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# Reading between the lines. Older people's maltreatment - from detection to reporting in primary healthcare

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## Abstract

The issue of older people's maltreatment (OPM) is gaining increased attention worldwide because of its significant short and long-term severe consequences. Healthcare professionals play a crucial role in detecting, reporting, and managing these cases, but many difficulties in these procedures exist, and underreporting is very frequent. Thus, the aim of this study was to identify the extent of and difficulties in detecting and reporting suspected OPM cases by general practitioner physicians in Portugal. A cross-sectional survey was conducted among general practice physicians (GPPs) to assess their perceptions, experiences, and challenges in detecting and reporting older people maltreatment (OPM). The 13-item questionnaire explored sociodemographic factors, responsibility, confidence, reporting practices, and training needs, providing an updated insight into OPM management in primary healthcare. It was anonymous and conducted through a self-report questionnaire distributed in paper format to GPPs working in the National Health Service in the Northern of Portugal. We received 356 completed questionnaires for further analysis. The findings indicate that, on average, physicians suspect fewer than one OPM case per year; only 32% suspected at least one case in the previous year, although 55.3% and 54.5% of the physician's revealed confidence in identifying signs of physical abuse and neglect, respectively. The ambiguity of the psychological symptoms was identified as a great challenge in detection (50.3%). Only 36.5% of the physicians were acquainted with the procedures for reporting suspected cases; however, of the 32% who suspected at least of one case in the previous year, only 39.5% reported all or at least some suspected cases; 16.9% chose not to report the case when requested by the victim or his/her caregivers. Most (91.6%) expressed a willingness to adopt protocols to assist them in managing such cases. A correlation was found between physicians' satisfaction with OPM reporting training during undergraduate and postgraduate education and their ability to report ( $p=0.024$ ), as well as with the number of reported cases ( $p=0.003$ ). Thus, the detection and reporting of OPM by physicians remain major challenges that need to be overcome. Further research and greater awareness of the importance of these procedures are essential to ensure victims' protection, safety, and health.

**Keywords** Older people, Maltreatment, Abuse, Neglect, Physician, Primary care

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## Introduction

Older people maltreatment (OPM) is one of the most recent violence issues and has gained the attention of the public, healthcare community, researchers, involved institutions, and decision-makers. While child maltreatment received significant attention in the 1960s and domestic violence against women in the 1970s [1], the medical literature did not describe OPM until 1975, when two reports of granny battering emerged [2]. The emergence of OPM as a recognised problem should be understood in this broader context, as awareness of elder abuse followed the earlier recognition of child abuse, domestic violence, and other social changes that brought issues of family violence into public and professional debate. Since then, healthcare professionals have gradually recognised this problem, and many reports have appeared in the United States [3, 4], Canada [5, 6] and Europe [7–9].

Between 1988 and 2019, at least 55 studies were published regarding healthcare professionals and OPM reporting in out-of-hospital and emergency department settings [3].

Also, prevalence data from community-dwelling cohort studies are also worth mentioning, as they provide essential insights into the magnitude and characteristics of elder abuse among older adults living in the community. For example, a WHO-supported meta-analysis estimated that approximately 15.7% of people aged 60 years and older experience some form of abuse each year [10].

The establishment of the *International Network for the Prevention of Elder Abuse* in 1997 indicates increasing international concern about OPM [11, 12].

A major impediment to raising awareness in OPM has been the widely varying and sometimes poorly constructed related concepts [13]. However, consensus has emerged regarding the concepts and classification of OPM [14], and according to the *World Health Organisation (WHO) Toronto Declaration*, the phenomenon is defined as “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” [15]. Consequently, OPM includes acts of commission, categorised as abuse, and acts of omission, categorised as neglect [11, 16]. It is typically divided into physical, emotional, and sexual abuse, as well as financial exploitation, neglect and abandonment [13, 17].

Although few systematic reviews depict the prevalence of OPM, the United Nations estimates that 901 million people worldwide are aged 60 years and older, with approximately 141 million victims of OPM annually [10]. According to the WHO, approximately 1 in 6 people 60 years or older experienced some form of maltreatment at home [18]. Despite the lack of reliable prevalence studies, experts believe that OPM in institutional settings is equally common or higher [19].

The Portuguese Penal Code criminalises violence against older people under two categories: (a) Domestic Violence (Article 152.º), defined as any behaviour that causes suffering. It can be done to ex-spouses, partners, parents, and children directly or indirectly, with or without intent. It also involves abuse of vulnerable cohabitants including the elderly, children, disabled, unwell, pregnant, or economically dependent; Maltreatment (Article 152º-A): This article covers neglect, physical abuse, and other harmful behaviours towards vulnerable people owing to age, disability, disease, pregnancy, or economic dependence. Even without a strong contact with the victim, it applies to anyone who care, supervise, or educate kids or vulnerable adults. Since 2001, both crimes have been officially recognised as public crimes in Portugal, meaning that the Public Prosecution Service automatically initiates criminal proceedings when it becomes aware of suspicions about such incidents, regardless of the source [20]. Health professionals, under Article 27 of the Code of Ethics of the Portuguese Medical Association, are required to report observed maltreatment of vulnerable individuals.

