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Author(s): Bernoth, M.A. ; Burmeister, O.K. ; Dietsch, J.E. ; Shwartz, M.

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Information management in aged care: Cases of confidentiality and elder abuse

Abstract

Typically seniors like others choose to avoid institutional care. However when age-related infirmity requires it, they not only enter into the care of others, but they do so as vulnerable members of society. As their frailty increases with age, so does their dependence on the professionals who care for them and on the enforcement of policies concerning their care. A qualitative case study involving seniors and their carers revealed that breaches of confidentiality, unprofessional behaviour and the non-enforcement of policy, continue to hide the physical and emotional abuse perpetrated by nursing and other staff on vulnerable consumers. Professional ethics, including at a corporate level, enforcing policy, protecting whistleblowers, and creating reporting mechanisms for aged care researchers, are amongst the recommendations arising from this study.

Keywords

Consumer; policy; privacy; professionalism; seniors; vulnerability.

Introduction

The focus of this case study is on issues of professionalism and confidentiality in the business of residential care for elderly citizens. The fiscal impact of institutional aged care on society is expanding. In Australia, the number of aged care residents is expected to increase by 180% - 250% by 2044/45 (Tannous & Luo, 2006). Globally, caring for the aged person has devolved from family care to institutional care with for-profit and not-for profit organisations providing this essential service. Tannous and Luo (2006) argue that the business of aged care must be sustainable and facilities will close when business viability is threatened, especially in Australian rural and remote areas. Despite many efforts to improve the standards of care,

the training of carers, and the development of ethical standards to govern staff and resident information management, there remains significant scope for improvement.

The professionalism of business managers, their managerial practice, and Australian legislative policy in regard to the environment within which aged care operates, all impact the ethical treatment of aged care clients; these are the factors that need to be re-examined in the light of the research reported here. Numerous ethical dilemmas and issues arise in the context of residential aged care. Issues include but are not limited to informed consent, decisional capacity, privacy and surrogate decision making. A recent review of business conduct in 92 countries supported claims in prior research which argued that the business environment impacts on the ethical behaviour of management, and concluded that the ethical conduct of businesses requires appropriate policy to be legislated (Ekici & Onsel, 2012). Furthermore, as seen in this exploration of a failure to protect the rights of vulnerable seniors in institutional care, Brown (2012, p.2) in contexts other than aged care stated that in their function as professionals, managers have a particular moral obligation to protect the vulnerable, claiming that “there is a responsibility to protect the vulnerable, reflected in policy making”. Thus in the business of aged care, ethical issues are intertwined with managerial practice, professionalism and policy.

The focus in this case study is on issues of confidentiality related to incidents of elder abuse which were disclosed by two daughters of abused residents during research interviews. However, other ethical issues arise because breaches of confidence frequently do not occur in isolation, but are part of wider ethical breaches in regards to an individual or a group of individuals within an institution. For example, Kapp (2008) claimed that issues of trust,

which he referred to as ethical fiduciary, place an obligation of confidentiality upon the health care professional, thus tying trust and confidentiality together.

In discussing breaches of confidentiality it is important to remember that there are justifiably instances when breaches ought to occur and therefore not all breaches are unethical. One instance occurs regularly, when seniors in a hospital voluntarily waive their right to confidentiality, concerning particular information about themselves, in order for that information to be accessed by third parties, such as care givers other than the medical personnel treating them. Other ethical issues can be involved, such as when a senior does not have the capacity to make such a decision for themselves, for example, when they have advanced Alzheimer's disease. In such a situation the surrogate decision maker needs to be fully informed about the situation, so that they can make an informed decision as to whether or not to waive the senior's right to confidentiality. Yet another instance occurs when an institution or care giver is compelled through a court order to release confidential information. In this context, it is appropriate to discuss what constitutes confidentiality, and thereafter to discuss how it specifically pertains to the business of institutional aged care and incidents of elder abuse which were disclosed during the course of a recent research project.

