When the Journal of the American Medical Directors Association approached me to lead a review series on elder abuse, I enthusiastically agreed. I was pleased to know the Journal recognizes that elder abuse is an important topic for medical directors. This invitation also reflects the fact that there is a growing body of knowledge relevant to medical directors. Medical directors need to recognize and address elder abuse, not only at the bedside but also at team meetings and at the administrative level. With the increase in the number of research articles on elder abuse appearing in top general medical journals and journals in gerontology and geriatrics over the last few years, the time is ideal for a review series that translates the research into practical relevance for the medical director.

Our increasing knowledge in elder abuse has not yet made a general impact in clinical practice. Most clinicians, even geriatricians, still tell me anecdotally that they either, “see elder abuse everyday and don’t know what to do,” or “didn’t recognize it was elder abuse.” Elder abuse is very much under-recognized and under-reported. For every case that is reported, an estimated five to seven cases of abuse are not reported in the United States.1 Health professionals, as mandated reporters, constitute a small minority of the people who report abuse, and physicians make up an even smaller percentage.2 Even when the abuse is recognized, physicians often do not intervene. Some do not consider it a medical problem and delegate it to the social worker, despite statements dating from the 1990’s from the American Medical Association3 and the U.S. Department of Health and Human Services4 defining elder abuse as a public health issue. Others admit their frustration that they do not know what to do or pessimism that “nothing can be done or will be done.” Indeed, most physicians have received little to no formal training in elder abuse and therefore, have seen few, if any, successful resolutions of elder abuse cases, though such successes occur on a daily basis. To this day, few medical schools in the United States cover elder abuse anywhere in their curriculum.5

Medical directors, however, of all physicians are in the best position to address elder abuse. They have at their disposal the most successful, proven intervention for elder abuse, the interdisciplinary team.6,7 The physician leader of the team is well situated to synthesize all the information from the different disciplines. Neither the social worker nor the nurse has the medical background necessary to perform an adequate evaluation of elder abuse. The medical director is, therefore, ethically and professionally responsible to lead the team in such cases.9 Indeed, elder abuse cases include some of the most challenging cases that an interdisciplinary team may address. Without adequate leadership, team conflict and staff burnout may occur. Medical director leadership can also reduce the liability of such cases for the team, the agency or the facility.9

This series will present state-of-the art information relevant to the different setting in which medical directors practice. The first article in this issue will cover physical abuse in an assisted living setting. Future articles will cover neglect in the home and nursing home, financial abuse, and sexual abuse. On behalf the authors of the series, I hope that this series will empower medical directors to be more confident and proactive in reporting, preventing, and intervening in elder abuse cases.

REFERENCES