Nordic Gerontological Federation

GeroNord

News on research, developmental work and education within the ageing area in the Nordic Countries

Volume 22, no 3, 2013

Geriatric Medicine at the borders to other specialities

Geriatic medicine has many bordes to other specialities. This is not least apperant in the service for demented individuals. From the perspective of clinical medicine, dementia can be served by three different specialities, neurology, psychiatry and geritrics. In fact, all three specialities are active in this field in the Nordic countries, differing not only by countries but also by sites inside countries. Other fields of gerontology are also divided in this respective.

The reason for this is the manyfold tasks. One is *diagnosing* cognitive failure and dementia. This has classically been the task of neurology and continues to be so in many settings. Another task is to deal with the *psychiatric and behavioural symptoms* caused by dementia, a very common spectrum of problems. This has classically been the task of psychiatry. The problem is that when the diagnosis has been made and the psychiatric symptoms have been corrected, the cognitive impairment per se is still there with all its possible complications. At this point geriatrics and the related professions enter the stage. Furthermore, with the increasing role of geriatrics in service provision and treatment, geriatricians have in many sites taken over the classical tasks of neurologists and pshychiatrists in diagnostics and in gero-psychiatric assessment and treatment. The very nature of geriatric medicine, being holistic and non-organ specific is helping in this regard.

As a cause of the different roots of dementia treatment and care the terminology has been confusing. The various specialities like to use terminology that fits to their own professional background. In psychiatry, it is customary to talk of "geriatric psychiatry" or simply "old age psychiatry". The problem with this is that in dementia, a proportion of the individuals are not elderly. In Neurology the term used is "Cognitive Neurology" thus not implying age. In geriatric medicine, the term is not linked to a speciality in the same manner but more often to the service provision such as "Dementia Units".

There is therefore a need for a common terminology encapturing the real world in spite of the speciality working in the field, mirroring all aspects of treatment and care and fitting to all the different specialities. One possibility is simply to use the terms "Dementology" and for the professionals, "Dementologists". This circumvents the professional backgrounds and describes the actual tasks that are included and this terminology. As dementia has been considered to become one of the main tasks of the health service in the 21st century, it is important that the terminology is reflecting the real world.

Jon Snaedal, President of the NGF

Content

Age Well - Challenges for individuals and society

22nd Nordic Congress of Gerontology, 2014

Scientific program:

The program for the 22nd Nordic Congress in Gerontology in Gothenburg, Sweden, May 25-28th is now in progress.

Plenary speakers:

We are happy to announce that Prof. emeritus Arvid Carlsson, Nobel prize winner for his work on dopamine and Parkinsons disease will be the first plenary speaker on Monday. He will be followed by Prof. James Vaupel, director of the Max-Planck Institute for Demographic Research in Germany and known world-wide for his forecasts of future population longevity. Other key note **speakers/state-of-the-art-lectures** are presented in the program overview on the website www.22nkg.com, and updated continuously.

Submission of symposia proposals:

You are invited to **submit symposia. Note** deadline **October 1st**. For submission use below template and information, see http://www.22nkg.com/symposia+proposals/6182/Page.aspx).

Abstract submission:

Opens at the end of October and the deadline is January 15th 2014.

Prizes and Awards – for details see
http://www.22nkg.com/prizes+%2f+awards/6140/Page.aspx

NGF invites for nominations of candidates for the most prestigious Nordic Prize in Gerontology, the Sohlberg prize of € 10.000 sponsored by the Päivikki and Sakari Sohlberg Foundation.

NGF also announces a new prize for promising researcher in gerontology for the first time. The prize is intended for researchers from one Nordic country. At the 22nd Congress the prize is offered to a candidate from the country that will host the next Nordic Congress of Gerontology, namely Finland (Tampere, 2016).

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Social program:

At the congress you will meet old friends and establish new productive contacts. The theme of the congress will also make sure that you will feel well in friendly Gothenburg during the Congress.