Confidentiality

Confidentiality is an important area of ethical information management. It concerns issues of restricting the flow of information. Professional codes of ethics, from engineering, to computing, to nursing, contain statements that explicitly deal with confidentiality. Despite this, it is frequently misinterpreted as an aspect of privacy. For instance, in an article on "Computer and Information Ethics", Bynum (2011) reviewed the history of the development

of computer ethics, and described privacy and confidentiality as synonymous. Similarly, in a review of the then code of ethics of the Australian Computer Society, Burmeister (2000) pointed out that the clause on confidentiality, that had been endorsed by a two-thirds vote of members, was absent in the online version of the code of ethics, and claimed that the reason was that it had been seen as synonymous with privacy and was therefore deemed redundant. Thus in this section confidentiality is first defined generically, and then specific reference is made to aged care nursing codes and how they address confidentiality.

The confusion between privacy and confidentiality is not unique to computer professionals. In the field of nursing, *The Code of Ethics for Nurses in Australia* (Australian Nursing & Midwifery Council, 2008) does not differentiate between privacy and confidentiality but the concepts are always spoken of in combination. For example, Value statement 7: Nurses value ethical management of information, discusses how the ethical management of information involves respecting people's privacy and confidentiality without compromising health or safety. A search in The Stanford Encyclopaedia of Philosophy on 'confidentiality' yields multiple results that combine these two ethical issues. For example, the first result is an article titled "Privacy and Medicine", in which Allen (2011) states that "Individuals, institutions and governments practice … As a general rule (tries) to limit access to health information". She goes on to distinguish privacy and confidentiality, claiming that privacy is about controlling the access of health information that is required/desired by governments, institutions and individuals, whereas "many medical professionals, hospitals, insurers and other entities with access to health information regard maintaining the confidentiality of medical communications and the security of medical records as paramount professional responsibilities" (Allen, 2011). One can see then that the two are closely related and are usually but not always distinguishable. Generally the difference can be described as that

privacy is about people, whereas confidentiality is about data. The focus in this article is on confidentiality of data but that confidentiality is intricately linked to people's right to privacy.

With regard to health information, confidentiality has been defined as "restricting information to persons belonging to a set of specifically authorised recipients … (and that it is achieved) … through professional silence and secure data management" (Allen, 2011). Legal professionals can be required to keep matters confidential that are concerned with the representation of a client, hence the well known 'attorney-client privilege'. Similarly, conversations between health professionals and clients relate to privileged information that ought to be treated as confidential. In the field of social epistemology, that is, the study of the social dimensions of information (Goldman, 2010), the concept is exemplified by claiming the acceptance of "laws enabling journalists to protect the confidentiality of their sources". For instance, in discussing intellectual property rights, Quinn states that "any creator of a piece of intellectual property has the right to keep his ideas a secret" (Quinn, 2011, p. 186) Quinn's reference is close to the notion of 'commercial in confidence', that is, that there is a natural right to keep some things secret, or at least for the time, be it for commercial or other reasons.

'Commercial in confidence' is an important ethical principle. In the context of the business of aged care, one of the main reasons is that it promotes an environment of trust, between the resident and the nurse or the aged care worker. Although trust is generally of importance when dealing with situations of confidentiality, it has been shown to be particularly important to seniors, as it is caught up with related concepts of showing appropriate respect (Burmeister, Weckert, & Williamson, 2011). It should also be noted that there are exceptions to confidentiality, in which it is recognised that the professional has an obligation to breach

confidentiality, for the attainment of a greater good or for the prevention of harm, such as in an instance of elder abuse, suicidal behaviours or some other situation which contravenes their duty to protect the resident, or to protect colleagues; the latter might arise if a professional encounters a situation where someone has homicidal plans.

To conclude this section, one can argue that confidentiality is an extension of privacy. In an aged care setting, confidentiality is about managing the protection of private resident data that has been disclosed to others in a situation of trust. The expectation is that the information will not be disclosed, except in such circumstance as have previously been agreed upon, or in situations where the law requires such disclosure. This expectation for confidentiality has implications for research in aged care, where the majority of staff are personal care assistants working under the direction of nurses.

