

# General practitioners' knowledge and experience of the abuse of older people in the community: report of an exploratory research study in the inner-London borough of Tower Hamlets

CLAUDINE MCCREADIE

GERRY BENNETT

ANTHEA TINKER

## SUMMARY

*A pioneering study aimed to quantify general practitioners' (GPs') knowledge of cases of elder abuse in the community. The research found that elder abuse is a problem encountered by GPs, and that a large majority of responders would welcome training in the identification and management of the problem.*

*Keywords: elder abuse; general practitioners; knowledge.*

## Introduction

ELDER abuse refers to a range of actions, by someone known to an older person, in their own home or in a care setting, that harms them. These actions cover aggressive and violent behaviour, emotional cruelty, the theft of money or property, forced involvement in sexual activity, and the neglect of basic needs. Prevalence studies are limited, but suggest a figure of around 5% for all types of abuse in the community,<sup>1</sup> with higher figures (nearer 40%) reported for some selected samples.<sup>2,3</sup> Despite contributions by the medical profession<sup>2,4-6</sup> and the *prima facie* case for arguing that the role of GPs within the primary health care team is central in the prevention and treatment of elder abuse cases,<sup>7</sup> there has only been one discussion of the role of the GP,<sup>8</sup> and no research.

## Method

The research took place in Tower Hamlets, an area marked by social and economic deprivation and a racially and culturally diverse population, although the vast majority of the older population (93%: 1991 Census figures) is white. General practice covers a range of settings from purpose-built group practices to single-handed surgeries in poor quality accommodation. There are proportionately fewer one- or two-handed practices than in England as a whole, and proportionately more five- and six-handed ones.<sup>9</sup>

The main research tool was a self-completion questionnaire, developed especially for the research, as previous work was limited.<sup>10-12</sup> In addition to direct questions about abuse, using standard definitions,<sup>1</sup> GPs were asked about situations that, from

research knowledge, either describe an abusive situation or a situation that might trigger abuse.<sup>1</sup> The questionnaire was designed to find out about GPs' experiences of a range of situations, *not* about the prevalence of abuse.

The questionnaire was sent to all 107 GP principals in October 1996, and 68% responded ( $n = 73$ ). Non-responders were disproportionately male, in single-handed practices, and of Asian origin.

## Results

Table 1 gives the main results relating to knowledge of elder abuse cases. The most commonly reported type of abuse (by 26 GPs) was psychological (defined as persistent emotional behaviour; e.g. bullying that harms the older person), followed by neglect (18), financial abuse (16); physical (10) and sexual abuse (5). GPs were most likely to know of a case through their own diagnosis or through a third party rather than by the abused person or the abuser telling them.

Responders were presented with 20 at-risk situations in which it would be reasonable for them to suspect abuse. The number of such situations known ranged from none to 12 (mean = 3.87; SD = 3.32). Twelve GPs (16%) knew of none. The 27 GPs with knowledge of five or more at-risk situations accounted for two-thirds of those GPs who had direct knowledge of an abuse case.

Comparatively few GPs — 12 (16%) — had any training in elder abuse, compared with a large majority — 56 (77%) — who had training in child abuse. Fifty-one GPs (70%) would welcome training. There was a wide variation in the extent to which GPs made contacts about abusive situations with other people. Contacts were most likely with other GPs and with district nurses. Only half the GPs were in regular contact with social services.

## Discussion

One caveat concerns the generalizability of our findings. Although there is no research suggesting that abuse is correlated with social deprivation, nor any suggesting that professional practice in Tower Hamlets is distinctive, the only way of finding out if the findings are highly specific is to replicate the study. We are currently doing this.

The major limitation of our study is that it gives no indication of how many abuse cases a GP could expect to have on his/her list. Prevalence data are extremely limited. However, questions are raised about the adequacy of identification and response by GPs. If cases are being missed, or responses are limited, it would not be surprising given the absence of training and the subtleties and complexities of abusive situations. The association with the number of home visits paid in the last fortnight might help explain differences in knowledge about abuse cases and the range of responses about risk situations, but it begs the question as to whether GPs visited more often because of abuse/risk situations or identified them because they visited.

C McCreddie, MA, research associate; and A Tinker, PhD, professor of social gerontology, and director, Age Concern Institute of Gerontology, King's College London. G Bennett, MRCP, reader, Department of Health Care of the Elderly, St Bartholomew's and the Royal London School of Medicine and Dentistry, London.

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**Table 1.** GP knowledge of abuse and of risk situations for abuse related to characteristics of GPs and their practices.

GPs knowing in the last 12 months	n (%)	Age <sup>a</sup>	Sex <sup>b</sup>	Associations with			
				Ethnic background <sup>c</sup>	No. of older people registered with practice <sup>a</sup>	No. of home visits paid by GP in past fortnight <sup>a</sup>	Knowledge of an abuse case <sup>b</sup>
At least one type of abuse	36 (49%)	n.s.	n.s.	n.s.	0.04	0.008	—
Five or more risk situations	27 (37%)	0.003	n.s.	0.047	0.02	0.047	0.0005

<sup>a</sup>t-test; <sup>b</sup>chi square, <sup>c</sup>Fishers exact test.

Although younger GPs were more likely to know of five or more risk situations, they were not more likely to know of an abuse case, despite the fact that these two variables were strongly related. Further work is needed to explain this inconsistency.

## Conclusions

The combination of GP knowledge of cases, or risk situations, and the variations in response, with their endorsement of the need for training, supports the view of members of the medical profession here and abroad of the primary importance of increasing doctors' awareness of the possibility of abuse.<sup>13-17</sup> Education at the undergraduate, postgraduate, and practice level is therefore important. In our view, the health check for over-75s is potentially a useful assessment tool for exploring the issue of abuse with an older person<sup>18</sup> and is equally suitable for use with the under-75s. More generally, at the primary health care team level, there is a need for GPs and others to contribute to current debates about the problem of elder abuse and its management.

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## Address for correspondence

Claudine McCreadie, Age Concern Institute of Gerontology, King's College London, Cornwall House, Waterloo Road, London SE1 8WA.