The first Portuguese prevalence study, based on a representative probability sample of 1,123 older adults, aimed to estimate the 12-month prevalence of abuse and neglect in family settings and to examine their association with sociodemographic and health characteristics. Data were collected through a telephone survey that assessed 12 abusive behaviours alongside demographic variables. The study revealed that 12.3% of older people had experienced at least one abusive situation in the previous 12 months., with the following distributions: 6.3% psychological abuse, 6.3% financial abuse, 2.3% physical abuse, 0.4% neglect, and 0.2% sexual abuse [8]; this study also revealed that OPM is related to several health consequences. In fact, another Portuguese study, including a population of 68,094 individuals [17], revealed that people considered suspected victims of OPM presented much higher rates of traumatic injuries, intoxication, mental health and somatic disorders than did the remaining population. This retrospective, observational, cross-sectional study, conducted in local healthcare units in Matosinhos and based on secondary analyses of electronic health records (EHRs) and healthcare registers, reported that only 4.5% of the older population was suspected by physicians of being victims of maltreatment. Similarly, Hoover and Polson [21] also reported lower prevalence rates.

Explanations for the low detection rates of older people maltreatment are multifactorial, involving factors related to victims, healthcare professionals, and broader organisational and policy-level determinants.

Victims frequently refrain from disclosing their experiences for multiple reasons. Their physical and mental

vulnerabilities, along with associated impairments, may hinder their ability to articulate mistreatment or to seek assistance [11, 22]. Dependence on the abuser, combined with the fear of losing personal ties, is particularly relevant when the perpetrator is a relative or intimate partner [23, 24]. Fear of possible legal consequences for the offender may also discourage disclosure [25–28]. Uncertainty about the seriousness of the situation further contributes to underreporting, as perpetrators often convince victims that the behaviour is not severe enough to warrant reporting or that authorities will neither believe them nor intervene [24]. Additional barriers include fear of institutionalisation [24, 29] and fear of retaliation, often fuelled by threats of escalating violence used as a silencing tactic [27, 28]. Feelings of shame, guilt, and worthlessness, instilled by the offender, further inhibit disclosure [29], as do difficulties in help-seeking or communication challenges linked to mental health problems [22, 29]. Stigma associated with being a victim of maltreatment, especially in certain cultural or familial contexts, may also generate fear of judgment or ostracism [23]. Moreover, many victims experience social isolation imposed by perpetrators, restricting their access to supportive networks and information about how to report abuse [29]. Finally, financial dependency is highly influential, as offenders may control victims' resources, thereby limiting their ability to access services or support systems that could facilitate disclosure [11].

Healthcare professionals also face significant difficulties and doubts regarding the detection of older people maltreatment. Barriers often arise during patient interviews, as many physicians report feeling undertrained and insecure about how to approach suspected cases [26, 27, 30]. The presence of an accompanying person, who may sometimes be the suspected abuser, further complicates assessment [27]. Diagnostic uncertainty is another obstacle [26], particularly in distinguishing the aetiology of traumatic physical injuries [21, 31]. In addition, organisational deficiencies—such as limited consultation time, difficulties in ensuring privacy [26, 27], and the absence of established protocols on OPM—undermine physicians' capacity to detect abuse effectively [26, 28].

The literature also shows that, in general, maltreatment is underreported by professionals, and this tendency equally applies to older people maltreatment. Healthcare professionals constitute an important group, which is particularly relevant because the health system is a significant and frequent entrance door for these patients. For every reported case of OPM by health professionals, another 23.5 cases are unreported; cases of neglect are the least likely to be reported, with only 1 in every 57.5 cases being addressed [32].

Several factors contribute to the difficulties healthcare professionals face in addressing cases of older people

maltreatment (OPM). Fear of diagnostic uncertainty, particularly the risk of mischaracterising an injury as intentionally inflicted, represents a significant barrier [33]. In addition, insufficient training and feelings of insecurity in dealing with suspected victims—together with fear of offending patients who may deny maltreatment and thereby jeopardising the patient–provider relationship—further inhibit detection [27]. Professionals may also be concerned that reporting suspicions could aggravate the violence suffered by victims [26]. Limited awareness of OPM contributes to under-recognition [28], while organisational deficiencies, including the lack of established reporting protocols and insufficient consultation time to address the issue, also play a critical role [26–28].

Given that a comprehensive healthcare response is essential to a coordinated community-wide approach to family violence, particularly OPM, the general aim of this study is to identify the extent and challenges in detecting and reporting suspected OPM cases by general practitioner physicians (GPPs) in Portugal, providing a perspective on the level of knowledge and awareness of OPM. The specific goals are (a) to assess their perceived responsibility, experience and capacity, as well as challenges in detecting OPM; (b) to assess their perceived responsibility, experience and capacity in reporting OPM; and (c) to identify physicians' needs for improving their performance in the detection and reporting of OPM and their availability for training and other actions in the issue.

