



Doctors' competences in caring for older people in situations of violence: scope review

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Abstract

Objective: describing by means of the evidence in the literature, the competences of doctors in hospital services in situations of violence against older people (VAOP). **Method:** scope review with search in databases/platforms/searchers and grey literature covering Medline; VHL; Embase; CINAHL; Web of Science; BDTD, OpenGrey, OpenThesis, RCAAAP, Portal de Teses e Dissertações da CAPES, DART-Europe E-theses Portal and Theses Canada Portal (Aurora and Voilà catalogs). The descriptors and keywords used, combined with the Boolean operators OR, AND, NOT were: “Physicians”, “Doctors”, “Attitude”, “Attitude”, “Knowledge”, “Knowledge”, “Behavior”, “Medical Care”, “Medical Care”, “Medical Care”, “Hospital Services”, “Hospital Services”, “Hospital”, “Hospitalists”, “Hospital Doctors”, “Older People Abuse”, “Older People Abuse”, “Physical Abuse”, “Older People Neglect”, “Aged Abuse”, “Older People Mistreatment”. **Results:** six papers were selected. There was a lack of knowledge on the topic and the approach, and of specific training. As for skills, the findings that most led doctors to suspect abuse were physical findings linked to appearance, hygiene and injuries - communication and relationship problems were little mentioned. In the attitude, there was a research of abuse in only 44% of the suspicions and low or null percentages on case reporting. Only one study explored the attitude towards negligence, where 24.8% reported to social services and 21.3% informed the police. **Conclusion:** most cases of VAOP remain unnoticed and therefore unreported or unhandled. There are multiple problems regarding the competences of hospital doctors when dealing with such situations, a scenario that exposes the demand for measures to raise awareness, training, and encouragement to adequately deal with VAOP.

Keywords: Health Services for the Aged. Elder Abuse. Clinical Competence.

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INTRODUCTION

The percentage of older people in the population is growing fast. In Brazil, it is expected to increase over the world average: the 60 year older people or more in 1950 corresponded to 4.9% of the total population and reached 14% in 2020¹. This growth, associated with changes in families and social transformations has translated into a rise in Violence Against the Older People (VAOP)².

Multiple types of violence victimize them: physical, emotional, financial, sexual abuse and mistreatment, as well as abandonment, neglect, and self-neglect in any environment. Such aggressions, regardless of the type, can cause intense psychological distress, increase in physical illnesses and the use of health services, trauma and even lead to death^{3,4}. The question is therefore multifactorial, coated with great complexity and usually underreported⁵.

The Statute of the Older People typifies VAOP, recommends compulsory notification even in suspicions and advocates punishment⁶. The Ministry of Women, Family and Human Rights (MDH) reveals via Disque 100 that the number of complaints jumped from 8,224 in 2010 to 37,454 in 2018, the main ones being: Negligence (79.54%), Financial and Economic Abuse / Property Violence (41.7%) and Physical Violence (26.49%)⁷.

Since VAOP is frequent, impactful and little diagnosed, the contact of the older people with the medical team can be an unique opportunity for detection and approach^{8,9}. There is evidence that older people victims of violence and neglect are less likely to receive Primary Health Care (PHC) than other older people. However, they will probably receive hospital care, usually emergency, more frequently⁸.

The doctor's performance transcends the diagnosis and management of physical effects of violence. It should participate in the organization of the multiprofessional approach, sensitize professionals and refer the treatment of repercussions and the accountability of the causative ones⁸. To do so, one must have the necessary competences to address VAOP.

In Healthcare, competences are considered as knowledge, skills and attitudes required to solve problems efficiently and effectively. These three aspects are known by the acronym KSA. Knowledge is the theoretical knowledge, acquired with schooling, experience and facilitators. Skill is knowing how to do, putting knowledge into practice, and it depends on training and experience. Attitude is willingness to do, implementing practice, making it happen. Doctors need to develop the essential ones (knowledge, interest and research of cases, ability to identify and manage them), which ensures expertise and confidence to work with patients, family members/caregivers, colleagues, and health systems in the face of VAOP¹⁰.

In the literature there are few studies emphasizing the medical care of VAOP, many focused on urgency/emergency contexts⁸. In view of this scenario, the present study justifies a scope review whose objective is describing, by means of literature evidences, the competencies of doctors in hospital services in relation to VAOP, divided into knowledge, skills and attitudes¹¹.

METHOD

This is a scope review with analysis of information on medical care in hospital services for older people victims of violence, according to the method proposed by the Joanna Briggs Institute (JBI). This type of study maps the main concepts, elucidates areas of research and identifies knowledge gaps¹².

In the preparation, the protocol Preferred Reporting Items for Systematic Reviews and Meta-Analysis - Extension for Scoping Reviews (PRISMA-ScR) was followed, to add reliability to the review by refining the analysis and reporting process of the included studies¹³. Systematic search was conducted between August and October 2020 in medline databases/platforms Medline; Biblioteca Virtual em Saúde (BVS); Embase; Cumulative Index to Nursing and Allied Health Literature (CINAHL); and Web of Science.