Further information:

In case you need more information please contact 22nkg (22nkg@congrex.com)

We are looking forward to meeting you in May 2014

Boo Johansson
President of 22 NKG

Sten Landahl
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www.herlevhospital.dk/effect

Nutritional Intervention in a Cross-sector Model for the Rehabilitation of Geriatric Patients (FNUG)

The majority of studies of the beneficial effect of nutritional treatment among undernourished older adults have used industrial mad oral nutritional supplements (iONS) (1). In some of these studies the participants' compliance to the iONS has been low, due to e.g. dislike of taste and gastrointestinal disturbances (1). Apparently none of these studies have used a multifactorial approach in the nutritional treatment of older adults, even though the causes to the decreased nutritional status e.g. chewing and swallowing problems, side-effects of medication, ADL-dependency and so on (2) calls for the co-operation with e.g. occupational therapists, doctors and physiotherapist.

Further the evidence for a beneficial effect of nutritional treatment of older patients after discharge is limited (3). Recently we therefore conducted a randomized controlled trial (RCT) to assess the additional benefits of individualized nutritional counseling by a registered dietician in undernourished geriatric patients´ home after discharge from Herlev hospital, in relation to risk of re-admissions, functional status, nutritional status, and use of social services (4). A multifactorial approach was intended since our plan was to offer both groups three home visits from their general practitioner (GP), in order to deal with medication and eventual problems in relation to this. But, while the compliance with the planned nutritional counseling was almost 100%, we did not succeed in involving the GPs (4).

As a result of this we now try a new multifactorial approach 'FNUG'. This RCT again includes older undernourished geriatric patients from Herlev hospital. During their hospital stay our aim is to increase their intake of protein mainly at the main meals. An occupational therapist and a registered dietician are involved in this. At discharge both groups are followed home by a 'Follow-home team', consisting of a physiotherapist or an occupational therapist. At the visit in the patients' home the focus of the team is on medication, ADL-dependency and so on. If the patient is in the intervention group, a registered dietician participates in the visit. The idea is that the registered dietician and the 'Follow-home team' can exchange information that is relevant for the nutritional treatment of the older adults, so that the registered dietician can include these in her next two planned home visits. More information about 'FNUG' can be found on Clin Trials Gov NCT01776762.

1. Milne AC et al. Protein and energy supplementation in elderly people at risk from malnutrition. Cochrane Database Syst Rev 2009;2, CD003288. doi: 10.1002/14651858.CD003288.pub3.
2. Salva A et al. Nutritional assessment of residents in long-term care facilities (LTCFs): recommendations of the task force on nutrition and ageing of the IAGG European region and the IANA. J Nutr Health Aging 2009; 13. 475-483.
3. Beck A, et al. Limited benefit of oral nutritional supplements on recovery and rehabilitation in old people at risk from malnutrition after discharge from hospital – a review. Clin Rehab 2012;27:19-27
4. Beck A, et al. Follow-up home visits with registered dieticians have a positive effect on the functional and nutritional status of geriatric medical patients after discharge. A randomized controlled trial. Clin Rehab 2013; 27: 483-93

Older people identifying as lesbian, gay, bisexual, transgender or queer have very different experiences than younger LGBTQ people since they have experienced tremendous legal and social changes in the society during their lives. Older lesbian and gays in Sweden for example have experienced how their sexualities caused them to be criminalized (until 1944), then seen as mentally ill (until 1979) and in many contexts considered as deviant. While today, when LGBTQ people have gained more rights and visibility, coming out is a strong norm – it has for older people often been different, where hiding and secrecy many times have been the only option.

In a new book, *LHBTQ-personer och åldrande: Nordiska perspektiv*, authors from Sweden, Norway, Denmark and Finland write about different perspectives on LGBTQ aging. While these countries are similar in many ways regarding LGBTQ history, rights and living conditions, there are also differences. For example, Finland and Norway decriminalized homosexuality much later (1971 respectively 1972) compared to Denmark (1930) and Sweden (1944). This has consequences for people's experiences and perceived possibilities to what extent they have been able to be open with their sexualities.