## Materials and methods

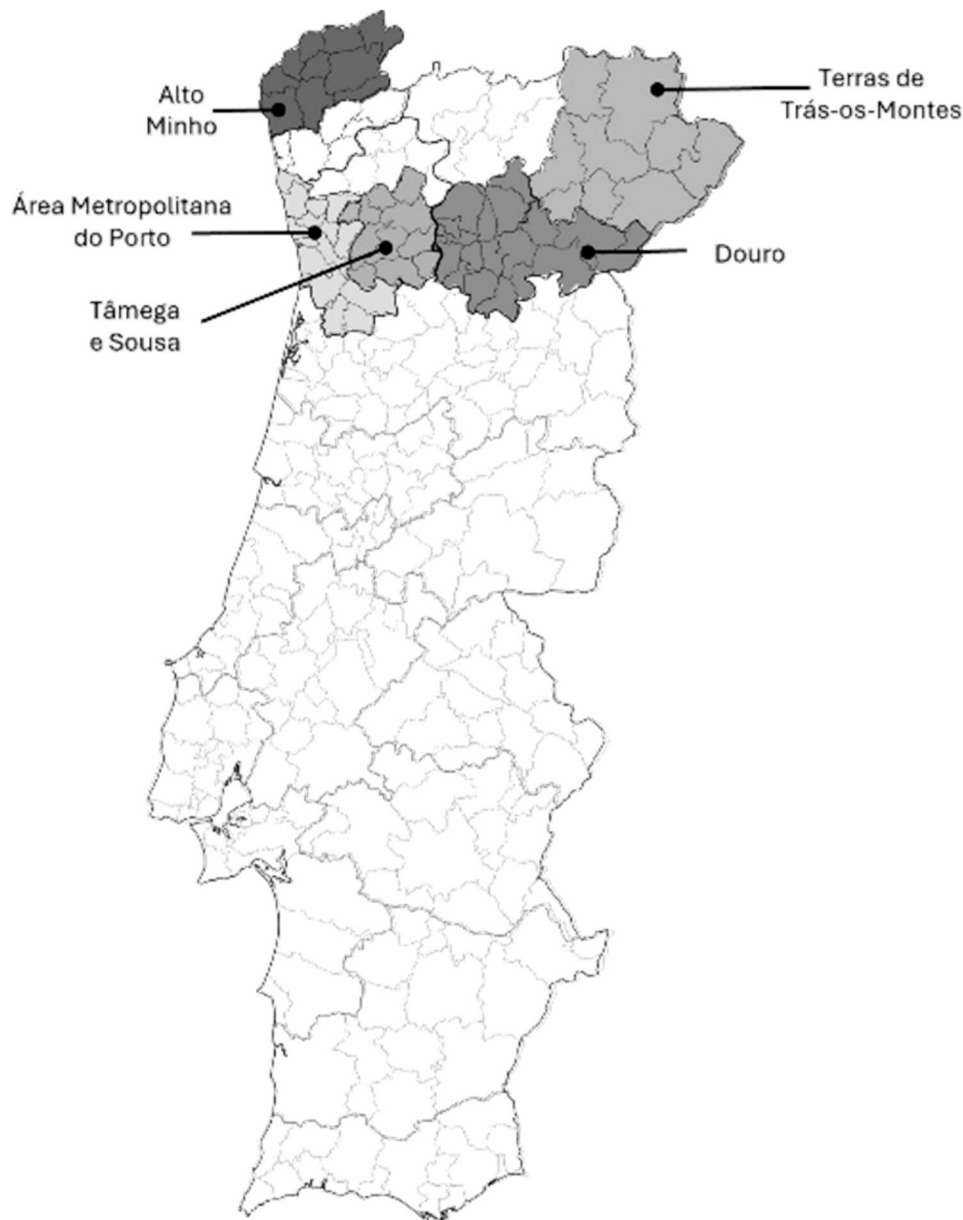
### Sample

The inclusion criteria were as follows: (a) physicians specialised or residents in general and family medicine; (b) working in primary healthcare facilities of the National Health Services (NHS) in the Northern of Portugal (*Alto Minho, Porto, Tâmega e Sousa, Douro and Trás-os-Montes*); the choice for this geographical distribution for sample collection was determined by the objective of representing the universe of GPP in the Northern of Portugal; (c) regardless of age, sex, career length and degree; and (d) assured physicians' informed consent to participate and coordinators' unit acceptance.

### Methods

A survey was conducted among general practice physicians (GPPs) working in primary healthcare facilities of the NHS in the Northern of Portugal, particularly in the following areas: *Alto Minho, Porto, Tâmega e Sousa, Douro and Trás-os-Montes* (Fig. 1).

The choice for this geographical distribution for sample collection was determined by the goal of representing the universe of GPPs in the Northern of Portugal.



**Fig. 1** Location of participating health units in Portugal

According to the 2021 Census, the Northern region of Portugal had 810.256 residents aged 65 years or older, representing 22.6% of its total population (INE, 2022).

The survey was developed in Portuguese language, and it comprised 13 items organised into four sections, each exploring specific aspects related to the detection and reporting of older people maltreatment (OPM). The first section gathered sociodemographic information (age, sex, years of professional practice, and career stage). The second section assessed physicians perceived responsibility for detecting OPM, their confidence in recognising abuse indicators, and the number of suspected cases identified during the previous 12 months.

The third section explored physicians' responsibility and experience regarding the reporting of suspected OPM, including knowledge of mandatory procedures, reporting frequency, and perceived barriers. The fourth section examined physicians' needs to improve their performance in this area, such as satisfaction with previous medical training, collaboration with social workers, and support for implementing specific protocols. Overall, the survey was designed to capture physicians' perceptions, experiences, and training needs, providing a comprehensive perspective on OPM detection and reporting in primary healthcare. It was pilot tested with 10 general practice physicians (GPPs) and subsequently revised. The

final version was self-administered and required on average 15 min to complete (Additional file 1).