The search for grey literature and unpublished studies included: Digital Foundation of Theses and Dissertations (BDTD), OpenGrey, OpenThesis,

Repositórios Científicos de Acesso Aberto de Portugal (RCAAP), Portal de Teses e Dissertações da CAPES, DART-Europe E-theses Portal and Theses Canada Portal (Aurora and Voilà catalogues). Additionally, the search strategy Snowballing was used in the references of the articles selected for this revision¹⁴.

This study followed the PCC strategy, acronym for Population (P), Concept (C) and Context (C)¹¹; being P (hospital service physicians), C (knowledge, attitudes and skills of hospital doctors on VAOP) and C (older people victims of violence treated in hospital services). From this arose the main question: what are the competencies presented by hospital doctors in the face of VAOP cases?

This was followed by the definition of the descriptors and keywords contained in the MeSH (Medical Subject Headings) and in the DeCS (Descriptors in Health Sciences), used combined with Boolean operators OR, AND, NOT: "Physicians", "Doctors", "Attitude", "Attitude", "Knowledge", "Knowledge", "Behavior", "Medical Service", "Medical Care", "Medical Care", "Hospital Services", "Hospital Services", "Hospital", "Hospitalists", "Hospital Doctors", "Older People mistreatment", "Elder Abuse", "Physical Abuse", "Elder Neglect", "Aged Abuse", "Elder Mistreatment", applied in the search strategies explained in Table 1.

Table 1. Search strategies used in databases/libraries/search engines and grey literature included in the scope review on the competencies of hospital doctors in VAOP cases. João Pessoa, PB, 2021.

Database/ Grey Literature	Search Strategies
BVS (BIREME)	(tw:(older people mistreatment)) AND (tw:(doctors)) AND (tw:(hospital)) AND (tw:(knowledge OR attitudes OR skills OR medical conduct))
PubMed Central: PMC	((elder abuse[Title/Abstract] OR elder neglect[Title/Abstract] OR aged abuse[Title/Abstract]) AND (physicians[Title/Abstract] OR doctors[Title/Abstract] OR hospitalists[Title/Abstract] OR medical staff, hospital[Title/Abstract])) AND (attitude[Title/Abstract] OR knowledge[Title/Abstract] OR behavior[Title/Abstract] OR practice[Title/Abstract] OR management[Title/Abstract] OR approach[Title/Abstract] OR treatment[Title/Abstract])
Web Of Science Main Collection	AB=("elder abuse") AND AB=(Knowledge OR Attitude OR Hability) AND AB=(Hospital OR "Medical Staff, Hospital" OR Hospitalist) AND AB=(Physicians OR Doctors)
Scopus (Elsevier)	TITLE-ABS-KEY (("elder abuse") AND (knowledge OR attitude OR ability) AND (hospital OR "Medical Staff, Hospital" OR hospitalist) AND (physicians OR doctors))
EMBASE (Elsevier)	(('elder abuse':ti,ab,kw OR 'elder neglect':ti,ab,kw OR 'aged abuse':ti,ab,kw) AND physician:ti,ab,kw AND 'medical staff':ti,ab,kw OR hospital:ti,ab,kw) AND attitude:ti,ab,kw AND (elder:ti OR older:ti OR aged:ti) AND [2004-2020]/py
CINAHL (EBSCO)	(elder abuse or elder mistreatment or elder neglect) AND (physicians or doctors or clinicians) AND hospital AND (attitudes or perceptions or behavior or knowledge)
BDTD	(Summary Portuguese:older people abuse And Summary Portuguese:doctors And Summary Portuguese:hospital)
OpenGrey	(elder abuse OR aged abuse OR elder neglect) AND (physicians OR doctors) AND hospital
OpenThesis	text((physicians OR doctors OR "medical care") AND hospital AND ("elder abuse" OR "elder neglect" OR "aged abuse"))
RCAAP	physicians AND (attitudes OR knowledges OR skills) hospital AND older people abuse
Portal de Teses e Dissertações da CAPES	("medical care" OR "medical care" OR doctors) AND hospital AND ("older people abuse" OR "older people neglect" OR violence against older people")
DART	(physicians OR doctors OR "medical care") AND hospital AND ("elder abuse" OR "elder neglect" OR "aged abuse")
Library and Archives Canada (Theses Canada Portal)	"physicians" AND hospital AND ("elder abuse" OR "aged abuse" OR "elder neglect" OR "physical abuse")

We included studies that met the theme, including scientific papers (quantitative, qualitative and mixed) and grey literature (dissertations and theses, medical guides, expert texts and medical or legislation related to the subject); in English, Portuguese or Spanish; published from October 1, 2003 to October 20, 2020 - a limit defined as immediately after the enactment of the Statute of the Older People in 2003. Studies that: did not address the theme studied; integrative or systematic reviews; did not present the possibility of being located in full in electronic or printed media; and those who demonstrated no ethical conduct were excluded.