While research on LGBTQ aging is an established field in the US, there is not as much knowledge within the Nordic context. In the US, there has been more research, several well-organized LGBTQ senior groups work political for these issues and there are several education programs for care institutions – something that is lacking here. A senior housing project for LGBTQ people are opening in Stockholm which has sparked some discussions, but there are no bigger studies nor any strategic plans for creating care for older people that are not heteronormative.

Many different themes and perspectives cut through the different chapters in the book. Some focuses on care contexts, illustrating how many older LGBTQ people are worried for future needs of care, and to be discriminated against because of sexuality or gender identity. In one of the chapters where managers of nursing homes are interviewed, the authors problematize the discourse on "equal treatment" that is central in the interviews, since this is based on heteronormativity thus conceal LGBTQ experiences. Another chapter illustrate how it can be to live with HIV as older. While HIV drastically increases among older gay men, preventive information is most often directed to younger groups. Ageism, homo- and transphobia within care contexts are illustrated through several of the chapters.

Another focus is intimate relations and community, illustrating how the concept of family are reformulated for many LGBTQ people, where one's family could be a chosen such, with friends, lovers and partners rather than biological family members. The book also illustrates how norms on gender, sexuality and age are perceived during life course for those who do not fit into heteronormative life scripts. Aging can mean different challenges, as for trans people who come out in later life and want to transition – but then realize it is too late since one's body can not cope with the surgeries one desires.

Studentlitteratur 2013, ISBN: 9789144077697
https://www.studentlitteratur.se/#35883

The ethical committees of the Nordic Medical Associations held their biannual seminar in Bergen in 28. - 30. August. Thirty-five physicians attended this seminar from the five ethics committees of the respective associations. Three topics had been chosen specifically for in-depth discussion. The first topic was ethics regarding the establishment and use of health databases. A second issue was how health service to irregular immigrants was provided for in the Nordic countries or rather the lack of it. The third topic is however of specific interest to those treating and caring for patients in their last phase of life; euthanasia and physician assisted suicide. It is therefore appropriate to give some glimpse of this delicate issue as they were presented and discussed at this meeting.

Prof. Lars Johan Materstvedt from Department of Philosophy and Religious studies in Trondheim gave a presentation, focusing on the situation in the country that has the most experience in this regard, Holland. Furthermore, he informed how various groups and thinkers have been presenting this delicate issue through the last decades. The topic of euthanasia tends to create interest and there is always some dialog of this kind somewhere in the Nordic countries, most often spurred by individual stories and experiences and often lacking the necessary balance.

The concept euthanasia is defined as an act of a physician with the intention of ending life of a competent patient that has made an explicit wish to die (1). As this definition is used, the term "passive euthanasia" is internal contradictory and thus not a real term even though prominent philosophers have advocated for that (2). Euthanasia has been practiced in Holland for the last 30 years even though a legislation specifically allowing for this kind of procedure was not adopted until 2002. The proportion of deaths in Holland during these years have been fluctuating but seems to be increasing in recent years and is currently a little less than 3% of all deaths. The cases coming into consideration have however changed. Originally, only individuals with life threatening and unbearable physical condition came into consideration but later the term 'mental suffering' has been taken into consideration. This is reflected by the changing motives for requests for euthanasia during the past 30 years with physical motives such as pain and dyspnoea decreasing but hopelessness and deterioration increasing (3). The legislation in Holland was established after thorough dialog for a long time and the Dutch Medical Association was playing a central role. This was not the case in Belgium that past a legislation on euthanasia later the same year. The Belgium legislation on euthanasia was adopted following a general election without much debate. The political parties forming the government had this on their agenda, without having advocating for this specifically before the election and put this into action in the following months. It has therefore been said that the Belgian population was taken by surprise. Is this thinkable in the Nordic countries? There are political parties in these countries with this topic in their party program such as Fremskritspartiet in Norway. Nevertheless, this seems unlikely, as an issue of this kind needs to be debated before any legislation could be adopted.

