EXPLORING NEW GIANTS IN GERIATRICS

DOLMEN HOTEL, QAWRA
Friday 3rd May 2019

Geriatric Medicine Society of Malta Conference
I would like to welcome you to this third conference organized by The Geriatric Medicine Society of Malta. What had started four years ago as an occasion to celebrate the Society’s tenth anniversary, has now become a biennial event, thanks to the encouraging attendances at the previous two conferences and the positive feedback always received.

The eminent Professor Bernard Isaacs, originally from Glasgow, Scotland, first coined the term ‘Geriatric Giants’ in the nineteen sixties. He was referring to the original four: intellect impairment, incontinence, immobility and instability, which in his own words produced a ‘gigantic’ onslaught on the independence of a ‘gigantic’ number of older people. Over the last half century, new giants have since been added, such as iatrogenesis, sarcopenia and frailty amongst others, what John Morley, a well known contemporary American geriatrician, calls them ‘Modern Geriatric Giants’. Therefore, in keeping with such new ideas and terminology, the title ‘Exploring New Giants in Geriatrics’ was chosen for today’s conference.

The three gigantic themes of today’s conference are end-of-life care, dementia and frailty. I am sure everyone in this audience agrees that these conditions and situations are commonly encountered in older persons. For example, end-of-life care creates a lot of physical and psychological burden on patients and caregivers, coupled with a good dose of ethical dilemmas, and such issues will be highlighted by the speakers of the first session. In addition, the number of people suffering from dementia is rapidly increasing as those aged eighty years and over, the old old, continues to rise, producing new challenges again in end-of-life care. Frailty, a more modern topic, is being increasingly researched and as most of you know, there are now multiple tools to help assess and grade frailty. Malta is proud to be a partner of the ADVANTAGE-JA project, a project aimed at managing better this condition.

Before concluding, I would like to thank the both invited speakers, Dr Pace, Prof. Grassi and Prof. Hendry for kindly accepting our invitation to share their expertise with us and the local speakers who will be telling us about their research on the care of older people. I would also like to thank the members of the scientific and organizing committee and all those who have contributed to help make this event a success.

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As the status of health of the population improves and people live longer, fewer and fewer people are dying of single discrete conditions. Instead, frailty, due to multiple conditions impinging on the individual's health, has rapidly become one of the commonest causes of deterioration, disability at the end of life and of death. Dementia is one condition that is frequently associated with frailty, and especially when advanced, the two overlap and share many common characteristics. Dementia has now become the commonest cause of death in many countries, including the United Kingdom. For palliative care to maintain its relevance to society, it must engage with such radically changing patterns of dying, just as it has engaged with cancer and with organ failures. However, the model of care also needs to be radically different as the problems faced by people dying of frailty are in many essential ways dissimilar from those of the more traditional causes of death in the 20\textsuperscript{th} century. This presentation will briefly look at our current understanding of the concept of frailty, and tease out the characteristics of dying from this condition. It will then suggest some directions in which palliative care for people who are frail needs to develop.
Forbidden Death - Death and Dying in the current age

Mr Mark Piscopo M.Psy(Melit), PgD(Les), B.Psy(Hons)(Melit)
Psychologist, Hospice Malta

We are currently in an age were death and dying has no place. By any means possibly we try to dissociate ourselves from this process and all the difficult emotions it brings. We are in an age where difficult emotions are considered pathology. How does all this colour the way patients and professionals deal with the process of death and dying when there is no other option but to face it? Current literature from the social, philosophical and psychological field will be explored.
The claim of whether a right to die exists has been a debate in philosophy, religion and courts since the era of Ancient Greece. Due to advancements that have been made in the field of medicine, attitudes towards end-of-life care have increased in complexity. A question central to the discussion on end-of-life care is whether a right to die exists. The aim of this presentation shall be to indicate how from an ethical, moral, and philosophical viewpoint, the right to die cannot exist.

First, current right to die practices in the European Union, Switzerland, and the United States of America shall be presented, providing a statistical picture where possible. Following this, the main discussion shall be divided into two sections. The first part shall favour the existence of the right to die, through presenting arguments from utilitarian and deontological points of view, namely through the principles of autonomy, right to privacy, quality of life, dignity and suffering. A brief perspective on the psychological effects of right to die practices shall also be presented.