The selection of the studies took place in two stages: an initial screening, by reading the title and the abstract, and a second screening, by reading the full text, selecting the papers according to the criteria mentioned above. Data extraction occurred through an instrument developed by the reviewer, which included title, author(s), year of publication/country, objective, method, professional categories of participants, main results related to the competencies of hospital doctors on VAOP. The methodological quality of the articles and the level of scientific evidence were not considered for the exclusion of papers, because this type of review seeks to gather all the production found on the object of study¹².

RESULTS

The searches in the databases revealed 161 papers, 36 found in the BVS, 40 in PubMed, 2 in Web of Science, 16 in Scopus, 60 in EMBASE and 7 in CINAHL. In the research of grey literature, 119 papers were found, 4 in BDTD, 61 in OpenThesis, 6 in the Portal de Teses e Dissertações da CAPES and 32 in RCAAP. No material was obtained from DART-Europe E-theses Portal, OpenGrey and Theses Canada Portal.

Thirty seven out of the 280 records found were duplicated and they were excluded, remaining 193 for reading the respective titles and abstracts. This process led to the exclusion of 175 publications for not adapting to the inclusion criteria, and to the pre-selection of 18 papers for full reading, where two papers were obtained by the Snowballing strategy. At the end there were 06 papers that fit this study¹⁵⁻²⁰. The result of the search and selection process is described in Figure 1.

One study came from Italy, two from Turkey, one from Israel, one from Canada and one from Ireland, produced from 2007 to 2018, all published in medical journals. Regarding methodological characteristics, the studies selected in this review are all quantitative descriptive, and used convenience sampling.

Regarding the professional categories addressed, only in two studies (33%) the Doctor was the only professional approached, while 6 studies (50%) included the Nurse. Other professionals such as the Social Worker and the Nursing Technician were considered in two studies (33%). These data and the objectives of the studies can be observed in Table 2.

The competencies of doctors in the studies involved general knowledge on the subject and approach, as well as specific training; detection and management skills, as well as experience with cases; and attitudes towards real or hypothetical cases, emphasizing case report and the identified barriers.

Knowledges

Table 3 presents the description of the competence of doctors' knowledge faced with VAOP assessed in the studies.

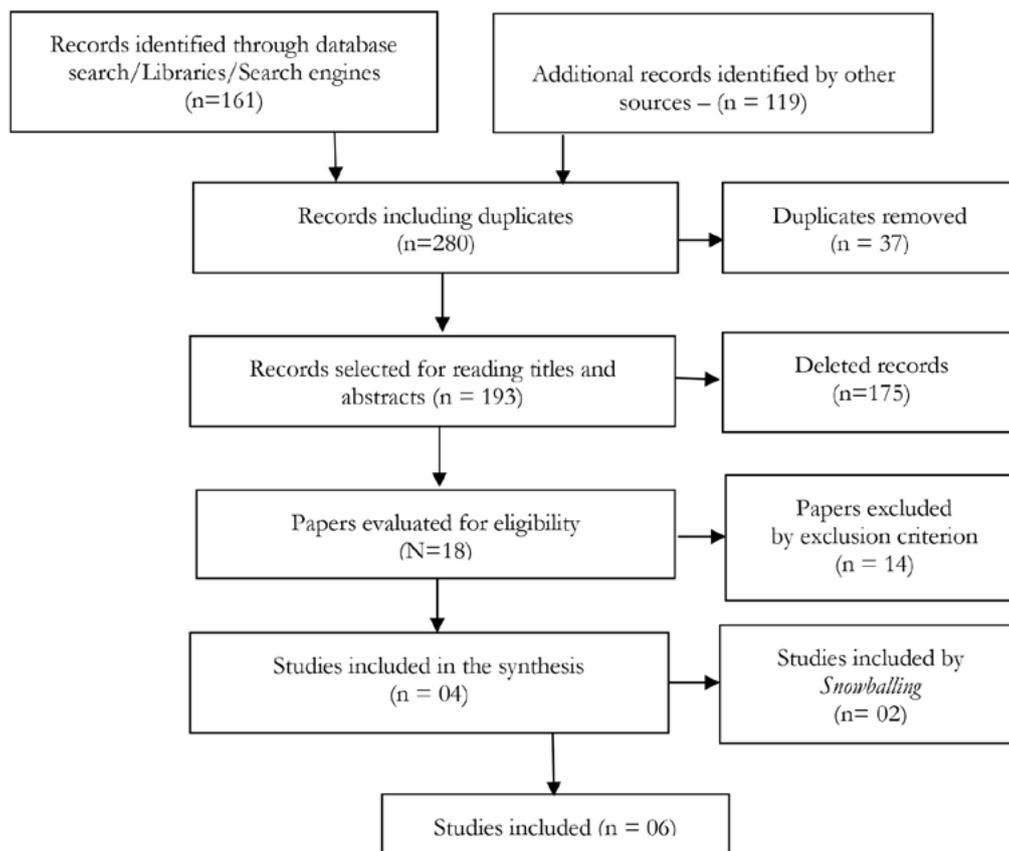


Figure 1. Flowchart of search and selection of studies on the competencies of hospital doctors in the face of VAOP cases. João Pessoa, PB, 2021.

