Elder Abuse and Neglect Intervention in the Clinical Setting: Perceptions and Barriers Faced by Primary Care Physicians in Malaysia

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Abstract
This qualitative study attempts to explore the definition, perceptions, practice experience, and barriers of primary care physicians (PCPs) in identifying and intervening in cases of elder abuse and neglect at the primary care level. Semistructured in-depth interview was conducted among 10 PCPs. Participants were selected by purposive sampling. The interviews were audio recorded, transcribed verbatim, and analyzed using thematic analysis. In general, PCPs showed consistency in defining elder abuse and neglect. PCPs considered that they were optimally positioned to intervene in cases of elder abuse and neglect, but indicated the potential of overlooking such problems. The hurdles faced by PCPs in the identification and intervention of elder abuse were determined to be occurring at three levels: clinical, organizational, and policy. At the clinical level, PCPs recognize that they are lacking both the confidence and knowledge of elder abuse and neglect intervention. PCPs’ conflicting personal and professional beliefs create barriers during the clinical practice. Time constraints, patients’ other

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clinical problems, and, in addition, the preservation of a good doctor–patient relationship overshadow the importance of addressing and intervening in elder abuse and neglect issues during the consultation. This is further exacerbated by the barriers perceived by the patients: their nondisclosure and reluctance to accept outside intervention. At the organizational level, the lack of efficient interagency networks or support for the health system poses barriers. At the policy level, the absence of legislation specifically addressing elder abuse also creates considerable difficulties. However, PCPs gave differing responses when asked about a law concerning the elderly and mandatory reporting. Addressing these multilevel barriers is critical for ensuring that opportunities arising at the primary care level for elder maltreatment intervention are correctly utilized.

**Keywords**
elder abuse and neglect, primary care physician, perceptions, barriers, qualitative research, Malaysia

**Background**

In the World Health Organization’s (WHO’s) *World Report on Violence and Health*, released in response to the Forty-Ninth World Health Assembly, violence was declared a major and growing public health issue across the world (Krug, Mercy, Dahlberg, & Zwi, 2002). Action on Elder Abuse (AEA), a specialized organization from the United Kingdom, developed the following definition of elder abuse and neglect: “a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (Krug, Mercy, Dahlberg, Zwi, & Lozano, 2002, p. 126). This type of abuse contains the following categories: physical abuse, psychological or emotional abuse, financial or material abuse, sexual abuse, or neglect. This definition was subsequently adopted by the WHO (2016). Furthermore, it has also been used in Malaysia in a national report on violence and health (WHO, 2006). Elder abuse and neglect is a type of interpersonal violence, which was first described, in the medical community, in 1975 as “granny battering” in a letter sent to the *British Medical Journal* (Burston, 1975). However, it remained a private matter, hidden from the public view (Kahan & Paris, 2003). Recently, the issue has gained recognition in public health debates and criminal justice (Kinnear & Graycar, 1999).

Globally, an increasing number of older people require long-term care. Furthermore, the occurrence and severity of elder abuse and neglect are
estimated to increase markedly (Sooryanarayana, Choo, & Hairi, 2013). A systematic review of the prevalence and measurement of elder abuse in the community from 1990 to 2011 revealed that developed countries have the highest prevalence, with Spain having 44.6% overall prevalence of suspicion of abuse, whereas developing countries are exhibiting lower estimates, ranging from 13.5% to 28.8% (Sooryanarayana et al., 2013). However, the reported prevalence is likely to be underestimated as elder abuse is seldom reported (Krug, Mercy, Dahlberg, Zwi, & Lozano, 2002). In Malaysia, there are no published studies to estimate the prevalence of elder abuse and neglect (Esther, Shahrul, & Low, 2006).

Previous studies reported that elders who experienced maltreatment found difficult to seek help and receive support from others (Chokkanathan, Natarajan, & Mohanty, 2014; Guruge et al., 2010). Primary care physicians (PCPs) have the privilege of playing a central role in elder abuse and neglect intervention (Harrell et al., 2002). This is mainly because PCPs have great access to the patient due to continued contact and also provide holistic care, which involves the whole family (O’Brien, Riain, Collins, Long, & O’Neill, 2014). In a study done among PCPs and general internists in the United States, three quarters of the respondents felt that elder abuse is an issue in which physicians can effectively intervene, with PCPs considered to be in a better position than other health care providers to identify domestic violence (Kennedy, 2005). General practitioners in Ireland perceived that they play a significant role both in the detection of and intervention in elder abuse cases (O’Brien et al., 2014). The majority of general practitioners in Ireland have also noticed an improvement in the situation of the victim after a physician’s intervention (O’Brien et al., 2014). Early identification of elder abuse and neglect allows early intervention, which can subsequently reduce mortality and morbidity (Baker, 2007).

Nevertheless, previous studies in developed countries have demonstrated that PCPs faced barriers to provide necessary elder abuse interventions. The barriers for identification and management of elder abuse and neglect among primary health care workers, including physicians, nurses, and allied health care workers were revealed to be at multiple levels of the health organization (Killick & Taylor, 2009; Schmeidel, Daly, Rosenbaum, Schmuch, & Jogerst, 2012; Vandsburger, Curtis, & Imbody, 2012).