The second part shall present counter-arguments to those afore mentioned, hence to identify why a right to die cannot exist based on these respective principles. Relevant court cases and legal documents shall be presented to support this claim. A section on sanctity of human life will also be included, along with a discussion on the psychological effects experienced by physicians who participated in assisted suicide, concluding with a discussion on a potential slippery slope situation.

In conclusion, the above findings shall be used to ascertain that a right to die cannot exist.
A Maltese Perspective on Breaking Bad News in Cancer: An Assessment of Patients’ Preferences

Dr Joëlle Azzopardi MD (Melit.) MRCP (UK) MA Bioethics (Melit.) MRCP Resp (UK)
Resident Specialist Respiratory Medicine, Mater Dei Hospital, Msida, Malta

Purpose

It is unclear whether Maltese cancer patients wish to know their diagnosis or to what extent they want to be informed. The aim was to assess patients’ preferences for receiving a cancer diagnosis and being involved in the decision-making process, and then compare with results from similar international studies.

Methods

Two hundred fifty-two Maltese adult cancer patients were invited to complete two standardised tools: the Measure of Patients’ Perspective (MPP), assessing patients’ preferences for receiving news about their cancer, and the Control Preferences Scale (CPS), examining involvement in decision-making.

Results

Maltese patients rated the ‘content’ subscale (information given; mean 4.17, SD 0.59) as significantly more important ($p<0.001$) than ‘support’ (offering comfort/support; mean 3.73, SD 0.68) and ‘facilitation’ (how information is given; mean 3.86, SD 0.68). Patients with higher levels of education had significantly higher scores for ‘content’ ($p=0.018$) and ‘facilitation’ ($p<0.001$) on the MPP, while lower education levels preferred a passive role ($p=0.01$) on the CPS. Although there is a trend towards a collaborative and even an active role in treatment decisions, patients still exhibit a paternalistic attitude towards their physician. Age, gender and medical variables had no significant influence on response.

Conclusions

Maltese cancer patients want to be informed of their cancer diagnosis, its treatment and prognosis, similar to other international studies. However, 60% of Maltese patients prefer a more paternalistic approach towards their physician when compared to other studies.
Dignity is a multifactorial construct, consisting of three primary domains i.e. illness-related concerns, such as symptom distress; dignity-conserving perspectives and practices, such as continuity of the self, maintenance of pride, hopefulness; and social dimensions of dignity, such as privacy concerns, burden to others, aftermath concerns (Chochinov, 2002; Chochinov et al., 2002). Dignity conserving care (DCC) has been the focus of research in both somatic and mental settings. In patients suffering from somatic disorders, particularly chronic and progressive disorders (e.g. cancer) or at the end of life, loss of dignity is often manifested by loss of identity, shattering of self-image, or having psychological, interpersonal, spiritual and existential needs that are not being adequately addressed. Similar issues apply to psychiatric patients, where stereotypes, prejudice, and discrimination continues to exist within the health care setting, and can enter into relational encounters in daily life, and among healthcare providers. A specific intervention – Dignity Therapy (DT) – based on DCC has also been developed as a brief, individualized intervention aimed at relieving emotional, spiritual and existential distress and improving the experiences of patients whose lives are threatened by illness. The intervention offers patients an opportunity to reflect on issues that are important to them or other things that they would like to recall or transmit to others and for these reasons it has been successfully applied not only in palliative and end-of-life care, where it was developed, but in other settings including geriatrics, and more recently psychiatry, and jail.

The delivery of dignity conserving care and the application of specific intervention such as DT are therefore essential in achieving a holistic and healing approach, improving the satisfaction of patients, families and health care professionals alike.

References
Chochinov HM. Dignity-conserving care--a new model for palliative care: helping the patient feel valued. JAMA. 2002;287(17):2253-60
Dignity Therapy: A Model for a Palliative Approach for Informal Carers in Dementia?

Prof. David Mamo MD, MSc, FRCPC, DiplABPN
Consultant Psychiatrist, Mount Carmel Hospital, Attard, Malta

Dignity therapy is a brief individualized psychotherapy developed to alleviate the emotional and existential distress and enhance the quality of life in individuals at the end of life. While the therapy bears resemblance to other forms of therapy related to life review, dignity therapy differs in its focus on meaning and preservation of dignity through the collaborative creation of a generativity document as a lasting written legacy. It has been shown to decrease psychological distress, depression, and anxiety in patients at the end of life, as well as an improved perceived end-of-life experience in their carers. Recently the model has been studied in a small group of elderly patients with cognitive decline with promising results. However, the nature of dementia suggests that modifications in the goals and application of the dignity therapy must be undertaken in dementia. Preventing caregiver burden and burnout is key to the successful provision of community care in dementia since it is the most common reason for admission to long-term care. A re-evaluation of the model, therapeutic process, and goals of dignity therapy to alleviate the protracted grief and psychosocial distress in caregivers of patients with dementia is presented as a basis for future empirical testing.
Person-centred dementia care in hospital settings