Source: adapted from PRISMA-ScR¹².

Table 2. Characteristics of the studies included in the scope review on the competencies of hospital doctors in the face of VAOP cases. João Pessoa, PB, 2021.

Authors, year of publication, type of study	Education of the main author, country	Professional category(ies) addressed	Study Objective(s)
Corbi et al., 2019 ¹⁵ , descriptive comparative study	Doctor, Italy	Doctors, nurses and nursing technicians	Establish the level of awareness and perception of abuse to older people by health workers, and understand whether they were able to properly identify and report abuse, also to identify physical signs of abuse and negligence
Eraslan et al., 2018 ¹⁶ , descriptive quantitative study	Doctor, Turkey	Clinical doctors, specialists and resident doctors	To assess doctors' perspectives on abuse and neglect of older people and to understand their knowledge and approaches, to raise awareness of the subject, and to identify abuse and offer possible solutions
Caines et al., 2017 ¹⁷ , descriptive study	Doctor, Canada	Doctors	Examine the depth of knowledge and approach of Canada's emergency doctors on older people abuse
Almogue et al., 2010 ¹⁸ , descriptive comparative study	Doctor, Israel	Nurses and doctors	To assess the level of knowledge and attitudes of doctors and nurses regarding older people abuse in Israel, comparing doctors and nurses and analyzing the results according to workplace, specialization and professional and geriatric experience

to be continued

Continuation of Table 2

Authors, year of publication, type of study	Education of the main author, country	Professional category(ies) addressed	Study Objective(s)
Kennelly et al., 2007 ¹⁹ , descriptive comparative study	Doctor, Ireland	Doctors and Medicine social workers	To assess the awareness of health professionals about older people abuse
Mandiracioglu et al., 2006 ²⁰ , descriptive comparative study	Doctor, Turkey	Doctors, nurses and other specialties	To assess the definition of older people abuse, level of knowledge, attitudes and practices of emergency medical service personnel

Table 3. Knowledge of hospital doctors in the face of older people in situations of violence in the studies included in the scope review. João Pessoa, PB, 2021.

Studies	Knowledge of hospital doctors in the face of older people in situation of violence
Corbi et al., 2019 ¹⁵ , Italy	All aware that many older people are victims of abuse, and 93.8% of the sample put the abuse of older people as a violation of human rights. Of the total, 44.7% knew the standard procedures for reporting and approaching, and 40% of the doctors did not believe that negligence is a form of abuse.
Eraslan et al., 2018 ¹⁶ , Turkey	Specific training was received by 14.9% of the doctors. The trained group reported more than the untrained group ($p < 0.001$) and revealed a higher rate of abuse cases realization ($p = 0.04$), more often felt able on the subject ($p < 0.001$), and defined older people as older than 65 years ($p = 0.02$). They also defined old age as a period of dependence/need less frequently than the untrained group ($p = 0.02$). Doctors from public institutions had higher training on the subject ($p = 0.004$) and higher rates of case communication ($p = 0.005$) than those in the private sector.
Caines et al., 2017 ¹⁷ , Canada	Sixty-eight percent of the doctors felt able to report suspected cases of domestic abuse, and 63% in institutional cases. Regarding specific training, 35% did not complete it and 83% felt that the training was insufficient, in addition to 77% not being aware of all community services available to victims of abuse and their families. Half reported that their services did not have a written protocol to address cases of abuse, and 39% were uncertain whether there was protocol in their services.
Almogue et al., 2010 ¹⁸ , Israel	Doctors had no differences by service type (general or geriatric hospital). A total of 43% of the professionals knew that older people could receive state assistance if necessary, and 14% knew that there was no possible penalty if the case was not reported. There was a correlation between knowledge on the subject and that related to important laws and protocols ($p = 0.006$).
Kennelly et al., 2007 ¹⁹ , Ireland	A total of 45% of the doctors never heard the term older people abuse, and 30% read some technical material about it, while 85% felt that abuse was common and underreported. No doctor received formal training, and only one knew guidelines for this management.
Mandiracioglu et al., 2006 ²⁰ , Turkey	75% of the doctors believed that older people abuse was not common in Turkey. The scores obtained were high in understanding risk factors, intermediaries in knowledge and attitude towards cases and in diagnosis, and low in knowing their legal obligations in relation to cases. Twenty-four percent never received training.

