Turkish Journal of Geriatrics
DOI: 10.31086/tjgeri.2018240416
2018;21 (2):157-165

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Received: 01/02/2018
Accepted: 27/04/2018

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RESEARCH

A STUDY ON PHYSICIANS' PERSPECTIVES ON ELDER ABUSE AND NEGLECT

Abstract

Introduction: Rapid developments in science and technology, increased quality of life, and developments in in methods for diagnosing and treating diseases have led to an increased geriatric population worldwide. This is associated with an increased risk of elder abuse and neglect. In the present study, we aimed to evaluate physicians' perspectives on elder abuse and neglect, to understand their knowledge and approaches, to raise awareness on the subject, and to identify the abuse and offer suggestions to resolve it.

Materials and Method: This study was conducted on 524 volunteer physicians working at public institutions and hospitals or private hospitals and private clinics. They completed a questionnaire including questions evaluating physicians' demographic characteristics, education regarding elder abuse and neglect, diagnostic approaches, and knowledge about the approach to elder abuse and neglect. Data were analyzed using descriptive statistics and graphical analysis using SPSS 21.0 software.

Findings: Forty five percent of the physicians indicated that they encountered elder abuse and neglect. Neglect was most common, with 37.4% of physicians reporting this. Only 24.3% of the physicians who encountered elder abuse and neglect stated that they had notified the authorities of the same. When the physicians were asked for their reasons for not reporting elder abuse and neglect cases, the most common response (62.3%) was concern that the older person could be harmed further.

Conclusion: Based on our findings, necessary legal arrangements should be made to provide home care for the older persons, families should be financially supported, research into this topic should be conducted, and propose solutions should be developed.

Keywords: Elder Abuse; Physician; Jurisprudence

ARAŞTIRMA

HEKİMLERİN YAŞLI İSTİSMARINA VE İHMALİNE BAKIŞ AÇISINI DEĞERLENDİREN BİR ÇALIŞMA

Öz

Giriş: Bilim ve teknolojideki hızlı ilerleyiş, yaşam kalitesindeki artış, hastalıkların tanı ve tedavi yöntemlerinin gelişmesi dünyadaki yaşlı nüfusun artmasına yol açmıştır. Bu durum yaşlının istismar ve ihmal edilme riskini artırmaktadır. Bu çalışmada; hekimlerin yaşlı istismar ve ihmaline bakış açılarını değerlendirmek, bilgi ve yaklaşımlarını öğrenmek, konuya farkındalık kazandırmak, istismarın tespit edilmesi ile çözümüne yönelik öneriler sunulması hedeflendi.

Gereç ve Yöntem: Araştırma, Türkiye'de kamu kuruluşu hastanelerinde ya da özel hastane ve muayenehanelerde görev yapan 524 gönüllü doktor üzerinde gerçekleştirildi. Ankette; hekimlere ait demografik özellikler, yaşlı istismarı ve ihmali konusunda aldıkları eğitimler, ihmal deneyimleri, tanıda izledikleri yollar, olguya yaklaşım ve ihmal konusundaki bilgi düzeylerini ölçen soruları içermektedir. Elde edilen veriler SPSS 21.0 istatistik programı kullanılarak tanımlayıcı istatistik ve grafik analizi ile değerlendirildi.

Bulgular: Mesleki uygulamaları sırasında hekimlerin %45.0'ı yaşlı istismarı ve ihmali ile karşılaştığını belirtti. En sık karşılaşılan tür %37.4 sıklık ile ihmal olarak tespit edildi. Yaşlı istismarı ve ihmali ile karşılaştığını belirtenlerin sadece %24.3'ü bu konuda resmi makamlara bildirimde bulunduğunu belirtti. Hekimlere adli olgu bildiriminde bulunmama nedenleri sorgulandığında ise en fazla işaretlenen seçeneğin %62.3 ile yaşlının zarar görebileceği endişesi olduğu görüldü.

Sonuç: Yaşlılara evde bakımın temin edilebilmesi için gerekli yasal düzenlemeler yapılmalı, bu konuda aileler ekonomik açıdan desteklenmeli, konuya yönelik araştırmalar yapılmalı ve bu verilere dayalı olarak çözüm önerileri geliştirilmelidir.

