type of abuse, frequency and severity of abuse, danger to the victim, perpetrator's intent and level of stress

Involve other professionals (social worker, visiting nurse and geriatric assessment team)

Document injuries (e.g., take photographs)³⁷

Assess the victim's health, functional status and social and financial resources

Assessment of decision-making capacity of the victim

Assess cognitive state and emotional health

Measures if the victim is competent

Provide information to the victim

Outline choices (e.g., temporary relocation, home support, community agencies, criminal charges)

Support the victim's decision

Measures if the victim is not competent

Separate the victim and the perpetrator

Relocate the victim

Arrange advocacy services for the victim

The outcomes of interventions for elder abuse have not been evaluated in rigorous studies.⁴² In case series, the results reported are generally disappointing, partly because elderly people who have been abused frequently refuse assistance. Even when an intervention was completed, 45% to 95% of cases were not satisfactorily resolved.^{13,14,43,44}

In a situation of abuse the needs of the perpetrator as well as those of the victim should be recognized. It is suggested that physicians should provide caregivers with information about the elderly person's disorder, encourage caregivers to meet their own needs, address the main behavioural problems of the elderly person, arrange for respite or alternative care if the caregiver's burden becomes too great and help the caregiver to enhance the abilities of the elderly person.⁴⁵

The Canadian Association on Gerontology, with the support of the Family Violence Prevention Division of Health Canada, is conducting a national project on abuse and neglect of seniors in Canada called "Abuse and Neglect of Older Canadians — Strategies for Change." A book of the same name will be published in 1995 as part of the project. A resource document, arranged by province and territory, entitled *A Shared Concern* is available from the Seniors Directorate, Health Canada, Ottawa, ON K1A 0K9; tel (613) 952-7606, fax (613) 957-7627. A practical handbook for the management of elder abuse is also available.⁴⁶

Recommendations (Table 5)

There is insufficient evidence to recommend screening for elder abuse in the periodic health examination, or

Table 5: Summary of manoeuvres, effectiveness, levels of evidence and recommendations for detection of elder abuse and intervention

Manoeuvre	Effectiveness	Level of evidence	Recommendation
Detection of elder abuse by questionnaire	Few questionnaires detect psychologic, social or financial abuse or neglect; none addresses the difference between effects of disease and abuse; and few have been tested empirically	Descriptive studies ³⁰ (III)	Poor evidence to include in or exclude from periodic health examination of elderly people (C)
Intervention by professionals, singly or in teams	Mandatory reporting of elder abuse in the US has not proven effective; removal of the victim from the home may not meet his or her needs; informing the victim of his or her rights and options, and helping him or her find community services, is most respectful of victims' rights and autonomy	Descriptive studies ^{13,14,39,43,44} (III) Expert opinion ³¹ (III)	Poor evidence to include in or exclude from periodic health examination of elderly people (C)

to recommend against such screening. There is also insufficient evidence to favour any specific protocol or treatment. However, physicians should be alert to indications of elder abuse and should take measures to prevent further abuse. Physicians, with the help of a multidisciplinary team, are uniquely positioned to advocate for the victim, and they have the authority and ability to act in the victim's best interests.

Validation

The recommendations of the American Medical Association (AMA) differ from those of the Canadian Task Force because of the requirements for mandatory reporting of elder abuse in the United States.³¹ The AMA recommends that "physicians . . . incorporate routine questions related to elder abuse and neglect into their daily practice." A report from the CMA Council on Health Care recommends that "physicians should be alert to signs of battering such as bruises in various stages of healing . . . and interpersonal difficulties in the family."⁴⁷ In a report on guidelines for institutional programs, Health Canada stated that it is "important to be aware of signs or symptoms which might cause suspicion of abusive treatment."⁴⁸ Guidelines endorsed by the British Geriatrics Society recommend action when a situation that could lead to abuse is identified.⁴⁹ Recent guidelines for Ontario physicians stated that "physicians at all levels must appreciate the extent of the problem, its recognition and approaches to management."⁵⁰

Research priorities

1. Determination of the causes of elder abuse in different ethnic and cultural groups in Canada.
2. Determination of the prevalence of abuse in Canadian institutions.
3. Development of valid, reliable assessment tools for use in such settings as primary care, hospital emergency departments and institutions.
4. Evaluation of the effectiveness of interventions for elder abuse.

We thank Elizabeth A. Podnieks, Professor, Ryerson School of Nursing for her comments and critical review of the manuscript.

The task force is funded by Health Canada. Dr. Christopher Patterson was supported in part by the Educational Centre for Aging and Health, McMaster University, Hamilton, Ont.

