

**ELDER ABUSE REPORTING OBLIGATIONS:  
How To Keep Rocky From Being KO'd  
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In 2006, the first of the baby boomer generation will turn sixty years old.<sup>1</sup> One of these individuals is Sylvester Stallone, the famous actor who played Rocky Balboa in the film “Rocky” and the painfully numerous sequels thereto. As odd as it may seem, Stallone, the ultimate tough-guy from ‘80’s Hollywood, will join the ranks of those considered frail and vulnerable simply due to his age. Already a rapidly growing segment of the population, the sixty-somethings, or “elderly” as some states define the term, will begin what will be a tremendous surge in population growth. It is estimated that there will be 65 million Americans age 65 or older by the year 2020.<sup>2</sup> This will mean one in six Americans will be “elderly”.<sup>3</sup> As many as 6.5 million of these elders could be the target of abuse.<sup>4</sup> Hopefully by 2020, the same year Rocky IX is to début, governments will have adopted elder abuse provisions that intelligently address the abusive situations. By then, though, it will be too little too late for some.

In 1981, the United States House of Representatives took the initial steps towards enacting legislation that would finally address a problem long overlooked by government and society in general. After six years of debate, the Older Americans Act (OAA) was amended to include federal definitions of elder abuse, neglect, and exploitation.<sup>5</sup> The amendments also included provisions authorizing the use of Federal funds to induce

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<sup>1</sup> <http://www.aoa.gov/press/did%5Fyou%5Fknow/2006/apr/apr%5Fpf.asp>

<sup>2</sup> Jennifer N. Phan, *The Graying of America: Protecting Nursing Home Residents by Allowing Regulatory and Criminal Statutes to Establish Standards of Care in Private Negligence Actions*, 2002 Hous. J. Health L. & Pol’y 297, 302 (2002) [Hereinafter *Graying*]

<sup>3</sup> Id.

<sup>4</sup> See *Fact Sheet: Elder Abuse Prevalence and Incidence*, National Center on Elder Abuse, 2005, 1 [Hereinafter *Fact Sheet*], citing Mark S. Lachs & Karl Pillemer, *Elder Abuse*, *The Lancet*, October 2004, 1192-1263 (stating that the frequency of elder abuse ranges from 2-10%)

<sup>5</sup> 42 U.S.C. § 3001 et seq. (2006)

states and local communities to create elder abuse regulatory programs, as well as for certain elder abuse awareness, training, and coordination activities.<sup>6</sup> The result was a nationwide movement towards regulation of elder abuse through the enactment of numerous variations in state laws. Unfortunately, these efforts have not been enough to combat the problem.

Statistical information regarding elder abuse is difficult to decipher and can vary depending on the source.<sup>7</sup> These discrepancies occur due to the differences in state definitions of terms leading to under- and over-reporting of incidences, the lack of a uniform reporting system for states to adopt, and the fact that no comprehensive national data has been collected.<sup>8</sup> However, according to most estimates, between 1 and 2 million Americans age 65 or older have been abused, neglected, or exploited by someone whom they depend on for care and protection.<sup>9</sup> In 2000, states indicated that 472,813 incidents of elder abuse were reported to authorities, although it is estimated that for every case of abuse, neglect, or exploitation reported, about five more go unreported.<sup>10</sup>

According to the National Elder Abuse Incidence Study conducted in 1996, an estimated 79% of elder abuse cases went unreported to authorities.<sup>11</sup> Of the 236,479 cases that were reported, 115,110, or nearly half, were substantiated after investigation with another ten percent still under investigation.<sup>12</sup> Data on abuse in domestic settings suggest

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<sup>6</sup> 42 U.S.C. § 3058b (2006)

<sup>7</sup> *See Fact Sheet* at 1

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *National Elder Abuse Incidence Study*, The National Center on Elder Abuse, September 1998, p 4-3 [Hereinafter *Incidence Study*]

<sup>12</sup> *Id.* at 4-4.

that 1 in 14 incidents, excluding incidents of self-neglect, come to the attention of authorities.<sup>13</sup>

Of the cases reported, family members account for about twenty percent of the substantiated reports.<sup>14</sup> Healthcare personnel, hospitals and physicians, nurses, and clinics, account for more than twenty five percent of these substantiated reports.<sup>15</sup>

All fifty states and the District of Columbia have enacted legislation authorizing the provision of adult protective services (APS). These services generally provide for a system of reporting and investigation of abuse.<sup>16</sup> These programs vary widely from state to state and have various definitions and scopes of application.<sup>17</sup> Some states have laws specific to institutional communities to account for deficits in APS laws that sometimes only cover those who live in the public community.<sup>18</sup> Long Term Care Ombudsman programs are mandated as a condition of receiving federal funds for each state and represent the bulk of the federal government's response to the problem thus far. These programs, authorized under the OAA, utilize volunteers to advocate on behalf of residents of long term care facilities and sometimes investigate reports of abuse.<sup>19</sup>

Criminal laws are becoming more prevalent in all states, although with varying degrees of harshness.<sup>20</sup> Regardless of abuse specific laws, though, most states' basic

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<sup>13</sup> See *Fact Sheet*, at 1.

<sup>14</sup> See *Incidence Study* at 4-8

<sup>15</sup> *Id.*

<sup>16</sup> *Information About Laws Related to Elder Abuse*, American Bar Association Commission on Aging, 2, 2005, available at <http://www.elderabusecenter.org/pdf/publication/InformationAboutLawsRelatedtoElderAbuse.pdf>

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

criminal laws, such as battery, assault, and rape, cover most types of abuse.<sup>21</sup> Similarly, civil tort actions can also provide relief.

Because of the continued and increasing problem of elder abuse in spite of these state laws, the prior failures of governments to enact legislation against abuse does not seem to have been the problem. The problem now lies more in government failure to recognize the need for more effective “finding tools” for such abuses. According to the American Bar Association, as recently as 1995 eight states had yet to enact mandatory reporting laws penalizing those who fail to report instances of elder abuse.<sup>22</sup> The states that had enacted such laws have penalties ranging from misdemeanors, imprisonment, fines, civil liability, and licensure actions.<sup>23</sup> But are mandatory reporting laws the answer?

Mandatory reporting obligations have long been controversial. Some healthcare providers argue against these statutory provisions on numerous grounds. One such argument against mandatory reporting is that reporting or disclosing personal information regarding patients violates physician patient confidentiality. This confidence is integral to the effective diagnosis and treatment of the patient. Violating this trust may cripple the provider’s ability to render appropriate care. The confidentiality argument is closely tied to another common argument against reporting: that reporting could discourage those being abused from seeking medical assistance. This chilling effect caused by the mandatory provisions could have the opposite effect initially intended.

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<sup>21</sup> *Id.*

<sup>22</sup> *Facts About Law and Elderly: Table 2*, American Bar Association, available at <http://www.abanet.org/media/factbooks/eldt2.html>

<sup>23</sup> *Id.*

Proponents of mandatory reporting argue that the duty of care the provider owes to the patient outweighs his duty of confidentiality, and, therefore, the provider should render the “treatment” necessary to protect the patient’s health. Further, most states’ reporting provisions provide immunity against civil or criminal liability for those who report as long as the report is made in good faith.<sup>24</sup> Therefore, the legislatures have consciously made the determination that the interest the public has in the welfare of these individuals outweighs any duty of confidentiality.<sup>25</sup>

Mandatory reporting is also said to violate an elderly individual’s right to self-determination.<sup>26</sup> These requirements would only further the ageist perception society has against elderly individuals.<sup>27</sup> Stripping the elderly of their right to control and manage their affairs perpetuates the feeling that elderly are helpless and child-like.<sup>28</sup> However, proponents argue that abused elderly are living in more isolated settings with limited access to support systems than those who are not being mistreated.<sup>29</sup> Those who are abused are typically socially isolated and dependent on others, often the abusers, for care.<sup>30</sup> Therefore, the support these individuals need to make a free choice about self-reporting may not be available.<sup>31</sup>

These same concerns and arguments are seen in other public health problems. Public health surveillance of infectious diseases focuses on identifying and controlling persons with communicable diseases through state laws establishing reporting protocols

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<sup>24</sup> See e.g. Fla Stat. § 415.1034 (2006), Ga. Code Ann. § 30-5-4 (2006)

<sup>25</sup> Seymour Moskowitz, *Saving Granny from the Wolf: Elder Abuse and Neglect-The Legal Framework*, 31 Conn. L. Rev. 77, 112 (1998) [Hereinafter *Saving Granny*]

<sup>26</sup> *Id.* at 108

<sup>27</sup> *Id.*

<sup>28</sup> See *id.*

<sup>29</sup> *Id.*

<sup>30</sup> *Diagnostic and Treatment Guidelines on Elder Abuse and Neglect*, American Medical Association, (October 1992), 7 [Hereinafter *AMA Guidelines*]

<sup>31</sup> *Saving Granny*, 31 Conn. L. Rev at 111

for certain reportable infectious diseases.<sup>32</sup> Private physicians believe this mandated reporting violates their duty of confidentiality to their patients. Safeguarding the confidence an individual has with his physician is seen as a higher priority than protecting the population as a whole.<sup>33</sup> As will be discussed though, mandating reporting, as is a popular device used to combat the spread of infectious diseases, may be more effective if a more individualized approach is considered. Better results could be achieved by incorporating the involvement of physicians and their expertise instead of continually placing additional statutory responsibilities and duties on them that conflict with their historical practices.