Professionalism, nursing and confidentiality

The Code of Ethics for Nurses in Australia (Australian Nursing & Midwifery Council, 2008)[1] has been developed under the auspices of peak nursing bodies, the Australian Nursing and Midwifery Council (ANMC), Royal College of Nursing Australia (RCNA) and the Australian Nursing Federation (ANF). The Code of Ethics for Nurses in Australia is to be considered in conjunction with companion documents, the Code of Professional Conduct for Nurses in Australia (Australian Nursing & Midwifery Council, 2008a) and the National Competency Standards for the Registered Nurse (Australian Nursing & Midwifery Council, 2005). The Code of Professional Conduct for Nurses in Australia (Australian Nursing & Midwifery

[1] The Australian Nursing and Midwifery Council governs the professions of midwifery and nursing, and is thus the most appropriate professional body to turn to for the ethical behaviour of nursing professionals who work in aged care.

Council, 2008a) does differentiate between privacy and confidentiality under Conduct Statement 5, registered nurses are to protect the privacy of people and treat as confidential information gained from the relationship. The National Competency Standards for the Registered Nurse (Australian Nursing & Midwifery Council, 2005) requires nurses to identify unprofessional practice as it relates to confidentiality and privacy legislation and to ensure privacy and confidentiality when providing care. Respecting the privacy of individuals and the confidentiality of information gained in the course of practice is fundamental and at the core of being a registered nurse.

The vulnerable consumer

At this point confidentiality has been defined in general terms and in terms of the aged care nursing profession. This article addresses the situation of elder abuse, as it is defined in the literature. This is exemplified by case studies, in which issues of confidentiality arise in the context of wider ethical issues, when situations of elder abuse in institutional aged care were disclosed in a research study.

Importantly such elders in institutional aged care constitute vulnerable consumers. The person is in residential aged care because they require the services that such a business offers. If an alternative existed they would most probably have availed themselves of it. Their inability to do so depicts their status as consumers of that service in that they require it and no alternative exists for them. In such a relationship, where the one party is dependent upon the other, the dependant party is in a position of vulnerability. This is compounded by the associated increasing frailty of the older person which heightens their dependency.

There has been discussion of such vulnerable consumers that is germane to this article. Ringold argued that "vulnerable consumers cannot navigate the marketplace" because they lack "the wherewithal (i. e. knowledge, skills, and freedom) to do so" (2005, p. 202). That is certainly the situation of the resident in aged care. Realistically their options are limited. Ignoring the dynamics of the aged care market itself, and the alternative options – or, more realistically perhaps – the lack of readily available alternatives within that market, the elderly in aged care have no option: they require aged care. It has been suggested that various vulnerable consumer groups, such as the poor, will eventually escape their current situation and because of that "for the most part, vulnerability is a short-run phenomenon" (Baker, Gentry & Rittenburg, 2005, p. 136). That, however, is not a probability for the ageing person. They can only age and in the process may become increasingly dependent upon such services and, simultaneously, more vulnerable. Baker, Gentry and Rittenburg also highlight how "consumer vulnerability is closely tied to identity" (2005, p. 136) where the vulnerable unable to assert any control in that situation "may believe (or think others believe) they are . . . less than human" (2005, p. 136). Consumer vulnerability occurs because these consumers are "powerless" (Baker, Gentry & Rittenburg, 2005, p. 134). Such situations are characteristic of those posing ethical dilemmas. Our population is ageing, subsequently the business of aged care provision is increasingly the reality for the older person.

Elder abuse

The Australian Federal Government defined elder abuse when it legislated for mandatory reporting of such in 2007 after a number of widely publicised incidents through the media (Department of Health & Ageing, 2008). The Complaints Investigation Scheme (CIS) was established to investigate reports of sexual abuse and unreasonable use of force (Department of Health & Ageing, 2008). They determined that "Elder abuse is a single or repeated act,

occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. Abuse can include physical, sexual, financial, psychological abuse and/or neglect" (Department of Health & Ageing, 2007). Since 2010, the Department of Health and Ageing has begun the phasing in of the Aged Care Complaints Scheme to replace the CIS (Department of Health & Ageing, 2012).

Professionalism and confidentiality in aged care

This section draws on two specific case studies from a recent research project reported to the Productivity Commission: Caring for Older Australians (Not disclosed for review purposes, 2010). The case studies and the issues they uncover are not uncommon but are used as exemplars to make visible the ethical dilemmas that can arise during research, especially projects related to vulnerable people, in this instance the older person dependent on institutional care. These two specific case studies were selected because they highlight the complex nature and potential repercussions of reporting elder abuse for the vulnerable consumer and their loved ones. Furthermore, nurses, aged care workers and nurse researchers can also be caught in an ethical dilemma because they fear that reporting elder abuse as recommended by Professional Codes for Nurses working in the business of Aged Care (Australian Nursing & Midwifery Council, 2005, 2008, 2008a; Department of Health & Ageing, 2007) may exacerbate the abuse, place their jobs in jeopardy or limit research opportunities that may bring about positive change for the vulnerable older person reliant on aged care services.