A systematic review of professional decision making on elder abuse found that professional background can influence the perceptions regarding the magnitude of the problem of elder abuse (Killick & Taylor, 2009). This review identified that the barriers operate at a number of different levels. At the individual or the victim’s level, the elderly experiencing abuse usually suffers in silence as they are often isolated from social networks and have no contact
with health care professionals. Victims are also reluctant to report abuse for a number of reasons: shame, humiliation, fear of retribution, and the negative consequences of a professional intervention such as placement in institutional care. At the health professional level, the reasons for lack of reporting include the reluctance of clinicians to acknowledge abuse, lack of protocol to identify abuse, and fear of liability. At the system level, there were only a limited number of services available to implement for abuse intervention.

In the United States, health care professionals in the primary care setting faced barriers regarding the detection of elder abuse and neglect that was related to professional orientation, assessment, interpretation, systems, knowledge, and education (Schmeidel et al., 2012). PCPs in this study perceived that maintaining trust in the clinician–patient relationship and other patient care issues outweighs their role to detect elder abuse and that such issues should be passed to social workers. A different study, also in the United States, grouped the barriers in the following categories: organizational or systems, health care professionals, and public or victim’s factors (Vandsburger et al., 2012). Lack of appropriate community service and unclear definitions of elder abuse were among the barriers at the organizational or system level. At the individual level, these professionals felt that they were lacking training, awareness, and knowledge of elder abuse and neglect. They also felt overworked in dealing with elder abuse (Vandsburger et al., 2012). Barriers at the public and victims’ level were the lack of awareness and recognition of elder abuse in the community and the elders’ lack of understanding that they have been abused (Vandsburger et al., 2012). In addition, health care professionals perceived that the victims are also not forthcoming due to their insistence on preserving their honor and cultural traditions (Vandsburger et al., 2012).

In Malaysia, there is a progressive demographic shift toward an aging population (Department of Statistic Malaysia, 2015); yet, research on elder abuse is still in its infancy (Esther et al., 2006). Unlike for child abuse, there is no specific agency that monitors elder abuse in Malaysia (WHO, 2006, 2014). The fourth nationwide Malaysian Population and Families study, conducted in 2004 by the National Population and Family Development Board of Malaysia, among people above 50 years of age revealed that more than 636,000 or 26% of Malaysian senior citizens do not receive financial assistance from their children (National Population and Family Development Board Malaysia, 2004). The study also showed that the increased life expectancy and a growing elderly population was creating a greater burden on the working age population (15-64 years). Furthermore, the dependency ratio increased from 1:15 in the year 2000 to 1:11 in the year 2004. Hence, this study showed that elderly persons in Malaysia are experiencing financial
problems and are lacking basic living needs. The high dependency ratio will increase the caregiving responsibilities and will also bring the change in relationship dynamics. With an increasing number of old people who require long-term care, the occurrence and severity of elder mistreatment is likely to increase markedly (Krug, Mercy, Dahlberg, Zwi, & Lozano, 2002).

Unlike in developed countries, not much is known about the barriers faced by the PCPs in Asian countries, especially Malaysia. Furthermore, health care professionals in Malaysia may not receive any formal training to be able to identify and manage elder abuse and neglect (Esther et al., 2006). The Malaysian legal system does not have a law for mandatory reporting of elder maltreatment and neglect cases (Esther et al., 2006). The victim of maltreatment has the duty of pressing charges against the offender, and it will be taken into account only if the police have sufficient evidence the criminal offense was committed. No other formal systems for proactive assistance or reporting targeted exclusively at elder abuse and neglect, exist in Malaysia (WHO, 2014).

This qualitative study aims to explore the definition of elder abuse and neglect and the PCPs’ perceptions, practice experience, and barriers they have to face in the clinical practice regarding elder abuse and neglect. Only by understanding their perceptions and the barriers that they face, one can design strategies that could assist PCPs in providing better care for elderly patients who experience abuse and neglect in Malaysia.

**Method**

A qualitative approach was utilized to explore the definition, perceptions, practice experience, and barriers in managing elder abuse and neglect among PCPs in Malaysia. The semistructured in-depth interviews with PCPs and the field notes provided the data for analysis. This study has obtained approval from the University Malaya Medical Centre Ethics Committee.

**Setting**

This study was carried out in Klang Valley, Peninsular Malaysia, the most densely populated area in Malaysia, according to the results of the 2010 population census conducted by the Malaysian Department of Statistics (Department of Statistic Malaysia, 2011). Just as in other regions of Malaysia, primary health care services are provided by the public and private sectors. The public primary care sector is mainly funded by the Malaysian Ministry of Health, whereas private primary care clinics are run by solo practitioners or by groups of medics. These primary care services are
easily accessible to patients who live within a 5- to 10-km radius (Ministry of Health Malaysia, 2015).

**Participants, Recruitment, Sampling**

All practicing PCPs who work in a government-funded primary care clinic were recruited using purposeful sampling. In this particular study, the PCPs have the following qualifications: general practitioners, postgraduate trainees, and medical officers. In the selected hospital, which hosts the primary care clinic, there are 50 practicing PCPs. We should mention that all participating PCPs were invited via email and that their email addresses can be found on the hospital’s website. During the next stage of the recruitment process, the PCPs who agreed to join the study were contacted via telephone to confirm their participation and were scheduled for an interview. Moreover, all interviews were conducted according to the availability of the PCPs. It should be noted that efforts were made to ensure maximum variation based on age, race, gender, and years of working experience.