Dr Anthony Scerri PhD, B.Sc.(Hons.) Nursing Studies, M.Sc. (H.S.M.), M.Ger., S.R.N.
Lecturer
Department of Nursing, Faculty of Health Sciences, University of Malta, Msida, Malta

Older persons with dementia may have additional co-morbidities that put them at a higher risk of being admitted to a hospital. It is estimated that between 13% to 63% of acute hospital admissions have some degree of cognitive impairment. Patients with dementia tend to stay longer in hospitals during which time they may experience a higher risk of functional decline and a worsening of their symptoms, thus becoming more likely to be discharged to a care home. This presentation seeks to give a picture of the current state of dementia care in hospital settings both locally and abroad. Factors influencing the implementation of person-centred dementia care practices in hospitals will be discussed. Finally, a number of strategies how to improve person-centred dementia care in hospital settings will be proposed.
The challenges faced by clinicians and family members in dementia decision-making

Dr Joe Dimech M.D., M.Ger.
Consultant Geriatrician, Karin Grech Hospital, G’Mangia, Malta

Decision-making in the management of swallowing difficulty in end-stage dementia is a complex process involving medical, ethical, social, legal, institutional and cultural variables. All is complicated by the fact that the patient in care is in a vulnerable position in view of lack of decision-making capacity to decide issues related to personal care.

The presentation looks at how clinicians and family members interact together to plan and decide end-of-life care for persons with dementia. Particular attention is given to the challenges encountered in the clinician / family relationship in care as opposed to identified good practices in decision-making that safeguard the patient's current needs, values and preferences for care.
Integrated care for Frailty: Lessons from Scotland and from ADVANTAGE JA

Prof. Anne Hendry MB ChB, FRCP (UK)
Consultant Geriatrician
Clinical Lead for Integrated Care
Senior Associate, International Foundation for Integrated Care
Work Package Leader ADVANTAGE JA

Frailty is a public health priority due to the associated demand for acute and long-term health and social care support, and the impact of frailty on the lives of individuals, caregivers and families. It is increasingly considered as a chronic condition with the potential to benefit from integrated care to improve health and wellbeing outcomes and reduce costs. ADVANTAGE Joint Action (www.advantageja.eu), co-funded by the European Union and 22 Member States, aims to develop a common approach to the prevention and management of frailty in Europe.

Partners from the Ministry for the Family and Social Solidarity in Malta are supporting colleagues from Scotland and Andalusia who lead Work Package 7 on models of care for frailty. The current evidence for a Frailty Prevention Approach views frailty as a chronic condition / syndrome that requires early intervention with education, enablement and rehabilitation to optimise function, particularly at times of a sudden deterioration in health, or when moving between home, hospital or care home. In all care settings, these approaches should be holistic and person centred, supported by comprehensive assessment and multidimensional interventions tailored to modifiable physical, psychological, cognitive and social factors and appropriate to the goals and circumstances of the individual.

The presentation will outline policy and practice in integrated care, good practice examples of integrated care for frailty, and the experience and outcomes of system wide redesign of care for older people in Scotland.

Keywords: Integration; Frailty; chronic care; intrinsic capacity; function
An Alternative paradigm on frailty: 
Anthropological, sociological and gerontological views

Prof. Marvin Formosa B.Psych., P.G.C.E., M.A., PhD. (Bristol) 
Associate Professor and Head of the Department of Gerontology and Dementia Studies, Faculty for Social Wellbeing, University of Malta, Msida, Malta 
Director, International Institute on Ageing, United Nations, Malta