The research project informing this paper (and the report to the Productivity Commission: Caring for Older Australians) explored the experiences of families and friends who had a person they love in a residential aged care facility. The paper is framed by the narratives of

participants as they described their perceptions of the conditions experienced by their loved ones and other vulnerable older people in the aged care facility.

Method

The project was informed by phenomenology, utilizing an interpretative paradigm and involved 20 participants from across New South Wales and the Australian Capital Territory. The small number of participants was in keeping with the inductive reasoning inherent in the methodology used (Nagy, Mills, Waters & Birks, 2010). Recruitment was via press, television and radio media releases, inviting participants to share their stories of having a family member in residential aged care. There was no preconception as to whether experiences would be positive, negative or a mixture of both. Data was collected through in-depth interviews which were audio taped and transcribed verbatim, and the data analysis was thematically driven.

A multi-layered approach to data analysis facilitated the emergence of themes. Narrative thematic analysis ensured that nuances and how the experiences were shared by participants were given credibility. Descriptions and interpretations of participant stories gained through content analysis, helped maintain the centrality and significance of their experience. The final layer of thematic analysis studied discourses to enable a critical lens to be applied to the themes derived through earlier analysis. This approach to thematic analysis meant that themes could be integrated, revealed, described, interpreted and critiqued in a way that valued participant experiences while revealing aspects of fear and power that continue to hide the phenomena of elder abuse. The Institutional Ethics Committee (IEC) of the university where the researcher worked at that time gave its approval for the project.

Findings

Participants described specific incidences of abuse inflicted on their loved ones and other residents by staff at the facility. These incidents included rough handling causing skin tears; leaving residents in dirty soiled clothing; dirty eating utensils; unclean kitchen and staff taking the home-cooked food left for their loved ones. The participants described how staff would go for a cigarette instead of assisting the residents with meals. They also reported that one resident who was blind and non-communicative often did not receive any food. Some of the participants had complained to the facility management and advocated for more staff to enable better care, but one feared she was perceived as a "trouble-maker" when she did so,

> *It's even come to the stage where they're nearly going to evict mum because I keep telling them they need more staff, they need someone to watch...*

One participant provided photographs of her mother and the facility that graphically portrayed what she had described,

> *I took photographs ... of my mother in this nursing home. Now if you think ... someone should end up being like that, you have a look at her. They're disgusting aren't they? You have a look at that.*

The photographs illustrated skin tears to arms and legs, bruising to her mother's face; food soiled clothing and dirty cutlery and crockery.

Multiple ethical dilemmas arose from these interviews and many were grounded in the concept of confidentiality. Confidentiality in the given context will be explored from the perspective of all five key stakeholders. First, the elderly residents being abused; second, the participants who disclosed the abuse in the context of the research project; third, the government complaints processing agencies; fourth, the facilities where the abuse was alleged to have taken place and finally, the ethical dilemmas faced by the researcher.

Unprofessional treatment of vulnerable consumers

The person most vulnerable in these case studies is the resident because repercussions from exposing the abuse may be directed toward them. Following an earlier abusive episode that had been reported, the elder being abused in this instance pleaded with their daughter (the research participant) not to report the abuse and even not to visit them,

> *And Dad said to me, "You can eff off!" and my dad never swears … "Your so called friend* [Assistant in Nursing] *you were talking to yesterday came in here and she abused me!" … So that's when I didn't go up for two days, and when I went back … he was stinking and I mean stinking …* [I] *nearly vomited …* [so] *I decided I was going to shower Dad and I got abused off the registered nurse, because I showered my Dad.*

The quandary for participants is then whether they remain silent about the neglect (as described above) with the belief that the silence would protect their loved ones from retribution or should they report it in an attempt to stimulate change in the standard of care? One participant shared how she made the choice to speak up but her mother suffered the consequences she feared. The following narrative is the participant relaying a dialogue between herself and her loved one.