After the healthcare units were contacted and authorisation was obtained from the coordinators, the surveys were distributed during medical staff meetings. During these meetings, a member of the research team explained the purpose of the study. An informed consent form was provided, addressing all ethical considerations, including confidentiality and the anonymity of the respondents. The completed questionnaires were collected at the end of these meetings, resulting in a total of 356 completed responses. It is difficult to estimate the precise number of general practice physicians (GPPs) working in Northern Portugal. According to Granja et al. [34], in 2021 there were 8,685 general practice physicians (GPPs) in Portugal, of whom 5,684 worked in the public sector. Of the total, 39% were based in the northern region, corresponding to approximately 3,387 GPPs. Our questionnaires were completed exclusively by physicians working in the public sector. If both public and private sector physicians were considered, our sample would represent 10.5% of the GPPs working in Northern Portugal.

The study was conducted between 2023 and 2024.

### Statistical analysis

The survey results were analysed using statistical procedures in SPSS (Statistical Package for the Social Sciences, version 29). To achieve the study's objectives, both descriptive and inferential statistics were employed. Descriptive statistics, including percentages and frequencies, were used to summarise the variables. Inferential statistics were applied via cross-tabulations and a non-parametric chi-square test. A significance level of 0.05 was used to assess whether suspicion and reporting of maltreatment were associated with other variables studied in the survey.

### Results

The respondents ( $n=356$ ) presented an average age of  $35.95 \pm 12.26$  years and a median age of 29 years (min = 24; max = 64). Most were female ( $n=248$ ; 69.7%). The medical staff presented an average of  $9.8 \pm 11.81$  years of professional experience, with a median of 3 years (min = 1; max = 42), and most were residents ( $n=226$ ; 63.5%).

**Table 1** Detection of OPM in the preceding twelve months ( $n=356$ )

	<i>n</i>	%
None	232	65.2
1 to 3	104	29.1
4 or more	10	2.9
Don't know	10	2.8

### Detection of OPM cases

Almost all respondents (93.8%,  $n=334$ ) agreed that detecting cases of older people maltreatment (OPM) is part of a physician's responsibility. Yet, when asked how many older people they had suspected of being victims in the previous 12 months, physicians reported on average fewer than one case each ( $0.74 \pm 1.61$ ; range 0–15). As shown in Table 1, two-thirds had not suspected any cases during this period.

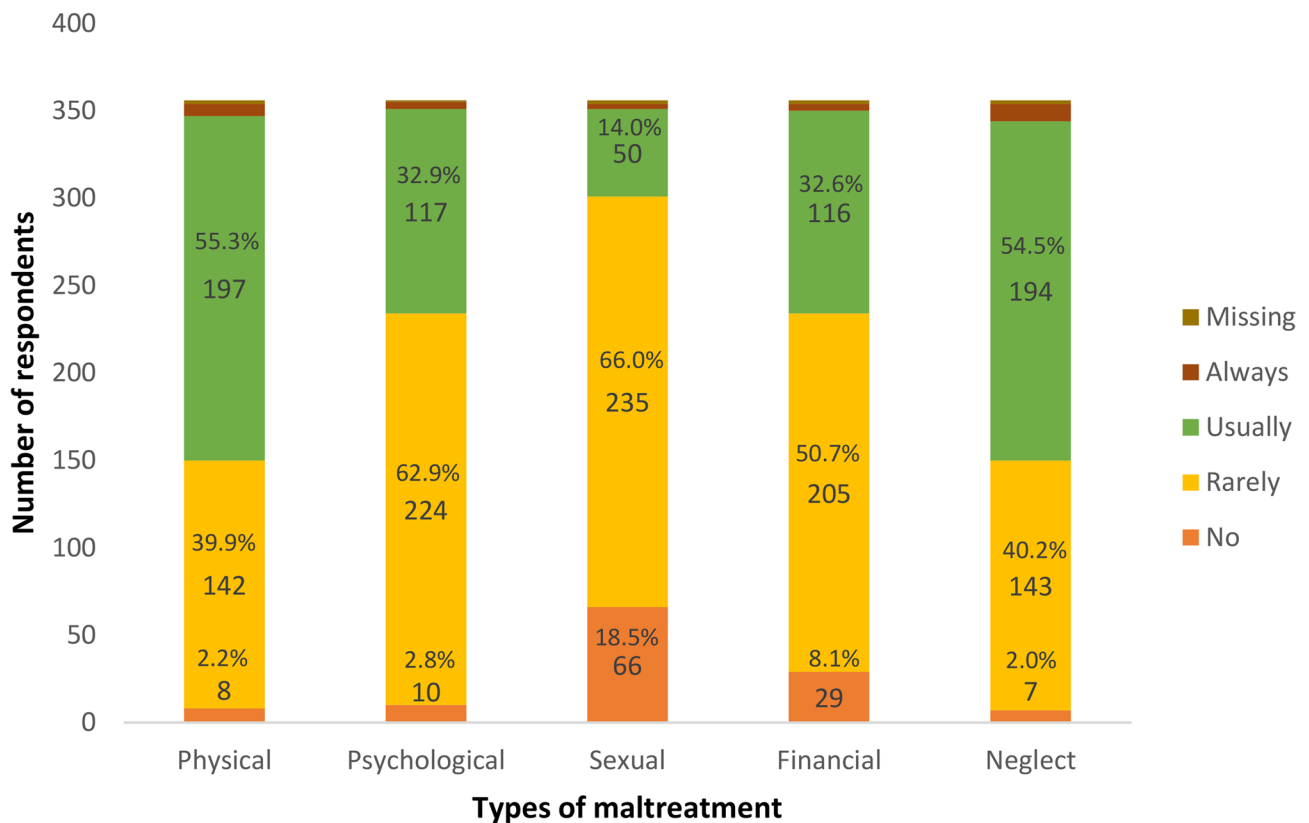
When asked whether they felt confident in detecting indicators of maltreatment, responses varied according to the type of abuse considered. As shown in Fig. 2, indicators of physical abuse posed the least diagnostic challenge, with over half of physicians (55.3%,  $n=197$ ) usually feeling confident in recognising them, though 39.9% ( $n=142$ ) reported rarely being able to do so. Confidence in detecting neglect showed a similar pattern, with 54.5% ( $n=194$ ) usually confident and 40.2% ( $n=143$ ) rarely confident. In contrast, physicians felt least confident in identifying financial and sexual abuse. For financial abuse, half of respondents (50.7%,  $n=205$ ) admitted rarely detecting it, and only 1.1% ( $n=4$ ) reported always being able to do so. Sexual abuse presented the greatest challenge, with two-thirds (66.0%,  $n=235$ ) rarely confident, and less than 1% ( $n=3$ ) always confident in detection.

