Medical Law and Ethics
Handout 2.4
Reporting Duties for Healthcare Professionals
Part II: Abuse

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Introduction

We are going to continue our discussion from the previous handout and examine the steps and procedures in which healthcare professionals approach sensitive matters with patients and their family members. Physicians and other healthcare professionals must show sensitivity when a patient discloses information related to abuse or maltreatment.

During physical examinations, a healthcare professional may encounter injuries which may or may not be related to an accident or disease. Although it has been established that physicians and other healthcare professionals should protect confidential information given to them by the patient, it may present a challenge when mandatory reporting of abuse is required by law. Other cases may involve signs of neglect in which the needs of an individual (e.g. a child, dependent adult, or elder) are not being met by the caregiver (e.g. the parent, guardian, or healthcare staff).

A key point when speaking with patients is to ensure that they can be honest with the physician and healthcare professionals treating them, but the issue of mandatory reporting may elicit hesitation for fear that it may create additional conflict or alert the suspected abuser. These issues will be covered in greater depth in the handout.

Due to the amount of references for this handout, they will be put as links in a separate handout page instead of on the website to keep it organized. The references are also in alphabetical order on the reference handout [to make it easier to spot] so they won't be in numerical order on this handout.

Reportable Injuries and Deaths

From our previous handout we learned the about the conditions in which a physician, coroner, or medical examiner verifies the death of an individual.

There are certain injuries and deaths in which a healthcare professional must report to law enforcement officials. An example would be injuries inflicted by a firearm. When individuals receive an injury which may have potentially been caused by a criminal act, physicians and healthcare professionals (e.g. staff from the emergency department) are required to notify local law enforcement.

Under *New York State Penal Law Section 265.25* ***Certain wounds to be reported***, wounds related to a firearm or sharp instrument (such as a knife or icepick) must be reported to law enforcement officials by the physician or administrative healthcare professional (e.g. hospital superintendent) in charge of the case. If these instances are not reported, the physician or administrative professional will be charged with a Class A Misdemeanor.

Under New York State Penal Law,

"*Upon conviction of a Class "A" misdemeanor, a court may sentence an individual to a maximum of one year in jail or three years probation. In addition, a fine of up to $1,000 or twice the amount of the individual's gain from the crime may be imposed.*"

(Please refer to Reference 14)

(Please refer to Reference 15)

Under North Carolina law (G.S. 90-21.20), cases similar to what we had discussed above from NYS Penal Law are also covered. Criminal acts such as poisoning or injuries from violent actions as well as non-accidental illnesses and grave injuries to a child must be reported to law enforcement officials.

(Please refer to Reference 20)

Medical Jurisprudence

Law and medicine work together under the branch of medical jurisprudence. **Medical jurisprudence** (also known as **forensic medicine**) refers to the branch of law pertaining to the applications of legal concepts to the medical field. (Some definitions will word it the other way around such as in the textbook. In either case, the main point to note is that law and medicine are intertwined when handling cases such as abuse or criminal deaths.)

A few key issues which may be examined in medical jurisprudence include physical or sexual abuse, circumstances concerning unnatural deaths (e.g. homicide, suicide, or fatal accidents), or deaths from the following causes: unidentified individuals, major disease outbreaks, and terrorism.

Physicians who specialize in the examination of cases related to these circumstances are called **forensic pathologists**. In New York City, the **Office of Chief Medical Examiner** (**OCME**) handles this role by performing autopsies, inquests, and biological testing. An **inquest** is an investigation performed by the medical examiner to determine the cause of death. An **autopsy** (also referred to as a **post-mortem examination**) is a comprehensive surgical examination performed after the death of an individual on the organs and tissues of the body to determine the cause of death and any underlying conditions related to it (e.g. disease, poisoning, or drug overdose).