Anahtar sözcükler: Yaşlı İstismarı; Hekim; Yasal yükümlülük

INTRODUCTION

Rapid developments in science and technology, increased quality of life, and developments in the methods of diagnosis and the treatments of diseases have resulted in an increased mean human lifespan. As a result, the geriatric population increases every year (1). While the size of the population was 542 million in 1995, it has been estimated to rise to approximately 1.2 billion by 2025 (2). This situation is similar in Turkey. Data from the Turkish Statistical Institute for 2016 revealed that while the size of the geriatric population was 5,682,003 in 2012, it increased by 17.1% in the last five years and was reported to be 6,651,503 in 2016 (3).

Aging is associated with various problems including decline in physical and cognitive functions, financial difficulties, health issues and decreased social support. With modernization of traditional society of Turkey, younger generations are paying lesser attention to the care of older relatives (4). Consequently, difficulties experienced during the care of an older person individually at home or in an institution increases the risk of abuse and neglect.

According to the Toronto Declaration by the World Health Organization (WHO), elder abuse is defined as "single or recurrent inappropriate behavior that harms or distresses to an older people in a relationship based on trust expectation" (5). This definition includes physical, emotional, sexual, and economical abuse and neglect.

Physicians also witness elder abuse and neglect while making diagnoses and during treatment. Physicians have an important role in determining the findings of abuse and neglect, reporting suspected cases and discovering barriers and supports in the detection and management of elder abuse cases (6,7,8).

The present study aimed to evaluate the perspective of physicians on elder abuse and neglect, to understand their knowledge and approaches, to raise awareness on the subject, and to offer possible solutions.

MATERIALS AND METHOD

Study design and participants

A total of 524 physicians including practitioners, specialists, and academics with medical background from public hospitals or private hospitals and private clinics in Turkey participated in this descriptive study. In this study, convenience sampling method was used to generate the sample. Questionnaire forms prepared for this study were administered via an online platform exclusively for physicians where around 15000 physicians all across Turkey were members of or as printed materials to voluntary participants. The sample size was calculated as 375 with 95% confidence interval level, 50% frequency and 10% sampling error. Incorrect filling of questionnaire and ratio of replies being under 80% are accepted as exclusion criteria, 450 people were targeted to minimize the sampling error. The number of participants in this study corresponds the minimal sampling size. The participants were informed about the topic and purpose of the study and were assured that the information they provided was only going to be used for the study and was strictly confidential. Physicians were asked to answer questions in relation to their thoughts and knowledge. The questionnaire included 24 questions, of which the first six were prepared as a data collection tool to determine the sociodemographic characteristics (such as age, gender, marital status, specialty, professional experience) of physicians. The latter questions to evaluate physicians' perspectives on elder abuse and neglect, education, types of elder abuse encountered, diagnosis criteria, and approach to cases and were presented as multiple-choice questions.

Statistical analysis

The data obtained from the researchers were transferred to the computer. Data were analyzed with descriptive statistics and graphical analyses using SPSS 21.0 statistical analysis software (SPSS Inc. Chicago, IL, USA). The chi-square test was used

to compare the groups. $p<0.05$ was considered to be statistically significant. While evaluating the questionnaires, it was noticed that physicians did not answer some questions; therefore, statistical analyses were conducted using appropriate valid data.

Ethical considerations

The study was approved by the Ethical Board at the Faculty of Medicine at Istanbul University on 03.16.2017 (Number: 53239941-604.01.02-104683).

RESULTS

Of the 524 physicians who agreed to participate, 68.7% were female, 31.3% were male, 74.7% were married, 25.3% were single, 79.3% worked in public institutions, and 20.7% worked in the private sector. Furthermore, 42.1% of the participants were practitioners, while 51.1% and 6.7% were specialists and academics with a medical background, respectively. The mean age was 36.2±8.3 years, and the mean duration of professional experience was 12.2±8.5 years.

Sixty percent of the physicians stated that care support was given to the older persons in their homes (mostly grandparents) and that the average care period was 4.4 years.

Totally, 56.9% of the physicians considered patients older than 65 years to be older persons.

A total of 90.6% of the physicians stated that they were obliged to report elder abuse to the authorities.

Almost half (45.0%) of the physicians stated that they encountered elder abuse and neglect during their practice. The types of abuse they encountered were neglect (37.4%), emotional abuse (25.1%), economic abuse (22.2%), physical abuse (15.7%), and sexual abuse (1.1%). Only 24.3% of the physicians who encountered abuse and neglect reported it to the authorities. When the physicians were asked about their reasons for not reporting abuse to the authorities, the main reason (62.3%) was concern that the older person would suffer (Figure 1).