**Data Collection**

The interview guide was composed according to the theory of planned behavior, which consists of three main domains. The theory argues that the attitude toward behavior, subjective norms, and perceived behavioral control are crucial in guiding an individual’s behavioral intentions and behaviors (Ajzen, 2011). The theory of planned behavior was chosen because it can accurately explain the factors that contribute to individual intention, in this particular case, the PCPs’ intention to intervene in cases involving elder abuse and neglect. For example, under the attitude domain, a few questions were asked to explore PCPs’ attitude toward intervening in elder abuse and neglect cases in the clinic. Questions related to PCPs’ confidence and perceived adequacy of past training was used to understand the PCPs’ perceived behavioral control. The interviews were conducted in English language after clinic hours, and in the doctors’ offices or consultation rooms. A total of 13 questions was asked to achieve study objectives. The questions explored the PCPs’ understanding and their definition of elder abuse and neglect, together with their perceptions, clinical practices, and the barriers they faced in intervening such cases. The remaining questions were determined by the flow of the discussion and depended on the related information raised by the PCPs during the interview. During the interview process, iterative questioning methods were used (DiCicco-Bloom & Crabtree, 2006). The interviewer returns to matters previously raised by an informant and extracts-related data through rephrased
questions. The interviewer also made use of probes to elicit detailed data. The interviews were conducted between July and December 2013. Field notes were taken during the interviews. Each session ranges between 45 min to 1 hr. The sample size was determined by data saturation, which is the point where no more relevant information can be accrued from an ongoing study and at which data collection can be stopped (Marshall, 1996).

Data Analysis

In-depth interviews were appropriate for exploring a complex domain that is yet not fully understood: in this particular case, the PCP perceptions and their perspectives on, and the barriers to, the detection and management of elder abuse, which is not well explored in Malaysia (Esther et al., 2006). Moreover, the approach is meant to be hypothesis generating rather than hypothesis testing (Legard, Keegan, & Ward, 2003). Thematic analysis approach was used to analyze data obtained from the interviews (Boyatzis, 1998). The researchers immersed themselves in the data by reading and rereading the transcripts, and paying special attention to patterns that occur (Boyatzis, 1998). Two researchers independently coded three transcripts to come up with the coding scheme. It began by conducting a careful line-by-line and paragraph-by-paragraph analysis of the interview transcript (Boyatzis, 1998). During the next stage, codes are generated in a systematic manner through the whole data, and organizing data relevant to each code. Each interpretation captured was labeled discretely as a code (Boyatzis, 1998). Initial codes were generated by carefully documenting where and how patterns occur. Any discrepancies that appeared during the data coding were discussed and reconciled among the researchers. The first researcher coded the rest of the data, but any new emerging codes were discussed with the others before including them in the coding list. Then, data reduction was done, and researchers collapsed the data into labels and rearranged them under key categories/concepts for a more efficient analysis. Thus, the researcher made inferences about the meaning of the codes. Themes were identified using constant comparison methods (Ryan & Bernard, 2003). These actions provided a good starting point for identifying initial phenomena and producing a list of themes of importance to the participants.

To ensure scientific rigor, all data were obtained exclusively from PCPs who manage geriatric patients in their daily practice. The geriatric population who are more than 60 years old represents about 12% of the total number of patients who visited Malaysian primary care clinics in 2012 (Sivasampu et al., 2014). To ensure honest information, the involvement of PCPs in this study was entirely voluntary (Shenton, 2004). In addition, PCPs were also
encouraged to be frank with their statement during the interview. A reliable and truthful PCP is crucial as he or she might not be defensive or respond in a way he or she perceived or accepted by others when being asked regarding his or her attitude and practices on certain matters. The rigor of the collected data would be affected if the PCPs’ responses were not truthful. All interviews were audio recorded and transcribed verbatim. The transcripts were verified with the audio recordings for accuracy. Member checks (Shenton, 2004) were completed by two PCPs to ensure the accuracy of the data interpretation, and no changes were made. Frequent debriefing sessions between the researchers throughout the study helped the researchers to become more aware of their views regarding the data. The coding scheme was organized with the help of Nvivo 10 software.

Results

Ten PCPs, six female and four male, were interviewed. They are from three major ethnicities in Malaysia. Their ages ranged from 29 to 43 years, and they had been practicing for 5 to 17 years. All PCPs have experience in identifying and managing problems related to elder abuse and neglect. However, none has had special training in elder abuse, although all have undergone training for either child abuse or domestic violence.

Three distinct conclusions emerged from the interviews regarding elder abuse and neglect. The first was a definition of elder abuse and neglect, the second was about their perceptions, and the last was about the barriers in the path of a successful intervention regarding elder abuse and neglect.

Defining Elder Abuse and Neglect

The PCP group was able to find common ideas to define elder abuse and neglect. Most of them mentioned various types of abusive behaviors, with physical and emotional abuse being the most mentioned. Other types of abuse such as sexual, financial, and neglect were also indicated during the latter part of the discussion or after prompting. PCPs reported that they came across more emotional abuse among older patients. They also mentioned the existence of physical abuse, but concluded that the signs might not be obvious for them to pick it up. Although most participants did not relate abuse to age, a few of them specifically defined elderly abuse.

Elder abuse includes physical abuse, for example, beating, punching and kicking; sexual abuse is also another type of abuse. Financial abuse will be you
don’t give them enough money and food. Scolding and calling “bad” names are example of psychological abuse. (Dr. 8)

Well, the abuse itself is ill treatment so elder abuse will be . . . ill treatment of the elderly. Elderly I would say those ages more than 60 years old and . . . ill treatment abuse it can be physical and emotional. I suppose it can also be sexual abuse. (Dr. 9)

PCPs also mentioned that the perpetrators are usually persons close at a personal level for the elders such as family members or trusted caregivers.