There are certain cases in which the next of kin may reject the performance of an autopsy (e.g. religious objection from certain faiths). Should this occur, the next of kin may hire an attorney and take the case to court so that a judge may issue a decision on whether to proceed with the autopsy or not. In New York City, nonreligious objections to autopsies "*have no standing in the law*" as determined by the OCME.

(Please refer to Reference 13)

Abuse

Abuse refers to behaviors and actions which bring harm or injury to an individual. Note that abuse does not have to be physical. It can include behaviors such as maltreatment and neglect (e.g. verbal and emotional abuse or failing to provide basic human needs for an individual being cared for).

In the following sections, we will look at several types of abuse which affect vulnerable population groups.

Signs and Evidence of Abuse

Physicians and other healthcare professionals must be aware of any suspicious signs of abuse encountered during examinations and treatment. An important question to consider is whether a physical injury was accidental or done on purpose.

A few common signs to look out for include:

- Bruises
- Fractures
- Burns
- Bites, scratches, and lacerations
- Bodily fluids
- Injuries to the genital region
- Sexually transmitted infections
- Malnutrition (e.g. poor growth and development)
- Neglect of basic needs

- Nonverbal cues (e.g. anxiety, fear, or depression)
- Covering up injuries (e.g. sunglasses, clothing, or makeup)

When physical evidence of abuse is being collected at the facility, physicians and other healthcare professionals should maintain accurate documentation and reporting of any evidence which may be examined by law enforcement and the court.

Collected evidence may include the following:

- Soiled clothing
- Photographic documentation (e.g. photos of injuries including areas of bruising, bleeding)
- Foreign objects (e.g. hair not belonging to victim, bullets, restraints such as rope or handcuffs, objects used for penetration into body cavities)
- Body fluid specimen (e.g. blood, saliva, semen, vaginal or rectal smears)

Any evidence gathered should be protected from improper handling (which may lead to contamination or damage to the evidence). The evidence should be labeled properly and have identifying information including the patient's name, written documentation by medical staff pertaining to the evidence, and the time and date of collection.

The evidence should also be noted on the medical record along with the patient's reason for the visit to the hospital or facility.

The Cycle of Violence

In many cases of abuse (whether it is substance, sexual, domestic, child, elder, etc.) certain social and environmental factors put individuals at higher risk. These may include poverty, violence in the household or community setting, external life stressors such as financial issues or unemployment, dealing with an abuser who has a history of being abused (as well as abusing others), and victims being younger in age.

In addition, abusers who have an external locus of control have a higher chance of inflicting physical or emotional damage on their victims. An **external locus of control** refers to when an individual does not believe his/her behavior can have an impact on external forces and those outside forces are outside of his/her control. Those with an external locus of control shift the blame on outside factors.

There is a cycle which occurs throughout the abusive dynamics between the abuser and the victim. This is referred to as the **Cycle of Violence**.

First, a major life event or stressor triggers a response from the abuser. This event may be a recent job loss, financial hardships, an unplanned pregnancy, or discord with family. The abuser may also be triggered by the victim through jealousy (e.g. the victim gets a promotion at work while the abuser remains unable to get a job). The victim may feel the tension in the environment and may do his/her best to keep it under control.

Next, the abuser will experience a violent episode. The tension escalates between the initial shock during the time the life event or stressor occurs until the abuser feels resentment and anger. The abuser then reacts and lashes out at the victim (verbally or physically). After the event occurs, the abuser will assure the victim (or other affected party) that it was just that time that it will occur (referring to it as an isolated incident).

Finally, the abuser will feel remorse and attempt to reconcile with the victim. During this time, the abuser may give the victim gifts and be generous and kind towards the victim. Afterwards, the victim may feel guilty that he/she was responsible for causing the abuser to act that way and be empathic to the abuser's emotional pain.

However, after the period of reconciliation, a similar (or new) stressor or event may trigger the tension to return again. The cycle **repeats** (as noted above) leading to the abuser having another episode, then feeling remorse, and reconciling again with the victim.