### **Roadmap**

This paper will analyze the failures of these various laws and offer suggestions regarding proper drafting of more effective laws. With the proper legislation in place, healthcare providers will be better equipped and more motivated to assist in combating this problem. Current mandatory reporting laws, although founded on admirable principles may be improperly placed and over-inclusive. By narrowing these laws, problems and concerns regarding these laws might be reduced.

One of the most cited reasons for failing to report abuse are the providers' concerns regarding the effectiveness of investigative or interventional services. APS programs seem to be under-funded and unable to properly deal with the number of reports they already receive. Mandatory reporting laws that are not properly drafted and therefore are over-inclusive will only enhance this problem and further medical professionals' doubts in regard to the intervention system. Reporting statutes that are

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<sup>32</sup> Lawrence O. Gostin, *Mandatory Reporting of Diseases: Partner Notification*, Public Health Law: Power, Duty, Restraint, (2000), at 116

<sup>33</sup> *Id.* at 120

narrowly drafted should lead to reduced numbers of reports, and, therefore, surplus resources available to APS. However, this should be cautiously approached to ensure the most problematic cases of abuse remain covered. Properly drafted statutes could increase the percentage of reports of substantiated claims while at the same time reduce the number of total reports and thereby reduce the burden on investigative and intervention services.

Properly drafted reporting statutes could also help to alleviate medical professionals' concerns regarding breaches of physician patient confidences. Broad mandatory reporting statutes could chill patients' desire to disclose certain facts during diagnosis and treatment, or worse, chill the desire of a patient to seek medical attention due to fears of retaliation by the abuser or simply fear of embarrassment regarding the situation. This paper will describe how narrowing the reporting statutes and educating patients in regards to reporting obligations could help alleviate this problem

Lack of education regarding elder abuse and the failure of medical personnel to diagnose abuse is another factor that contributes to the overall elder abuse situation. Establishing and promoting a uniform screening procedure would not only help these personnel identify more cases of abuse, but would assist court systems in imposing civil liability by further developing and solidifying a standard of care by which healthcare personnel would be accountable. The paper will discuss various screening and assessment tests already used by healthcare personnel to better understand how a standard of care might be established. As a result, this standard of care could become more widely accepted and understood by patients and other members of the general public, thus leading to more effective enforcement of mandatory reporting statutes through civil

causes of action. A comparison of the penalties involving child abuse reporting will demonstrate how the current penalties maybe misplaced and how better education for medical professionals could ultimately lead to more quality reporting and enforcement.

In additional to medical personnel education, the paper will also explain how patient education regarding reporting laws could assist with the above mentioned confidentiality problem and its chilling effects. A more thorough understanding of how the laws work and when a provider is required to report would help instill more confidence in the physician patient relationship. This paper will discuss how patient education might be achieved using processes commonly utilized in healthcare law.

We will begin by exploring the complexities of current laws. An examination into various states' approaches will enable the reader to understand the problem with greater acuity. The paper will also examine various efforts by other entities and government agencies to combat the problem. State Boards and Agencies, Professional Associations, and private entity policies and procedures could all assist in combating the abuse problem.

The paper will also examine how federal assistance could improve reporting. A comparison of how federal programs have succeeded or failed in other areas, including child abuse and disease surveillance, will show how federal assistance could help alleviate these problems. The paper will also explore how competing models used in child abuse intervention should influence the model for elder abuse intervention.

### **What is Elder Abuse?**

As alluded to above, one major problem facing governments in evaluating the extent of elder abuse and the effectiveness of laws established to combat the problem is

the lack of a uniform dialect for all practitioners and program sponsors to use in calculating numbers of elder abuses. Varying definitions of abuse not only compromises statistical data, but the problem also hinders practitioners in knowing how to recognize when someone is being “abused”. Healthcare personnel, along with other possible reporters, must know how to identify the problem. In order to accomplish this effectively, there must be some uniform understanding of the terms.

Definitions of elder abuse, neglect, and exploitation are broadly defined by the OAA to provide states with guidelines for defining the terms.<sup>34</sup> Although the breadth of these definitions may hinder their effectiveness if adopted by states, it is important for the reader to understand the breadth of definitional possibilities in regards to elder abuse terms. The term "abuse" is defined as “the willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish, or deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness.”<sup>35</sup> Elder abuse is broadly defined as the abuse of an older individual.<sup>36</sup> Abuse includes sexual assault, confinement, verbal, and physical abuse.<sup>37</sup>

Abuse can be actively inflicted physically, sexually, or emotionally<sup>38</sup> Physical abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment, and may include, but is not limited to, such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping,

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<sup>34</sup> *Elder Abuse Awareness Kit*, National Association of Adult Protective Services Administrators, April 2001, at 5 [Hereinafter *Awareness Kit*]

<sup>35</sup> 42 U.S.C. § 3002 (2006)

<sup>36</sup> *Id.*

<sup>37</sup> *Awareness Kit* at 5

<sup>38</sup> *Id.* at 4

kicking, pinching, and burning.<sup>39</sup> In addition, it may also include the inappropriate use of drugs and physical restraints, force-feeding, and physical punishment.<sup>40</sup> Sexual abuse is defined as non-consensual sexual contact of any kind with an elderly or disabled person or with any person incapable of giving consent.<sup>41</sup> It includes but is not limited to unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.<sup>42</sup> Emotional or psychological abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts.<sup>43</sup> Emotional/psychological abuse includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment.<sup>44</sup> In addition, treating an older person like an infant, isolating an elderly person from his/her family, friends, or regular activities, giving an older person the "silent treatment", and enforced social isolation are examples of emotional/psychological abuse.<sup>45</sup>

The term "neglect" means the failure to provide for oneself the goods or services that are necessary to avoid physical harm, mental anguish, or mental illness, or the failure of a caregiver to provide the goods or services.<sup>46</sup> Neglect may also be defined as the refusal or failure to fulfill any part of a person's obligations or duties to an elder.<sup>47</sup> Neglect may include starvation, dehydration, over- or under-medication, unsanitary living conditions, or lack of heat, running water, electricity, lack of medical care, and personal

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<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> 42 U.S.C. § 3002

<sup>47</sup> See *Awareness Kit* at 4-5

hygiene.<sup>48</sup> Neglect may also include failure of a person who has fiduciary responsibilities to provide care for an elder (e.g., pay for necessary home care services) or the failure on the part of an in-home service provider to provide necessary care.<sup>49</sup>

The term "exploitation" means the illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit, or gain.<sup>50</sup> Exploitation is misusing the resources of an elderly person for personal or monetary benefit, and includes taking of Social Security income, abusing a joint checking account, and taking property and other resources.<sup>51</sup>

States define these terms themselves with varying specificity.<sup>52</sup> However, generally, there are three types of elder abuse: 1) self-neglect, also referred to as self-abuse; 2) domestic abuse; and 3) institutional abuse.<sup>53</sup> This paper will generally refer to all of these types of abuse as "elder abuse", and will discuss the reporting obligations that are most likely to affect each.

### **Federal Laws**

As mentioned the Older Americans Act represents the current extent of federal government involvement in elder abuse and neglect issues. Primarily, the OAA provides for elder abuse awareness, training and coordination activities in local and state communities. The Act authorized the Administration on Aging (AoA), a division of the Department of Health and Human services, to create and fund the National Center on Elder Abuse (NCEA). The NCEA is a national resource for elder rights, law enforcement

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<sup>48</sup> *Id.* at 5

<sup>49</sup> *Id.* at 4.

<sup>50</sup> 42 U.S.C. § 3002

<sup>51</sup> See *Awareness Kit* at 4

<sup>52</sup> *Graying*, 2002 Hous. J. Health L. & Pol'y at 302

<sup>53</sup> *Id.*

and legal professionals, public policy leaders, researchers, and the public. NCEA's mission is to promote understanding, knowledge sharing, and action on elder abuse, neglect, and exploitation. As discussed supra, this organization could play a vital role in educating healthcare providers in regards to elder abuse reporting laws.

More importantly, the OAA established and carried out a program for making allotments to States to pay for the cost of carrying out vulnerable elder rights protection activities.<sup>54</sup> The Act authorizes appropriations for state Long-term Care Ombudsman Programs, as well as, programs for the prevention of elder abuse neglect and exploitation, typically Adult Protective Services (APS) programs.<sup>55</sup>

Under Long-term Care Ombudsman Programs, States must establish and operate an Office of the State Long-Term Care Ombudsman Program.<sup>56</sup> The State Ombudsman, or representatives thereof, identify, investigate, and resolve complaints that are made by, or on behalf of, residents of long-term care facilities that relate to action, inaction, or decisions that may adversely affect the health, safety, welfare, or rights of the residents, of providers, or representatives of providers, of long-term care services. In addition, they provide services to assist the residents in protecting the health, safety, welfare, and rights of the residents.<sup>57</sup> This program relies on paid and volunteer ombudsmen to assist in investigations, advocate on behalf of residents, provide information, and work to effect structural changes at the local, state, and national level.<sup>58</sup>

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<sup>54</sup> 42 U.S.C. § 3058 (2006)

<sup>55</sup> *Id.*

<sup>56</sup> 42 U.S.C. § 3058g (2006)

<sup>57</sup> *Id.*

<sup>58</sup> Wei, Gina S., *Reporting Elder Abuse: A Medical, Legal, and Ethical Overview*, Journal of the American Medical Women's Association, (2004), 248-254, 251

The State Ombudsman agency is required to establish a statewide uniform reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities and to residents for the purpose of identifying and resolving significant problems.<sup>59</sup> However, this is not the equivalent to requiring mandatory reporting obligations for certain individuals. This merely requires the agency to have a system of collecting data and reporting instances of abuse to certain other agencies.