When the physicians were asked about under which circumstances they suspect about the abuse of older people; the most frequent response was "the presence of numerous physical trauma traces on the body that are in different healing stages". When the same question was repeated for elder neglect, the most common answer was "insufficient hygiene and care of nails, hair, beard, mouth, body, and clothes" (Table 1).

When asked about the physicians' approach in cases that were determined to be elder abuse, 55.1% of the physicians stated that they reported such cases to the police without informing the family. When the same question was repeated for elder neglect, 24.8% of the physicians stated that they reported such cases to social services and 21.3% of them informed law enforcement agencies (Table 2).

Physicians' obligations to report elder abuse and neglect were compared according to whether they had received education. The reporting rate of the educated group to the authorities was higher than that in the group without education, and this difference was statistically significant ($p<0.001$). Similarly, the educated group reported a higher rate of encountering elder abuse ($p=0.04$) and suggested that "they feel sufficient about elder abuse," "previous notifications were not useful," and "governments did not provide older victims enough support" at a higher rate than the other group ($p=0.01$, $p=0.04$, and $p=0.006$, respectively; Table 3). The educated group defined "older person" as an "individual older than 65 years" at a higher rate than the group without education on the subject ($p=0.026$). Similarly, the educated group defined the period of old age as a "period of resting/peaceful life" at a higher rate ($p=0.02$) than the group without education on the subject but defined it as a "period of dependence/neediness

from others" at a lower rate (p=0.02) than the group without education on the subject.

When the answers of the physicians were compared taking gender into account, it was observed that female physicians encountered elder abuse and neglect at a higher rate than their male counterparts (p=0.006), while there was no difference between the two genders for reporting cases (p=0.35) (Table 3).

When the physicians were compared according to the sectors they worked in, those in the public sector had higher education about the subject (p=0.004) and higher rates of reporting (p=0.005) than those in the private sector (Table 3).