(Please refer to Reference 11)

According to the Centers for Disease Control and Prevention, protective factors which decrease instances of abuse are (1) parents using reasoning to resolve family conflicts, (2) emotional health and connectedness, (3) high academic achievement, (4) empathy and concern for how the individual perceives how his/her actions affect others.

Also note that the same reference discusses risk factors for abuse. We will talk about those points in the next few sections.

(Please refer to Reference 21)

Although we discussed these signs of abusive behavior in general terms in this section, we will go into more specific detail as we cover each point in greater depth.

Substance Abuse

In a previous handout (Handout 2.2 pp. 2-5), we discussed the law as it pertained to controlled substances. Controlled substances are categorized under five schedules (I through V) in which the lower numbers have a higher potential for abuse (Schedule I drugs cannot be prescribed or administered in the United States).

In addition to controlled substances, other substances may become addictive such as alcohol, nicotine (from cigarettes and other tobacco products), and other drugs (not classified as a controlled substance). There are a wide range of substances that have the potential to be abused, but we will focus on the most common ones in this section: prescription drugs, alcohol, and tobacco/nicotine.

» Prescription Drugs

Substance abuse is a critical issue in the United States. According to the National Institute of Drug Abuse's (NIDA) DrugFacts, prescription and over the counter medications are the most commonly abused drugs after marijuana and alcohol for Americans aged 14 and older.

These individuals commonly acquire these drugs from relatives and acquaintances for whom these were originally prescribed to.

According to DrugFacts, there are several factors that can lead to prescription drug abuse:

- Sharing unused prescription medications with a relative or friend
- Taking in an increased dosage or administering the drug through another route than prescribed (e.g. injection or snorting)
- Using the drug other than what it is originally intended for (e.g. using stimulants to focus for class examinations)

(Please refer to Reference 4)

» Alcohol

There is a high prevalence of alcohol use and Alcohol Use Disorder (AUD) in the United States. According to 2014 statistics from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), 87.6 % of American adults (18 years of age and older) reported drinking alcohol at one point in their lives. 24.7% of adults reported engaging in binge drinking and 6.7% reported engaging in heavy drinking within the past month.

16.3 million American adults and an estimated 679 000 adolescents between the ages of 12 and 17 had an AUD.

Common consequences related to drinking include injuries and deaths from motor vehicle accidents, sexual assault, violence, and poor performance in school and the workplace. Alcohol-related liver disease and disorders affecting fetuses of pregnant women (i.e. Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders) are also health consequences encountered with alcohol abuse or misuse.

When taken in moderation, alcohol consumption may provide health benefits (although current research is still being conducted to produce definitive results).

(Please refer to Reference 1)

» Tobacco/Nicotine

According to the Director of the National Institute on Drug Abuse, Dr. Nora Volkow, 440 000 Americans die from tobacco use each year (more than the combined deaths from alcohol, illicit drug use, automobile accidents, AIDS, homicide, and suicide).

The 2010 National Survey on Drug Use and Health had estimated that 69.6 million Americans (12 years of age and older) used tobacco (cigarette smoking being the most widely used).

Due to nicotine's addictive nature, it has a high potential for abuse. Nicotine's pleasurable effects can enable an individual to continue smoking in order to avoid any effects from withdrawal as well as to maintain those feelings of pleasure. A few negative effects from withdrawal include anxiety, depression, irritability, gastrointestinal issues, and difficulty with concentration.

These factors contribute to the difficulty of quitting the use of tobacco and tobacco related products.

(Please refer to Reference 24)

Sexual Abuse and Assault

Although information and resources on sexual abuse and assault are tailored for women, many other population groups are also affected such as men, children, the elderly, and members of the lesbian, gay, bisexual, and transgender (LGBT) community (to name a few).

Sexual abuse refers to attempted or forced sexual contact or behaviors with an individual without receiving their permission (consent). Examples of sexual abuse include rape, abuser having unwanted, nonconsensual sexual contact with the victim, or forced penetration of objects into the victim orally, vaginally, or anally.