Another action termed LAWER ("a life ending act without explicit patient request") has also been used in Holland but is not legalized. This is the active termination of the life of an individual who is not competent to make a wish for this action. The two most likely individuals in these cases are neonates on one hand and older persons with advanced dementia on the other. In spite of non-legislation it is estimated that up till 0.4% of deaths in Holland occur in this manner.

The third act of purposely ending the life of individuals is physician assisted suicide and this is legalised not only in the BeNeLux countries but also in Switzerland and in four states in USA. This act is not formally legal in Germany but is being tested in court. The definition of physician-assisted suicide is, as the wording implies, when a physician provides for all the means for

ending life but the individual is performing the act. This is not an excepted procedure anywhere in the Nordic countries.

One medical decision that is sometimes confused with euthanasia is non-treatment decision. The result of such a decision is usually that the patient dies. The intention is however the decisive item in these cases. The intentions of euthanasia and physician assisted suicide are to end the life of the patient but the intention of non-treatment decision is to have nature taken its course. The decision is however an active one when life sustaining or life prolonging treatment that has been deemed disproportionally harmful or futile is withhold (4). Another medical decision that sometimes is discussed alongside with euthanasia is terminal sedation. This again is an act that is not performed with the intention to end life but to treat a patient and this is a very important difference. Terminal sedation is thus not euthanasia even though the result is much the same as the patient dies.

All these different ways of ending life in a more or less active way create emotional responses but any dialog needs to include ethical considerations. When the act of euthanasia is considered, both subjective and objective issues most be taken into account according to the laws. The subjective issues are the values of the patient such as how the term "unbearable suffering" is understood. The seemingly objective issues are however evaluated by the physician and his co-workers such as the effectiveness of the treatment for pain, dyspnoea and other physical discomfort and the prospect for improvement (or lack thereof). The objective evaluation is however also influenced by subjective evaluation of the physician.

Facts that have come out of research into this field should raise concern. According to one project, the proportion of depression in those entering euthanasia was three times higher than in those that were in a similar position but chose not to receive euthanasia. A good proportion of those with depression had not received any treatment for their condition. Another cause for concern is how the indications for euthanasia seem to be widening and how so many participating in the dialog are accepting more lax term to be eligible for euthanasia such as mental suffering and life dissatisfaction, a term that is extremely difficult to get a grip off. One aspect of this "slippery slope" is the concept that actually is used in some places, the LAWER (5). The central issue when considering euthanasia is the real will of an individual that is considered competent. It is not possible to be sure of the real causes for the wish of an individual to die, as it is not possible to rule out undue pressure, direct or indirect, on the individual to make this choice. This pressure is rarely direct but can arise from the feeling of the individual that his life has become a burden for his family or even for society. When patients are in an advanced state, their competence can be questioned. The term "advanced directive" has therefore been advocated regarding euthanasia but has still not gained a legal status in this context.

The understanding of those that advocate euthanasia and physician assisted suicide is that there is no reasonable alternative. Some of those argue that euthanasia is in fact a part of palliative care (6). In countries that do not allow these actions, euthanasia is on the other hand not a reasonable alternative. Let us keep it that way in our countries but the dialog will certainly continue.

References

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2. Rachels J. Active and passive euthanasia NEJM 1975;292:78-80.
3. Marquet RL et al. Twenty five years of request for euthanasia and physician assisted suicide in Dutch general practice: trend analysis. BMJ 2003;327:201-2.
4. Materstvedt LJ . Palliative care ethics: the problems of combining palliation and assisted dying. Progress in Palliative Care 2013;6:1639-44.
5. Verhagen E. The Groningen protocol for newborn euthanasia; which way did the slippery slope tilt? J Med Ethics 2013;39:293-5.
6. Bernheim JL et al Development of palliative care and legalisation of euthanasia; antagonism or synergy. BMJ 2008;336:864-7.