From a list provided in the survey, respondents were asked to select two reasons they believed explained the challenges in detecting OPM. The most frequently cited obstacles were the *ambiguity of psychological symptoms* (50.3%) and *insufficient training*, particularly during graduate (34.3%) and undergraduate (25.8%) medical education. Other difficulties included *distinguishing neglect from self-neglect* (30.3%), the *low recurrence of victims in contact with the National Health Service* (21.4%), and the *presence of caregivers during consultations* (15.7%). Less frequently reported challenges concerned the *ambiguity of physical injuries* (15.5%) and *genital injuries* (4.8%). A small proportion (2.0%) were unable to identify any reason (Table 2).

### Reporting OPM cases

Regarding reporting responsibilities, 96.3% of respondents ( $n=343$ ) agreed that it is a physician's duty to report OPM, and 90.2% ( $n=321$ ) considered reporting to be mandatory. Nevertheless, 63.5% ( $n=226$ ) admitted not knowing how to report an OPM case to the criminal justice system. In practice, more than half of the physicians (55.3%) had not reported any suspected cases in the previous 12 months (Table 3).

These findings highlight a critical gap: although physicians recognise their responsibility and the mandatory nature of reporting, a lack of knowledge about the procedures significantly hinders the translation of suspicion into actual reports.



**Fig. 2** Confidence in detecting suspected OPM cases (n=356)

**Table 2** Perceived challenges in detecting OPM (n = 365)

	n	%
The ambiguity of the psychological symptoms	179	50.3
Lack of instruction during graduate medical training	122	34.3
Difficulty distinguishing neglect from self-neglect	108	30.3
Lack of instruction during undergraduate medical training	92	25.8
Paucity of recurrence of the victim to the National Health Service	76	21.4
Awkwardness before the caregiver also present at the consult	56	15.7
The ambiguity of physical injuries	55	15.5
The ambiguity of genital injuries	17	4.8
Unknown	7	2.0

**Table 3** Reports of OPM-detected cases in the preceding twelve months (n = 114)

	n	%
None	63	55.2
Just some suspected cases	15	13.2
All suspected cases	30	26.3
Suspected but did not answer	6	5.3

When asked whether they had ever chosen not to report a case of maltreatment at the request of the victim or their relatives, most respondents (81.5%, n = 290) stated that they had not refrained from reporting.

However, 16.9% (n = 60) acknowledged having complied with such requests.

This finding suggests that while most physicians uphold their reporting duty, a minority may be influenced by family or victim pressure, which poses a significant barrier to ensuring adequate protection for older adults at risk.

**Needs perceived by physicians to better manage OPM cases**

When asked whether communication with the local social worker was productive for handling OPM cases, 57.9% of respondents (n = 206) answered positively, while 41.0% (n = 146) considered this articulation insufficient. Physicians were also asked about the adequacy of their medical training regarding the reporting of OPM: of the 354 respondents, answers were almost evenly divided between positive (48.0%, n = 171) and negative (51.4%, n = 183) evaluations. Finally, when questioned about the implementation of protocols to simplify reporting, the vast majority (91.6%, n = 326) expressed support for this measure.

**Correlation analysis**

A chi-square test of independence was performed to examine the relationship between being a resident or

specialist and detecting OPM cases in the past year ( $p=0.05$ ) as well as having reported OPM cases in the same period ( $p=0.02$ ), suggesting that specialists are more likely to detect and report OPM cases than are residents.

With respect to the sex of the respondent, no correlation was found with detection ( $p=0.60$ ) or reporting ( $p=0.77$ ).

Significant correlations were found between (a) knowing how to report and having reported at least one case of suspected OPM ( $p<0.001$ ); (b) satisfaction with medical training on OPM reporting and knowing how to report ( $p=0.024$ ); and (c) satisfaction with medical training on OPM reporting and the number of reported cases ( $p=0.003$ ).