> Loved one to participant: *"You think it's all right … but when you're not here you don't know what they become".*
>
> Participant to researcher: *They used to yell at her and they hurt her…*
>
> Loved one to participant: *She come in and abused me after you left, you got no idea what she said to me… They get me in the shower and they hurt me … they were that rough.*

Participant to researcher: *I'd go up to see her and she'd have all these bruises on her.*

The researcher at this stage recognised she had an ethical dilemma that mirrored the daughter's dilemma. To speak up and potentially exacerbate the situation for the participant and for the resident or to hide behind the concept of confidentiality as promised to the participant when they consented to being recruited to the research.

Confidentiality and complaints processing by government agencies

The confidentiality of the participants is compromised when they have a propensity to advocate on the behalf of their loved ones. The researcher advised them to contact what was then known as the Complaints Investigation Scheme (CIS) and on investigation, one facility was found to be in breach of four of the accreditation standards. The investigation by the CIS, even though it is meant to be confidential, was obviously instigated by the participant because of the care issues being investigated. The participant believed that because she reported to the CIS, there was an exacerbation of the neglect and abuse of her mother. Furthermore, the staff ignored the participant,

And since then she [the nurse] *won't even look at me!*

In the participant's opinion, the outcomes of the CIS investigation brought about little to no change at the facility and she became physically ill.

The CIS was not contacted about the alleged abuse of the second resident as the participant's father had died prior to the research being conducted.

Confidentiality of the facility

Data related to one facility was revealed through the experiences of the participant and was emotively illustrated by the photographs she had taken. The participant was compelled to take these to demonstrate the claims that she was making. Her anxiety partially stemmed from the fear that she would not be believed; that her story required substantiation. However, the photographs have consequences as they have implications for the confidentiality of the facility, as it was identifiable in the photographs.

Staff employed by a facility, have the obligation to maintain confidentiality about both the residents and facility business. Although it is mandated that they report incidents of abuse under the Aged Care Complaints Scheme, one participant reported,

> … [the staff] *said to me that they know that I'm right in what I'm doing but if they say anything they'd lose their jobs and they can't afford to lose their jobs.*

Staff were concerned that in reporting abuse, their job and work conditions would be jeopardized. That is, tension exists for staff members between legally reporting incidents of abuse, and fear of repercussions in multiple ways, which mediates this legal responsibility. This again exemplifies the need for trust in a confidential reporting process. It reveals that staff do not trust that they will be protected from retribution if they engage in whistle blowing, such as with the de-identification of them from the complaints data. That is, they do not trust in the confidentiality of the complaints process.

Confidentiality of the researcher

Following the disclosure of elder abuse, the researcher sought the advice of the IEC that had approved the study. The chairperson of the IEC and a legal advisor were consulted and the advice at that time was to refer the participant to the statutory authorities and this was done.

The participant was also provided with the means to contact the researcher if they needed further support. The participant did contact the researcher to debrief their experience and disappointment about the outcomes of the CIS but declined the offer to be referred for professional support and counseling.

A further ethical quandary for a researcher in aged care is that reporting adverse situations involving poor standards of care to any level of management eventuates in alienation, and a reluctance of aged care facilities to participate in future research projects, impacting on the evolution of evidence based care in the aged care sector.

Discussion

The findings reported, above, do not provide clear answers to the ethical dilemmas inherent in researching residential aged care. However, they uncover many questions that do require answers through further research. This project exposed the vulnerability of the older person as well as the participant when they or their family members make a complaint. There can even be life-threatening quandary when elder abuse is disclosed by a third party. In this case-study, the elder involved pleaded with their daughter not to disclose the abuse. The elder is an adult with the right to autonomy. However, they are a vulnerable adult and should their right to autonomy take precedence over their right to be safe and cared for? The elder abuse was reported but, as a result of confidentiality breaches, the abuse was then exacerbated. This illustrates that reporting of elder abuse does not necessarily lead to the anticipated protection of the person being abused.