(Please refer to Reference 7)

According to the Rape, Abuse, and Incest National Network (RAINN), survivors of sexual abuse and violence are impacted physically, psychologically, and emotionally. A

few of these consequences include eating disorders, self-harm, dissociation, suicidal ideation or attempt, and substance abuse.

Perpetrators of sexual violence are often committed by acquaintances or an individual familiar to the victim. 3 out of 4 rape victims **knew** the person who committed the act (around 70% are friends, acquaintances, or a current significant other such as a boyfriend/girlfriend). Additionally, a majority of the perpetrators had a history of criminal conduct.

(Please refer to Reference 5)

(Please refer to Reference 17)

Recall from Handout 1.6 (p. 3) we discussed the statute of limitations. The statute of limitations refers to the time period in which an individual has in order to file a lawsuit. Reporting incidents of sexual misconduct also adhere to the law. Each individual state has laws regarding the time period for reporting. Some acts may have a time limit for commencing legal proceedings while others do not. For example in New York State, the victim has to report sexual misconduct within 2 years of the offense and sexual abuse in the first degree within 5 years of the offense.

However, a criminal sexual act in the first degree does not have a time limit for legal proceedings. According to New York Penal Law § 130.50, criminal sexual acts in the first degree include oral or anal sexual conduct concerning the following: through force/coercion, with those who are physically incapacitated/helpless, with a minor under 11 years of age, or with a minor who is less than 13 years of age and the perpetrator is 18 years of age or older.

(Please refer to Reference 2)

According to The National Intimate Partner and Sexual Violence Survey (NISVS) by the Centers for Disease Control, members of the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) communities reported intimate partner violence or some form of sexual violence at **equal or higher rates** than their heterosexual counterparts.

40% of gay men and 47% of bisexual men experienced some form of sexual violence (not including rape) compared to 21% of heterosexual men.

44% of lesbian women and 61% of bisexual women experienced some form of sexual violence, stalking, rape, or intimate partner violence compared to 35% of heterosexual women.

48% of bisexual women reported being raped at earlier ages (around 11 to 17 years of age) compared to 28% of heterosexual women.

Transgender women reported sexual assault at a higher rate than transgender male peers.

(Please refer to Reference 16)

(Please refer to Reference 6)

Women and young girls experience sexual violence at higher rates than men. After experiencing sexual violence, many women experience post-traumatic stress disorder (PTSD) or contemplate or attempt suicide. Victims are also at an increased risk for becoming pregnant or receiving a sexually transmitted infection (STI).

Victims of sexual violence experience problems at work, school, or the home environment as well as develop moderate to severe distress. These may include arguing with household members, distrusting others, or work or school tasks being affected by professional and emotional distress.

(Please refer to Reference 25)

An important note is to take patient confidentiality into consideration when fulfilling mandatory reporting duties as required by law. Healthcare professionals should disclose any requirements or obligations that they may have to victims when reporting instances of abuse. This notification should be performed **before** starting assessments, verbal inquiries, or documentation pertaining to abuse.

Child Abuse

In the United States, the **Child Abuse Prevention and Treatment Act (CAPTA)** mandates that cases of child abuse must be reported. Initially enacted in 1974, it was recently updated in 2010. CAPTA works to ensure that programs receive funding from the federal government to support endeavors (e.g. research and prevention initiatives) to provide assistance and improve the quality of life for abused children. CAPTA also sets the regulations and requirements for the mandatory reporting of child abuse and neglect.

Parents and guardians are expected to support the child's basic needs. These include providing the child with food, shelter, clothing, education, standard healthcare, supervision, and physical and emotional support throughout their development. Tending to these needs contribute to a child's physical, psychological, and emotional growth and development. When parents and guardians do not adequately (or refuse to) fulfill these basic needs, **child neglect** occurs.