### **State Laws**

According to 42 U.S.C. 3058i, States are to coordinate the LTCO programs with other State programs for the prevention of elder abuse, neglect, and exploitation. Usually these laws are in the form of APS programs. All fifty states have APS programs of some sort, however there are numerous variations and methods. Most reporting statutes require reporting instances of abuse to APS programs, however, they differ in the method of reporting, who shall report, how to report, whether reporting is mandatory or voluntary, and the nature of penalties for failing to report when mandatory. Certain variations of these statutes will be discussed in detail below, but in order to understand how to properly structure these statutes, we must first examine the problems facing the APS programs charged with handling the reports of abuse from the mandated reporters.

APS referrals are increasing and becoming more complex, necessitating specialized services and case management.<sup>60</sup> Lack of funding for the programs, deficiencies in staff training, and increases in workloads have lead to the inability of

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<sup>59</sup> 42 USCS § 3058g

<sup>60</sup> Joanne Otto & Joan Cass Bell, *Problems Facing State Adult Protective Services Programs and the Resources Needed to Resolve Them*, Survey Report from the National Association of Adult Protective Services Administrators for the National Center on Elder Abuse (2003), 1 [Hereinafter *Survey Report*]

these programs to effectively manage the reports they have received.<sup>61</sup> The absence of reliable data from state and national sources compound the difficulties in analyzing the effectiveness of these programs.<sup>62</sup> Limited funds being earmarked as mandated by the OAA has become a serious obstacle. Twenty-five percent of state programs that responded to a survey cited the lack of emergency and alternative placement resources as the major problem surrounding APS programs' failures.<sup>63</sup> Problems with law enforcement of reporting obligations are seen as a substantial barrier to almost twenty percent of the state programs.<sup>64</sup> At least one state mentioned that neglect and exploitation cases may sit in the prosecutor's office for six to nine months with no action.<sup>65</sup>

Solutions cited by the programs include additional funding, improved training, public awareness, changes in the role of the federal government, and uniformity among data collection systems.<sup>66</sup> Although these concerns are valid and their solutions apparently worthy of consideration, the solutions to overburdened APS programs should not focus on increased funding to better control demand for services. The proper course of action should focus on filtering out the less serious cases and redirecting these cases to trained professionals who can treat the problems medically, while allowing APS to focus their efforts on the more serious cases where medical intervention would be futile.

As mentioned above, most States have both APS laws and LTCO laws, however these statutes differ greatly in their application. For example, Georgia's APS law is The Disabled Adults and Elder Persons Protection Act, originally enacted in 1981 and

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<sup>61</sup> *Id.* at 3

<sup>62</sup> *Id.* at 4

<sup>63</sup> *Id.* at 3

<sup>64</sup> *Id.* at 4

<sup>65</sup> *Id.*

<sup>66</sup> *Id.* at 5

codified at O.C.G.A. § 30-5-1 *et seq.* However, the LTCO provisions are located at O.C.G.A. § 31-8-51 *et seq.* and O.C.G.A. § 31-8-81 *et seq.* . The LTCO statute defines “abuse” as “any intentional or grossly negligent act or series of acts or intentional or grossly negligent omission to act which causes injury to a resident.”<sup>67</sup> “Resident” is defined as a person receiving treatment at a long term care facility, nursing home, skilled nursing facility, personal care home, or community living arrangement licensed by the department.<sup>68</sup> The APS statute defines “abuse” as “the willful infliction of physical pain, physical injury, mental anguish, unreasonable confinement, or the willful deprivation of essential services to a disabled adult or elder person.”<sup>69</sup> “Disabled adult” and “elder person” both exclude from their respective definitions residents of long term care facilities.<sup>70</sup> Therefore, the mandatory reporting provisions of O.C.G.A. § 30-5-1 *et seq.* do not apply to healthcare providers who render treatment to persons in long term care facilities. Although both laws provide for mandatory reporting obligations under their respective provisions, the LTCO provisions do not provide for a statutory penalty.

This phenomenon is common for state LTCO programs, and highlights one of the glaring deficiencies in the federal program. The discussion below will focus on the APS laws for certain states, as this is usually where the general reporting obligations are more prevalent and more stringent, however, the suggestions rendered in this paper for the improvement of APS legislation designed to prevent elder abuse could be similarly applied to improve LTCO programs.

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<sup>67</sup> Ga. Code Ann. § 31-8-81 (2006)

<sup>68</sup> *Id.*

<sup>69</sup> Ga. Code Ann. § 30-5-3 (2006)

<sup>70</sup> *Id.*

All states have enacted some form of legislation regarding elder abuse, although some have not enacted legislation regarding *reporting* of elder abuse. States vary on numerous aspects of the laws regarding reporting obligations. The most common differences are recognized in regards to definitions of abuse terminology, to whom the statute imposes the duty to report, whether the reporting obligation is mandatory or voluntary, who the statute considers elderly or protected, the standard necessary to invoke the duty, the penalty, and whether immunity is provided. Examples of each of these differences will be outlined below.

As mentioned, Georgia's definition of "abuse" requires willful actions or omissions. However, the reporting statute does not even include the term "abuse", instead requiring certain individuals to report when they have reason to believe "physical injury or injuries [have been] inflicted upon such disabled adult or elder person, other than by accidental means".<sup>71</sup> The statute does, however, include "neglect" which is defined as "the absence or omission of essential services to the degree that it harms or threatens with harm the physical or emotional health of a disabled adult or elder person."<sup>72</sup> Although the definition does exclude accidental injuries, it still imposes an obligation to report those instances occurring as a result of unintentional neglect. This type of neglect could occur as a result of an overburdened caregiver. For instance, unintentional neglect could occur when an elderly husband has assumed the responsibility of caring for his elderly wife and is ill informed regarding essential services such as proper oral hygiene or is ill equipped to provide this type care due to injuries of his own. A report to the state APS by a local dentist upon seeing the woman would create an embarrassing situation for the husband

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<sup>71</sup> O.C.G.A. § 30-5-4 (2006)

<sup>72</sup> *Id.*; Ga. Code Ann. § 30-5-3

when all that is needed is a small intervention that could be accomplished by an oral hygienist while the husband is waiting for his wife's treatment to conclude.

Florida requires reporting when an individual has reason to suspect the protected class is being "abused" or "neglected".<sup>73</sup> "Abuse" includes any "willful act" that is "likely to cause significant impairment" and includes acts or omissions.<sup>74</sup> "Neglect" means a "failure or omission" by the caregiver to provide care and includes "repeated conduct or a single incident of carelessness".<sup>75</sup> Similar to the Georgia statute, this reporting statute broadly includes acts and omissions that could easily be remedied by minimal medical intervention tailored to the specific deficiency without the need to expend the time and resources that involving APS would necessitate. Thus, an appropriate definition of "abuse", as discussed, *infra*, would reduce the amount of unnecessary reports to APS.

The next area that states' APS reporting statutes differ is in regards to whom the statute mandates as a reporter. In other words, who is supposed to do the reporting? Georgia provides a laundry list of people who must report under the statute.<sup>76</sup> Included are law enforcement personnel and medical personnel such as physicians, osteopaths, and other hospital or medical personnel, including interns and residents; dentists, psychologists, chiropractors, podiatrists, pharmacists, physical therapists, occupational therapists, and nursing personnel; coroners, medical examiners, and employees of a public or private agency engaged in professional health related services to elder persons

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<sup>73</sup> Fla. Stat. § 415.1034 (2006)

<sup>74</sup> *See Id.* § 415.102 (2006)

<sup>75</sup> *Id.*

<sup>76</sup> Ga. Code Ann. § 30-5-4(a)

or disabled adults.<sup>77</sup> This non-exhaustive list seems to include all healthcare related individuals from low-level healthcare employees through physicians, dentists, and pharmacists. The statute also includes certain financial institution employees and social workers.<sup>78</sup>

Similarly, Florida's law includes a laundry list of persons bound by the statute.<sup>79</sup> However, this statute goes even further to include "personnel engaged in the admission, examination, care, or treatment" of protected individuals, and even includes spiritual healers in the list of healthcare personnel.<sup>80</sup>

The Texas law is even broader as it applies to any "person".<sup>81</sup> The statute explicitly states that the duty imposed by the statute "applies without exception to a person whose knowledge concerning possible abuse, neglect, or exploitation is obtained during the scope of the person's employment or whose professional communications are generally confidential, including an attorney, clergy member, medical practitioner, social worker, and mental health professional."<sup>82</sup> Therefore, physicians cannot rely on their duty of confidentiality as their reason for failing to report.