Frailty occupies a dominant position in both geriatrics and public policy. Yet, the concept of frailty faces a growing resistance from other health-care professionals, and it is not yet clear how older people themselves experience or define frailty. Moreover, geriatrics seems unable to overcome the dialectic impairment-disability dialectic, overlooking how whilst the former emerges in a clinical setting the former is a social construction. The aim of this paper is to scrutinise frailty from a phenomenological lens, focusing on the lived experiences of older people who meet the objective, or clinical, criteria of frailty. The emergent data criticises the hegemonical perception that frailty is normal in later life, and argues that its popular use is tantamount to label defenseless sectors of older persons as having ‘failed’ to age actively and successfully, and abetting the development of a ‘fourth age’ identity whereby vulnerable older persons take an active part in confirming their frailty to others. In Foucauldian discourse, frailty constitutes a ‘dividing practice’, a way of categorising people and creating policy for the benefit of the state, professionals and family carers who wish to equate ‘care’ with order, discipline and surveillance - thus, controlling the ‘older population’ by a ‘medical gaze’.
Deprescribing – when risk outweighs benefit

Dr Marise Gauci B.Pharm(Hons), MSc, PhD
Senior Principal Pharmacist, Karin Grech Hospital, G’Mangia, Malta

Older people are living longer with complex co-morbidities, functional disability and cognitive impairment all of which contribute to frailty and limited life expectancy. In such patients, there is the necessity to re-evaluate treatment goals, particularly medication intended to improve long-term prognosis. These considerations have renewed an interest in the concept of ‘deprescribing’ which describes the process of consideration of whether a drug has the potential to cause more harm than benefit and should be withdrawn, prescribed at a decreased dose or substituted.

Clinical practice guidelines and medication review tools are increasingly considering the older population but recommendations for deprescribing are generally lacking. Workload implications and fear of negative consequences are other barriers to deprescribing. Shared decision-making should be an integral part of the deprescribing process although its implementation in clinical practice is complex and challenging.
**Falls Prevention Interventions in Dementia**

*Ms Karryn Darmanin Kissaun Dip. Health Science, M.Ger  
Physiotherapist, St Vincent de Paul – Long-term Care Facility*

**Background:** In order to stand and move through the environment safely the human body requires the integration of intact cognition and sensory, motor, vision, postural control and balance. Persons with Dementia (PwD) are 4 to 5 times more susceptible to falls than older adults who are not cognitively impaired, due to neurodegenerative changes which progress throughout the course of the disease. Furthermore, foot problems, which are prevalent in older adults at large, have been indicated to contribute to falls.

**Aims:** The main objective of this study was to assess whether the provision of appropriate footwear, orthoses and assistive devices, supplemented by a tailored group exercise programme impacts function and rate of falls in persons with moderate to severe dementia, over a period of 3 months, in a long-term care facility.

**Method:** Participants (males=18, females=17) were selected through a battery of tests, met the inclusion criteria and divided into 3 groups (group 1=correct footwear and/or orthosis, group 2=group exercise programme, group 3=correct footwear and/or orthosis and group exercise programme. Group Comparisons were used to analyse an individual’s pre/post differences in measurement scores. The significance level was set at p=0.05. Out of 35 participants, 8 dropped out, due to the progression of the disease. The final sample size was 27 (males=13, females=14). No multiple imputations of missing data were carried out in order to get as accurate an estimate of potential effect as possible.

