

# The Role of the Dentist in Recognizing Elder Abuse

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## SOMMAIRE

Reconnaître les mauvais traitements est crucial pour protéger la proportion croissante d'aînés dans la population canadienne. Or les dentistes se trouvent dans une position idéale pour déceler et signaler les présumés cas d'abus, car ils font un examen complet de la région de la tête et du cou et ils voient généralement leurs patients 2 fois par an. Une bonne aptitude à communiquer est cependant nécessaire pour améliorer le dialogue avec les patients. Cet article vise à fournir aux dentistes des outils pour reconnaître les abus ainsi qu'un arbre de décision pour gérer et suivre les présumés cas d'abus chez les aînés. Grâce à une meilleure sensibilisation, les dentistes pourront jouer un rôle important dans la protection des aînés contre les mauvais traitements.

Pour les citations, la version définitive de cet article est la version électronique : [www.cda-adc.ca/jcda/vol-74/issue-8/715.html](http://www.cda-adc.ca/jcda/vol-74/issue-8/715.html)

Seniors comprise the fastest growing segment of the Canadian population. In 2006, seniors represented 13.2% of Canada's total population or 4.2 million people; by 2036, the proportion is expected to increase to 24.5% or 9.8 million seniors. The increase is attributed to a decreasing birth rate, increased life expectancy and the impact of the aging "baby boom" generation. The fastest growing group will be seniors over the age of 80 years, who are expected to increase from 2.1% of the total population to 5.8% between 2021 and 2056.<sup>1</sup> The number of elderly seeking dental care is also expected to increase, not only because of this shift in demographics, but also because of such factors as decreased edentulism, increased disposable income and increased awareness of oral care and its potential link to systemic illnesses.<sup>2</sup>

Elder abuse has been defined as single or multiple hurtful acts of commission or omission inflicted on an elderly person by a person in a position of trust.<sup>3</sup> The hurtful act is considered

to be one that is intentional, wilful or non-accidental. Elder abuse is becoming a public issue, with the frequency of such acts increasing as the population ages. The concept of oral care providers recognizing and reporting child abuse is recognized as obligatory; however, extension of this practice to the elderly is not often considered. Bomba<sup>4</sup> has developed a validated template to help physicians recognize elder abuse and counsel seniors at risk. With permission, I have modified this template for use by dentists (Figs. 1 and 2). In this article, I review the topic of elder abuse and present a modified geriatric medical template to help dentists recognize elder abuse and counsel at-risk seniors.

## Prevalence

Elder abuse affects every social stratum and shows no regard for race, creed or colour. The frequency of elder abuse is difficult to quantify as many abused elderly people are afraid to report their abusers to the appropriate

Signs that raise suspicion of elder abuse, neglect, financial exploitation	Management and monitoring
<p><b>General</b></p> <ul style="list-style-type: none"> <li>• Delays between dental injury or disease and assessment</li> <li>• History from victim and perpetrator differs</li> <li>• Implausible or vague explanations</li> <li>• Functionally impaired patient presents without caregiver</li> <li>• Cognitively impaired patient presents without caregiver</li> <li>• Radiographic results inconsistent with history</li> <li>• “Physician/dentist hopping”</li> </ul> <p><b>Physical abuse</b></p> <ul style="list-style-type: none"> <li>• Bruises, welts, cuts, wounds, cigarette/rope burn marks</li> <li>• Blood on person, clothes</li> <li>• Injuries: fractures of teeth or jaws and related structures</li> <li>• Painful body movements unrelated to illness</li> <li>• Avulsed or loose teeth</li> </ul> <p><b>Psychological abuse</b></p> <ul style="list-style-type: none"> <li>• Sense of resignation or hopelessness</li> <li>• Passive, helpless, withdrawn behaviour</li> <li>• Fearful, tearful, anxious, clinging</li> <li>• Self-blame for life situation or caregiver behaviour</li> </ul> <p><b>Neglect</b></p> <ul style="list-style-type: none"> <li>• Unclean appearance, excessive plaque</li> <li>• Untreated caries</li> <li>• Underweight, frail, dehydrated</li> <li>• Inappropriate use of medications or failure to purchase medications</li> <li>• Long-term use of fractured dentures</li> </ul> <p><b>Financial exploitation</b></p> <ul style="list-style-type: none"> <li>• Unexplained change in power of attorney, will, legal documents</li> <li>• Missing cheques, money</li> <li>• Unexplained decrease in bank account, bounced cheques</li> <li>• Missing belongings</li> </ul> <p><b>Sexual abuse</b></p> <ul style="list-style-type: none"> <li>• Laceration of labial frenum, palatal petechiae</li> </ul> <p><i>Modified Ohio A &amp; DVLL Screening Tool, NEAN 13(2) 2001:35</i></p>	<p><b>Assess for safety:</b> <b>Is there immediate danger?</b></p> <p>Yes → Immediate referral to police</p> <p>No ↓</p> <p><b>Does the patient accept intervention?</b></p> <p>Yes ↓</p> <p>No ↓</p> <p>• Provide emergency information • Educate the patient • Develop goals of care • Alleviate causes of abuse • Refer patient and family for services e.g., community health centre • Arrange follow-up</p> <p><b>Does the patient have the capacity to refuse treatment?</b></p> <p>Yes ↓</p> <p>No ↓</p> <p>• Provide emergency information • Educate the patient • Develop goals of care • “Gentle persuasion” • Arrange follow-up</p> <p>• Refer to hospital geriatric team Possible actions: - financial management - guardianship - court proceedings • Arrange follow-up</p> <p><i>Modified AMA Diagnostic and Treatment Guideline on Elder Abuse and Neglect, 1992</i></p>