California utilizes the term "mandated reporter" to describe who is bound by the statute.<sup>83</sup> A "mandatory reporter" is defined as "any person who has assumed full or intermittent responsibility for the care or custody of an elder or dependent adult."<sup>84</sup> Therefore, this provision apparently only applies to those who undertake an affirmative responsibility, such as healthcare providers, social workers, and guardians. The statute

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<sup>77</sup> *Id.*

<sup>78</sup> *Id.*

<sup>79</sup> Fla. Stat. § 415.1034

<sup>80</sup> *Id.*

<sup>81</sup> Tex. Hum. Res. Code § 48.051 (2006)

<sup>82</sup> *Id.*

<sup>83</sup> Cal. Wel. & Inst. Code § 15630 (2006)

<sup>84</sup> *Id.*

applies regardless of whether or not he or she receives compensation, and includes administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency.<sup>85</sup> However, in order to be required to report the abuse, the mandated reporter must have learned of the abuse within the scope of his employment or in his or her professional capacity.<sup>86</sup>

Each of these approaches to defining “mandatory reporters” includes far too many reporters to be effective. These statutes mandate reports from individuals who have no experience in diagnosing abuse in a clinical situation. Through their training and expertise, upper level professionals like physicians, dentists, and pharmacists have a unique ability to evaluate the extent of an abusive situation or the propriety of the care being rendered to an individual. Including individuals within the mandatory reporters who lack this training and expertise will result in ignorant, false reports being made to APS. That is not to say that these individuals should remain silent when suspicions of abuse and neglect present themselves. These individuals should work together to evaluate the situation and determine the proper course of action, utilizing the skill of the upper level professional in making the final determination. A proper structure for those mandated to report, as detailed, *infra*, will also reduce the number of unnecessary reports.

Who the statute protects is another area where states’ APS laws differ. Some states classify protected individuals by age while others have definitional categories of

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<sup>85</sup> *Id.*

<sup>86</sup> *Id.*

those protected. Many states define elderly as age sixty or over.<sup>87</sup> As mentioned *supra*, Georgia's APS provisions limit the definition of "abuse" to elder persons and disabled adults. The law also defines "elder" as someone sixty-five years of age and older.<sup>88</sup> A "disabled adult" means a person 18 years of age or older who is not a resident of a long-term care facility, but who is mentally or physically incapacitated.<sup>89</sup> Similarly, Texas considers a person age sixty-five and older as an elderly person, however, is more specific in terms of disabled adults.<sup>90</sup> "Disabled person" means a person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for the person's care or protection and who is 18 years of age or older, or under 18 years of age and who has had the disabilities of minority removed.<sup>91</sup>

California also utilizes the "sixty-five years or older" requirement and includes dependant adults.<sup>92</sup> "Dependent adult" means any person between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age.<sup>93</sup> However, "dependent adult" also includes any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility.<sup>94</sup>

The incorporation of any chronological age factor within these statutes is misplaced. Using this arbitrary characteristic as a factor in determining who should be in

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<sup>87</sup> Conn. Gen. Stat. § 17b-450 (2006)

<sup>88</sup> Ga. Code Ann. § 30-5-3(1)

<sup>89</sup> *Id.*

<sup>90</sup> *Compare* Ga. Code Ann. § 30-5-3 to Tex. Hum. Res. Code § 48.002 (2006)

<sup>91</sup> Tex. Hum. Res. Code § 48.002

<sup>92</sup> Cal. Wel. & Inst. Code § 15630

<sup>93</sup> Cal. Wel. & Inst. Code § 15610.23 (2006)

<sup>94</sup> *Id.*

the protected class inserts an ageist philosophy into the statute and unnecessarily infringes on older individuals' rights to self-determination. The ability to refuse assistance, even in the form of investigation, is as important to self-image as the ability to seek and secure that assistance."<sup>95</sup> Those individuals who have no impairment to their ability to make rational decisions regarding their health should not have others' will imposed upon them.

Florida currently uses the term "vulnerable adult" to describe those protected by its statute.<sup>96</sup> "Vulnerable adult" means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.<sup>97</sup> This approach seems to utilize a medical determination of the person's capacity. If properly incorporated into a statute, this concept would be useful in narrowing the scope of abuse claims reported to APS. Otherwise, Sylvester Stallone might get a visit from APS.

States also vary on the level of knowledge required to invoke the application of the laws, although many states recognize an objective "reasonable" standard. For example, in Georgia, the individual is required to report if he has "reasonable cause to believe" there has been an instance of abuse.<sup>98</sup> South Carolina actually mandates "anyone" who has "actual knowledge" of abuse to report the abuse, however, only healthcare providers are mandated to report "likely" abuse.<sup>99</sup> Once again, the breadth of

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<sup>95</sup> Laerence R Faulkner, *Mandating the Reporting of Suspected Cases of Elder Abuse: An Inappropriate, Ineffective and Ageist Response to the Abuse of Older Adults*, 16 Fam. L. Q. 69, 90 (1982) [Hereinafter *Mandating*]

<sup>96</sup> Fla Stat. § 415.1034

<sup>97</sup> *See id.* at § 415.102 (2006)

<sup>98</sup> Ga. Code Ann. § 30-5-4

<sup>99</sup> S.C. Code Ann. § 43-35-25 (2006)

these provisions hampers the effectiveness of these laws. By mandating the reporting of every “likely” instance of abuse, states are effectively restricting the healthcare professionals’ ability to exercise treatment protocols that maybe effective to eliminate the abuse. As with our oral hygiene example, *supra*, the dentist would be forced to contact APS instead of utilizing the capabilities of the healthcare facility in alleviating the likely unintentional neglect. Contacting APS should be reserved for those instances when the healthcare professional feels the abuse is beyond his treating capabilities. The professional “duty”, as explained, *infra*, should only arise when there is a quantifiable risk of harm.

Penalties for failing to report also vary among the states. Ohio, although mandating reporting from a vast array of individuals, has no penalty associated with the statute.<sup>100</sup> Unfortunately, this same scenario is present in Delaware, Maryland, and North Carolina.<sup>101</sup> Although troubling, fashioning penalties to statutes may not be the appropriate response. For example, California, like numerous others, uses a misdemeanor penalty for failing to report elder abuse, punishable by not more than six months in jail, a fine of not more than \$1000, or both.<sup>102</sup> However, should the violation be willful and the abuse result in death or great bodily harm, the penalty is raised to not more than one year in jail, \$5,000 or both.<sup>103</sup> Interestingly, these penalties are the same as those assessed against mandated reporters who fail to report an instance of child abuse.<sup>104</sup> The parallels of these penalties do not reflect the differences in the two problems and once again

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<sup>100</sup> Or. Rev. Stat. § 5101.61 (2006)

<sup>101</sup> Del. Code Ann. tit. 31 § 3910 (2005); Md. Code Ann. [Fam. Law] § 14-302 (2006), N.C. Gen. Stat. § 108A-102 (2006)

<sup>102</sup> Cal Wel & Inst Code § 15630

<sup>103</sup> *Id.*

<sup>104</sup> Cal. Pen. Code § 11166; *See also id.* §11166.01

applies an ageist approach to the solution. Mandatory reporting constitutes an involuntary intervention into a person's life and, therefore, should be thoroughly justified by need.<sup>105</sup> The need for child abuse reporting laws is justified due to the child's inability to act on his own due mostly to his minority status. However, the states' *parens patriae*, as discussed, *infra*, differs in its application in child abuse as compared to elder abuse. These differences should be reflected in the proposed legislation.

Even in states that criminally penalize failures to report, criminal prosecutions are virtually non-existent.<sup>106</sup> Some states believe a better solution to be civil causes of action. Whereas criminal prosecutions are brought at the behest of authorities, civil actions are controlled by the abused, or family members thereof and, therefore, are more likely to be utilized if desired.<sup>107</sup> Four states provide for civil penalties and private causes of action: Arkansas, Iowa, Michigan, and Minnesota.<sup>108</sup> These states have incorporated into their statutes the specific language outlining their citizens' desire to hold those who fail to report civilly liable. At least one state's resistance to read a private cause of action into its criminal statute shows the importance of affirmatively expressing legislative intent.<sup>109</sup>

In Mora, Florida's Court of Appeals ruled that its criminal statute mandating reports of elder abuse does not provide a private civil cause of action.<sup>110</sup> The plaintiff claimed that the statute provided a private cause of action and, therefore, did not make a claim of simple negligence.<sup>111</sup> The Court noted that a 1995 amendment included a section

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<sup>105</sup> *Mandating*, 16 Fam. L. Q. at 80

<sup>106</sup> *Saving Granny*, 31 Conn. L. Rev. at 124

<sup>107</sup> *Id.*

<sup>108</sup> See Ark. Code Ann. § 5-28-202 (2006); Iowa Code § 235B.3 (2006); Mich. Comp. Laws § 16.411 (2006); Minn. Stat. § 626.557 (2006).

<sup>109</sup> *Mora v. South Broward Hospital Dist.*, 710 So. 2d 633 (1998)

<sup>110</sup> *Id.* at 634.