As for general theoretical knowledge about VAOP, three¹⁸⁻²⁰ papers had low levels of knowledge. Kennelly et al. evidenced that 45% reported never having heard the term older people abuse, and only 30% read technical material²⁰. In another study, they obtained only intermediate scores in knowledge¹⁹. Only 43% knew that the victim could receive state aid, and only 14% knew that without complaint, there would be no penalty for the aggressors¹⁸.

Two studies evaluated the knowledge about procedures to report cases. Corbi et al. found that only 44.7% of the doctors were aware of the procedures. In another study, most doctors felt able to report domestic (68%) and institutional cases (63%)¹⁷.

An aspect considered central in acquiring knowledge to face the problem was having received specific training to manage cases; it was measured

by four studies. In one of them, only 14.9% received specific training¹⁶, while another pointed out a percentage of 24%¹⁹. The Irish study pointed out no formal training¹⁹. Caines et al. evidenced that 35% did not complete training on older people abuse, 83% felt that the training was insufficient, 50% reported that their services did not have a written protocol to address cases of abuse, and 39% were uncertain whether there was a protocol in their services¹⁷.

Comparing trained doctors with those who were not, one study highlighted that the former reported more than the others ($p < 0.001$), with a higher case finding rate ($p = 0.04$) and, more often, they felt able to address the topic ($p < 0,001$)¹⁶.

Comparing doctors from public and private institutions, one study revealed that the former had higher education on the subject ($p = 0.004$), with higher rates of reporting cases ($p = 0.005$)¹⁸. Another study showed that those in university hospitals outperformed those in private hospitals²⁰. However, the study by Almogue et al. did not find this difference¹⁸.

Regarding case experience, in two studies doctors never worked with a case of abuse or neglect^{15,16}. In the Irish study¹⁹, 65% said they had treated at

least one suspected case of abuse in the last year. In the study by Caines et al., 78% suspected cases in their careers¹⁷.

Skills

Table 4 presents the description of the competence doctors' Skills faced with VAOP assessed in the studies.

The situations that led doctors to suspect abuse were raised in two studies. One revealed that physical findings related to older people's appearance and hygiene were the main indications for 91.4%. The problematic communication between older people and family/caregivers was the least pointed out, with 56.8%¹⁷. The other study also highlighted physical findings, emphasizing burns, bruises, abrasions, and varied stages of healing of bruises and fractures¹⁵.

Attitudes

Table 5 presents the description of the competence doctors' Attitudes faced with VAOP assessed in the studies.

Table 4. Hospital doctors' skills faced with older people in situations of violence in the studies included in the scope review. João Pessoa, PB, 2021.

Studies	Hospital doctors' skills faced with older people in situation of violence
Corbi et al., 2019 ¹⁵ , Italy	As potential signs of abuse, doctors often indicated physical findings such as burns, bruises, abrasions, and varied stages of healing bruises and fractures. All personal negligence was a form of abuse for 60% of the doctors, and 48.7% suspected abuse less than 3 times in their careers.
Eraslan et al., 2018 ¹⁶ , Turkey	45% of the doctors witnessed cases in their practices. They were able to suspect abuse more frequently in the face of physical findings related to the appearance of the older people (91.4%), such as inadequate care in hair, nails, mouth and body hygiene; communication between older people and family members/ caregivers was the least pointed out, with only 56.8%. The most frequently found types of abuse were negligence (37.4%), emotional (25.1%), financial (22.2%), physical (15.7%), and sexual (1.1%).
Caines et al., 2017 ¹⁷ , Canada	Regarding the perception of cases, 85% considered that abuse occurred sometimes, and 78% suspected cases in their careers (73% in the last 5 years, and 45% in the last 12 months). The type of abuse considered most common was negligence, followed by financial.
Kennelly et al., 2007 ¹⁹ , Ireland	As for the experience, 65% had come across at least one suspected case in the last year.
Mandiracioglu et al., 2006 ²⁰ , Turkey	Half of the sample would not know what to do faced with a case. Doctors had low scores in performing anamnesis and physical examination focused on the diagnosis of abuse, and on knowing their legal obligations in facing cases. The least identified risk factors were linked to sexual and financial abuse.

Table 5. Hospital doctors' Skills faced with older people in situations of violence in the studies included in the scope review. João Pessoa, PB, 2021.