Battered child syndrome was coined and examined by pediatricians Drs. C. Henry Kempe and Brandt F. Steele which brought the issue of child abuse to the attention of medical and healthcare professionals. Battered child syndrome refers to the series of injuries inflicted upon children by their caregivers (e.g. parents or guardians). These injuries can be damaging (or potentially fatal) and include fractures, burns, bruises, or

swelling. While battered child syndrome may be present at any given age, children under 3 years of age are most affected.

From the study, it was noted that the parents or those responsible for beating the child exhibited characteristics such as having an unstable marriage, alcohol abuse, sexual promiscuity, and displaying emotional issues (e.g. immaturity, inability to handle or control aggression, self-centered). It was also noted that the parents committing these acts experienced abuse when they were children.

(Please refer to Drs. Kempe and Steele's paper under Reference 22)

When an investigation of neglect and child abuse is going to be initiated, the state will require probable cause before proceeding forward. **Probable cause** is a reasonable belief that a crime has occurred or a connection to a crime has been established based on sufficient facts.

Physical abuse against children leads to long term medical and health problems. Acts of physical abuse include shaking, beating, punching, and throwing. Issues with physical development can include neurological problems from abusive head trauma (Shaken Baby Syndrome), problems stemming from the flight-or-fight stress response (e.g. anxiety, post-traumatic stress disorder, sleep disorders), difficulties with learning and memory, and behavioral problems.

Children may also become victims of sexual abuse. Actions include children being coerced into nudity or performing sexual acts, adults engaging in sexual acts with children, child prostitution, or the creation and distribution of child pornography.

Similar to physical and sexual abuse, psychological and emotional abuse perpetrated against children can have damaging consequences. Children who have been psychologically abused experience fear and inability to trust others. As they grow up, a few problems that may arise include depression, suicidal ideation, and difficulty forming relationships with other individuals. In most cases, physical, sexual, and psychological abuse tie in together. Children who have been abused are more likely to engage in risky behaviors when they are older. A few of these activities include alcohol and drug use, unsafe sexual practices, and crime.

(Please refer to Reference 9)

According to James Garbarino, **five behaviors** by adults are present when they mistreat children (psychological maltreatment):

- Rejecting
- Isolating
- Terrorizing
- Ignoring
- Corrupting

Rejecting refers to actions in which an adult refuses to consider a child's self-worth and needs. A few examples include disregarding a child's thoughts and feelings and using verbal insults on the child (e.g. calling him/her worthless and useless).

Isolating refers to actions in which a child is prevented from having normal social experiences such as friendships and interpersonal interactions. The adult will also make the child feel "*alone in this world*". Isolation can also include physically holding the child in confinement to limit (or prevent) any interactions with the outside world.

Terrorizing refers to actions in which an adult makes the environment hostile and tense. The child becomes fearful and apprehensive as a result of these actions. A few examples include verbal threats of harsh punishment if the child does not meet unrealistic expectations, exposing the child to dangerous environments (e.g. households with drugs and violence), and making the child feel stressed and fearful of his/her environment.

Ignoring refers to actions in which an adult inhibits the child of *"emotional growth and intellectual development*" by denying a child of stimulation (i.e. refuses to interact with him/her).

Corrupting refers to actions in which an adult "*mis-socializes*" a child and makes him/her engage in antisocial, deviant behavior. The adult will reinforce the child's negative behavior resulting in the child's inability to adapt to societal norms. A few examples include allowing the child to engage in violent or sexual acts (e.g. fighting, drug dealing, or prostitution) and thus, encouraging his/her failure to normally thrive physically, socially, and emotionally.

(Please refer to Reference 23)

Healthcare professionals who do not report cases of child abuse can be held liable in court. 48 states including the District of Columbia hold the mandated reporter responsible for failing to make a report when child abuse is suspected. **Mandated reporters** are professionals who are required by law to report child abuse and maltreatment if they have reasonable cause that the child's caretaker (e.g. parent or guardian) is responsible for the neglect and abuse.