<sup>111</sup> *Id.*

entitled "Civil Penalties".<sup>112</sup> This section provided that anyone named as a perpetrator in a confirmed report of abuse shall be subject to civil fines.<sup>113</sup> This section also provided victims with a private cause of action against the perpetrator of the abuse.<sup>114</sup> However, this section failed to provide civil penalties against those who merely fail to report an incident.<sup>115</sup> Instead, misdemeanor penalties are provided for violation of the mandatory reporting requirements.<sup>116</sup>

The Court concluded that the legislature considered both civil and criminal penalties under the statute but subjected only actual perpetrators of abuse to civil penalties.<sup>117</sup> This, the Court said, is strong evidence of a legislative intent not to provide a civil cause of action for victims against those who fail to report the abuse as required.<sup>118</sup> Further, the amendments made in 1995, mirrored amendments made to the state laws protecting abused and neglected children.<sup>119</sup> Florida courts have consistently refused to impose civil liability for the failure to report suspected child abuse.<sup>120</sup> The Court, however, left open the opportunity for future Plaintiffs to sue under negligence.<sup>121</sup> "We have considered Department of Health and Rehabilitative Services v. Yamuni, 529 So. 2d 258 (Fla. 1988), in which the court held that HRS may be sued for negligence where it failed to prevent the further abuse of a child. However, the plaintiff in Yamuni was not

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<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

<sup>117</sup> *Id.*

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

<sup>120</sup> *J.B. v. Department of Health and Rehab. Servs.*, 591 So. 2d 317 (1991); *Freehauf v. School Bd. of Seminole County*, 623 So. 2d 761 (1993); *Fischer v. Metcalf*, 543 So. 2d 785 (1989).

<sup>121</sup> *Id.*

suing for violation of a statute, but for common law negligence.”<sup>122</sup> Thus, apparently a claim of negligence may have prevailed.<sup>123</sup>

This case shows that the express intent of the legislature must be obvious from the language used in drafting the statute. The negative connotation and relative ineffectiveness of criminal penalties in regards to elder abuse, as discussed, *infra*, should be replaced with a more appropriate approach utilizing civil causes of action that sound in medical malpractice. Similar to many states’ informed consent laws, statutes regulating elder abuse should outline the process medical professionals should use when treating victims of elder abuse. And following this established model, medical malpractice is the appropriate cause of action for suits questioning deviations from this process. But claims of medical malpractice would face an uphill battle as well unless the statutes expressly provided the appropriate tools.

### **Medical Malpractice**

In order to prove medical negligence, one generally must establish a duty owed to the Plaintiff by the Defendant, a breach of that duty, a causal connection between the breach and the resulting injury, and the damages resulting therefrom. There could be varying theories put forth to establish a duty in an action for failing to report an instance of suspected abuse. First, a duty may arise from the special relationship that exists between physicians and patients.<sup>124</sup> However, courts maybe reluctant to impose a duty upon a professional whose job does not necessarily require diagnosing and treating abuse symptoms. For example, orthopedists arguably may not have a duty to diagnose and treat sexual abuse. Similarly, gynecologists arguably may not have a duty to diagnose

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<sup>122</sup> *Id.*

<sup>123</sup> *See id.*

<sup>124</sup> *AMA Guidelines* at 22

psychological abuse. Alternatively, Courts could rely on, contrary to the Mora decision, the reporting statutes themselves provide an affirmative duty.<sup>125</sup> This duty could arguably include the duty to screen and diagnose regardless of the medical specialty.<sup>126</sup> Without express legislative intent, though, courts maybe reluctant to find a duty, and even if the Courts found a duty in one of these examples, establishing a breach of that duty would be tough due to the varying standards of care for each specialty in regards to diagnosing and treating the abuse.<sup>127</sup>

Once a duty has been established, the court must determine what the appropriate standard of care is and whether that standard was followed. Standards of care are clinical diagnosis and treatment policies that are formed over time through accepted protocols, guidelines, and peer discussions.<sup>128</sup> Expert testimony is necessary to establish what exactly the standard calls for.<sup>129</sup> Experts may utilize protocols and guidelines from professional authorities, as well as knowledge gained through their own experience and practice, to testify regarding whether the Defendant's action or inaction fell below accepted levels.<sup>130</sup>

One such resource for professional standards might be guidelines produced by the American Medical Association. These guidelines outline an approach physicians can use to facilitate recognition of elder abuse and neglect.<sup>131</sup> There are numerous protocols designed to assist the physician in determining whether mistreatment is present.<sup>132</sup> The

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<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

<sup>127</sup> See, e.g. *Mora*, at 634

<sup>128</sup> *Saving Granny*, 31 Conn. L. Rev. at 129

<sup>129</sup> *Id.* at 130

<sup>130</sup> *Id.*

<sup>131</sup> *AMA Guidelines* at 5

<sup>132</sup> See, e.g. Nelson, H. et al., *Screening Women and Elderly Adults for Family and Intimate Partner Violence: A Review of the Evidence for the U.S. Preventive Services Task Force*, *Annals of Internal*

protocols may include narratives or checklists and may include direct questions to the patient regarding abuse or neglect.<sup>133</sup> The AMA suggests protocols available from Beth Israel Hospital in Boston, Massachusetts or Harborview Medical Center in Seattle, Washington.<sup>134</sup> Most importantly, the AMA suggests that all clinical settings should have a protocol for the detection and treatment of elder mistreatment.<sup>135</sup> Therefore, regardless of the specialty, if the standard of care was properly established, all specialties, including the examples above, would be bound to adhere thereto.<sup>136</sup>

The common down-fall for many of these protocols is the difficulty practitioners encounter in distinguishing between normal elderly injuries and those occurring due to abuse.<sup>137</sup> However, as discussed, *infra*, adopting a “team” intervention approach would assist practitioners in diagnosing and treating victims of abuse.

If a practitioner fails to utilize some sort of diagnostic assessment tool, or fails to properly diagnose abuse after performing the assessment, the court, or jury as the case may be, may find the practitioner negligent. However, the Plaintiff must also be able to establish the causal connection between the injuries suffered and the negligent act or omission.

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Medicine, March 2, 2004, 387-404; Meeks-Sjostrom, D., *A Comparison of Three Measures of Elder Abuse*, *Journal of Nursing Scholarship*, 247-250 (2004)

<sup>133</sup> *Saving Granny*, 31 Conn. L. Rev. at 121

<sup>134</sup> *AMA Guidelines* at 8

<sup>135</sup> *Id.* at 8

<sup>136</sup> Another such protocol is the Elder Assessment Instrument (EAI). The Elder Assessment Instrument (EAI) is a 41-item Likert scale assessment instrument that has been in literature since 1984. This protocol is comprised of seven sections that review signs, symptoms and subjective complaints of elder abuse, neglect, exploitation and abandonment. There is no “score” and the assessment takes approximately 10-12 minutes. A patient should be referred to the appropriate authorities if there is any evidence of mistreatment without sufficient clinical explanation, whenever there is a subjective complaint by the elder of mistreatment, or whenever the clinician believes there is high risk or probable abuse, neglect, exploitation, abandonment. Fulmer, T., *Elder Abuse and Neglect Assessment*, *Journal of Gerontological Nursing*, January 2003, 8-9

<sup>137</sup> Interview with Dr. John H. Dorminy, III, M.D., OB/GYN (April 16, 2006)

Plaintiffs must establish that, but for the professional's failure to report, the damage subsequent to the omission would not have happened.<sup>138</sup> The Defendant would argue that the acts of the perpetrator supercede or cut off liability for the practitioner's negligence.<sup>139</sup> However, as stated in the Second Restatement of Torts, "if the likelihood that a third person may act in a particular manner is the hazard or one of the hazards which makes the actor negligent, such an act whether innocent, negligent, intentionally tortious, or criminal does not prevent the actor from being liable for harm caused thereby."<sup>140</sup> Therefore, the acts of the perpetrator arguably do not cut off liability. Regardless of this legal premise, a properly structured duty expressed in the statute, as detailed, *infra*, would prohibit the court in finding an intervening superceding cause. No only would this have an affect on the causal connection required for medical negligence, this may also have an effect on the amount of damages imputed to the practitioner.<sup>141</sup>

Proving damages in the elder abuse reporting malpractice case also presents unique problems for Plaintiffs. Intervening causes may deplete the amounts recoverable from the medical professional because of the harm attributable to the various factors that contributed to the injury. Also, although the Plaintiff could successfully claim bodily harm, financial loss, and medical expenses, loss of earning capacity and loss of consortium claims have less value in elder cases than in other tort cases.<sup>142</sup> Further complicating matters, elderly individuals generally have more physical problems than other classes of individuals, therefore, ascribing a cause to those injuries could be

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<sup>138</sup> *Saving Granny*, 31 Conn. L. Rev. at 146

<sup>139</sup> *Id.*

<sup>140</sup> Restatement (Second) of Torts 449 (1965)

<sup>141</sup> *Saving Granny*, 31 Conn. L. Rev. at 156-157 (explaining the risks and rewards of impleading the perpetrator)

<sup>142</sup> *Id.* at 148

extremely difficult.<sup>143</sup> Once again, a properly drafted mandatory reporting statute could assist in curing these problems. But states should not limit their focus on the mandatory reporting statutes when fashioning a response to the elder abuse reporting problem.

### **Licensing**

Although exorbitantly expensive in some areas, healthcare providers can purchase liability insurance to provide protection from malpractice claims. However, professional licensing sanctions in the form of suspension or revocation cannot be insured and can be much more devastating to a healthcare provider.<sup>144</sup> Thus, these type penalties could prove more effective than civil penalties.<sup>145</sup> These sanctions threaten practitioners' livelihoods and standing within their community and their profession.<sup>146</sup>

Although the majority of states do not have provisions addressing licensing in relation to failures to report elder abuse, there are numerous approaches states have used in implementing license sanctions. The first approach is to incorporate licensing notification within the statutory scheme. Alaska provides that if a person convicted under its mandatory reporting provision is a member of a profession or occupation that is licensed, certified, or regulated by the state, the court shall notify the appropriate licensing, certifying, or regulating entity of the conviction.<sup>147</sup> Some states simply rely on statutes that allow discipline if the physician is found to have engaged in negligent practice.<sup>148</sup> This, however, would most likely require a judicial determination of liability as a prerequisite to sanctions.