Studies	Hospital doctors' Knowledge faced with older people in situation of violence
Corbi et al., 2019 ¹⁵ , Italy	In both suspected and witnessed cases, doctors neither reported it to the authorities nor notified the protection agencies - 22.4% of the doctors witnessed abuse 1-3 times during their careers, but never reported it to the authorities, although 88.2% considered it a duty to report abuse.
Eraslan et al., 2018 ¹⁶ , Turkey	90.6% of the doctors said they had an obligation to notify the authorities. 24.3% of the doctors who found abuse and neglect reported it to the authorities. The main reason for not reporting (62.3%) was the concern that older people could suffer even more damage after the complaint, while 49% considered as insufficient the resources offered by the government to address the issue, and 35.2% thought that the legal process would be stressful for them. Faced with confirmed cases, 55.1% claimed having reported cases to the police without informing the family, 23.1% met the older person's wishes, and 17.5% spoke to the family, warning about the subsequent complaint to the police in the case of recurrence. When the same question was repeated for negligence to older people, 24.8% reported to social services, 21.3% reported to police agencies and 19.5% consulted the multidisciplinary team.
Caines et al., 2017 ¹⁷ , Canada	Regarding the performance of VAOP research, doctors "always" or "often" asked directly about abuse in 44% of the suspects, and 64% did not report suspected cases, but 83% considered as a medical responsibility to report.
Almogue et al., 2010 ¹⁸ , Israel	Of the total, 79% indicated that it was their responsibility reporting cases of abuse; and 88.5% agreed that all health professionals have a legal responsibility of reporting it. There was a general tendency towards neutrality in relation to older people abuse: given the allegation that only the interventions of legal authority will prevent older people abuse, the opinions were neutral. There was disagreement about the statement that placing the victim of abuse in a nursing home against their will is an effective intervention. Forty-one percent 41% considered that reporting abuse would make the aggressor angrier. Twenty-eight percent agreed that family members would assume that the whistleblower was a member of the team and 59% of respondents were sure that if they reported, their relationship with the patient would not be impaired. Now, 30% were certain that victims would generally deny abuse. The main reasons pointed out for not reporting the cases were the desire of not being legally involved, the denial of abuse by the victim, the non-recognition of abuse in consultation, lack of clarity in the definition of case of abuse or negligence and uncertainty about how to proceed with the complaint.
Kennelly et al., 2007 ¹⁹ , Ireland	The usual conduct pointed out was to seek advice from senior colleagues when managing suspected cases of abuse, and 46% would feel uncomfortable using the label of "older people abuse."
Mandirioglu et al., 2006 ²⁰ , Turkey	They had low scores in disposition to report. Most considered it an unacceptable invasion asking about abuse and that it would affect the professional-patient relationship.

Regarding attitudes, all studies reported doctors' considerations on several VAOP aspects. Opinions on certain management behaviors appeared in a study that included doctors and nurses. They were neutral faced with the claim that only interventions of legal authority would prevent VAOP. Placing victims in nursing homes has been seen as beneficial provided it is voluntary - there have been conflicting opinions about compulsory institutionalization. The majority found it helpful to obtain a restraining order against an aggressor¹⁸.

In this study, 41% considered that reporting abuse would make the aggressor angrier, and 28% agreed that families would consider that it was a team member who reported the abuse. Near 30% were certain that the victims would generally deny abuse¹⁸.

There was no unanimity regarding the doctor's responsibility to report VAOP cases in the four studies that evaluated this aspect¹⁵⁻¹⁸. Percentages ranged from 79%¹⁵ to 90%¹⁶. The effect of reporting on the doctor-patient relationship on the victim

was considered negative in a study²⁰, with doctors considering invasive asking about abuse. In the Israeli study, 59% evaluated that the bond would not be impaired¹⁸.

Contrary to what was found in the other studies, 75% of the doctors in the study by Mandiracioglu et al. believed that older people abuse was rare in Turkey²⁰. In the Irish study, although 85% of the doctors considered abuse as common and underreported, 46% felt uncomfortable defining cases as older people abuse¹⁹.

The VAOP research when there was suspicion was addressed by only one study, where doctors "always" or "often" asked directly about abuse in 44% of suspicions¹⁷.

Regarding the reporting of cases, doctors did not report it in 75% of the studies. One study showed that they reported no suspected or witnessed cases, neither to authorities nor regulatory agencies¹⁵. In another study, 24.3% reported VAOP cases to the authorities, although 45% witnessed it¹⁶, a finding similar to that of Caines et al¹⁷. In another study, there was a general tendency towards neutrality¹⁸. Another study revealed low scores in disposition to report and to know their obligations faced with the cases²⁰.

In investigating the reasons why doctors did not report the cases, one study detailed the reasons. Concerns were highlighted about the possibility of the older person suffering more damage, insufficient resources to manage the issue, and the probable stress with the complaint process¹⁶. Another study pointed out the desire of not being legally involved, abuse denial by the victim, non-recognition of abuse in consultation, lack of clarity of VAOP case definition and uncertainty about how to proceed with the complaint¹⁵.

The specific actions in the face of VAOP cases were related by a study where 55.1% reported cases to the police without informing the family, while 23.1% met the older person's wishes, and 17.5% spoke to the family, warning about the subsequent complaint to the police in the case of recurrence¹⁶. In another study, they reported customary seeking advice from more experienced colleagues to manage cases¹⁹.

