Geriatric Giant Lecture Series
Medicolegal Issues

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Departments of Medicine and Family Medicine
University of Alberta

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A. ELDER ABUSE

1. Definition

Any act of commission or omission that results in harm to an elderly person.\(^1\)

A high index of suspicion is the key to the recognition, diagnosis, and treatment of elder abuse.

2. Prevalence/Incidence

This is difficult to document as both victim and abuser deny or minimize the problem, and health care professionals tend to downplay complaints.\(^3-11\) About 4% of elderly are abused or neglected each year.\(^12\) (randomized cross Canada survey). Only one in six cases is reported, compared to one in three for child abuse. It is recurrent in 80% of cases. The rate may be as high as 40% in LTC, excessive use of restraints, pushing, grabbing, shoving, pinching, slapping or hitting.\(^6\)

Risk profiles indicate men and women living alone are equally affected. Long term verbal abuse between spouses is equal. Physical violence is more likely to occur between spouses with men and women equally affected, but abuse perpetrated by men being more severe.

Elder abuse is an international problem found among all racial, ethnic and socioeconomic backgrounds.

3. Types of Elder Abuse – Health Canada\(^2\)

- Physical Abuse- assault, rough handling, sexual abuse
- Psychosocial Abuse- verbal assault, social isolation
- Financial Abuse - misuse of money or property
- Neglect- active: consciously fail to meet senior’s needs
  - passive: unintentional injury of the elderly
  - self

4. Detection

Red flags:
- Comes to clinic/ED without caregiver
- Delayed presentation of illness
- Recent fractures
- Unexplained falls
Risk factors:
S - stress / social isolation
A - Alcohol / drug abuse
V - Violence (previous history)
E - Emotions (psychiatric illness)
D - Dependency / dynamics in family

History – always interview patient and caregiver separately. When possible an in home assessment is preferred. Ask the patient:
- Has anyone ever hurt you?
- Has anyone ever taken your things without asking?
- Have you gone without food, medical aid, or medicines?

In the caregiver look for signs of stress

Physical examination:
- Physical abuse:
  - bruises, lacerations, abrasions, fractures
- Neglect:
  - poor hygiene, dress, malnutrition, dehydration
- Psychosocial:
  - agitation, passive, withdrawn, depressed
- Sexual abuse:
  - difficulty walking, sitting, bruises, bleeding

5. Community Resources and Safety Plan

- Elder Abuse Intervention Team (477-2929)
  - social worker and police detective
  - assessment, emotional support, follow ups
  - safety plan
- Seniors Abuse Helpline (484 8888)
- Edmonton Seniors Safe Housing (7021520)
- Homecare/ Lifeline
- Day Program
- Enduring power of attorney, personal directives

Safety Plan:
- Know how to call police
- Keep a written journal
  - date, time, description of events
- Inform someone you trust
- Improve personal safety
  - Have someone stay with you
  - communicating acceptable boundaries / rules
- Secure your home
– change door locks, telephone number
• Secure your mail
• Secure bank accounts, credit cards, ATM
• Have a plan next time abuse happens
  – Senior safe houses
• Court Protection Order

6. Reporting
This is mandatory in Newfoundland, Nova Scotia and Prince Edward Island.

B. COMPETENCY

1. Definition

“Decision Making Capacity”
• In the context of an important decision, can this person…
  – Take in relevant information
  – Weigh out the pros and cons
  – Justify and then make a decision…
  ….based on their own set of values
• Time sensitive
• Maximise potential
• Domain and question specific – least restrictive alternative

2. Types of Competency Issues

• Personal Issues:
  – living arrangements
  – personal contacts
  – health care
  – legal matters
  – daily living routines
• Financial Issues

3. Approach to Assessing Competency
Trigger – refusal of treatment/placement, risk to self or others, suspect abuse, undue influence
Information gather – diagnose physical and mental illness/collateral
Engage the patient – assent not consent
Assessment – context/choices/consequences
Act

• Is the source internally consistent and reliable?
  – Do different sources have similar observations?
• Ask about:
  – past history of patient’s ability to make decisions
  – functional history – financial and other IADL
  – cognitive history
Assessment:
• Always assess patient at his/her best
• State what kind of assessment this is
• 3 components:
  a. Functional history
  b. Cognitive assessment
  c. Decision making ability:
    – Does patient recognize and understand the problem at hand? CONTEXT
    – Does the patient know the potential solutions for problems? CHOICES
    – Does the patient understand the consequences of the choices available to him / her? CONSEQUENCES
    – Can they enact their decisions once made?
    – Does the patient know how to ask for help?
    – Can educate patient of choices and consequences but they must be able to summarise and offer their opinion back.
    – Should evaluate consistency on two separate occasions

4. Financial/Personal Paperwork

<table>
<thead>
<tr>
<th></th>
<th>Competent</th>
<th>Incompetent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial:</td>
<td>EPOA</td>
<td>Trusteeship</td>
</tr>
<tr>
<td>Personal:</td>
<td>Personal Directives</td>
<td>Guardianship</td>
</tr>
</tbody>
</table>
5. Certification

Form 1
- Requirements:
  • unsuitable for admission to a facility other than as a formal patient
  • risk of harm to self/others
  • mental disorder
- lasts 24 hrs
- 2nd form 1 needs to be filled before 24 hrs are up by a 2nd physician at a designated facility
  • lasts 30 days

Form 2: Renewal certification
- 1st lasts 30 days, 2nd lasts 30 days, 3rd lasts 6 months

Form 3
- allows police to bring back a formal patient who has AWOL

Form 6
- allows transfer of a formal patient to another facility

Form 8
- Waiver of right to automatic hearing

Form 10
  Statement of a peace officer

Form 11
  filled by physician when a formal pt. is not mentally competent to make treatment decisions
  substitute decision maker
  pt or family or guardian can ask for a review by a review panel
  completed 7 days upon receiving the application