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<sup>143</sup> *Id.*

<sup>144</sup> *Saving Granny*, 31 Conn. L. Rev. at 160

<sup>145</sup> *Id.*

<sup>146</sup> *Id.* at 161

<sup>147</sup> Alaska Stat. § 47.24.010 (2006)

<sup>148</sup> Mich. Comp. Laws § 333.16221 (2006)

A more direct approach is presented in the District of Columbia Code whereby “any health-care administrator or health professional licensed in the District who willfully fails to make a report..., or willfully makes a report ...containing information that he or she knows to be false, shall be guilty of unprofessional conduct and subject to any sanction available to the governmental board, commission, or other authority responsible for his or her licensure.”<sup>149</sup>

Other states, including Georgia, have enacted statutes not directly relating to elder abuse reporting that allow sanctions against any physician who violate state laws regarding the practice of medicine in general.<sup>150</sup> Therefore, any violation of law that relates to the practice of medicine could subject the physician to sanctions. Georgia also imposes a duty upon insurers to notify the Composite State Board of Medical Examiners whenever a judgment is rendered or settlement is reached concerning a medical malpractice claim regardless of the amount.<sup>151</sup> Any appropriate legislation aimed at improving elder abuse reporting should include some form of licensing consequences for failures to adhere to the standard of care. Any of these approaches could be effective, however, if adopted as part of a comprehensive package, the legislature should adopt a licensing review process that would compliment the reporting statute and provide for a lower trigger point whereby the actions of the medical professional would be reviewable. This would provide added incentive for the professional to adhere to the statutory procedures and provide an alternative means of enforcement in case the affected individual failed to bring a civil action.

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<sup>149</sup> D.C. Code § 7-1912 (2006)

<sup>150</sup> *See e.g.*, Ga. Code Ann. § 43-1-19 (2006)

<sup>151</sup> Ga. Code Ann. § 33-3-27 (2006)

## Accreditation

For the same reasons licensing affects practitioners, accreditation should influence healthcare organizations to establish similar policies and procedures for dealing with elder abuse. The Joint Commission on the Accreditation of Healthcare Organizations evaluates and accredits more than 15,000 health care organizations and programs in the United States.<sup>152</sup> This independent, not-for-profit organization is the nation's predominant standards-setting and accrediting body in health care.<sup>153</sup> The Joint Commission's comprehensive accreditation process evaluates an organization's compliance with these standards and other accreditation requirements.<sup>154</sup>

In the hospital manual standard PC.3.10 for identifying victims of abuse, at EP 6 requires "all cases of possible abuse or neglect are reported to the appropriate agencies according to hospital policy and law and regulation". Further, EP 7 states "all cases of possible abuse or neglect are immediately reported in the hospital". These standards, however, merely require an organization to include these standards within their policies and procedures.

However, the accreditation process could be useful as an incentive for healthcare organizations to follow the statutory mandates. Consequentially, this would only indirectly influence individual healthcare professionals to abide by these standards. Also, this does not provide a quantifiable and meaningful incentive to those professionals who are not directly associated with the hospital, especially in sparsely populated areas containing a single regional hospital with a uniquely captive market. These providers have but one choice of hospital regardless of its accreditation. A proper scheme to

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<sup>152</sup> [http://www.jointcommission.org/AboutUs/joint\\_commission\\_facts.htm](http://www.jointcommission.org/AboutUs/joint_commission_facts.htm)

<sup>153</sup> *Id.*

<sup>154</sup> *Id.*

combat elder abuse should provide an incentive to practitioners in institutional settings as well as those in private practice settings. The proposed approach addresses this concern and explains the role of JCAHO in its efforts to provide a tangible incentive to all practitioners.

### **How to Improve Reporting**

Federal legislation could provide invaluable assistance to state programs. Some scholars propose that elder advocates should take lessons from the development of child abuse protection efforts.<sup>155</sup> They believe focusing on changing attitudes toward the elderly and engaging the medical community are the keys to successfully changing our current system of elderly protection.<sup>156</sup> Although most of this type effort would be in educating the general public and the medical community, support for these type educational programs originates from federal legislation.

The federal Child Abuse Prevention and Treatment Act is the primary resource for states to rely when enacting and implementing legislation regarding child abuse. Besides providing minimum definitions of abuse terminology, the Act authorizes grants to states for the improvement of child protective services.<sup>157</sup> This is accomplished through the intake, assessment, screening, and investigation of reports of abuse and neglect, developing and facilitating training protocols for individuals mandated to report abuse and neglect, and developing and facilitating research-based strategies for training individuals mandated to report child abuse and neglect.<sup>158</sup> Under the Act, all 50 states

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<sup>155</sup> Nina A. Kohn, *Second Childhood: What Child Protection Systems Can Teach Elder Protection*, 14 Stan. L. & Pol'y Rev. 175, 184

<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> *Id.*

have passed laws mandating the reporting of child abuse and neglect.<sup>159</sup> Each state is responsible for providing its own definition of child abuse and neglect, describing the circumstances and conditions that obligate mandated reporters to report known or suspected child abuse, providing definitions for juvenile/family courts when to take custody of the child, specifying the forms of maltreatment that are criminally punishable.<sup>160</sup> The Act also mandates a report on the effectiveness of the state voluntary reporting laws.<sup>161</sup> Federal legislators should model federal elder abuse legislation in a similar fashion. CAPTA provides the model for a foundation of support for states that desire to enact better elder abuse reporting laws.

On November 16, 2005, the United States Senate introduced the Elder Justice Act<sup>162</sup> Originally introduced in 2002, this Act would provide numerous grants for abuse research, clinical practice, and training facilities, shelters, and nonprofit volunteer programs providing abuse services.<sup>163</sup> It would also authorize the Attorney General to award victim advocacy grants and grants for specialized support for local and state prosecutors handling elder abuse related cases.<sup>164</sup> The Bill also provides for reporting to law enforcement officials crimes occurring in federally funded long-term care facilities.<sup>165</sup>

The bill also provides \$3.9 billion over seven years. Of that, for the first time, the federal government would directly fund \$300 million per year for state Adult Protection Services programs. The bill also includes a mandate to the Attorney General to examine

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<sup>159</sup> *Id.*

<sup>160</sup> *Id.*

<sup>161</sup> *Id.*

<sup>162</sup> S. 2010, 109<sup>th</sup> Cong. § 1 *et seq.* (2006)

<sup>163</sup> *See id.*

<sup>164</sup> *Id.* at § 204

<sup>165</sup> *Id.* at § 207

state laws and report on their effectiveness in areas such as definitions and mandatory reporting. Within two years from enactment, the bill requires recommendations for model state laws regarding elder abuse.

A similar bill was introduced into the House on March 16, 2006, however both have been sent to committees.<sup>166</sup> This seems like a step in the right direction, however, a version of the Elder Justice Act has been introduced in every term of Congress since 2002 with little success at progressing past committee, although a 2004 version passed out of the Finance Committee.

The legislation proposed below could be included within the Elder Justice Act, however, this would most likely be met with even greater resistance from the healthcare industry, making the success of the Act even less likely. If the proposed legislation were included, though, the need for additional funding to APS would be lessened. Easing the burden on the budget may lead to more support for the bill.

If the federal government wishes to become more proactive in the battle against elder abuse, the means to establish an effective statutory structure are available and could be utilized. Statutes mirroring other federal provisions could be proposed as model laws to assist states in amending their reporting statutes. The Emergency Medical Treatment and Active Labor Act, or EMTALA, was enacted in response to the perceived crisis in the healthcare industry regarding “patient dumping”, a term used to describe how private hospitals, after learning of a patient’s lack of insurance, were refusing to treat patients and instead were transferring them to public hospitals. Under EMTALA, if a hospital has an emergency department, if any individual comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical

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<sup>166</sup> *Id.*; HR 4993, 109<sup>th</sup> Cong. (2006)

condition, the hospital must provide for an “appropriate medical screening” examination within the capability of the hospital's emergency department, to determine whether or not an emergency medical condition exists.<sup>167</sup> If the hospital determines that an emergency medical condition exists, it must provide “stabilizing treatment” within its capabilities or make an “appropriate transfer” of the patient.<sup>168</sup>

Other provisions of EMTALA require the hospital to retain medical records of patients,<sup>169</sup> and to post signs regarding patients’ rights.<sup>170</sup> Further, upon information regarding a reported violation, investigators have the ability to review medical records from each hospital to determine the hospital’s compliance.<sup>171</sup> If a hospital fails to meet the requirements of EMTALA, the government may terminate the hospital’s Medicare Medicaid provider agreement.<sup>172</sup>

Adopting a similar form of legislation as a model for states to adopt could provide the basis for a more effective abuse reporting structure. Federal recommendations, however, are not always followed. For instance, the Centers for Disease Control publish a list of recommended diseases for states to adopt in regards to their mandatory infectious disease reporting. Of the fifty eight diseases and conditions recommended for national reporting, thirty five, or sixty percent, were reportable in greater than ninety percent of the states and territories.<sup>173</sup> States need an incentive for adopting this legislation.