Most of the time this kind of abuse; for example emotional abuse and neglect, it is usually done by their family members and their loved one. (Dr. 9)

Sometimes the caregiver is so tired taking care of their elders. For example, if the patient is bedridden. So, sometimes because of the frustration, they just like taking the frustration over and vent it out on the elders. (Dr. 2)

**PCP Perceptions of Elder Abuse and Neglect**

PCPs revealed different perceptions about elder abuse and neglect. Their perceptions were primarily influenced by personal and professional values. Mistreatment of the elderly is also seen as inappropriate and unacceptable in the community.

I think . . . that definitely not right, any form of abuse is not right . . . It is unacceptable if abuse happening in our community. (Dr. 6)

Despite the negativity surrounding elder maltreatment, when compared with other typical clinical conditions, PCPs did not perceive elder abuse and neglect as a priority during clinical consultations. They considered that dealing with medical conditions was easier in contrast, dealing with social issues such as elder abuse and neglect.

In the clinic, we will focus on the patient’s medical problem. We don’t really spend a lot of time to ask about family background or explore on elder abuse and neglect issues. (Dr. 9)

PCPs concluded that they are in a better position and have the duty to intervene in cases of elder abuse and neglect.
We at primary care are in the front line and have a good opportunity to identify elder abuse and neglect cases. We have frequent contact with them. As their family doctor, they trust us. Patients also have easy access to us. (Dr. 9)

As a primary care doctor, we are the responsible to give a holistic care to all of our patients. This includes treating their medical problem and also addressing other issues such as elder maltreatment among our older patients. Not to forget . . . preventing it from happening if we could identify some risk factors . . . the risk factor can be from the patient or caregiver factor. (Dr. 7)

**Barriers to Elder Abuse Detection and Management**

Based on the available data, barriers to the intervention of elder abuse and neglect in primary care settings occur at three levels: clinical, organizational, and policy (Figure 1).

**Barriers at the Clinical Level**

*Physician-related factors.* The surveyed PCPs affirmed that they felt unprepared and lacked confidence to identify and manage cases involving elder abuse and neglect. Their previous clinical training was inadequate in preparing them to deal with elder abuse and neglect. They felt incompetent to intervene in elder abuse cases due to their lack of knowledge and skills in exploring and managing in this area. PCPs also mentioned that they were unsure how to refer such cases to the official authorities. Assessing and diagnosing elder abuse were practical barriers that many PCPs found difficult to do considering the limited resources available in their clinical practice.
Not confident at all. This is not what we really learn in our training so we only hear bits and pieces of information about this. I personally never went through any training in this field so it could be a challenge to address this issue to our patients. (Dr. 6)

I’m not that sure if I have adequate knowledge and skills. I’m not confident to ask the patient and manage this case if I encounter one. I fear that I’m not ready to address this issue at the moment. (Dr. 7)

PCPs stated that the effort needed to identify elder abuse and neglect was also time-consuming. In clinics with a high patient load, opportunities for the detection or assessment of elder abuse and neglect were extremely limited. Priority was usually given to known diseases or treatable physical conditions. They were more focused on cases that were considered to be more manageable and less time-consuming.

Because it’s going to consume a lot of consultation time to explore this kind of issue (elder abuse and neglect). (Dr. 10)

From prior experience I think most doctors are probably in the rush. If they encountered elderly who had a fall, they will just focus on the injury . . . but they would never ask like what actually happen that lead to that event? (Dr. 1)

Then, if in a busy clinic, if and elderly patient with chronic illness had a fall, I will talk about fall prevention, then move on. It did not really make me think this injury could be related to abuse. Further exploration will be time-consuming. (Dr. 4)

Personal values related to filial piety pose an additional barrier among those PCPs who expressed concerns about wrongly accusing caregivers of maltreating the elderly. Discussing about possible abuse among the caregivers was difficult as in filial piety; children are expected to respect and obey the elderly. PCPs were concerned about offending the patients and caregivers when asking about abuse.

It might sound offensive to them, you know. They will (say) “No, no, my children take good care of me.” Maybe in this Asian culture, we are supposed to be taking care of our parents. So it’s like, it sounds rude if we ask, “So your daughter is not taking care of you is it?” You know its sound rude. (Dr. 1)

It can because it’s like you are like suggesting that somebody known to them actually abuse them. Or like they will feel . . . do you think I’m a person who can be easily abused? They might get offended by this question. It’s not usual for doctors here in Malaysia to ask “are you being abused?” (Dr. 9)
Perceived patient-related factors. The barriers against intervening in cases of elder abuse could also originate from the patients themselves. PCPs reported that older patients might not realize that the maltreatment they subjected to is abuse. Some elders might even deny experiencing it for fear of the implications related to them or their caregivers in the case of an intervention.

If I ask a patient “Are you being treated badly at home?” then certainly as a parent, they won’t say anything bad about their children. They will say no, because they don’t want to put their children or relative into trouble. (Dr. 4)

Patient may fear that if they say they have been abused and neglect, then we may take action to the perpetrator; that might be their children. (Dr. 2)

Some of them even if they know they being treated badly at home, there are signs and symptoms of abuse, most of them will choose not to report because they are somebody close to them. (Dr. 7)

In addition, their dependency on their children for their living expenses and their reluctance to bring shame and embarrassment to the family with the disclosure of abuse are some of the barriers for the elderly to come forward.