References

1. Subcommittee on Institutional Guidelines: *Health Care Related to Abuse, Assault, Neglect and Family Violence*, Health Services Directorate, Health Services and Promotion Branch, Department of National Health and Welfare, Ottawa, 1989: 69-80
2. Frail and vulnerable: elder abuse in Canada. *Vis-à-Vis* 1983; 1 (2): 1-2
3. Council on Scientific Affairs: Elder abuse and neglect. *JAMA* 1987; 257: 966-971
4. Cassel C, Walsh JR (eds): *Geriatric Medicine*, Springer-Verlag, New York, 1984: 211-235
5. National Clearinghouse on Family Violence: *Elder Abuse*, Department of National Health and Welfare, Ottawa, 1990
6. Hudson MF: Elder mistreatment: a taxonomy with definitions by Delphi. *Annu Rev Gerontol Geriatr* 1986; 6: 1-20
7. Stones MJ: Measuring perceptions of elder abuse. In *Abstracts of the 22nd Annual Scientific and Educational Meeting of the Canadian Association on Gerontology*, Canadian Association on Gerontology, Ottawa, 1993
8. Gioglio GR, Blakemore P: *Elder Abuse in New Jersey: the Knowledge and Experience of Abuse among Older New Jerseyans*, Department of Human Services, Trenton, NJ, 1983
9. Pillemer K, Finkelhor D: The prevalence of elder abuse: a random sample survey. *Gerontologist* 1988; 28: 51-57
10. Podnieks E: National survey on abuse of the elderly in Canada. *J Elder Abuse Neglect* 1992; 4: 5-58
11. Gardner K, Halamandaris VJ: *Elder Abuse: an Examination of a Hidden Problem. A Report With Additional Views by the Select Committee on Aging*, US House of Representatives Select Committee on Aging, Washington, 1981
12. Clark CB: Geriatric abuse — out of the closet. *J Tenn Med Assoc* 1984; 77: 470-471
13. Block MR, Sinnot JD (eds): *The Battered Elder Syndrome: an Exploratory Study*, Centre on Aging, University of Maryland, College Park, Md, 1979
14. O'Malley H, Segel H, Perez R et al: *Elder Abuse in Massachusetts: a Survey of Professionals and Paraprofessionals*, Legal Research and Services for the Elderly, Boston, 1979
15. Pillemer K, Moore DW: Abuse of patients in nursing homes: findings from a survey of staff. *Gerontologist* 1989; 29: 314-320
16. Jorgensen B: *Crimes Against the Elderly in Institutional Care*, Concerned Friends of Ontario Citizens in Care Facilities Inc, Toronto, 1986
17. Baril M, Beaulieu M: *Vivre en résidence : les témoignages des personnes âgées*, Centre international de criminologie comparée, Université de Montréal, Montreal, 1989
18. Wolf RS: Elder abuse: ten years later. *J Am Geriatr Soc* 1988; 36: 758-762
19. McDonald AJ, Abrahams ST: Social emergencies in the elderly. *Emerg Med Clin North Am* 1990; 8: 443-459
20. Taler G, Ansello EF: Elder abuse. *Am Fam Physician* 1985; 32: 107-114
21. Pillemer K, Finkelhor D: Causes of elder abuse: caregiver stress versus problem relatives. *Am J Orthopsychiatry* 1989; 59: 179-187
22. Kosberg JI: Preventing elder abuse: identification of high risk factors prior to placement decisions. *Gerontologist* 1988; 28: 43-50
23. Boydston LS, McNairn JA: Elder abuse by adult caretakers: an exploratory study. In *Physical and Financial Abuse of the Elderly* [pub no 97-297], US House of Representatives Select Committee on Aging, Washington, 1981: 135-136
24. Wolf RS, Strugnell CP, Godkin MA: *Preliminary Findings from Three Model Projects on Elderly Abuse*, Centre on Aging, University of Massachusetts Medical Centre, Worcester, Mass, 1982
25. Lau E, Kosberg JI: Abuse of the elderly by informal care providers. *Aging* 1979; Sept-Oct: 10-15
26. Homer AC, Gilleard C: Abuse of elderly people by their carers.