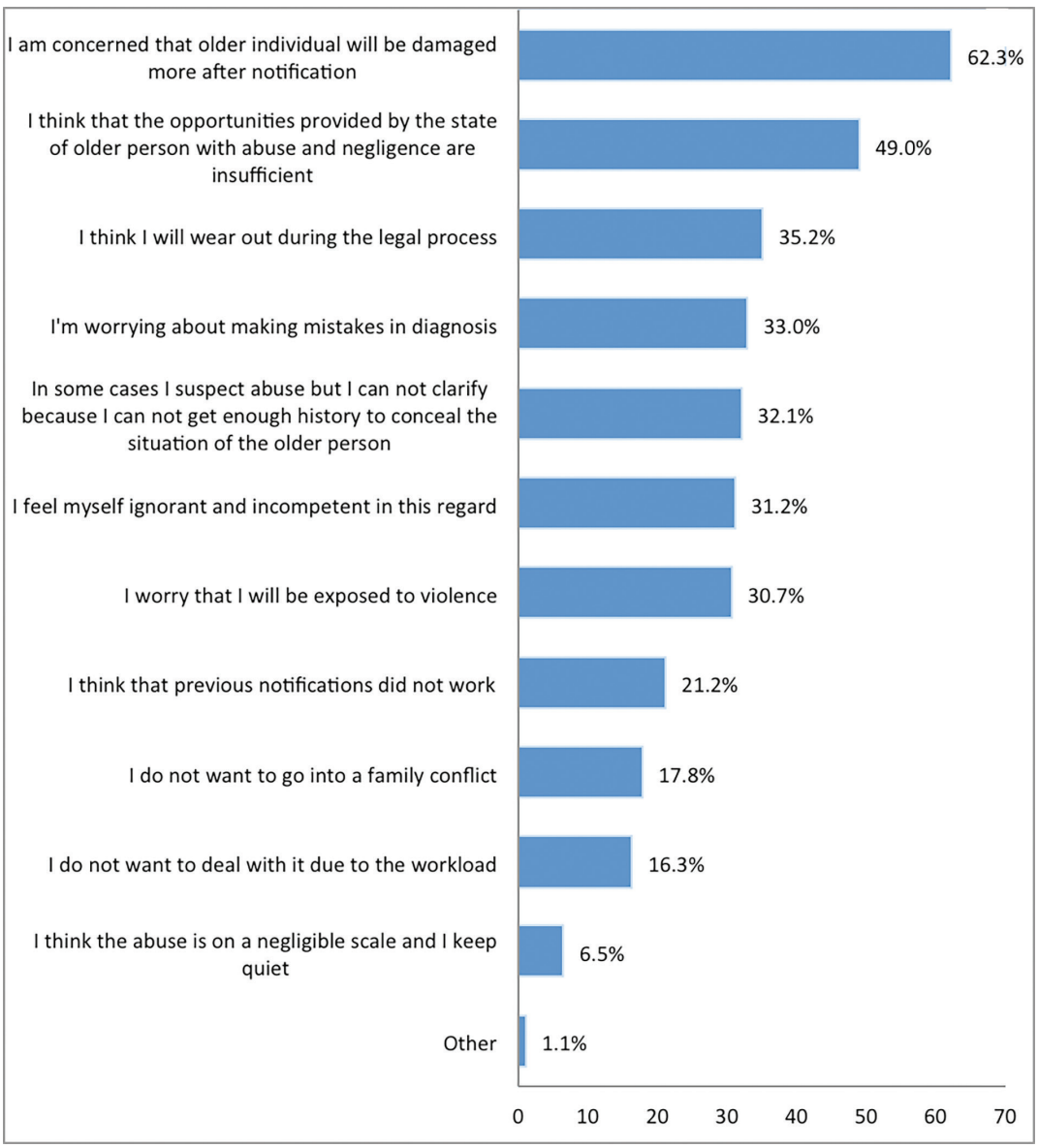

Figure 1. Reasons for physicians not reporting elder abuse.

Table 1. Situations raising doubt of elder abuse and neglect.

	n	%
Situations raising suspicion of abuse*		
Presence of numerous physical trauma traces on the body that are in different healing stages	482	92.9
Although the older person has economic power, the basic needs of the older person have not been met and their financial resources have been used by relatives	462	89.0
Older person in a cowardly, timid manner while in a relationship with family members	434	83.6
Presence of suspicious genital or anal wound(s)	420	80.9
Presence of delayed or untreated disease(s) in the older person	420	80.9
Situations raising suspicion of neglect*		
Inadequate nail, hair, beard, and mouth care; body hygiene; and laundry cleaning	476	91.4
Failing to meet the basic needs of the older person while having enough financial power	469	90.0
Presence of delayed or untreated disease(s) in the older person	440	84.5
Inadequate nutrition of the older person despite adequate financial power in the family	432	82.9
The care of the family (according to economic power) can not meet the social needs of the older person	359	68.9
Hearing, vision, and other support devices not adequately provided	305	58.5
No communication between family members and the older person other than to meet basic care needs	296	56.8

* For both of the questions, the participants were allowed to choose more than one choice.

Table 2. Approach to cases in which physicians are convinced that elder abuse and neglect.

	n	%
Approach to cases determined to be abuse*		
Make a direct police statement without informing the family	284	55.1
I definitely take the advice of the older person about reporting and act in accordance with his/her requirements	119	23.1
I inform the family and tell them that if it is repeated, I will inform the police	90	17.5
I remain silent	1	0.2
Others	21	4.1
Approach to cases determined to be neglect*		
I notify the social services	127	24.8
I report it to the hospital police/law enforcement	109	21.3
I apply a multidisciplinary approach (consultation)	100	19.5
I inform family members	79	15.4
I take the advice of the older person about reporting and act in accordance with his/her requirements	72	14.1
I ask for support from the forensics department	15	2.9
I remain silent	2	0.4
Others	8	1.6

* Some of the participants did not answer these questions.

Table 3. Comparison of physicians' education status in elder abuse and neglect.