The elderly patient is mostly dependent on their caregiver due to age and health disability. They might say that they are staying in their children’s house, their children are taking care of them, providing food and shelter, so they feel that they shouldn’t be ungrateful and then report that their children are abusing them. (Dr. 2)

With a belief system where the good name of the family needs to be upheld, discussing about sensitive issues such as abuse and neglect would be difficult. The elders might keep their suffering to themselves to avoid bringing shame to the family.

I think Asian family; we tend to conceal everything in the family. You don’t want other people to talk about your family. You don’t want to bring the family matter out for publicity to let other people know about these things. (Dr. 8)

PCP also perceived that the difficulty in accepting any intervention among the older patients with abuse experience might be due to self-blame about their parenting style.

Like I said, they probably have some guilt feeling, or maybe because they (the elderly) didn’t provide them with good education so now that’s why (children are abusing me). They always put the blame on themselves. (Dr. 7)
Elderly patients who do not have access to a clinic or hospital suffer in isolation. Physical disabilities and dependence on others for mobilization might be the barriers to get assistance from others. Elderly people might also have difficulty to disclose their abuse experience if they have speech difficulties, whereas some who are bed bound do not go to the clinic at all.

Elderly has been abused; he would be suffering alone in the house or the nursing home because usually they (the caregiver) wouldn’t bring them to the hospital. (Dr. 5)

If they (the elderly) are not able to talk, they might have stroke, and they will have dysphasia and physical disability. So, those kinds of disabilities hinder them from coming forward and open about it with their doctors. (Dr. 7)

Barsiers at the Organizational Level

PCPs perceived the elder abuse and neglect as a new social issue in the local setting. Specific protocols or local guidelines are not available to guide them on the correct ways to intervene in cases of elder abuse and neglect in their clinical setting. Getting support from other agencies was not an option. The PCPs felt isolated when managing cases of elder abuse and neglect. Many stated that they were unsure which agency to refer such cases.

I think referring to welfare, also has its challenges. In a way, especially if you are referring to the district welfare officers. They have lots paperwork and investigations and this will take time, so it will take longer to offer help to these victims. During the process how do we ensure the victims’ safety? (Dr. 7)

I’m not sure whether there is any a guideline or protocol to say this is abuse and this is not and how to manage this kind of cases. Whereby, for pediatric cases, it is well-defined. (Dr. 8)

There is no special team or whatever to care for this abused elderly. Geriatrics team does not have such as SCAN (Suspected Child Abuse and Neglect) team to help you to support if you suspect elderly abuse. (Dr. 9)

Barsiers at the Policy Level

In the absence of a specific law in Malaysia targeting elder abuse and neglect, PCPs are left without guidance with regard to the type or nature of the intervention, particularly in matters related to reporting abuse. PCPs also mentioned
that without a proper law, elderly victims would be less likely to receive any protection.

At the moment I would say I don’t think there’s any law in that sense that mandate us to report this elder abuse and neglect in our country. (Dr. 6)

I wouldn’t know where to or how to assist them in pressing charges if they want to do. Since there is no mandatory reporting, how do we ensure the elderly safety? (Dr. 1)

I don’t think that there is any law in Malaysia that requires doctors to report to authority. So, basically if there is no mandatory reporting like the child abuse case, we doctors have no say if the elderly refused to take action on the perpetrator. (Dr. 7)

PCPs gave mixed responses when asked about an elderly law and mandatory reporting. PCPs considered that the elderly are adults who still had the capability to decide whether they wanted or not to draw legal action on the perpetrator. Nevertheless, by making the decision compulsory, some elderly people who are not able to get to a decision would gain from this as this would be a channel for them to be safe and secure.

Mandatory reporting because it’s the word mandatory means is by law. If there is, you (physician) have to report if you don’t report, you are wrong and then you (physician) might face legal consequences. (Dr. 2)

Pros are actually it helps the patients as they have their rights to live happy and have a better quality of life. It will also guide the doctors to have a proper ways to help and make a decision for them (the elders). So, if we report action will be taken and the elderly will have their rights. (Dr. 4)

**Discussion**

This study aimed to identify the definition of elder abuse, perceptions, and barriers faced by the physicians in managing elder abuse and neglect in primary care clinic settings in Malaysia. Identifying their perceptions and the barriers they have to navigate is becoming important considering the growing segment of aging population in Malaysia. Malaysia has a very well developed health care system (WHO, 2012). Despite this, data from this study showed that PCPs faced barriers at different levels of their practice.

The PCPs who took part in this study are fairly consistent in their definition of elder abuse and neglect. They defined elder abuse as a combination of
abusive behaviors, ranging from emotional and physical to sexual and financial. Moreover, most of the times, elders were victims of close family members or trusted caregivers. They also mentioned, which types of abusive behaviors occur more often based on their clinical experience. However, they were uncertain regarding which actions are perceived as abuse and neglect by the elderly. This is due to the contrasting perceptions and views of physicians and elderly on how to define abuse. A study about what constitutes elder maltreatment, involving health professionals, caregivers, and elderly persons from Australia, found that health professionals were more probable to identify abuse and potentially abusive actions than caregivers or healthy older people (Hempton et al., 2011). These discrepancies can have, as a result, the underdiagnosing of elder abuse and neglect. These differences also have implications on what actions have to be taken, which also contributes as one of the barriers in the identification and management of elder abuse and neglect.