27. Kane RS, Goodwin JS: Spontaneous fractures of the long bones in nursing home patients. *Am J Med* 1991; 90: 263-266
28. *Elder Mistreatment Guidelines for Health Care Professionals: Detection, Assessment and Intervention*, Mount Sinai Victim Services Agency Abuse Project, New York, 1988
29. Bourland MD: Elder abuse. *Postgrad Med* 1990; 87: 139-144
30. Sengstock MC, Hwalek M: A review and analysis of measures for the identification of elder abuse. *J Gerontol Soc Work* 1987; 10: 21-36
31. *Diagnostic and Treatment Guidelines on Elder Abuse and Neglect*, American Medical Association, Chicago, 1992
32. Fulmer T, O'Malley TA: *Inadequate Care of the Elderly: a Health Care Perspective on Abuse and Neglect*, Springer Publishing Company, New York, 1987
33. Phillips LR, Rempusheski VF: A decision-making model for diagnosing and interviewing in elder abuse and neglect. *Nurs Res* 1985; 34: 134-139
34. Phillips LR, Rempusheski VF: Making decisions about elder abuse. *Soc Casework* 1986; 67: 131-140
35. Daniels RS, Baumhover LA, Clark-Daniels CL: Physicians mandatory reporting of elder abuse. *Gerontologist* 1989; 29: 321-327
36. Cochran C, Petrone S: Elder abuse: the physician's role in identification and treatment. *Ill Med J* 1987; 171: 241-246
37. Wolf RS, Pillemer K: *Helping Elderly Victims: the Reality of Elder Abuse*, Columbia University Press, New York, 1989
38. Gilbert DA: The ethics of mandatory elder abuse reporting statutes. *Adv Nurs Sci* 1986; 8: 51-62
39. Beth Israel Hospital Elder Assessment Team: An elder abuse assessment team in an acute hospital setting. *Gerontologist* 1986; 26: 115-118
40. Faulkner LR: Mandating the reporting of suspected cases of elder abuse: an inappropriate, ineffective and ageist response to the abuse of older adults. *Fam Law Q* 1982; 16: 69-91
41. Krauskopf JM, Burnett ME: The elderly patient: when protection becomes abuse. *Trial* 1983; 19: 61-67
42. McDonald PL, Hornick JP, Robertson GB et al: *Elder Abuse and Neglect in Canada*, Butterworths, Toronto, 1991: 92-95
43. Chen PN, Bell S, Dolinsky D et al: Elderly abuse in domestic settings: a pilot study. *J Gerontol Soc Work* 1981; 4: 3-17
44. McLaughlin JS, Nickell JP, Gill L: An epidemiological investigation of elderly abuse in Southern Maine and New Hampshire. In *Elder Abuse* [pub no 68-463], US House of Representatives Select Committee on Aging, Washington, 1980: 111-147
45. Zarit SH: The organic brain syndrome and family relationships. In Ragan E (ed): *Aging Parents*, University of Southern California Press, Los Angeles, 1979
46. *Elder Abuse: a Practical Handbook for Service Providers*. Ontario Association of Professional Social Workers, Toronto, 1992
47. Ghent WR, Da Sylva NP, Farren ME: Family violence: guidelines for recognition and management. *Can Med Assoc J* 1985; 132: 541-553
48. *Guidelines for Establishing Standards: Health Care Related to Abuse, Assault, Neglect and Family Violence*, Subcommittee on Institutional Guidelines, Health and Welfare Canada, Ottawa, 1989: 75
49. Age Concern, British Association of Social Workers, British Geriatrics Society et al: *Abuse of Elderly People: Guidelines for Action*, Age Concern England, London, England, 1993
50. Patterson C, Podnieks E: A guide to the diagnosis and treatment of elder abuse. *Ont Med Rev* 1993; 60 (1): 11-17

Conferences continued from page 1409

- Mar. 2-4, 1995:** College of Family Physicians of Canada, Alberta Chapter, 40th Annual Scientific Assembly: Fun, Fitness and Facts
Banff, Alta.
Conference Support, Office of Continuing Medical Education, Faculty of Medicine, University of Calgary, 3330 Hospital Dr. NW, Calgary, AB T2N 4N1; tel (403) 220-7240, fax (403) 270-2330
- Mar. 16-17, 1995:** 3rd European Congress on Ambulatory Surgery and 1st International Congress on Ambulatory Surgery
Brussels, Belgium
Official language: English
Dr. Claude De Lathouwer, Brussels One Day Clinic, rue Pangaert 37-47, B-1080 Brussels, Belgium; tel 011-32-2-422-4271 or -4242, fax 011-32-2-425-7076
- Les 16 et 17 mars 1995 :** 3^e Congrès européen de chirurgie ambulatoire et 1^{er} Congrès international de chirurgie ambulatoire
Bruxelles, Belgique
Langue officielle : l'anglais
Dr Claude De Lathouwer, Nouvelle clinique de la basilique, rue Pangaert 37-47, B-1080 Bruxelles, Belgique; tél 011-32-2-422-4271 ou -4242, fax 011-32-2-425-7076
- Mar. 19-22, 1995:** 2nd International Conference on Gallstones: Causes and Management
Tel Aviv, Israel
Gallstone Conference Secretariat, Peltours-Te'um Congress Organizers, PO Box 8388, Jerusalem 91082, Israel; tel 011-972-2-617402, fax 011-972-2-637572
- Mar. 20-25, 1995:** Youth Health Assembly (includes 6th International Congress on Adolescent Health, Youth for Youth Health Conference and 27th Society for Adolescent Medicine Annual Meeting; cosponsored by the Society for Adolescent Medicine and the International Association for Adolescent Health)
Vancouver
Venue West Conference Services Ltd., 645-375 Water St., Vancouver, BC V6B 5C6; tel (604) 681-5226, fax (604) 681-2503
- Mar. 23-24, 1995:** 5th Annual Rotman Research Institute Conference — Cognitive Rehabilitation: Advances in the Rehabilitation of Acute and Age-Related Brain Disorders
Toronto
Poster deadline: Dec. 16, 1994
Education Department, Baycrest Centre for Geriatric Care, 3560 Bathurst St., Toronto, ON M6A 2E1; tel (416) 785-2500, ext. 2365

continued on page 1435