**Results and Conclusions:** No statistically significant difference in scores was recorded between Group 1, Group 2 and Group 3 for both the female and the male participants. The efficacy of the intervention could not be determined statistically due to the small sample size and clinical trends were varied and, in some cases, contradictory. A larger sample size would have had workload implications and a substantial increase in cost of footwear and/or orthosis. In this pilot study, we are able to calculate an appropriate sample size for a full-scale multicentre trial allowing for patient attrition. Due to the heterogeneity of the disease and its progression, such interventions may not improve function or prevent falls in the later stages of
dementia residing in long term facilities. The interventional effect on persons with severe dementia might be too small to achieve a clinically significant result.
The Hon. Mr Anthony Agius Decelis, Parliamentary Secretary for Persons with Disability and Active Aging, was born in Pietà, Malta on October 23, 1967. He currently lives in Mosta but is originally from Gzira. On May 20, 1989, he married Josette Agius Decelis and together they are proud parents of Danika, Ann Marie and Jeanine. Hon. Anthony Agius Decelis received his formal education at the Government Primary School in Naxxar and later, in 1992, graduated with Honours from the University of Malta in Youth and Community Studies in Informal Education. He continued his studies with a Post Graduate Diploma in Health Management and later obtained a Master Degree in Gerontology & Geriatrics. Throughout his career, he worked in the Health Care Department, specifically in the PSG Cat-Lab. He spent more than 20 years as an Electro-Cardiographer. Since a young age, he had particular interest in current affairs and occupied various roles within the Partit Laburista youth forum. Hon. Decelis was elected Member of Parliament in Malta in 2008. He contested successfully again in 2013 and 2017. In 2014, he was officially appointed as the Commissioner for Simplification and Reduction of Bureaucracy to be part of the Office of the Prime Minister. He was also the Chairman of the Family Affairs Committee and Member of Parliament. During this time, he had the opportunity to meet and hold discussions with various stakeholders in different sectors, including public, and private profit and non-profit organisations. During the last election, Hon. Agius Decelis contested again on the same districts and was re-elected from the 11th District. Today, Hon. Agius Decelis is the Parliamentary Secretary for Persons with Disability and Active Aging.
**Victor Pace** is a Consultant in Palliative Medicine at the Darent Valley Hospital and Greenwich and Bexley Community Hospice. Dr Victor Pace developed his interest in palliative care when he was in medical school in Malta, and was one of the founder members of the Malta Hospice Movement (now Hospice Malta) in 1989. He trained in the specialty at St Christopher’s Hospice, in London, and after three years as consultant in Eastbourne, returned to St Christopher’s, where he stayed as a consultant for 19 years. He recently moved to a joint post between a hospital and a hospice. He has had an interest in the palliative care of dementia and frailty for the last 12 years, and set up and ran the United Kingdom’s first project taking a close look at the needs of people dying of advanced dementia. He subsequently edited the first book looking in detail at the clinical and holistic palliative care of people with advanced dementia, and organised and spoke at a number of national and regional conferences about the issue. He was also a member of committees which produced documents for NICE, The National End Of Life Programme, and the National Council for Palliative Care about advanced dementia. Over the last couple of years, he was involved in an innovative project working out how to provide a palliative care service for the frail elderly in one London borough, working closely with geriatricians, social care, old age psychiatry, primary care and voluntary agencies. He has written, lectured, and worked on various projects around his broad interests in palliative care including pharmacological, medicolegal, clinical and emotional care topics.

**Mark Piscopo** is a warranted counseling psychologist who has been working in the field of psycho-oncology for the past four years. Currently he provides individual and group therapy to patients and their relatives at Hospice Malta. His main interest is existential anxiety and how different individuals live with it. He obtained a Bachelor in Psychology (Hons.) from the University of Malta, furthering his studies by obtaining a Post-graduate Diploma in Applications of Clinical Psychology from Leicester University and a Master in Psychology in Counseling Stream from the University of Malta. He attended post-qualification training courses by attending ‘Meaning Centred Psychotherapy: IPOS’ delivered by Prof. William Breitbart and ‘Psychoanalytic views on Death and Dying’ at the Fried University in Vienna.
Stephanie Abela Fiorentino is a registered nurse, and has been working in a medical setting for the past six years. She is a trained nurse-mentor and acts as clinical supervisor and examiner for nursing students from the Faculty of Health Sciences, University of Malta. Stephanie has a special interest in death and dying, especially in relation to right to die practices, their ethical considerations, and their effect on society. Stephanie completed postgraduate training in Bioethics at the Faculty of Theology, University of Malta, where she successfully presented and defended a Masters' Thesis entitled “Does a Right to Die Exist?”

Joëlle Azzopardi graduated as a Doctor of Medicine from the University of Malta in 2006, and became a member of the Royal College of Physicians (UK) in 2010. She continued to specialise in Medicine, obtaining her Certificate of Completion of Training (CCST) in Internal and Respiratory Medicine, after obtaining the Specialist Certificate Examination (SCE) in Respiratory Medicine from the Royal College of Physicians (UK) in 2015, and is currently a Resident Specialist at Mater Dei Hospital. Her interest in the field of Bioethics led her to read for a Masters of Arts in Bioethics at the University of Malta, for which she was awarded a scholarship by the Malta Government Scholarship Scheme, and graduated with a first class degree in 2014. She also obtained a European Certificate in Essential Palliative Care from St Alice Hospice (UK) in 2016, and is now a facilitator for this course. She has been providing tutorials to medical students since 2010, and is now a Lecturer in Bioethics to medical students and other health care professionals at the University of Malta.