In terms of approach in cases of negligence, one study pointed out that in 24.8% of the responses the doctors reported to social services, 21.3% reported to police agencies, and 19.5% consulted a multidisciplinary team¹⁶. No other study specifically explored the attitudes towards negligence cases.

DISCUSSION

The results made clear the shortcomings in the competencies necessary for hospital doctors in properly tackling VAOP. Lack of knowledge on the subject and its approach, absent or insufficient specific training, little appreciation of communication problems and relationship between older people and their guardians, case research in the minority of suspicious situations, and few or null complaints emerged among the problems found.

VAOP is an important public health issue^{15,17} and, in this scenario, it is expected an increasing number of vulnerable people. Yon et al. estimated the overall VAOP prevalence at 15.7%, one out of 6 adults over 65 years²¹. However, a study carried out by Cornell University and the New York City Department of Aging revealed that only one out of 24 cases is reported²².

Hospital medical services play a crucial role in detecting and managing these cases, as they are usually the first service with medical back-up accessed by this population^{9,15,23} and may provide necessary conditions for the evaluation of the case, such as confidentiality, privacy and multidisciplinary approach. Therefore, VAOP's routine and comprehensive approach in these services is vital, with research on event's evidences, initial measures, follow-up, referrals for protection and long-term care and recurrence prevention².

VAOP cases are underreported and poorly documented due to the lack of knowledge and awareness on the topic²⁴. The lack of knowledge exposed by the studies covers general knowledge¹⁸⁻²⁰ and procedures necessary to approach cases^{15,17}. It is probably one of the main reasons for the low number of diagnoses and case notifications and for the often neutral attitude on that matter¹⁸. Evaluations conducted with PHC doctors endorse this finding^{25,26}.

This lack of knowledge scenario is endorsed by the low percentages of doctors who received specific training^{16,19,20}, by the perception that this had been insufficient¹⁷ and the idea that negligence does not mean abuse for 40%¹⁵. When comparing VAOP-trained doctors to untrained doctors, one study highlighted that the former detected and reported more, besides feeling more able to address the question¹⁶. Similarly, conflicting perceptions and opinions about the subject were revealed, about the relevant legislation and conduct¹⁸.

The lack of training also appeared in studies with family doctors and it was determinant for the insecurity of doctors in detecting and reporting cases²⁵⁻²⁸. In the review conducted by Cooper et al. most professionals were unaware that many cases are not seem by serious damages²⁹. Doctors' awareness and perception level is still low, especially on how to report¹⁵. These facts reiterate the importance of approach protocols and multidisciplinary teams to ensure adequate, comprehensive and timely care, assistance and legal support¹⁷.

Educational activities involving group practical teaching can increase the knowledge of doctors³⁰. The training broadens the understanding of the theme, with greater sensitivity to it¹⁷. Studies are lacking to assess how much detection and management could improve, but there are findings associating reinforcement training and higher reporting rates, although without proof that there were more abuse diagnoses^{29,30}.

It should be noted that training professionals to identify signs of abuse is more complex than teaching bureaucratic reporting and referral procedures²⁹, and these processes must move forward together. More opportunities for continuing medical education are vital to improve VAOP approach. However, there is often a lack of resources to address this problem properly¹⁷.

Regarding the experience with cases, the low and variable percentages of doctors who worked with or suspected VAOP brings suspicion of the association with the lack of knowledge mentioned above and the barriers in dealing with VAOP. This possibility is echoed by the low notification of suspected cases demonstrated in two studies^{16,17} and in the absence of

notifications, despite the suspicion, in another study¹⁵, despite the ethical and legal obligation to do so.

Given the high frequency of cases, mostly in physically and mentally ill individuals²⁹, and by the studies that assessed professionals of reference services at hospital level, it was expected that they had found several cases throughout their careers. This is repeated in PHC, where services' offer, the accessible and widely used doorways, does not result in detection in the same proportion^{25,28,31}.

Addressing factors that generated suspicion of abuse, physical findings of appearance, hygiene and injuries were highlighted, to the detriment of clear problems in communication between older people and family members/caregivers¹⁶. Many social and emotional demands are neglected by the rational use of time, a fact emphasized by training that ends up limiting communication between the doctor and other entities²³, an important barrier to VAOP approach as a routine^{9,28}. This practice targeting without prioritizing VAOP research is more natural and easier than dealing with legal and social issues²⁸.

All studies evaluated the attitude of doctors on different aspects of the subject. Conflicting opinions and tendency towards neutrality prevailed, without researching the reasons. PHC studies had similar results, attributed to influences from personal or professional values^{25,28}. Family doctors tended to believe that social service professionals would have more chances of facing cases, and they would be the experts on the subject²⁵.