Examples of mandated reporters include school officials (e.g. teachers, administrative staff), healthcare professionals (e.g. social workers, nurses, physicians, therapists), and professionals in facilities that deal with children (e.g. daycare workers, camp director).

If the mandated reporter fails to report suspected child abuse, they will receive penalties from the court including fines and disciplinary action in their place of employment. Also note that 29 states have penalties for making false reports of child abuse and neglect.

(Please refer to Reference 10)

Religious Objections to Care

There are cases where parents will refuse medical treatment for their children due to their religious beliefs. The government of the United States acknowledges cases in which the legal caretaker of the child (e.g. a parent or guardian) who is a member of recognized churches or religious groups can present their religious beliefs as a defense in court.

The National Center for Prosecution of Child Abuse under the National District Attorney Association (NDAA) examined and compiled legal information for individual states covering religious exemptions for children's medical care. As of 2015, 39 states including the District of Columbia and Guam have laws in which parents and guardians who refuse medical treatment for their children on the basis of their religion will not be held criminally liable for harming the child. **There is no federal amendment which makes it mandatory for parent and/or legal guardians to provide medical care to a child which goes against their religious beliefs.**

The reference below **(Reference 18)** will provide information on how individual states interpret child abuse and neglect as it pertains to refusing to provide the child with proper medical care or treatment.

For example under New York State Penal Law § 260.15 (2015). *Endangering the Welfare of a Child; Defense*, a few conditions are required to establish the validity of the affirmative defense during prosecution for failing to provide a child with medical care: (1) the individual is legally responsible for the child's care, (2) the individual is a member of a church or religious group which uses prayer to treat illness, and (3) treated the child according to those beliefs.

Recall from Handout 2.1 (p. 10), **affirmative defense** is the set of facts introduced by the defendant to counter the claims presented by the plaintiff.

(Please refer to Reference 18)

The American Academy of Pediatrics presents a differing opinion on religious exemptions for medical care.

According to recommendations by the American Academy of Pediatrics (AAP) Committee on Bioethics, children should be able to have access to quality medical care and "*grow and develop free from preventable illness or injury*."

In addition, healthcare professionals are advised to respect the religious beliefs and wishes of parents who may not want to have their children receive medical care. However, the AAP stated that failing to provide medical care for children regardless of the reason is considered neglect and there should be no exemption from prosecution due to the parents' or guardians' religious beliefs.

(Please refer to Reference 19)

Domestic Abuse

According to the United States Department of Justice, ***domestic violence*** *(also referred to as intimate partner violence) is a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner.*

Abusive behavior may start off verbally (assault), but can escalate into battery (physical contact) or murder. The court may intervene in situations in which an abuser stalks, assaults, or harasses the victim. A **restraining (protective)** order is a court issued document prohibiting the abuser from performing certain actions such as contacting the victim or stalking him/her at a certain location.

(Please refer to Reference 3)

Statistics from a summary report (**National Intimate Partner and Sexual Violence Survey**) published by the Centers for Disease Control (CDC) in 2011 has shown the following:

More than 1 in 3 women and more than 1 in 4 men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.

Men and women who had experienced domestic violence, rape, or stalking were more likely to exhibit health issues such as frequent headaches, chronic pain, difficulty with sleeping, activity limitations, and poor physical and mental health compared to those who did not experience these cases.

(Please refer to Reference 12)

Anyone can experience domestic abuse regardless of race, ethnicity, gender, sexual orientation, socioeconomic status, religion, or any other status.

Risk factors that can contribute to domestic violence include societal, economic, and personal factors. For example, a society or culture which condones violence against one's partner, strict adherence to gender norms and roles, having multiple spouses or sexual partners, or poverty can play a role in the prevalence of domestic violence.

When socioeconomic factors are considered, a partner and/or the children may be at risk for bearing the abusive behavior when one partner controls the finances. The partner who is abused may not have the income to support himself/herself (as well as

the children, if they are involved) due to factors such as lack of employment or underemployment.