C. DRIVING ASSESSMENT

1. Epidemiology

- MVC per driver: low
- MVC rate per mile per driver: high\(^{13,14}\)
- more likely to result in serious injury/ fatality\(^{15-17}\)

2. Risk Factors

S - Safety Record
A - Attentional skills
F - Family report / function
E - Ethanol
D - Drugs
R - Reaction time
I - Intellectual impairment
V - Vision/Visuospatial function
E - Executive functions

Medical conditions increase at-fault MVC but the greatest increase in risk is when cognition is affected.\(^{18}\)

Increased risk of at fault crashes by medical condition in the elderly

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Risk Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>2.2</td>
</tr>
<tr>
<td>Vascular</td>
<td>1.8</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>2.1</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2.5</td>
</tr>
<tr>
<td>Neurology</td>
<td>5.1</td>
</tr>
<tr>
<td>Cognition</td>
<td>7.6</td>
</tr>
</tbody>
</table>

3. Safety Record

- Warning signs:
  - running stop signs or red lights
  - stopping at green lights
  - near misses without realizing it
  - going wrong way against traffic
  - merging into another lane without looking
  - stopping in middle of intersections
  - accidents / infractions
  - lost in familiar locations
4. Targeted History and Physical
See Tables 1 and 2

| Table 1 |
|-------------------|-------------------|
| **Targeted Medical History for Driving Assessments** |

1. **Prescription medications:**
   - a. Narcotics
   - b. Anticholinergic medications
   - c. Benzodiazepines
   - d. Psychotropics
   - e. Antispasmodics
   - f. Antiparkinson medications
   - d. Parkinson's disease
   - e. dementia
   - f. head injury/subdural
   - g. Multiple Sclerosis
   - f. others (specify)

2. **Non-prescription medications:**
   - a. Alcohol
   - b. Illicit drugs

3. **Visual problems:**
   - a. cataracts
   - b. glaucoma
   - c. macular degeneration
   - d. diabetic retinopathy

4. **Hearing problems**

5. **Cardiovascular disease:**
   - a. aortic aneurysm
   - b. arrhythmias
   - c. sick sinus syndrome
   - d. pacemaker
   - e. postural blood pressure changes causing dizziness
   - f. myocardial infarct
   - g. unstable angina

6. **Cerebrovascular disease:**
   - a. TIAs
   - b. strokes

7. **Respiratory Diseases:**
   - a. Chronic Obstructive Pulmonary Disease
   - b. obstructive sleep apnea

8. **Endocrine and Metabolic Conditions:**
   - a. Diabetes
   - b. Hyperparathyroidism
   - c. Hypothyroidism/Hyperthyroidism
   - d. electrolyte disturbances (e.g., sodium)

9. **Psychiatric Conditions:**
   - a. Depression
   - b. Schizophrenia
   - c. Bipolar Disorder
   - d. Psychosis

10. **Musculoskeletal Diseases:**
    - a. Osteoarthritis, Osteoporosis
    - b. Rheumatoid Arthritis
    - c. Peripheral Neuropathy

11. **Infectious Diseases:**
    - a. Respiratory
    - b. Urosepsis
    - c. AIDS

12. **Driving History:**
    - a. Infractions
    - b. Motor vehicle accident
### Table 2

#### ATargeted Physical Examination for Driving Assessment

<table>
<thead>
<tr>
<th>Category</th>
<th>Examination Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>Visual Fields, Snellen Acuity</td>
</tr>
<tr>
<td>Hearing</td>
<td>Whisper Test</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Normal exam, ECG if needed, postural BP</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Normal exam, if needed oximetry (rest and exercise)</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Standard exam</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>ROM Cervical spine, strength, tone, extension and flexion (shoulder, wrist, ankles, hips and knees)</td>
</tr>
<tr>
<td>Balance and Gait</td>
<td>Get up and go test (subject rises from chair, stands, then walks three meters, turns around and sits down)</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td>Normal exam, cerebellar (finger-nose, heel-shin), lower motor and upper motor findings, proprioception, sensory</td>
</tr>
<tr>
<td>Cognitive</td>
<td>Foisttein MMSE especially the intersecting pentagons, Clock Face, the praxis (ability to do a planned series of motor action on command), agnosia (ability to identify objects), executive function ability (Trails A and B Test), judgement, insight</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Normal exam, Geriatric Depression Scale if appropriate</td>
</tr>
<tr>
<td>Functional Decline</td>
<td>Assess decline in ADL (Activities of Daily Living) and IADL (instrumental activities of Daily Living) e.g. shopping, cooking, finances</td>
</tr>
</tbody>
</table>
5. Key Functions required for Driving\textsuperscript{19,20}

6. Testing

DriveABLE
- for medically at risk clients
- evidence based validated assessment
- competence screen- touch screen monitor
- road test for only those in indeterminate range
- cost: $ 250.00
GRH Driver Evaluation and Training

(MMSE, neuropsychological testing, family ratings of driving competence and conventional road tests correlate poorly with at risk driving)

7. Reporting

Non Mandatory but ethically indicated

Driver Control Board, Alberta Transportation and Utilities, Main Floor, Twin Atria Building, 4999-98 Ave, Edmonton, AB, T6B 2X3

8. Other Transport Options

ETS
DATS
Taxi
Driving Miss Daisy
Informal – family and friends

References

10. Gioglio GR, Blakemore P: Elder Abuse in New Jersey: the knowledge and Experience of Abuse among Older New Jerseyans, Department of Human services, Trenton, NJ, 1983