Figure 1: Template for dentists to use in assessing and managing elder abuse (adapted from Bomba<sup>4</sup>)

authorities. In 1981, a United States Congress Select Committee on Aging estimated that 5% of the American elderly or 1.5 million seniors were victims of abuse.<sup>5</sup> Some international studies have estimated the rate of abuse at 2%–10%<sup>6</sup>; however, 1 Israeli study indicates that it can be as high as 20%.<sup>7</sup> In 2003, in Canada there were 4,000 incidents of vio-

lence against seniors, 29% of them committed by a family member. Most physical abuse incidents took place in the home.<sup>1</sup> In the United States, it has been estimated that the rate of abuse increased 150% in the 10-year period between 1986 and 1996.<sup>8</sup> Although not well reported, this trend is probably occurring in Canada as well.

**As health care professionals, our challenge is to balance**

1. Duty to protect the safety of the vulnerable elder
2. Elder's right to self-determination

**Values**

- Treat elders with honesty, compassion, respect
- Goals of care should focus on improving quality of life and reducing suffering

**Principles: Rights of older adults**

- To be safe
- To retain civil and constitutional rights, unless restricted by courts
- To make decisions that do not conform to social norms if they cause no harm to others
- To have decision-making capacity unless courts decide otherwise
- To accept or refuse services

**Best practice guidelines**

- First **DO NO HARM**
- Interest of the senior is the priority
- Avoid imposing your personal values
- Respect diversity
- Involve the senior in the plan of care
- Recognize the senior's right to make choices
- Use family and informal support
- Recommend community-based services before institutional-based services, whenever possible
- In the absence of known wishes, act in the best interests of the patient and use substituted judgment

*Adapted and modified from A National Association of Adult Protective Services Administrators (NAAPSA) consensus statement.*

**Screening questions**

- Are you afraid of anyone in your family?
- Has anyone close to you tried to hurt or harm you recently?
- Has anyone close to you called you names or put you down or made you feel bad recently?
- Does someone in your family make you stay in bed or tell you you're sick when you know you aren't?
- Has anyone forced you to do things you didn't want to do?
- Has anyone taken things that belong to you without your OK? Are you often hungry?

**Figure 2:** Principles of dental assessment and management of elder abuse (adapted from Bomba<sup>4</sup>)

**Forms of Abuse**

Abuse can take a variety of forms: physical, emotional, sexual or financial abuse or neglect (**Table 1**).<sup>9</sup> Elder abuse can frequently involve 2 or more of these forms. Physical abuse is an injury or harm that causes pain, suffering, impairment or disease.<sup>10</sup> This may be caused by hitting with

hands or objects, burning or unjustified physical or pharmacologic restraint.<sup>11</sup> Scarring or bruising of wrists may indicate physical restraint. Hand- or knuckle-shaped bruises and fracture of facial bones and teeth may indicate physical abuse. Unexplained loss of hair may indicate hair pulling.

Emotional abuse involves intimidation, humiliation, belittling and threats of abandonment.<sup>12</sup> As this form of abuse may be displayed in both the dental operatory and waiting room, it is important for the office personnel to recognize and report it to the dentist. Victims of emotional abuse may often appear withdrawn, especially in the presence of their care providers.

Sexual abuse has been defined as nonconsensual sexual contact of any kind.<sup>13</sup> Intraoral palatal petechiae or torn labial frenum may be associated with forced oral sex.<sup>14</sup>

Neglect has been defined as the failure to provide goods or services necessary for a dependent person to function or to avoid harm.<sup>10</sup> It includes the failure to provide food, shelter, clothing and medical or dental care. Neglect can be active or passive. Active neglect is defined as the intentional withholding of the basic necessities of life. Passive neglect refers to the failure to provide these basic measures, not out of malice but as a result of lack of experience or ability.<sup>15</sup> The dentist should include neglect as part of a differential diagnosis when the dependent patient's mouth has abundant amounts of plaque or food debris. The patient may have numerous untreated caries, broken restorations, ill-fitting dentures and prolonged untreated soft-tissue pathologies.