One of the reasons the participants in this study agreed to take part in this study was their strong desire to share information; to have their story heard and validated. However, the quandary is now extended, rather than resolved. For the participants in this study who disclosed elder abuse they believed the abuse was exacerbated after they had participated in the research and protocols to refer the participant to the CIS had been followed. The participant had been involved in the research; they had disclosed incidents of elder abuse; been referred by the researcher to the CIS; the CIS had investigated the incidents of abuse which did not stop after the investigations but became worse. Their loved one was offered no protection; and neither were they.

It is not only the rights of the elderly person and the research participant that need to be considered when exploring issues around confidentiality in the aged care setting. As this article has identified, the staff members working in the aged care facility and the researcher also have professional and ethical responsibilities which need to be recognised.

Aged care facilities do not have ethics committees to oversee the implementation of research in their facilities. While professional Codes of Ethics and Conduct exist, managers and registered nurses generally do not have the skill of applying their knowledge of ethics to ensure residents rights are protected. While not bound by the same professional codes as nurses, aged care workers do need to adhere to legal requirements as specified under the Aged Care Act (Department of Health & Ageing, 2008) which includes reporting of suspected or actual elder abuse and neglect. Staff navigate their way through their legal responsibilities of mandatory notification while trying to avoid the obstacles they fear, for example, loss of employment.

In relation to the confidentiality of the facility, there are many unanswered and currently, unanswerable questions that still need to be asked. These include, what, if any are the rights of the proprietor in these circumstances? Do they have the right to determine what and who is photographed in their facility? Can protecting the confidentiality of a facility serve to cover-up the abuse? Equally, could the inaccurate or inappropriate identification of a facility as an alleged place of elder abuse deny justice and cause hardship and distress to owners, staff and residents alike?

The researcher in the study informing this article was a registered nurse and an academic whose clinical expertise and research experience was in aged care. These roles became blurred and incorporated a tension in relation to confidentiality; the registered nurse is mandated to report incidents of elder abuse. At the time of recruitment to the study, the researcher promised confidentiality, including that no participant, facility or person would be identified as a result of participating. The researcher then heard of incidents of abuse and observed photographs of a severely bruised woman with skin tears on her arms and legs but did not witness these events. There was the unwitnessed suspicion that elder abuse has occurred. Lewin (2007) cites a similar case in Sweden where an institutionalised man with an intellectual impairment was repeatedly assaulted but the staff member was not charged because there were no witnesses. This may reflect incidents of abuse in Australian residential aged care where there were signs that abuse may have occurred but there were no witnesses and the victims were unable to give evidence. Yet, even with the photographs taken by the participant in this study, they are not contextualised and there were no witnesses to the actual event, just the outcomes.

The researcher sought the advice of the legal team at the university and while not a focus of this paper, it could be argued that there is a sixth stakeholder impacted by issues of confidentiality in this study. That is, the IEC at the university at the time the study was approved.

Recommendations to assist aged care researchers include the need for clear guidelines to stipulate the requirement for researchers to be included elder abuse mandatory reporting mechanisms. This recommendation will assist researchers with their role delineation and responsibilities. Another recommendation is that informed consent forms state to potential participants the process that will be followed if elder abuse is disclosed. The question remains unanswered as to whether this will then inhibit participants from disclosing elder abuse, thereby closing an avenue for them to discuss their experiences.

Conclusion

This paper has implications for Aged Care businesses and professionals. It has aimed to make visible some of the limitations of having professional codes of ethics, codes of professional conduct and competency standards that rightly recommend the reporting of unprofessional, unsafe and unacceptable treatment of vulnerable, elderly consumers. The questions raised indicate that the issue of reporting elder abuse in businesses caring for the frail aged person is a complex one and not amenable to easy solutions. However, one starting point must be businesses and professionals (in this context, nursing) working in partnership to create environments where consumers, their family members, professionals and researchers feel safe to disclose and report suspected or actual elder abuse without fear of repercussion. Maintaining facility confidentiality and protecting businesses against false allegations is

important, but never at the expense of the vulnerable, older person depending on the agency for care.