PCPs in this study perceived themselves to be in a good position to identify and manage elder abuse and neglect in view of the patient accessibility, their patients’ trust, and the ability to provide continuity of care to the patients. PCPs also recognized their role in addressing elder abuse and neglect. This is consistent with other study results among PCPs from other countries (Kennedy, 2005; Perel-Levin & WHO, 2008; Wagenaar, Rosenbaum, Page, & Herman, 2010). Addressing elder abuse and neglect in primary care has a great impact on the professional and personal values of the physicians. The PCPs who participated in this study described elder abuse and neglect issues to be undesirable and a violation of elderly rights. This is similar to a study done in Sweden among health care workers and elderly where elder abuse was labeled as “crossing the line” and unacceptable by both physicians and the elderly (Berg, Erlingsson, & Saveman, 2001). Despite this, there are PCPs in this study who did not consider elder abuse and neglect as a priority issue compared with other medical problems in their clinical practice, which is further discussed in the barriers in intervening in cases of elder abuse and neglect.

PCPs described managing elder abuse and neglect issues as challenging in view of their lack of knowledge and skills. They associated their inadequacy with the lack of prior training. There is a concern when health care providers are inadequately prepared to intervene in elder abuse. A study conducted among health care professionals in the United Kingdom showed a positive correlation between the increase in reporting of elder abuse and the increase in knowledge and educational training about abuse (Richardson, Kitchen, & Livingston, 2002). The study showed that identifying, documenting, and reporting abuse of older people is not carried out consistently among the
health care workers. However, educational trainings did improve their attitude toward elderly people and the reporting of elder abuse and neglect. PCPs in this study did not know the definitions of elder abuse and neglect, understanding the magnitude of the problem, communication skills, ways of identifying the problem, and the availability of support groups. Nevertheless, the PCPs’ experiences are not unique as primary care providers elsewhere have also reported a limitation in their knowledge related to elder abuse intervention. These limitations act as barriers detecting and managing elder abuse in primary care (Krueger & Patterson, 1997; Schmeidel et al., 2012; Vandsburger et al., 2012).

Training on the topic of elder abuse and neglect is not commonly offered to Malaysian health care providers. PCPs in this study reported that their skills and knowledge in managing victims of abuse are based on their undergraduate training and continuous medical education on interpersonal violence other than elder abuse and neglect. With no specific training regarding to elder abuse and neglect issues, applying concepts inherent to child abuse issues when intervening in elder abuse and neglect, may cause difficulty, as they are dealing with adults assumed to be capable of making their own decisions.

In addition, the lack of time is another barrier that needs to be explored in regard to managing elder abuse and neglect. Gathering information and evidence concerning abusive events generally requires a longer consultation time, which may be difficult considering the high patient load of any PCP. Time constraints are common issues for PCPs elsewhere (Schmeidel et al., 2012; Vandsburger et al., 2012). Often, elder abuse and neglect are not top priorities and doctors tend to concentrate more on other medical issues. This practice may prevent them from making appropriate referrals (Houry, Feldhaus, Nyquist, Abbott, & Pons, 1999).

The other barrier that occurs at the individual level is linked with the PCPs’ personal values: fear of offending the patient and fear of retaliation, by the perpetrator, when talking about abuse. These types of barriers prevent the PCPs to officially label the elderly as being abused or neglected. PCPs also felt that the abovementioned issues might affect the doctor–patient relationship, which may eventually affect the patient’s care. Previous literature also verified similar challenges (Krueger & Patterson, 1997; Schmeidel et al., 2012; Vandsburger et al., 2012; Vetere, 2011). Health care professionals were found to be hesitant to label certain actions as abuse without gathering sufficient evidence (Rodríguez, Wallace, Woolf, & Mangione, 2006). PCPs are also community members and have their own personal values which, in turn, influence their management of elder abuse and neglect cases. Thus, without proper training, these PCPs may lack specific knowledge and follow their
personal values in managing elder abuse and neglect cases. In this context, PCPs from other countries with similar conditions—specific training or guidelines—may also face similar problems (Schmeidel et al., 2012; Vandsburger et al., 2012). Researchers have demonstrated that changes in the health care provider’s knowledge and attitude toward elder mistreatment occur with continuous educational efforts, and feedback about management through specific training and ongoing quality of improvement techniques (Alt, Nguyen, & Meurer, 2011; Richardson et al., 2002).

In the clinical practice, PCPs also mentioned their perceptions of patient-related barriers in intervening in cases of elder abuse and neglect. The main barrier mentioned was that elderly people might be unaware that the treatment they endured from the perpetrator is considered abuse. Elderly persons were also reported to deny experiencing abuse and refusing any active intervention. A review of a hospital-based elder abuse program in New York showed, despite suspicions of abuse, that victims denied the alleged abuse and attempted to justify the actions of the perpetrator, particularly if the perpetrator was someone close to them (Kahan & Paris, 2003). This is not surprising as it might be possible that elderly people fear the consequences of discussing about abuse with others or the perpetrators, which most of the times are their close family members. Older adults might not be willing to be separated from their families and transferred to an unknown environment. This conclusion is similar to the ones reached by studies done in the United States in which elderly people displayed strong denial of abuse and refused intervention or help out of fear that they or their perpetrators, usually close relatives, would face reprisals for reporting the abuse (Jones, Holstege, & Holstege, 1997; Krueger & Patterson, 1997).