Financial abuse is the financial exploitation of the elderly victim. The perpetrators may limit the amount of money available for food, housing, medicine and dental care. There are 3 types of perpetrators. The first is usually a person of trust, such as an accountant, lawyer, caregiver or clergy, who preys on the elderly because of greed and lack of ethics. The second is a family member who does not want to see any dilution of the future estate; this person may feel that he or she is entitled to the funds. The third is the scam artist, who may deceive seniors with false promises of lottery winnings or bogus home repairs.<sup>16</sup>

**Identification of Potential Abusers**

In 1 study,<sup>17</sup> abusers were interviewed to determine what characteristics increased their abuse potential. The investigators interviewed 2 distinct groups: 1 that physically abused and the another that neglected their elderly dependents. The abusers shared the following characteristics:

- they cared for an elderly person over 75 years of age
- they lived with their dependent
- they were inexperienced or unwilling caregivers
- they had high expectations of their elderly patient
- they had personal relationship conflicts and exhibited hostile, aggressive behaviour
- they had other caring demands, such as a spouse or children

**Table 1** Forms of elder abuse and their manifestations

Form of abuse	General manifestations	Dental manifestations
Punching or slapping	Multiple bruises at varying stages of healing	Hand print on face, swollen lips, facial contusions, fractured or avulsed teeth, muscle trismus
Pulling of hair	Unexplained alopecia	Unusual loss of hair in the head and neck areas
Physical restraints	Rope burns or loss of hair on arms from tape	Periorbital facial lacerations from tape over lips
Psychological abuse	Unexplained fear, withdrawn behaviour, crying	No pathological source of discomfort, patient may blame themselves for their current dental condition
Neglect	Unclean appearance, underweight	Abundant plaque and food debris in mouth, broken dentures or restorations
Financial exploitation	Patient may have unexplained power of attorney, will or other legal documents	Caregiver refuses to pay for basic dental care, unusual returned cheques
Sexual exploitation	Inappropriate touching	Palatal bruising or petechiae, torn labial frenum

- they were under stress due to lack of finances or poor housing
- they felt isolated and lacked community and personal support
- they may have been suffering from poor health
- they may have had a history of mental health problems including depression, anxiety, alcohol or drug abuse
- they may have been neglected or abused as a child or have had a family history of violence.

The study concluded that the probability of elder abuse or neglect increased with the number of these characteristics caregivers displayed.<sup>17</sup>

### Identification of the Abused

The identification of abused patients is difficult, as many of them will deny being abused. This is characteristically due to:

- a fear of retaliation or abandonment by their caregiver
- the feeling that they deserve the abuse
- a sense of helplessness — that nothing can be done
- shame in admitting that they are abused by their own family.<sup>18</sup>

A dentist who suspects abuse or neglect must empower the patient to speak freely. He or she should try to interview the patient without the suspected abuser present. **Figure 2** lists some screening questions that may help the dentist question a patient. The patient should be seated upright and the dentist should use eye contact to improve communication. The dentist should note the form of abuse, duration and possible triggers of the behaviour. The dentist must understand the dynamics of the family unit, i.e., which member is in charge of medical and financial issues, whether there is a possibility of more than 1 abuser, etc.

The following characteristics are commonly seen in the abused elderly:

- physical or mental dependence on the caregiver
- poor communication between the abused and the caregiver
- “accident prone,” suffering many unexplained falls
- submissive or withdrawn behaviour in the presence of their caregiver.

Obvious signs of neglect or abuse to the head and neck region that are readily apparent to the dentist are listed in **Table 1**. As with any patient, identification of these clues begins with a good head and neck examination.

### Rationale for the Dentist as a Screener

Dentists may evaluate their patients on entry into the office by observing gait, appearance, communication skills and, of course, the head and neck region.<sup>19</sup> Many patients visit their dentist every 6 months, whereas they visit their physician only yearly. Dentists are among the most trusted professionals, and patients feel comfortable communicating with them. This trust increases as dentists communicate with compassion and empathy.<sup>20</sup>

Conversations with a suspected victim should be in a private area without any of the patient’s significant others present, and they should be witnessed by another staff member. The dentist may decide to use some of the screening questions provided in **Figure 2**. Any physical evidence should be photographed and measured and its exact location documented. The patient must be constantly reassured, and all plausible explanations for any signs of abuse should be evaluated for consistency and probability. Many abused patients feel ashamed, experience self-denial and de-emphasize the abuse.<sup>21</sup>

The dentist may then interview the caregiver(s) and document the explanations given. The dentist must always be aware of natural changes associated with aging such as thinning of the skin, increased potential for bruising due to systemic illnesses or medications such as blood thinners. The latter 2 etiologies can be easily discerned from potential abuse by reviewing a comprehensive medical history.