## Discussion

Although most physicians acknowledged that detecting and reporting OPM is part of their professional responsibility, the number of suspected and reported cases was strikingly low. This gap may be explained by factors related both to victims—such as shame, fear of retaliation or institutionalisation, dependency on the abuser, communication difficulties, and stigma—and to physicians, who often face limited training, low confidence in identifying certain types of abuse (especially psychological, financial, and sexual), diagnostic uncertainty, and organisational barriers including lack of time, privacy, and clear reporting protocols. Together, these obstacles highlight the multifactorial nature of under-detection and under-reporting of OPM in primary care. These results are in line with those of other countries [27, 35], but few studies have investigated this specific topic [3], but unlike Patel et al. [27] and Yan et al. [35], which primarily explored physicians' knowledge, attitudes, and barriers towards OPM in broader or international contexts, our study provides an in-depth, regional perspective focused on general practice physicians working within the Portuguese National Health Service in the Northern region. While Patel et al. [27] emphasised gaps in training and the need for clearer reporting systems, and Yan et al. [35] highlighted cultural and systemic factors affecting under-reporting in Asia, our findings specifically demonstrate how these global challenges manifest locally in Portugal, particularly through limited medical training, difficulties distinguishing neglect from self-neglect, and the influence of caregivers during consultations. This contextualised evidence contributes to the literature by revealing region-specific barriers while reinforcing the universality of the difficulties physicians face in the detection and reporting of OPM.

## Detection of OPM cases

Our study revealed that the GPP detected fewer than one OPM case *per* year, on average, with 32% detecting at least one case in the previous year. This result is far below the known prevalence of OPM in Portugal (12.3%) [8]. A reason may be that almost half of the respondents displayed a lack of confidence in identifying suspected signs of sexual abuse, psychological abuse, neglect, and physical abuse. However, it is important to note that, according to the obtained answers, more than half of the GPP expressed confidence in the detection of OPM, confidence that it does not match the number of cases they claim to have detected. This suggests difficulty in self-assessment of one's true skills and the existence of major challenges in detecting OPM, which may not be perceived by physicians.

Numerous obstacles hinder general practitioner physicians (GPPs) in detecting older people maltreatment (OPM). One of the most common barriers is the ambiguity of psychological symptoms. In Portugal, psychological abuse is the predominant type of OPM, with prevalence rates ranging from 6.3% to 32.9% [8, 36, 37]. Detection becomes particularly challenging when patients present with cognitive impairment, as this makes anamnesis less objective and more time-consuming. The problem is compounded by the increasing prevalence of moderate cognitive impairment with advancing age, rising from 10.9% among those aged 50–59 years to 21.3% in individuals over 80 [38, 39]. People with dementia are also at greater risk of physical abuse, especially in institutional settings [40–42]. Their health conditions and reduced self-regulatory abilities increase their vulnerability to violence [42]. The situation is further complicated when caregivers are also elderly and frail, creating additional challenges for assessment. In such cases, both the victim and the caregiver may require support, making it essential to address these situations promptly [14]. Subtle signs of intimidation, such as when a patient defers questions to a caregiver or potential abuser, along with evidence of social isolation from previously trusted friends and family members, or the presence of depression and anxiety, may indicate psychological abuse [31]. In this context, the mental status examination, although time-consuming, remains essential, as its core components support the differential diagnosis of dementia, delirium, and other syndromes, thereby contributing to more accurate identification of abuse.

Another major difficulty lies in the lack of adequate instruction during medical training. Participants highlighted insufficient preparation in Portugal, a finding consistent with international evidence showing that physicians often perceive their training on OPM diagnosis as minimal or entirely absent [43–45]. Comprehensive theoretical and practical education is therefore essential

to equip physicians with the skills needed to apply recommended protocols for identifying and managing OPM cases effectively.

Distinguishing neglect from self-neglect represents a significant diagnostic challenge in older patients, who often present with high levels of dependency and vulnerability [32, 46]. Dependency on others increases sharply with age, affecting 23% of those aged 65–85 and 45% of individuals over 85, particularly men [47]. The situation is further complicated when perpetrators themselves rely on victims for financial or housing support, which heightens the risk of abuse [32]. Although the prevalence of neglect in Portugal is reported to be relatively low (0.4%), it is more frequently identified among dependent older adults [8]. Clinical signs such as dehydration, malnutrition, or pressure ulcers may indicate neglect [30], while self-neglect is often associated with loneliness, depression, reduced self-care ability, mental illness, or alcohol misuse [48]. Differentiating between the two requires sound clinical judgment, careful monitoring, and often separate interviews with patients and relatives. Although demanding, a multidisciplinary approach can provide more accurate assessments [49].

Another important obstacle is the low recurrence of victims within the National Health Service. Older adults experiencing abuse face multiple barriers to seeking help, including individual, familial, structural, and cultural factors [50]. Despite this, there is evidence of increasing visibility: the Associação Portuguesa de Apoio à Vítima (APAV) recorded a rise in older people requesting support, from 289 cases in 2000 to 1,671 in 2023 [51, 52]. Nonetheless, many healthcare professionals still lack sufficient knowledge of the concepts, epidemiology, diagnostic tools, and intervention strategies related to OPM [53].

The presence of caregivers during medical consultations was also identified as a significant barrier to detection. When the caregiver is a family member and potentially the abuser, maltreatment may remain hidden, particularly if the patient is highly dependent on them for basic needs. Research has shown that intrafamilial abuse is often concealed by other relatives [13, 54]. Hoover and Polson [21] highlight the importance of interviewing patients alone whenever possible, as caregivers who interrupt or answer on their behalf can raise suspicion. In Portugal, perpetrators are frequently close to the victim, including relatives (27%), descendants (16.1%), spouses or partners (13.4%), and friends or neighbours (11.6%), while 13.5% of victims refused to identify the offender [8]. Many older adults are dependent on caregivers and may have reduced autonomy or communication difficulties [41, 55], which increases their vulnerability and makes them particularly likely to remain silent victims.