As we had seen earlier in this section from the Department of Justice's definition of domestic violence, power and control by one partner on another are key points to consider. Alcohol and drugs can influence the perpetrator's perception of power and control in the relationship.

According to ***Massachusetts General Hospital Comprehensive Clinical Psychiatry*** (2008), perpetrators of abuse exhibit certain characteristics including:

- A family history of abuse (e.g. personally witnessing abuse of another family member or being a victim of abuse themselves)
- Previous history of abusive behavior towards past partners
- Unstable employment situation (e.g. unemployed or sporadic, intermittent employment)
- Issues pertaining to mental health (e.g. antisocial personality disorder or depression)
- Low educational/academic attainment

The abuser and the victim will exhibit characteristics displaying the power dynamic in the relationship. The abusers will exert their control on the victim and the victim will display characteristics such as a loss of independence and self-esteem. Abusers may also show different sides in private and in public. For example, abusers may be condescending to his/her partner or children in private, but be kind and generous to family, friends, and acquaintances in public. The abuser may also display different attitudes and show the same kindness to his/her victim in public settings to provide an illusion that everything is fine.

Abusers may control situations such as the following:

- the victim's access to family, friends, and loved ones (the abuser may forbid him/her to discuss these issues with the loved ones or restrict his/her social support network)
- may withhold finances (even if the money was earned by the victim) or limit his/her access to the money
- may restrict the victim's movement and independence (this can include not allowing the victim to voice his/her opinion as well as not allowing him/her to go out by himself/herself without the abuser accompanying him/her)
- may withhold assistance and care when the victim is sick or injured

The victim then internalizes the submissive role and becomes dependent on the abuser for support. The abuser will make excuses or justify his or her actions (e.g. "I'm sorry I

pushed you, I'm just stressed because I had to work overtime.") while the victim will take the blame on himself/herself (e.g. "It's understandable that he /she reacted that way since he/she is working long hours and I wasn't being understanding when I asked why he/she was always coming home late.").

The World Health Organization (WHO) identified factors which increased risks of domestic violence perpetrated against women. **Some of these factors concerning the male perpetrator include alcohol abuse, having multiple sexual partners outside of the relationship, experiencing abuse as a child, witnessing family violence and abuse throughout childhood and adolescence, and permissive attitudes towards beating one's spouse.**

Stable circumstances such as high socioeconomic status, secondary education, and formal marriage are a few of the protective factors which reduced instances of abusive behavior.

(Please refer to Reference 26)

Elder Abuse

The **Older Americans Act (OAA)** was passed in 1965 by United States Congress to address issues related to providing comprehensive services and care for older adults.

A common healthcare environment where elders experience maltreatment and abuse are nursing homes. In the matter of *Reid v. Axelrod*, 559 N.Y.S.2d 417 (N. Y. App. Div. 1990) the court found an orderly guilty of abusing an elderly resident. When the orderly was struck by a resident's cane, he stated that he pushed the cane so that he would not get hit again. However, the orderly's coworker testified that the orderly struck the resident in the chest after being struck the first time. The court ruled that the orderly was held accountable for abusing the elderly resident.

In addition to the case we previously discussed above as well as common methods of physical abuse (e.g. hitting, slapping, biting, or shoving), physical abuse against elderly individuals may also include being force fed food or medication, physically restraining them, or exposing them to unsafe environments (e.g. leaving them in an environment that is too hot or too cold).

In the case of *In re Axelrod* 560 N.Y.S.2d 573, (N.Y. App. Div. 1990), a health commissioner provided evidence to the court that the medical employee was guilty of resident abuse after forcing the patient to take the medication after refusal. The employee "*held the patient's chin and poured the medication down her throat*." The commissioner noted that there was no evidence of an emergency necessitating the patient to take the medication. The medical chart noted that if the resident refused to take the medication, the employee had to inform the head nurse.