			Did you receive education on elder abuse and neglect?				Gender				Sector			
			Yes	No	Value	p	Female	Male	Value	p	Public	Private	Value	p
Do you think that the physician has an obligation to officially report cases of elder abuse and neglect?		Yes	94.9%	89.9%	1.955	0.16	91.6%	88.4%	1.359	0.24	91,7%	86,9%	2,264	0,132
		No	5.1%	10.1%			8.4%	11.6%			8,3%	13,1%		
Have you ever encountered elder abuse and neglect during your professional practice?		Yes	55.8%	43.1%	4.276	0.04	49.0%	36.2%	7.454	0.006	46,7%	38,7%	2,187	0,139
		No	44.2%	56.9%			51.0%	63.8%			53,3%	61,3%		
Did you officially report it when you encountered elder abuse cases?		Yes	41.7%	14.9%	18.647	<0.001	17.8%	22.5%	0.882	0.35	21,7%	10,3%	3,829	0,050
		No	58.3%	85.1%			82.2%	77.5%			78,3%	89,7%		
What are the reason(s) for not informing officials in case of encountering elder abuse and neglect	A. I think the abuse is insignificant, and I remain silent	Yes	9.2%	6.1%	0.909	0.34	6.2%	7.3%	0.191	0.66	6,9%	5,6%	0,182	0,670
		No	90.8%	93.9%			93.8%	92.7%			93,1%	94,4%		
	B. I do not want to get into a family conflict	Yes	18.5%	17.7%	0.023	0.88	16.3%	21.2%	1.543	0.21	18,6%	14,6%	0,782	0,376
		No	81.5%	82.3%			83.7%	78.8%			81,4%	85,4%		
	C. I feel ignorant and incompetent in this regard	Yes	13.8%	34.3%	10.559	0.001	32.6%	27.7%	1.034	0.31	31,2%	29,2%	0,136	0,713
		No	86.2%	66.0%			67.4%	72.3%			68,8%	70,8%		
	D. I do not want to deal with it due to workload	Yes	13.8%	16.6%	0.315	0.58	15.6%	17.5%	0.247	0.62	18,6%	6,7%	7,373	0,007
		No	86.2%	83.4%			84.4%	82.5%			81,4%	93,3%		
	E. I worry that I will be exposed to violence	Yes	32.3%	30.3%	0.101	0.75	27.7%	37.2%	4.057	0.04	31,5%	27,0%	0,692	0,405
		No	67.7%	69.7%			72.3%	62.8%			68,5%	73,0%		
	F. I think that I will be worn out during the legal process	Yes	36.9%	34.8%	0.107	0.744	30.9%	44.5%	7.666	0.006	34,4%	37,1%	0,227	0,634
		No	63.1%	65.2%			69.1%	55.5%			65,6%	62,9%		
	G. I am worried about making mistakes in the diagnosis	Yes	23.1%	34.6%	3.318	0.07	34.5%	29.2%	1.220	0.27	33,5%	30,3%	0,326	0,568
		No	76.9%	65.4%			65.5%	70.8%			66,5%	69,7%		
	H. I think that previous notifications did not work	Yes	30.8%	19.5%	4.203	0.04	20.2%	23.4%	0.568	0.45	21,5%	21,3%	0,001	0,977
		No	69.2%	80.5%			79.8%	76.6%			78,5%	78,7%		
	I. I am concerned that the older person will be harmed further after the notification	Yes	55.4%	63.3%	1.487	0.22	62.2%	62.0%	0.001	0.97	61,0%	67,4%	1,231	0,267
		No	44.6%	36.7%			37.8%	38.0%			39,0 %	32,6%		
	J. In some cases, I suspect abuse, but I cannot clarify it because I cannot obtain enough history to disclose the situation of the older person	Yes	29.2%	32.5%	0.265	0.60	34.5%	26.3%	2.964	0.09	33,0%	30,3%	0,221	0,638
		No	70.8%	67.5%			65.5%	73.7%			67,0%	69,7%		
	K. I think that the provisions of the state for abused and neglected older people are insufficient	Yes	64.6%	46.2%	7.551	0.006	50.2%	46.0%	0.662	0.42	47,3%	53,9%	1,257	0,262
		No	35.4%	53.8%			49.8%	32.6%			52,7%	46,1%		

DISCUSSION

The WHO defines individuals older than 65 years as older person. A study that evaluated the perspectives of university students on older individuals showed that 57.8% of the participants considered individuals who were 60–65 years old as older person, while 27.8% considered individuals aged between 68 and 80 years to be older person (9). In the present study, 56.9% of the physicians considered individuals older than 65 years to be older person, as defined by the WHO, while 21.0% considered individuals older than 70 years to be older person. The reason for this might be an increased mean lifespan in conjunction with developments in medicine during the last years.

While 45.0% of the physicians encountered elder abuse and neglect during their professional practice, they most frequently encountered neglect (37.4%), emotional abuse (25.1%), economic abuse (22.2%), physical abuse (15.7%), and sexual abuse (1.1%). This study, neglect had the highest rate, similar to studies conducted in the Japan (10). Physical abuse was the primary type of abuse demonstrated in studies conducted in the South Korea (11). Sexual abuse was the least common type, similar to studies conducted in Ireland (8). The potential reason for these differences is different cultures and lifestyle in the countries.