### Obligation to Report Suspected Abuse

Barriers that may affect a dentist's willingness to report signs of elder abuse include lack of knowledge regarding legal responsibility, uncertainty about the diagnosis and fear that identification of the abused and abuser(s) might worsen the patient's situation.<sup>22</sup>

The confusion over legal responsibility stems from the Canadian legal structure, where federal, provincial and territorial governments have jurisdiction in specific areas of law designated by the Canadian constitution. Although criminal law is under federal jurisdiction, property rights, family law, human rights, consent and adult protection are provincial or territorial responsibilities. The Canadian Charter of Rights and Freedoms guarantees certain rights and liberties across Canada, and each province or territory adopts its own concepts into its laws. This has led to different responsibilities for dentists depending on the location of their practice.<sup>23</sup>

Figures 1 and 2 are the modified validated templates<sup>4</sup> for the recognition and assessment of elder abuse by dentists. The well-being of the patient is of prime importance. If the patient is deemed to be in immediate danger, the police should be notified at once. However, if the dentist recognizes an abusive relationship in a fully cognitive patient and the patient refuses intervention, this creates an ethical quandary. Is the dentist correct in breaching patient confidentiality and disclosing the suspected abuse to the authorities? The answer seems to depend on the province in which the dentist practises. In Nova Scotia, reporting of abuse and neglect is mandatory.<sup>24</sup> Newfoundland and Labrador have mandatory reporting of neglect but not abuse,<sup>25</sup> and Prince Edward Island, New Brunswick and British Columbia have legislated voluntary reporting.<sup>26</sup> The Ontario Long-Term Care Homes Act<sup>27</sup> passed in 2006 establishes mandatory reporting of abuse only in long-term care centres. In Quebec, the cognitive senior has the right to choose how he or she wants to live; the rationale is that these patients are already protected by laws against assault or fraud within the criminal code.<sup>28</sup>

In my opinion, patients have the right to choose how they are going to live; however, if the dentist suspects a life-threatening situation, then authorities should be contacted immediately. The dentist should suggest to the patient that he or she may benefit from the social services provided by community-based clinics. This should be done with a persuasive, empathetic tone, and not in the presence of the alleged abuser. The dentist may wish to contact a social

worker at such an agency. The dentist should employ a team approach involving the patient's physician and community health centre to allow for coordinated action. For patients who do not have the capacity to manage their own affairs, the local community health centre will refer the matter to the police and the courts. This will probably result in curatorship and possible criminal charges.

### Management and Monitoring of Abuse in Canada

Elder abuse is estimated to be as prevalent as child abuse, with only half of cases reported.<sup>26</sup> Most dentists would acknowledge their legal obligation to report child abuse, but many would not consider reporting elder abuse an obligation as well. This may be due to the fact that reporting child abuse is obligatory across Canada whereas the legal requirement to report elder abuse depends on the province in which one practises.

The question of mandatory reporting has been rejected by some organizations such as the Elder Abuse Prevention Unit in Queensland, Australia.<sup>29</sup> They believe that mandatory reporting will not improve or will have a negligible impact on the safety of older people and will divert resources away from addressing this issue. Further, the introduction of mandatory reporting denies the rights of seniors to make their own decisions, thereby reinforcing ageist stereotypes.<sup>28</sup> However, the Queensland group states that this policy does not extend to those with diminished capacity.

The Canadian Network for Prevention of Elder Abuse has adopted a position similar to that of the Queensland group.<sup>30</sup> They state that, unlike children, adults have the ability to make decisions about their own well-being and safety. They further state that seniors have the right to live their lives the way they want as long as they are mentally capable of doing so. Mandating reporting of abuse would be a violation of the mentally capable person's autonomy. There are already criminal, substitute-decision-making, guardianship and mental health laws available for the protection of people who are not mentally capable of protecting themselves.<sup>29-31</sup> This approach has been followed by the Quebec government, where there are no specific laws in connection with elder abuse, but individuals are covered by the Canadian criminal code for acts such as assault and fraud. The Quebec Human Rights Commission states that suspected abuse cases should be referred to local community health units and, if the threat appears imminent, to the local police.

### Conclusion

Elder abuse is becoming more frequent as the population ages, and recognizing abuse is paramount in the protection of seniors. Dentists are in an ideal position to identify and signal suspected abuse, as they perform a thorough examination of the head and neck region and generally see their

patients twice a year. Suspected abuse can be identified by approaching the patient with empathy and compassion. The dentist must use his or her clinical knowledge to distinguish abuse from normal fragility of the tissues. With the aid of the modified template (Figs. 1 and 2) dentists should play an important role in helping protect seniors from abuse. ♦

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