Given the technical information, the clinical experience and the privileged position of hospital doctors in finding older people abuse, it is remarkable that, even though the doctor's responsibility of reporting cases is acknowledgeable, there was no unanimity in the four studies that had assessed that aspect¹⁵⁻¹⁹, what confirms the education and practice shortcomings regarding clinical matters.

Doctors' attitudes revealed the barriers in notifying cases faced with the duty of reporting, generating obstacles to the approach itself, hindering both the overall necessary management as the pursuit of ending violence^{25,26,28,32}. In the meantime, professionals need to be fully secure before reporting

a case, a scenario where insecurity due to lack of knowledge further reduces the proportion of reported cases^{18,29}. In line with this reality, the low notification was the keynote in all studies, including a sample where no cases were reported, in no form¹⁵.

The obligation to inform the competent authorities of cases of abuse is provided for in the Statute of Older People⁶, which also determines that non-communication by the assistant health professional is an administrative offence punishable by a fine. Health workers should consider legal complaints as an exception to confidentiality, the importance of which comes from the need to investigate crimes, identify perpetrators and maintain the health of victims, without keeping any confidential information¹⁶. Hospital doctors, even though primarily aware of the responsibility to report VAOP, although not fully aware that it is a social issue¹⁵.

The results also pointed out that few ask about abuse, a finding similar to that of studies conducted in PHC^{25,26}. Family doctors also emphasized that cases were not reported because they were unable to hold the suspicion with evidences^{25,26}. As revealed by a systematic review, U.S. doctors who questioned VAOP were more likely to detect and report, corroborating the evidences that questioning older people and caregivers about it is probably the most effective isolated strategy for detection²⁹. However, it is clear once again that doctors are not familiar with identification, management, protocols, legislation and referral¹⁶.

Personal values appear as barriers to the approach, such as fears that the complaint would stress VAOP or affect the bond with the family or the older person, who could deny the fact^{15,19}. The fear of getting legally involved was also highlighted¹⁷, as well as the idea of questioning being invasive²⁰. Such perceptions are also explained at other levels of attention with similar difficulties and fears, preventing doctors from defining signs of abuse or negligence as VAOP situations^{26,28}.

Only one study¹⁶ addressed attitudes and barriers to cases of negligence. The underestimation of this might result from the common sense that the perception of older people abuse is something uncertain, based on physical signs¹⁵. Physical

examination findings can serve as warning signs for doctors to pay attention to the possibility, but they should not be considered diagnoses without circumstantial information supporting the fact², where negligence is often observed.

Important knowledge gaps, misperceptions and lack of translation of knowledge into better attitudes and skills, as well as better attitudes and skills after training. Barriers permeate the three aspects of competence and are interrelated, pointing to needs for qualified and continuing medical education. Many services do not even have VAOP protocols¹⁷.

Furthermore, the results showed that when there was a suspicion, action was seldom taken. Awareness campaigns, so fashionable in the media and in academia and recommended by the Ministry of Health should also reach doctors, encouraging them to constantly improve their approach.

Despite the contributions described, this study has limitations related to selection bias, due to restrictions on the inclusion of papers only in English, Portuguese and Spanish; texts available in full; and with temporal limitation. The fact that grey literature was included was considered a positive point.

The practical behaviors of doctors faced with abuse cases, exercising the role of articulating care, properly managing VAOP repercussions, and collaborating to hold the perpetrators accountable were not addressed in the studies. In addition, small samples with low response rates and questionnaires that are sometimes not very comprehensive due to the complexity of the topic compromise the accuracy of the findings of the selected studies in faithfully portraying reality. Such facts, associated with the small number of papers found and the lack of national studies on this theme constitute limitations to the extrapolation of the results to our reality, while elucidating extremely relevant facts to this confrontation.

There is a clear need for more studies to elucidate these aspects and enable the establishment of evidence-based strategies for broad professional training and the development or refinement of instruments to approach and evaluate cases, as well as their incorporation into clinical practice.

CONCLUSION

This study obtained concerning findings about the competences of hospital doctors in the face of VAOP cases. Because they are closely interrelated, the shortcomings identified in one sphere affect the others. As a result, there is a substantial loss of the capability to properly identify and address VAOP.

Low levels of knowledge were clearly evident, which directly impacted skills. The characteristics of medical training and practice focused on clinical diseases and the rational use of time, without specific training, as well as unprepared services largely devoid from action protocols result in a lack of preparation,

confidence and a proactive attitude from doctors who attend this large and vulnerable population.

The result is the sad scenario where there is still little research on abuses in the face of suspicions and allegations of VAOP, reinforcing the various barriers to the approach instead of mitigating them. Therefore, there is a lot of work to be done in medical education and in studies evaluating different forms of training and encouragement and the practical impact of these measures on medical skills, seeking to train professionals able to ensure care and protection for this vulnerable population.

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