Article 280 of the Turkish Penal Code No. 5237 (TCK) states that if a physician identifies a symptom of a crime being committed while performing his/her duties, if he/he does not report it to the authorities or is late in reporting, he/she can be punished with imprisonment for a period of up to one year (12). In the present study, there was a clear consensus (90.6%) among the physicians that elder abuse and neglect is a crime that must be reported to the authorities.

Healthcare staff must consider legal notifications as an exception to patient confidentiality. A physician's obligation to report such cases arises from the need to take precautions in matters involving following up crimes, arresting offenders, and maintaining public health. While this rationale is related to "public interest," it should not be implemented in such a manner as to ignore basic patient rights. If a person requiring treatment is involved in any crime or is victim to any criminal offense committed, it is the obligation of the healthcare professional who has discovered this during their professional practice to notify the appropriate authorities and not keep any information confidential. The present study revealed that 45.0% of the physicians indicated that they encountered elder abuse and neglect but that only 24.3% of them notified the authorities. An investigation into the reasons why physicians did not notify the authorities revealed that their greatest concern was that the older individual would be harmed further after notification (62.3%), followed by the belief that state provisions for abused and neglected older people were insufficient (49.0%; Fig. 1). Same concern about the future life quality of older person was also mentioned in a study conducted in USA (13). Accordingly, there is an apparent clash in legal and ethical responsibilities. On the other hand, it is clear that physicians make their evaluations considering their ethical responsibilities and have an ethical approach to the subject.

From previous studies, it can be seen that within the scope of providing health services, females are more at risk of being verbally violated, while males are more at risk of being physically violated (14). In the present study, it was observed that male physicians were more concerned about "being physically violated" and "being worn out during the legal process" after notifying the authorities than female physicians.

The evaluation of whether the physicians had received any education on elder abuse and neglect showed that only 14.9% of the physicians had received such an education. A statistical comparison of the group that was educated on elder abuse and neglect and the group that had not been educated on elder abuse and neglect, the obligation of notification to the authorities revealed that the group that was educated had higher rates of identifying abuse and neglect as well as notifying the authorities. This is because of the natural awareness of the physicians who had been educated and their increased sensitivity to the subject. It was determined that most physicians do not question geriatric patients about abuse because of inadequate knowledge on detection, management, the protocol surrounding the subject, legislations, and referral to appropriate institutions. Kennedy, Taylor and Schmeidel emphasize similar reasons (15-17). In a study conducted by Polat et al., it was suggested that health professionals have insufficient knowledge, skills, and attitudes about issues such as physical, sexual, emotional, and economic abuse and evaluation, monitoring, reporting, and legal initiatives (18). The group that was educated about elder abuse stated that "they feel sufficient about elder abuse" more than the group that had not received education on the subject. Previous studies have shown that educational intervention has an important influence on gaining experience, awareness, and knowledge (19-21). In the present study, it was determined that the group that was educated about the subject stated that "previous notifications to the authorities were not useful" and "governments did not provide older victims with enough support" at a higher rate than the group that was not educated on the subject. These data are valuable because together with increased knowledge, physicians start the legal process; however, at the end of the process, the result did not meet their expectations.

When the physicians were asked what situations triggered suspicion of elder neglect, 91.4% responded "Inadequate nail, hair, beard, and mouth care; body hygiene; and laundry cleaning." "No communication between family members and the older person other than to meet basic care needs" was the least common response (56.8%). The reason for this situation was thought to be due to a false social perception that only physical needs are met so that the older individual can survive and that the social and emotional needs of the older person can be ignored. Moreover, this false perception was interiorized among physicians in daily life as Sorenson mentioned (22). Due to this fact, during examination of older patient physicians are trying to limit their communication to shorten the duration of visit.

In conclusion, it is very difficult to uncover and identify elder abuse and neglect. This is because of reasons such as concerns of repeated exposure to violence and breaking ties with family members as well as the inability to deal with feelings of guilt due to the complainant.

When a physician finds any evidence of abuse during his/her intervention, it is his/her obligation to notify the appropriate authorities, even if the abuser is a close relative of the victim.

In-house education programs should be organized for physicians to prevent violence and abuse towards the older persons.

Concerns of physicians regarding their legal obligation to notify the authorities and the potential risks associated should be addressed.

Necessary legal arrangements should be made for care of the older person at home, and families providing care for the older person should be financially supported.

The number of organizations, such as shelters and care homes for older people, should be increased where victims can report abuse and violence and receive help.

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