This article has demonstrated that the main tension involved in reporting elder abuse is fear bought about by the complexity of the environment that enables elder abuse to remain hidden. This fear is warranted for elders, their loved ones who participate in research, aged care facilities, professionals and researchers in relation to reporting elder abuse. Elders and their loved ones fear exacerbation of the abuse if it is reported. Their dependence and vulnerability are sources of fear. Staff working in facilities may fear allegations of elder abuse which may prove to be unfounded or actual and loss of employment if they report elder abuse. Researchers fear that the participants are right when they say the abuse will get worse if reported; they also fear that without clear guidelines they may be acting unethically, whether they decide to report the abuse or not. Such tensions need to be resolved or there may be a reticence of researchers to engage in aged care research. It is incumbent upon all stakeholders whether they be business owners, staff or researchers to collaborate in answering the multiple unanswered questions asked in this case study and embedded in the ethical dilemma of reporting elder abuse.

References

Allen, A. (2011). Privacy and Medicine. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy*.

Australian Nursing and Midwifery Council. (2008). The Code of Ethics for Nurses in Australia. ANMC: Dickson. http://www.anmc.org.au

Australian Nursing and Midwifery Council. (2008a). The Code for Professional Conduct for Nurses in Australia. ANMC: Dickson. http://www.anmc.org.au

Australian Nursing and Midwifery Council. (2005). The National Competency Standards for the Registered Nurse. ANMC: Dickson. http://www.anmc.org.au

Baker, S. M., Gentry, J. W. & Rittenburg, T.L. (2005). Building Understanding of the Domain of Consumer Vulnerability. *Journal of Macromarketing* 25 (2), 128 – 139.

Not disclosed for review purposes, M. (2010). Submission to the Productivity Commission Inquiry into Caring for Older Australians. Retrieved from http://www.pc.gov.au/__data/assets/pdf_file/0018/101628/sub253.pdf

Brown, E. (2012). Vulnerability and the Basis of Business Ethics: From Fiduciary Duties to Professionalism. *Journal of Business Ethics.* http://www.springerlink.com/content/u48546646835lg0q/fulltext.html, accessed 31 July 2012.

Burmeister, O. K. (2000). Applying the ACS code of ethics. *Journal of Research and Practice in Information Technology, 32*(2), 107-120.

Burmeister, O. K., Weckert, J., & Williamson, K. (2011). Seniors extend understanding of what constitutes universal values. *Journal of Information, Communication & Ethics in Society, 9*(4).

Bynum, T. (2011). Computer and Information Ethics. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy*.

Department of Health & Ageing. (2007). *Help with health. Prevention of elder abuse.* Retrieved at http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Prevention+of+elder+abuse

Department of Health and Ageing (2008). Compulsory reporting guidelines for approved providers of residential aged care. Office of Aged Care Quality & Compliance: Dpt of Health & Ageing.

Department of Health & Ageing. (2012). Aged Care Complaints Scheme. Retrieved from agedcarecomplaints.govspace.gov.au

Ekici, A., & Onsel, S. (2012). How Ethical Behavior of Firms is Influenced by the Legal and Political Environments: A Bayesian Causal Map Analysis Based on Stages of Development. Journal of Business Ethics. http://www.springerlink.com/content/75436m72854p075r/fulltext.html

Goldman, A. (2010). Social Epistemology. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy*.

Kapp, M. B. (2008). Legal issues in dementia. *International Journal of Risk & Safety in Medicine, 29*(4), 91–103.

Lewin, B. (2007). Who cares about disabled victims of crime? *Barriers and facilitators for redress. Journal of Policy and Practice in Intellectual Disability*, 4(3), 170-176.

Nagy, S., Mills, J., Waters, D. & Birks, N. (2010). *Using Research in Healthcare Practice.* Broadway: Lippincott, Williams and Wilkins Pty Ltd.

Quinn, M. J. (2011). *Ethics for the information age* (4 ed.). Frenchs Forest: Pearson.

Ringold, D. (2005). Vulnerability in the Marketplace: Concepts, Caveats, and Possible Solutions. *Journal of Macromarketing,* 25(2), 202 – 214.

Tannous, W.K. & Luo, K. (2006). Ownership of Residential Aged Care Facilities in Australia. *Macquarie Economics Research Papers.* Sydney: Macquarie University. Retrieved from http://www.businessandeconomics.mq.edu.au/our_departments/Economics/econ_research/2006/8_2006_Tannous_Luo.pdf

World health Organization. (2002). *Missing voices: views of older persons on elder abuse*. Geneva:WHO.