(Please refer to Reference 8)

Although nursing homes are what come to mind for environments where elders may have an increased chance of being abused or neglected, the **home environment** where the elder resides is the more common place where abuse occurs. The elder's spouse or relatives are more likely to be abusive towards the elder if he or she is experiencing high stress (e.g. financial issues related to care or personal/work related issues), has a substance abuse problem, or may have mental health issues (e.g. depression, inability to control anger).

Poor self-care is a common occurrence for cases involving elder neglect. Elderly individuals may face health issues from Alzheimer's Disease, difficulties with mobility (movement), or substance abuse which could affect their ability to take care of their personal hygiene, take medications as directed, keep their environment clean, and have proper nourishment (i.e. eating and drinking adequately).

Financial abuse and neglect are also problems faced by elderly individuals. A few key signs to indicate that financial abuse is occurring (or may be at risk of occurring) include:

- Unexpected financial transactions (e.g. giving money and/or valuables to a family member or caretaker)
- Unexpected changes in financial documents (e.g. changing a will)
- Changes in banking practices (e.g. frequent withdrawals, sudden inclusion of another individual for a joint ownership of bank account)
- Lack of knowledge of financial matters resulting in designating an individual (or individuals) to handle the finances

Elderly individuals may also be victims of sexual abuse. Inappropriate sexual touching, photography, or forced nudity or sexual acts are a few cases of sexual abuse. Forcing an elder to watch pornography or having someone expose himself/herself to the elder (i.e. exhibition) are also considered sexual abuse. Note that as long as the action is performed against the individual's will (i.e. without their consent), it constitutes abuse. **The elder does not have to be physically raped or touched for it to be considered abuse.**

Elders are also vulnerable to psychological abuse and maltreatment. When elders are isolated from social interactions with loved ones and the community, treated improperly (e.g. like a child or humiliated in front of others), or are intimidated and bullied, they may become distressed. In addition to providing nourishment and shelter to take care of an elder's physical needs, they must also be given psychological and emotional support.

Examples may include providing companionship and being available to them when necessary (i.e. not leaving them alone for extended periods of time if they have special

needs). Providing elders with a chance to engage in physical or social activities can have positive benefits.

Employee Assistance Programs

Employee assistance programs (EAP) are confidential supportive services provided for employees and their immediate family members (who reside with them) to assist them with personal issues which may affect their physical or mental health as well as their work performance. EAPs are designed to help individuals identify a problem through confidential assessments and subsequently provide them with services such as counseling or referrals to help them move towards a resolution.

A few key issues may include:

- substance abuse
- finances (e.g. paying off debts or handling creditors)
- mental health (e.g. stress, trauma, depression, or burnout)
- personal (e.g. death of a loved one, marital)

Employers may notice changes in an employee's behavior such as constant tardiness or absenteeism, poor performance in their duties and work responsibilities, neglecting safety procedures, conflicting with coworkers and staff, or issues related to mood (e.g. irritability, anger, or anxiety). These signs could signal that an EAP may be required for an employee. If these signs are left unchecked, the employee may suffer a work related accident or the signs may progressively worsen.

Personal issues may interfere with an employee's work performance (which in turn affects the company's productivity), but finding an effective strategy to assist the employee with his or her problems may be more beneficial than simply punishing the employee or allowing the behavior to go unchecked. However, this does not mean that disciplinary actions cannot be enforced on difficult employees. Through an EAP, the employee's supervisor can monitor an employee's job performance, note improvements or areas which need to be worked on, consult with the EAP professional for guidance, and follow through with disciplinary actions (e.g. warning and appropriate documentation).

Services provided for employees uphold and maintain confidentiality of their personal information. In addition to providing counseling, EAP staff can help coordinate outside services (e.g. rehab treatment facility or medical care) and provide information for the physicians and healthcare professionals who will be in charge of the patient's care. The

employee **must provide** his or her consent to allow the EAP professional to disclose information to the healthcare staff at the facilities.