As an incentive for adopting this model form of legislation, the federal government could threaten to lower the proportion of Medicaid benefits it pays to states.

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<sup>167</sup> 42 USCS § 1395dd (2006)

<sup>168</sup> *Id.*

<sup>169</sup> 42 C.F.R. § 489.20 (2006)

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

<sup>172</sup> *Id.*

<sup>173</sup> Sandra Roush, et al, *Mandatory Reporting of Diseases and Conditions by Health Care Providers and Laboratories*, *Journal of American Medical Association*, July 14, 1999, 164-70

Revocation of Medicare provider agreements could also be used to encourage those in healthcare that are covered by the laws to comply.

### **Revise State Reporting Statutes or Adopt the Federal Model**

Mandatory reporting is a finding tool for abuse cases.<sup>174</sup> In such, the statutes themselves do not solve the problem, but instead identify the problem so that it may be addressed. However, to be justified, the statute, beyond case finding, should hold out promise of services and solution.<sup>175</sup> Thus far, according to the Survey Report from the National Association of Adult protective Services, the services are not properly accessible to those who need them.<sup>176</sup> In order to combat elder abuse, mandatory reporting laws must become more narrowly tailored to fit the characteristics of those whom it seeks to protect. This narrowing will reduce the numbers of reports APS will need to address and increase the proportion of serious claims of those that remain within its jurisdiction.

The proposed approach includes a much more prominent role for healthcare professionals. As elder abuse is considered a “health” issue, healthcare professionals should be tasked to render care in its regard. However, most scholars view elder abuse as a “public health” issue, and forming an individualized treatment approach to the problem may not be consistent with typical public health approaches that normally address problems on a more generalized and universal approach. The proposed approach assumes that the healthcare professionals actually are practicing their profession for the appropriate reason: to use their expertise to make the sick well. Labeling healthcare professionals as villains for failing to report abusive situations ignores the basic notion

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<sup>174</sup>*Mandating*, 16 Fam. L. Q. at 76

<sup>175</sup> *Id.*

<sup>176</sup> *See Survey Report*

that healthcare professionals wish to help patients and do not wish harm upon their patients. Healthcare professionals not only have an ethical duty to provide care for the patients they treat, but, even more so than the other citizens composing civilized societies, also have a personal moral obligation to protect those in need from harm.

But physicians would not be alone in the treatment of abusive situations. The healthcare professional, together with the social service staff from hospitals, would represent an interdisciplinary “intervention team” that could treat the victim and the abuser by educating the abuser on how to properly care for the patient. These teams would be composed of hospital social workers and medical professionals especially adept at handling abusive situations.<sup>177</sup> Coordinated through the hospital, physicians in a private practice could utilize these resources similar to any other resource in a hospital with which they have privileges. Effectively this would shift some of the burden of managing abuse cases from APS to the hospital.

Given the proper legal foundation, this approach would provide healthcare professionals with the opportunity to do what they do best: diagnose and treat their patients. To accomplish this goal of refocusing elder abuse reporting, though, appropriate definitions, inclusion of tailored interventions<sup>178</sup>, and civil causes of action must be the primary focus of state reporting statutes.

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<sup>177</sup> The Department of Social Work Services at the Mount Sinai Hospital was awarded a grant from the State of New York to provide direct services to elder abuse and neglect victims. The Mount Sinai Elder Abuse Program utilizes a high-risk intervention team coordinated by a social worker. Fay S. Kahn & Barbara E.C. Paris, *Why Elder Abuse Continues to Elude the Healthcare System*, *The Mount Sinai Journal Of Medicine*, January 2003, at 62-63

<sup>178</sup> See Mahnaz Ahmad & Mark S. Lachs, *Elder Abuse and Neglect: What Physicians Can and Should Do*, *Cleveland Clinic Journal of Medicine*, October 2002, at 801-808

Some argue that one problem with the elder abuse reporting model as currently adopted is that it is based on the child abuse model<sup>179</sup>. These abuse problems are not necessarily identical. The application of the physician patient relationship highlights the differences in the two types of abuse. The mandatory reporting provisions are based on states acting as *parens patriae*. This doctrine was adopted from the English sovereign's duty to protect the property of subjects too incompetent to handle their own affairs.<sup>180</sup> Over time, states have used this doctrine as an exception to the generalized rule that adults are free to live as they choose so long as other are not harmed.<sup>181</sup> This exception gives them the power to protect those that cannot protect themselves.<sup>182</sup>

The physician patient relationship provides the basis for the mandatory reporting model for child abuse and incorporates this notion of *parens patriae*.<sup>183</sup> Under physician patient confidentiality principles, it is the patient's right to either assert or waive the physician patient privilege.<sup>184</sup> However, when the patient is a minor child, this matter is complicated because the right of the minor child is vested in the parent and not the patient.<sup>185</sup> Therefore, the parent could ultimately shield the person who caused injury to the child by not waiving the privilege.<sup>186</sup> Accordingly, Courts have routinely held that the best interests of the child override the parent's right to assert a possible self-protective privilege on the patient's behalf.<sup>187</sup>

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<sup>179</sup> *Mandating*, 16 Fam. L. Q. at 74

<sup>180</sup> *Id.* at 76

<sup>181</sup> *Id.* at 79

<sup>182</sup> *Id.*

<sup>183</sup> Also pertinent to this discussion is the physician patient privilege exceptions designed to expose criminal offenders. The provisions for reporting violent crimes like gunshot wounds presume that a patient would not assert the privilege of confidentiality unless he/she was party to the crime. *See id.* at 83.

<sup>184</sup> *Id.* at 82-83, note 70

<sup>185</sup> *Id.*

<sup>186</sup> *Id.*

<sup>187</sup> *Id.*

This principle of protecting those who cannot protect themselves does not necessarily apply to all elder abuse situations and represents ageist principles. Of course, some elderly individuals have some physical or mental incapacity that would render them vulnerable and may justify this protective action, but arbitrary age designations, on which definitions in most states rely, do not focus on the characteristics that render these individuals vulnerable. Just as a man fifty-five years old could be incapable of caring for and protecting himself, an eighty-year-old woman could be perfectly capable of making rational decisions regarding her care and protection.

On the other hand, minors, until they reach a certain age, are incapable of caring for themselves and making rational decisions regarding their care regardless of their maturity relative to their age. Human biological development for the first twenty years varies from person to person little compared to biological effects aging has in the latter years of life. Our society has appropriately chosen ages below which minors are not legally capable of executing certain decisions. Due to biological development, the age determinations for minors reaching capacity and no longer needing protection are much less arbitrary than age determinations whereby older individuals become incapacitated and in need of protection. In this respect, child abuse differs from elder abuse. Therefore, the child abuse model maybe misplaced in the elder abuse context.

The creation of a duty to protect older individuals should not be arbitrarily set by a reporting statute. The statute instead should give rise to a duty to screen and treat arising from a reasonable suspicion of abuse. However, a duty to report should also be included for a diagnosis of abuse that has progressed beyond the treating capabilities of

the physician. In this respect, elder abuse reporting statutes could learn from legal precedent established in other reporting obligations relating to issues in public health.

In *Whalen v. Roe*, the Court held that a New York statute that effectively mandated reporting by physicians of certain prescribed drugs did not impinge on any right or liberty.<sup>188</sup> The Court found that the statute was a reasonable exercise of the state's police power.<sup>189</sup>

In *Tarasoff v California Board of Regents*, the California Supreme Court found, without specific statutory authority, that a medical professional owes a duty to warn when there is a foreseeable threat of harm.<sup>190</sup> The Court stated that when a therapist determines that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.<sup>191</sup> In meeting this duty, the therapist might be required to take one or more of various steps, depending upon the nature of the case.<sup>192</sup>

Taken together, these cases could provide a foundation for a mandatory reporting statute limited to those instances where the duty arises from a serious and foreseeable threat of harm. Creating such a duty would be a valid exercise of the state's police power.

Reporting duties infringe upon a citizen's right of self-determination.<sup>193</sup> States have a qualified power to infringe upon these rights when the law is rationally related to a public interest. But, a statute should not impose a duty to report that would infringe on this right merely because it is in the public interest to do so. Instead, reserve this

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<sup>188</sup> 429 U.S. 589, 603 (1977)

<sup>189</sup> *Id.*

<sup>190</sup> 17 Cal.3d 425, 431 (1976)

<sup>191</sup> *Id.*

<sup>192</sup> *Id.*

<sup>193</sup> *See, e.g., Saving Granny*, 31 Conn. L. Rev. at 108

infringement to those instances where there is a serious and foreseeable threat of harm to the individual.

The reporting statutes should reflect the patient's ability to make decisions if they have the capacity to do so. This, of course, would require a medical review of the individual's situation. Healthcare professionals are the most properly equipped personnel to accomplish this feat. The proposed statute reads, in part, as follows:

- (a) Any physician, regardless of specialty, who reasonably suspects abuse or neglect of any kind upon an adult shall provide an appropriate medical screening to determine if abuse has occurred. If upon completion of an appropriate medical screening, it is determined that abuse has occurred, the medical professional shall provide intervention and/or treatment to the adult in accordance with accepted medical practices;
- (b) If any physician, regardless of specialty, reasonably suspects willful abuse or neglect upon a vulnerable adult that the professional believes, to a reasonable degree of medical certainty, either: 1) will result in continued or increased substantial harm to the individual, or 2) will not be substantially reduced or eliminated in accordance with accepted medical interventions and/or treatments, shall report the abuse to APS;
- (c) Any other medical personnel who reasonably suspects abuse or neglect upon an adult shall report such abuse to the adult's physician and assist in intervention and/or treatment in accordance with accepted medical practices. If the adult does not have a physician, or the adult's physician is unknown, the medical personnel shall make an appropriate referral to a physician.