‘Nyt om Gammelt’ – News on the Old in Denmark 9

The Danish Gerontological Society has this year started an electronic newsletter, ‘Nyt om Gammelt’ (News on the Old), which is issued to our members four times annually. The newsletter supplements our journal ‘Gerontology’ which has been issued since 1985.

The newsletter contains news on research and practice developments, politics and policies, publications and the like. As a recurrent feature, ‘Det Gerontologisk Danmarkskort (the Gerontological Map of Denmark), introduces to old age research and educational institutions around Denmark and encourage these to present their activities. This virtual ‘tour de Denmark’ provides hopefully to the reader relevant news, but also enables the board of the Danish Gerontological Society to keep up to date with the various institutions. We also hope that this outreaching activity will strengthen our communication with present members and attract new members.

Have a look at the newsletter at:
http://gerodan.dk/nb/nyhedsbrev-nr-22013/

Interdisciplinärt forum 28 oktober i Sverige

Sveriges Gerontologiska Sällskap ordnar den 28 oktober 2013 ett nytt interdisciplinärt forum för möten mellan forskare i början av karriären och från olika discipliner.

Dagen ger en överblick över det interdisciplinära fältet gerontologi, genom att doktorander och nydisputerade ges möjlighet att presentera sina forskningsfält. Det kommer att finnas goda tillfällen att föra diskussioner och ställa frågor.

Dessutom bjuder Kenneth Abrahamsson, tidigare verksam på FAS, på en introduktion om karriärvägar och hur man lyckas med forskningsansökningar efter doktorsexamen.

Sista anmälningsdag 8 september.

Mer information: http://sgs.nu/aktuellt/SGS-konf/interdisc/program%2028%20okt.pdf

Anmälan: http://sgs.nu/aktuellt/sgs-konf/interdisc/anmalan.asp

Upcoming conferences 10

EUGMS 2013
2-4 October 2013, Venice, Italy
http://www.eugms.org/index.php/meetingscourses/futureeugmscongress/11-eugms2013

International Istanbul Initiative on Ageing, International Federation on Ageing
4-6 October 2013, Istanbul, Turkey
http://www.ifa-fiv.org/index.php?option=com_content&view=article&id=1297

International Psychogeriatric Association, Better Mental Health for Older People
1-4 October, 2013, Seoul, Korea
http://www.ipa-online.org/

2013 Aging and Society: An Interdisciplinary Conference
8-9 November, 2013, Chicago, USA
http://agingandsociety.com/the-conference

66th Annual Scientific Meeting of Gerontological Society of America
20-24 November, New Orleans, USA
http://www.geron.org/annual-meeting

8th International Conference on Cultural Gerontology
10-12 April 2014, Galway, Ireland
http://www.conference.ie/Conferences/index.asp?Conference=213

22nd Nordic Congress of Gerontology
25-28 May, 2014, Gothenburg, Sweden
http://www.22nkg.com/SiteSpecific/22NKG/StartPage.aspx

XVIII ISA World Congress of Sociology
Facing an Unequal World: Challenges for Global Sociology
13-19 July, 2014, Yokohama, Japan
RC11 Sociology of Aging
http://www.isa-sociology.org/congress2014/rc/rc.php?n=RC11

Share your activities!

GeroNord, and the website for NGF, are resources for the members within the member organization of NGF, aiming to work as a platform for news in the gerontological area. This is however based on the members to share news, activities and events. Therefore, we would like to encourage you to send information to us about new PhD's, upcoming seminars, conferences, books, courses, education and other activities within your member organizations. We would like you to use these resources as ways to spread information to the many persons working within the gerontological field that are reached by this newsletter.

The website is currently containing basic information about NGF but can also be used as a resource for spreading information about your activities. We would like your ideas and thoughts about what you wish to see on the website, and if you submit material for GeroNord, we are happy to share this on the website too if you wish.

Anna Siverskog, Secretary of NGF

The board of Nordic Gerontological Federation:

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2. vice chair: Boo Johansson
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The editorial staff of GeroNord wishes you a nice fall!