Luigi Grassi is Professor and Chair of Psychiatry at the University of Ferrara, Italy. Prof. Grassi’s clinical and research interests are in the area of psycho-oncology, consultation-liaison psychiatry and psychosomatic medicine, with particular reference to the cultural aspects of cancer in Southern European countries, and in the area of psychosocial rehabilitation in psychiatry. He has been the President of the International Psycho-Oncology Society (IPOS) (2006-2008) and the Italian Society of Psycho-Oncology (SIPO) (2003-2011) and he is currently the Chair of the World Psychiatric Association Section on Psycho-Oncology &
Palliative Care. He is also the President of the Italian Society of Consultation and Liaison Psychiatry and the Italian Association of Cognitive-Analytic Therapy.


David Mamo completed his medical studies at the University of Malta in 1993, then studied at the Institute of Psychiatry, London (MSc Neuroscience, 1995), University of Pittsburgh, USA (Residency and Fellowship in General & Geriatric Psychiatry, 2001), and the University of Toronto, Canada (Research Fellowship Geriatric Psychopharmacology, 2003). He served as consultant psychiatrist and associate professor of psychiatry at the Centre for Addiction and Mental Health & the University of Toronto until he returned to Malta in 2011 where he developed and leads the psychogeriatric service within the Malta Mental Health Service, and the Malta postgraduate training programme in psychiatry.

Anthony Scerri is a lecturer at the Department of Nursing, Faculty of Health Sciences at the University of Malta, Malta. He has a background in gerontology, geriatric rehabilitation and management and has a PhD in Gerontology that focused on the implementation of person-centred care in hospitals using an appreciative inquiry approach. Anthony is a member of the Malta Dementia Society, the National Working Group on Dementia, INTERDEM and the Alzheimer Europe Expert Advisory Panel.
Joseph Dimech is a Consultant Geriatrician in the Department for Active Ageing and Community Care. He has a special interest in end-of-life care in dementia and is currently reading for his PhD at the University of Malta with a study orientation on moral reasoning of clinical decision-making in end-stage dementia.

Anne Hendry is the Clinical Lead for Integrated Care and Senior Associate in the International Foundation for Integrated Care (IFIC). She is an Honorary Professor at the University of the West of Scotland, Honorary Clinical Associate Professor at the University of Glasgow and Senior Advisor for the Global Health Academy at the University of Edinburgh. Anne is a geriatrician, stroke physician and clinical lead for Integrated Care with extensive experience of improving health and social care for adults with long-term conditions in Scotland. Previous national roles include clinical lead for the Long Term Conditions Collaborative, for the Healthcare Quality Strategy, and the Reshaping Care for Older People programme in Scotland. As Senior Associate with the International Foundation for Integrated Care, she promotes the adoption of people centred integrated care, regularly contributes to conferences and Summer Schools, and has helped to coach system leaders in four continents. She chairs the Advisory Board of the International Centre for Integrated Care, hosted by the University of the West of Scotland, and coordinates the Integrated Care Matters webinar series and a number of IFIC special interest groups. Anne leads the UK participation in the European Joint Action on Frailty and was lead author for the WHO Practice Brief on continuity and coordination of care.

Marvin Formosa is Associate Professor and Head of the Department of Gerontology, Faculty for Social Wellbeing, University of Malta. He holds the posts of Chairperson of the National Commission for Active Ageing (Malta), Rector’s Delegate for the University of the Third Age (Malta), and Director of the International Institute on Ageing, United Nations - Malta (INIA). His interests include active ageing, social class dynamics, critical gerontology, and older adult learning. His most recent book includes Active and healthy ageing: Gerontological and geriatric inquiries (2018).
**Marise Gauci** is a senior principal pharmacist at Karin Grech Hospital where she is responsible for clinical pharmacy services. She holds a Masters degree in clinical pharmacy awarded by The Queen’s University of Belfast and a Doctorate degree by the University of Malta. She is a lecturer at the University of Malta where she teaches pharmacotherapeutics and clinical pharmacy practice. Her main area of interest is the development of clinical pharmacy services for the purpose of medicines optimisation. Her research has been published in several international peer reviewed journals.

**Karryn Darmanin Kissaun** graduated in 1997 with a Diploma in Health Science from the University of Malta. Ms Darmanin Kissaun has been working as a physiotherapist for the past 22 years. In 2000 she completed a postgraduate (level 6) course in Women’s Health at the University of Bradford (UK). She obtained her Masters degree in Gerontology and Geriatrics from the University of Malta in 2017. Her main interests are older adults with dementia, residential care services for older adults and sexuality in later life.
AUDITS/QUALITY IMPROVEMENT PROJECT

A1. Analysis on the clinical diagnosis of acute angina in Karen Grech Hospital
   P Sciortino, M Grech

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