The proposed approach is specific as to which definitions of "abuse" are required to be reported. Reportable abuse should not be broadly defined to include all harms to elderly individuals. Some harms can be averted in the future through simple medical intervention. APS referrals should be reserved for only seriously abusive situations. Accidental injuries caused by an overburdened or uneducated caretaker would not be

reportable unless the healthcare professional believed intervention and treatment would not be effective.

Mandatory reporting would be solely the duty of the physician. These professionals through their education and expertise are in the best position to determine when alternative intervention is needed. The duty would arise based on the medical judgment of the physician. Therefore, the physician does not have an elevated duty except to provide and appropriate screening. He/she must exercise their professional duty of care in determining the course of intervention.

However, other medical personnel, i.e. medical professionals and those associated with healthcare, would have a duty to inform the adult's physician whenever they reasonably suspect abuse. If the adult's physician is not known, then the medical personnel must make an "appropriate referral" to a physician. An "appropriate referral" of a patient to a physician could be defined as taking reasonable measures to ensure the patient kept a doctor's appointment. This could be accomplished by following up with the patient and scheduling appointments for the patient. Under this approach, the physician, not APS, would filter the claimed reports of abuse, leaving only those that are supported by medical evidence to be reported to APS.

To ensure that the patient's health insurance status, or inability to pay, does not hinder the patient's access to an appropriate medical screening, the statute could provide that there shall be no delay in providing an appropriate medical screening due to the patient's ability to pay.

The legislature could also draft a statute, similar to the South Carolina statute, mandating those in the general public to report known instances of abuse. This type

statute is narrowly tailored enough to remain effective. If the statute were to mandate all citizens who reasonably suspect abuse, it would impose a duty on those who are not trained in diagnosing injuries resulting from abuse, and, therefore, would lead to increased reports of unsubstantiated abuse claims, thus wasting APS assets on investigations. However, if someone in the general public has actual knowledge of an abusive situation, the duty to report arises. Thereafter, APS could determine the proper course of intervention, which could include referral to a medical professional for screening and intervention.

The proposed statute does not create an arbitrary age factor that would give rise to the duty. Medical professionals would have the duty to screen regardless of the person's age or physical or mental capacity. However, the duty to report would be limited to those cases where the individual is "vulnerable". This represents a policy stance that those individuals who are not incapacitated should still retain the right to self-determination. If, to a reasonable degree of medical certainty, the person is not suffering from diminished capacity, the physician patient confidentiality privilege still remains with the patient.

The reporting cases are limited to those instances where the abuse is reasonably suspected to be willful. This will avoid APS involvement with abuse and neglect that is merely accidental or negligent. Medical professionals and intervention teams should be effective in handling accidental and negligent abuse and neglect. Once again, this would reserve APS for those situations that pose a serious threat to harm.

Healthcare professionals, when faced with willful abuse, would be required to make a determination as to whether the abuse could be effectively treated before the statute mandated that the abuse be reported. Treatment of these types of abuse would

present novel issues for most medical professionals. The statute would require the professional to consult with intervention teams to determine a proper course of treatment for not only the patient but the caretaker/abuser as well. The teams could provide referrals of victims for follow-up medical care, ongoing social involvement or continued counseling, reassurance telephone calls to monitor victim's safety in the community, home visits to victims who are too frail to come to the hospital or doctor's office, placements of victims in assisted living facilities and involvement of APS. To help with those patients who cannot afford the interventions offered, the team social workers could advise the individuals on Medicare and Medicaid applications and benefits. The physician could continue to treat and monitor the patient as medically needed.

JACHO could also play a part in funding the resources necessary to establish this type statutory process. By offering awards programs to those healthcare organizations meeting certain higher standards, hospitals would have incentive to create these intervention teams. Also, many hospitals already have social workers on staff. JACHO could amend its standards for accreditation to include policies and procedures for creating and operating these type intervention teams. The minimal costs to hospitals for creating these teams could be recouped in part by the treatment charges associated with the interventions. The positive reinforcement created by the accreditation and certification programs are a valuable alternative to penalties associated with failing to report. In addition, the accreditation standards will act as an enforcement tool by risking losing accreditation if the hospital fails to comply with the standards.

One such certification program is the Disease-Specific Certification Program. According to JCAHO, "while accreditation ensures an organization's overall commitment

to quality, certification demonstrates excellence in fostering better outcomes by the integration and coordination of care.” Certification is designed to evaluate disease management and chronic care services that are provided by hospitals. The evaluation and resulting certification decision is based on an assessment of compliance with consensus-based national standards, effective use of established clinical practice guidelines to manage and optimize care, and an organized approach to performance measurement and improvement activities. With JCAHO’s approval, elder abuse could become one of the “diseases” covered by the certification program. The standards required for certification could also include criteria for creating and operating intervention teams.

### **Enforcement**

The proposed legislation provides for a reduced burden on enforcement as well. The physician’s obligations do not differ from those he already encounters on a daily basis. The duties contained within are tailored to turn on the medical judgment of the physician. Therefore, any concern regarding the physician’s failure to screen, treat, or report is enforceable through private causes of action sounding in medical malpractice. However, to ensure this is properly applied by the court system, the statute should contain explicit language to this affect. Malpractice suits are generally viewed as more effective than criminal sanctions.<sup>194</sup>

There are three areas that may present a potential cause of action under the proposed statute. The first cause of action would be whether the medical professional was reasonable in not suspecting abuse. A second cause of action could be whether the screening procedure performed was an “appropriate screening”. The above mentioned screening procedures may determine the standard for this analysis. The third cause of

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<sup>194</sup> *Saving Granny*, 31 Conn. L. Rev. at 118

action could be regarding the intervention and/or treatment and whether it was appropriate under the circumstances.

Like many of the statutes already in force, the statute would provide immunity for any good faith reporter. However, unlike many of the statutes, no criminal sanctions are available for failing to report.

Licensing sanctions would also be an important enforcement tool. Similar to the Georgia statute mentioned above, states could require insurance companies to notify the appropriate Medical Board should there be any judgment rendered or settlement agreement entered into.

## **Education**

In order to improve reporting, there must be more education available to both healthcare providers and patients. According to one report, 90% of all medical schools have curricula on child abuse while only 70% have curricula for elder abuse.<sup>195</sup> Also, 64% of healthcare workers recalled having training on child abuse while only 27% recalled having training for elder abuse.<sup>196</sup> Amending these curricula to include elder abuse would provide a greater understanding of the importance of reporting and the protocols to follow to diagnose mistreatment.

For those healthcare professionals already practicing, continuing medical education forums and seminars could provide updates on risk factors and screening techniques. Legal seminars could also provide a different perspective by educating healthcare professional on the legal aspects of reporting and failing to report. These seminars could also provide guidance on adapting policies and procedures for the

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<sup>195</sup> Alpert, Elaine, *Family Violence Curricula in U.S. Medical Schools*, American Journal of Preventative Medicine, at 273

<sup>196</sup> *Id.*

identification, treatment, and reporting elder abuse. Internal seminars for healthcare providers could also be a useful educational tool. Risk managers and the like could hold training sessions to educate nursing personnel on how to identify abuse and how to follow the policies and procedures already in place.

Patients, however, also need to be educated regarding the mandatory obligations of healthcare providers. Disclosure of reporting obligations prior to any incident will likely reduce the chances of distrust once a situation occurs. Posting notices in prominent areas of healthcare settings would make the patient aware of the providers' duty to screen for and report certain suspected mistreatment. Signed acknowledgements would also provide additional notice of the obligations to those seeking treatment. This may also have the effect of informing the patient that this provider is exactly to whom to turn for support in these situations. State statutes requiring these notices and informed acknowledgements could be enacted to ensure uniformity throughout the healthcare system.

### **Conclusion**

Elder abuse remains a significant problem in our society. The healthcare industry seems to have an important role in combating this problem, although resistance to a system of mandatory reporting is prevalent. In addition the system currently being utilized is overburdened and therefore cannot render the appropriate services. This leads to decreased faith in the effectiveness in the system and resistance to support the integrity of the system. Therefore, the federal government should take steps to encourage programs that specifically address these problems.

Although efforts have been admirable, these efforts should be refocused and tailored to adhere to the unique complexities of the situation. Narrowing the statutory approach to abuse reporting will assist in specifically meeting these complexities. Enlisting the help of the medical community, instead of blaming it, will encourage participation. Addressing their historical concerns in a way that promotes the profession's traditional values will also engender a feeling of professional obligation and ethical duty instead of legal mandate. The means are available for structuring a solution to the elder abuse problem, however, unless the proper approach is taken, success will not be realized.

The approach discussed herein would not only enhance the ability of APS to investigate and intervene, but would empower physicians with an increased sense of worth on the elder abuse assault, all while protecting older Americans and preserving their rights. Not to mention it would save us all from the confusion of seeing APS rushing into the ring in "ROCKY XIX: Look Adrian, No Walker".