Despite being deemed comparatively easier to identify, the ambiguity of physical injuries continues to provide a barrier. Physicians indicated a higher comfort level in identifying indications of physical abuse, attributing this to the familiarity, objectivity, and relative speed of physical examinations. Nonetheless, definitive or strongly indicative evidence of physical abuse are infrequent, and injuries may be accidental, pathological, self-inflicted, or iatrogenic, potentially resembling abuse [21]. A meticulous assessment is therefore crucial, and thorough evaluations should preferably be conducted by qualified healthcare practitioners [27]. In Portugal, this responsibility is often undertaken, in accordance with criminal legislation, by forensic physicians from the National Institute of Legal Medicine and Forensic Science (NILMFS). A critical diagnostic inquiry in these instances is whether the provided explanation aligns properly with the physical findings [21].

The detection of sexual abuse poses an even greater challenge. Among all forms of OPM, general practitioners expressed the lowest confidence in recognising genital injuries. This lack of confidence is understandable, as these assessments are complex and rare in clinical practice. In Portugal, suspicions of sexual abuse are systematically referred to medico-legal professionals, who perform specialised examinations and collect evidence either in hospitals or at the NILMFS, ensuring accurate and legally sound assessments. While this system provides physicians with additional security, it also reflects the infrequency of such cases in routine practice. The international literature on sexual abuse in older adults remains limited, with reported prevalence rates ranging from 0% to 8% [56].

#### Reporting OPM cases

In Portugal, reporting to authorities (criminal police or the public prosecutor officer) a suspicion of a public crime (such as OPM) is a mandatory procedure for all governmental employees, including healthcare professionals of the NHS case, when they become aware of it in the course of their duties or because of them, whether the victim agrees or not (articles 152 and 242, Portuguese Penal Code). Additionally, the Code of Ethics of the Portuguese Medical Association obliges all physicians to report this kind of suspicion (article 27).

In the present study, GPP revealed a significant responsibility for reporting OPM and knew that it was mandatory, but only a few knew how to do the report, and fewer reported all suspected cases in the previous year.

The process for reporting OPM in many countries, as in Portugal, closely resembles the established system for child abuse. Reports are typically categorised into informational reports, which are based on suspicion rather than proof, prompting adult protective services to start

an assessment and investigation [31]. Although physicians are rarely penalised for not reporting alleged cases of abuse, it should be part of one's moral and professional responsibility. According to the *National Elder Abuse Incidence Study* [57], family members reported 20% of all cases, hospitals reported 17.3%, and home health aides reported 9.6%, all of which are higher than the rates reported by physicians. The fact that, in our study, only 36.5% of the responders considered themselves to be acquainted with reporting procedures may be rooted in the lack of experience due to scarce cases of OPM handled or insufficient training during medical instruction [43–45] but also in the lack of available guidelines about this procedure.

After OPM was suspected, most physicians abstained from reporting, and few reported all suspected cases. These findings indicate that GPP rarely reports OPM, despite its frequent legal framing as a public crime, thereby leaving many victims unprotected.

Professionals frequently encounter several barriers that undermine their confidence in the process of informational reporting. A primary obstacle is the lack of awareness regarding mandatory reporting responsibilities, which highlights the need for comprehensive professional education to ensure clarity on this issue [27]. Another common barrier stems from the misconception that reporting constitutes a breach of confidentiality. This misunderstanding can be effectively addressed through educational initiatives clarifying that mandatory reporting laws typically contain provisions safeguarding the confidentiality of reporters [58]. In addition, some professionals deliberately avoid involvement in abuse cases for a range of reasons, many of which are rooted in misconceptions. These include concerns that reporting may aggravate the violence experienced by victims, apprehension about raising abuse-related questions, the belief that such cases are excessively time-consuming, fear of being wrong or of lacking sufficient evidence to justify a report, and a general reluctance to become entangled in the legal system [26, 57].

The development of a robust response system to the OPM can help eliminate these misconceptions and reluctance. This system could streamline the reporting process to reduce the time burden on professionals, provide evidence of the positive impact of interventions on the lives of older adults and their families, and ensure that professionals feel safe and supported when reporting and testifying in abuse cases [27]. By implementing extensive professional education and developing effective systems for responding to OPM, many of these barriers can be overcome [26, 27]. Previous studies support the findings of the present study, reporting that physician reporting accounts for only 2% of OPM reporting [21] and that despite older persons frequently seeking

medical help due to increasing vulnerability and decreasing health quality, OPM is seldom suspected. In a study conducted in Portugal, the reported prevalence of OPM was found to be 4.5% [17]. However, a GPP is strategically positioned to be involved not only in screening, detecting, and reporting OPM but also in ongoing case management [59]. Detection is a crucial step in this process, as without detection, reporting cannot occur.