Malaysia is a multiethnic and cultural society. The main ethnic group is the native Malay together with significant Chinese and Indian populations. Discussing about elder abuse is a social taboo in Malaysia as well as in some other Asian countries (Chokkanathan et al., 2014). Thus, PCPs also perceived that the elderly might be unwilling to approach the issue due to the social taboo of discussing family problems and the sensitive nature of the topic. A study surveying the preparedness of professionals who work with the elderly, in various fields that address abuse, showed that they also perceived the cultural background and the pressure to preserve honor as the main barriers to identify elder mistreatment (Vandsburger et al., 2012). This reluctance from the elderly can be attributed to the adherence to the values of “saving face,” which creates pressure on people to conceal family matters from the public. A study done among Malaysian women who experienced abuse showed that their cultural beliefs and values have affected their decision to seek help (Othman, Goddard, & Piterman, 2014). Similarly, in India, the identified
barriers to seeking help among abused elderly persons were their lack of awareness about help services, poor access to health care, fear of the consequences of intervention on their families or of retaliation, as well as the social taboo associated with elder abuse within their community (Chokkanathan et al., 2014).

The PCPs in this study also mentioned that among the elderly victims of abuse or neglect, many accept or respond to their experiences of abuse with self-blame, believing that the abuse is the result of their poor parenting skills. Studies also showed that in India, religious beliefs about Karma, a Hindu doctrine that purports that one’s current situation is a product of past actions, also constitute a barrier that prevents the abused from seeking help (Chokkanathan et al., 2014). Similarly, elderly people in Malaysia generally opt to suffer in silence instead of bringing embarrassment to their family by disclosing details of their experience of abuse (Esther et al., 2006). PCPs also felt that common elderly disabilities, such as dementia, stroke, and socioeconomic dependency on the caregiver contributed to their limited access to health care professionals. Regardless of that, accessibility to health care centers in urban and rural areas in Malaysia is relatively high (Merican & bin Yon, 2002). More than 95% of the population in Peninsular Malaysia and about 70% of the population in Sabah and Sarawak have access to basic health care through health facilities. In addition, there are also outreach services provided by the Malaysian Ministry of Health such as mobile health teams. Providing outreach services has a better chance to address elder abuse and neglect among the disabled elderly (Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2009). These mobile health services should be used as a platform to reach the elderly population who is unable to come to the health care center. These perceived barriers in identifying elder abuse are similar to the barriers to help seeking among elderly in Chennai, India, where the elderly also have medical disabilities and high dependency on their caregivers (Chokkanathan et al., 2014).

Barriers that were mentioned by the PCPs at the organizational level include the lack of protocols or guidelines about the efficient management of elder abuse and neglect, as well as an inefficient support group network. In Malaysia, there are no specific protocols or practice guidelines that address elder mistreatment (Esther et al., 2006). Studies in other countries have demonstrated that the lack of awareness about existing protocols was a barrier for the physician when confronted with abuse issues (Krueger & Patterson, 1997; Schmeidel et al., 2012; Vandsburger et al., 2012). However, a study of PCPs in Iowa reporting practices showed that the accessibility of protocols for reporting elder abuse and neglect in physicians’ clinics would lead to a higher reporting rate among physicians (Oswald, Jogerst, Daly, & Bentler, 2005).
PCPs also fear of losing confidentiality and express concern about patient safety as there is no efficient referral team. These ideas are similar to those mentioned in a previous study about professional barriers in addressing elder mistreatment (Vandsburger et al., 2012). The study indicated that the resources must be a group or team with continued multidisciplinary teamwork enacted, educational efforts involved to help the elderly population efficiently. The majority of the PCPs also felt that having a multidisciplinary team to manage this issue will benefit the elderly and help the physician in sending the victims to the appropriate person.

At the national level, there is no specific law enacted, in Malaysia, concerning elder abuse and neglect (Esther et al., 2006). Mandatory reporting laws, if available, are anticipated to bring the elderly victims and their perpetrators to the attention of relevant authorities. Policies and laws regarding elder abuse and neglect are important because they increase both physician and public awareness. The interviewed physicians have mixed feelings about the implementation, in Malaysia, of mandatory reporting of elder abuse and neglect cases. They believe that it will create unanticipated inconsistencies in their practice, which, in the end, does not resolve the root causes of elder abuse. The PCPs’ main concerns were the effects, both positive and negative, on the doctor–patient relationships, elderly quality of life, and making decisions based solely on the provision or to the best interest of the patient. Mandatory reporting will enable elderly victims to be safely handled and given help by physicians in decision making (Bergeron & Gray, 2003). Studies also demonstrated that physicians also face a dilemma regarding the incongruous effects of mandatory reporting in both ameliorating and worsening the quality of life of the elderly (Schmeidel et al., 2012). The reporting of abuse and neglect to the authorities might help to place the elderly victims in the safest places, but at the same time, the elderly will suffer because of the separation from their families. Implementing mandatory reporting in Malaysia will require a careful consideration of the many aspects involved, such as financial, human resources factors, and guidelines in assisting the physicians to make decisions in caring for elderly victims. The burden of the caregiver, identified as a perpetrator also needs to be addressed. Earlier literature mentioned that addressing the needs of both parties involved is vital in resolving the problem (Bradley, 1996).

Having no clear guidelines about the elder abuse intervention to assist them in clinical settings, the PCPs interviewed in this study wanted a practical education on the matter. They wanted to know how to best respond to elders who were confirmed or suspected of being victims of abusive behavior. Proper guidelines and protocol on elder abuse and neglect should be drafted with the goal of assisting the PCPs in intervening such issues.
Although not as obvious as physical ailments, elder abuse is far more prevalent and impactful on health than most clinicians recognize (Anetzberger, 2005). Physicians who consistently screen and assess cases of elder abuse need to know what should and can be done.