Most of our participants did not comply with the victims' or family members' request to not report. Prior studies have reported that most physicians are unsure of how to report OPM and lack knowledge, are unsure of the legal system's effectiveness, and fear retaliation) [21, 59–61]. Satisfaction with medical training was correlated with better reporting practices and with the number of reported cases. Additionally, having reported at least one OPM situation is significantly related to knowing how to proceed, suggesting that experience enhances practical knowledge and increases the likelihood of reporting cases. The information provided during both undergraduate and postgraduate medical training plays a crucial role in preparing physicians to report OPM. This finding indicates that optimising medical training in this area is essential for practical results. With the identification of this problem, the Directorate-General for Health [62] issued guidelines that highlight the critical role of healthcare professionals in detecting and managing OPM. Emphasis is placed on comprehensive training, systematic recording, and integrated response mechanisms to ensure effective intervention and support for victims. Addressing organisational limitations and fostering a culture of early detection and prevention are key to improving the healthcare sector's response to OPM in Portugal.

#### **Needs perceived by physicians to better manage OPM cases**

The majority of the GPPs endorsed the use of a local social worker to assess OPM cases. In the primary care facilities of the NHS, a social worker may be helpful in handling OPM situations more broadly. In the often busy GPP appointment, although suspicion may arise, questioning about OPM may be too time-consuming for a medical physician to undertake. Therefore, a social worker, if available, may be decisive in mitigating existing conflict, contributing to reporting OPM cases and providing additional help towards victim protection.

Future protocols should be implemented to simplify reporting procedures. Overall, the findings emphasise the need for enhanced training, clearer diagnostic criteria, and supportive protocols to improve the detection and reporting of OPM by healthcare professionals. This approach is essential for better protecting and caring for older adults. Owing to their frequent interactions with older adult patients seeking medical assistance,

healthcare professionals need adequate training to report OPM [63]. Despite the critical role that healthcare providers play, many hospitals lack comprehensive protocols and follow-up guidelines for effectively addressing OPM [64, 65]. We must leverage upcoming efforts to develop practical protocols that streamline the reporting process, thereby fostering an increasingly efficient strategy in OPM situations.

### Strengths, limitations and further research

This study provides one of the first systematic assessments of general practice physicians' (GPPs) perceptions and practices regarding the detection and reporting of older people maltreatment (OPM) in Portugal. The use of a structured and pilot-tested questionnaire allowed for the collection of standardised data, ensuring internal consistency and clarity in responses. The sample, although geographically limited, included a significant number of physicians from the public sector in the Northern region, which represents a large proportion of the Portuguese healthcare system. Importantly, the study also identified specific training needs and practical barriers reported by physicians, generating actionable insights for policy development, medical training, and healthcare practice.

Nonetheless, this study has some limitations. The number of respondents was relatively low, which may limit the generalisability of the findings. In addition, the sample was restricted to GPPs working in the Northern region of Portugal, so the results may not fully reflect the perspectives of physicians from other regions. A further limitation is the high proportion of younger respondents, which may have influenced the results, since less experienced physicians are generally less familiar with diagnosing OPM and navigating reporting procedures, and may also be more susceptible to family members' requests not to report.

Future research should aim to involve larger samples, include physicians from other medical specialties, and be conducted in a multicentric national and international scope to gain a more comprehensive understanding of physicians' role in suspecting and reporting OPM. Reporting systems also require optimisation, for instance through the implementation of digital tools within the National Health Service (NHS) and the introduction of anonymous reporting mechanisms to protect professionals. Furthermore, adopting a multidisciplinary approach—bringing together healthcare providers, social workers, and legal experts—could improve case management and ensure a more coordinated response. Finally, the establishment of a national database to monitor OPM cases, interventions, and outcomes would enable the identification of patterns and provide valuable guidance for evidence-based strategies.

### Conclusions

OPM is a family and social problem that is now seen as being within the scope of medical practice, namely, GPP.

Although general practitioner physicians (GPPs) in Portugal recognise their responsibility to detect and report older people maltreatment (OPM), detection rates remain far below prevalence estimates and reporting is inconsistent. Barriers include diagnostic uncertainty, insufficient training, misconceptions about confidentiality, fear of legal involvement, and organisational limitations. Physicians identified the need for clearer reporting protocols, closer collaboration with social workers, and improved undergraduate and postgraduate training. Strengthening these areas is essential to bridge the gap between awareness and practice, enabling a more effective healthcare response and greater protection for older adults at risk of maltreatment.

The present study contributes to direct future actions toward a wider awareness of physicians about the phenomenon and best practices in handling OPM cases and their victims in the Portuguese primary healthcare context.

By implementing a multidisciplinary and transdisciplinary, as well as an evidence-based approach, healthcare systems may significantly improve the protection and well-being of older people, victims of maltreatment.

### Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12889-025-25394-1>.

Supplementary Material 1.

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### Authors' contributions

SF and CM conceived the idea for the research collected and compiled the data and prepared the manuscript. PN executed the statistical analysis and interpreted the results. PVP and TM prepared the manuscript. All the author's equal contributions to the draft and the final manuscript. SF and CM contributed equally to this work.

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### Data availability

The dataset analysed in the current study is included in the manuscript and if needed may be available from the corresponding author upon reasonable request.

### Declarations

#### Ethics approval and consent to participate

This study was approved by the Ethics Committee for Health of the Northern Regional Health Administration, IP (process n.º T230). An informed

consent form was provided to participate in research in accordance with the Declaration of Helsinki, addressing all ethical considerations, including confidentiality and the anonymity of the respondents. Consent was given by everyone who took part in completing the anonymous voluntary survey.

#### Consent for publication

Not applicable.

#### Competing interests

The authors declare no competing interests.

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