This study provides further information to the existing knowledge regarding barriers to intervene in the elder abuse and neglect cases. The findings of this qualitative study are almost similar to the barriers identified by PCPs elsewhere. However, this study can shed some light on this issue in developing countries such as Malaysia as most of the previous studies were conducted in developed countries. Unlike in developed countries, which have well-established policies, legal remedies, and resources, in Malaysia, elder abuse and neglect intervention is still in infancy. In addition, there are limited resources for fighting against elder abuse and neglect. In this study, the perceptions and barriers of PCPs in Malaysia are uncovered. Nevertheless, the study also provides a clearer and stronger foundation that could be used to develop more objective questions and more quantitative studies that would assess whether similar perceptions and barriers are present among a larger sample of health care providers in Malaysia. Although these findings are only among Malaysian PCPs, the context may be applied in primary care settings in other countries.

These results have to be considered in the context of our study limitations. In our study, we asked only PCPs about their perceptions and barriers concerning the management of situations exclusively related to elder abuse and neglect. Although it was appropriate to fulfill our study’s purpose, to identify the range and complexity of issues and barriers perceived by PCPs in relation to elder abuse, collecting information from other stakeholders such as elders, caregivers, and other relevant agencies would further enhance our understanding of the matter. However, these PCPs are doctors who are currently managing elderly patients in primary care settings and they have previous practicing experience in various settings.

Based on the study’s findings, there is a real need for improvement in addressing elder abuse and neglect in Malaysia. At the clinical level, major focus should be toward increasing awareness among the public and health care professionals. Improving PCPs’ knowledge and skills will enhance the detection rate in the clinic. Clinical guidelines and management protocols should be developed according to the local setting so that the PCPs will act accordingly when intervening in cases of elder abuse and neglect. Researchers have demonstrated that increased screening and changes in the health care providers’ knowledge and attitude toward elder mistreatment occur only with continuous educational efforts and feedback about management through ongoing quality of improvement techniques (Kennedy, 2005; Krueger & Patterson, 1997).
A systematic approach for managing elder abuse and neglect requires easy access to referral teams and improvement in the providers’ management. Effective multidisciplinary specialist teams in addressing this issue should become available in Malaysia. This is also mentioned in a previous study that concluded that the availability of multidisciplinary teams is important to address both victims and perpetrator problems (Bradley, 1996). At the policy level, as mentioned earlier, there is still a mixed opinion about mandatory reporting. Mandatory reporting laws are known not to be the best way to prevent elder abuse as the effectiveness is not greater than their potential harm to victims (Rodríguez et al., 2006). This shows that there are gaps in enacting mandatory reporting concerning elder abuse and neglect. The benefits of all parties involved should be considered before enacting laws.

Consideration of these issues should be included in the training, guidelines, and ongoing support for PCPs in dealing with elder abuse and neglect. Preparation of an algorithm to help PCPs in Malaysia is the next phase of this study.

**Conclusion**

Elder abuse can present itself in various forms to primary care facilities. PCPs have identified themselves as having a role to intervene elder abuse and neglect. Despite taking elder abuse and neglect as something unacceptable, barriers to intervene appear at the clinical, organizational, and policy levels. Efforts should be taken to allow PCPs to address elder abuse and neglect effectively.

**Appendix**

- Personal and professional background questionnaire:
  - Participants will be asked to fill up questions regarding their backgrounds including their qualifications and special training on sociomedical issues.

- Interview guide:
  - Knowledge, belief, and practice
    - What do you understand by elder abuse and neglect?
    - What is your perception/estimation of the prevalence of elder abuse and neglect in your practice? (To be more specific, out of 100 elder patients coming to your clinical setting, how many do you think might be abused?)
- What is your role in elder abuse and neglect management?
- Tell me about your past training on elder abuse?
- How confident are you in addressing elder abuse and neglect in your practice?
- Share with me your experience with elder abuse patients in your line of work.
  - (Probe: What makes you suspect elder abuse and neglect? What factor facilitates identification of elder abuse and neglect?)
- What is possible impact for primary care physician dealing with elder abuse and neglect? Does this affect identification and management of elder abuse and neglect?
  - (Probe: What do you do after a patient discloses experiences of elder abuse and neglect?)
- Based on your knowledge, what are the available interventions for elder abuse and neglect at your workplace and in Malaysia?
  - Probe: What do you think about mandatory reporting for elder abuse?

■ Barriers
- Share with me the challenges you face managing with elders who experience abuse
  - Probe: How comfortable are you with the idea of directly asking your patients about elder abuse and neglect?
  - What challenges do you face in:
    - Asking about elder abuse and neglect?
    - Offering support to elderly disclosing that they are experiencing elder abuse and neglect?
    - Documenting abuse
    - Perpetrator

■ Suggestions for improvement
- Based on your experience as a clinician, how could identification and support of victims of elder abuse and neglect by primary care physician be improved?
- What, if anything makes it easier for you in:
  - Asking about elder abuse and neglect
  - Offering support to elderly disclosing that they are experiencing elder abuse or neglect?
• Would guidelines and specific training on dealing with identification and management of elder abuse and neglect improve clinical practice related to elder abuse and neglect?
  ○ Could you elaborate what specific training is needed

■ Is there anything else you would like to discuss before we stop for today?

Authors’ Note
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