



NGIG Publication

'The official publication of the National Geriatrics Interest Group



'Grandma' (By: Matthew Kennedy, University of Toronto)

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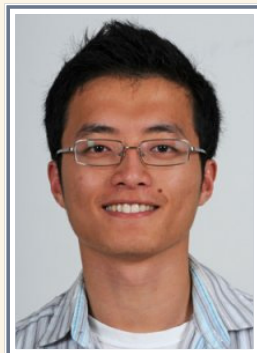
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Layout Editor

Peng You

Queen's University (2015)

Peng You is a second year medical student at Queen's University. Acting as the co-chair of Queen's Geriatrics Interest Group for the second year, Peng has been instrumental in the addition of new lunch time lectures, Christmas caroling at local long term care centers, a new geriatric skills night and a streamlined system for geriatrics observerships. Peng is excited to see and be apart of the growing interest in geriatric medicine.

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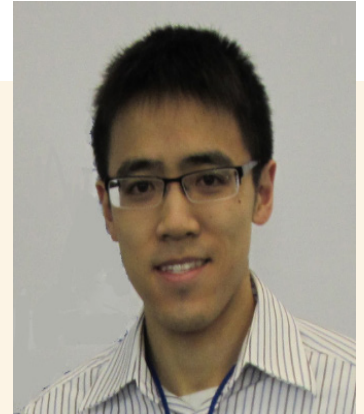
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Letter from the Editor



Dear Readers

It is with a great sense of excitement that I present the very first issue of NGIG's official publication! This inaugural issue has been a culmination of hard work from a team of very dedicated individuals, and I cannot be more proud of the final product that we've produced.

I must start off by thanking all members of the NGIG Publication Committee – Megan Clark, Anjori Pasricha, Laura Sims and Peng You – who were all instrumental in kicking this publication off the ground. Dr. Tricia Woo (McMaster University) has also been an invaluable mentor throughout this entire process, and this publication would surely not be possible without her kind and genuine support.

Although NGIG is grounded on a very specific interest in the field of geriatrics, it is a field that truly spans all areas of medicine and the content in this publication will hopefully appeal to all medical students across the country. In addition to presenting updates from local geriatrics interest groups, we also highlight pertinent issues in geriatric medicine through feature articles, commentaries and art submissions. Our feature interview is with Dr. Samir Sinha, an esteemed geriatrician from Mt. Sinai Hospital in Toronto who took the time to share his thoughts on medicine and provide some great advice for medical students. His work and accomplishments in geriatrics is not only an inspiration, but also a leading example of how rewarding a dedicated career in medicine can be.

On behalf of NGIG, I truly hope that you enjoy reading this publication. It has been wonderful working on such a meaningful project, and I cannot wait to start working on the second issue!

Wilson Kwong (Queen's University, 2015)
NGIG Editor-in-Chief

LETTERS

Letter from the Chair



Dear Readers

It is my privilege and great honour to present you with the first edition of this unique publication. This publication represents the collaboration of medical students across our nation with a common passion for geriatrics and is the first entirely student-led national publication with a geriatric-focus. On behalf of our talented editor, Wilson Kwong, the National Geriatrics Interest Group (NGIG) executive team and our supporters, I would like to thank you for your interest and support. This publication is a testament and showcase of the hard work and dedication of medical students across our country who are making a difference in their communities and in the provision of care to our geriatric population.

My name is Catherine Cheng and I am the 2012-2013 Chair of NGIG. NGIG is a centralized national student-led group started by medical students with the goal to unite students interested in geriatrics across the country. The group aims to build partnerships amongst individual local geriatrics interest groups to create a forum for Canada-wide education initiatives and discussion in the fields of aging and geriatrics.

This year has been an exciting year for NGIG. Along with welcoming the first issue of this publication which involved submissions from medical students across the country, we also launched our first set of web accessible podcasts created with medical

students in mind. We are also proud to continue to strengthen our relationship with the Canadian Geriatrics Society, the Resident Geriatric Interest Group and to build new partnerships with organizations such as the Alzheimer's Society of Canada. We will be hosting our 2nd National Geriatric Student Conference in April 2013, and hope that you will join us in Toronto for this event.

This publication would not be possible without the support of numerous dedicated individuals and organizations. I would like to thank the Canadian Geriatrics Society for their support and Dr. Tricia Woo for her continual mentorship. I would also like to commend Wilson Kwong for his dedication, the members of the NGIG executive team, and all the contributors for making this initiative a reality. Finally, I would like to thank you for your readership and your interest in the field of geriatrics, and I hope you enjoy the contents of this publication.

Catherine Cheng (University of Ottawa, 2014)
NGIG Chair, 2012-2013

FEATURED ARTICLES

Origin of NGIG

By: Dr. Magda Lenartowicz (University of Saskatchewan, PGY1 Internal Medicine)

WOW... is the most appropriate sentiment that comes to mind as I watch the wonderful progress of the National Geriatrics Interest Group (NGIG). Three years ago, when I started throwing around the idea of a national group dedicated to the care of older adults, the expectations were modest. After all, we have all heard the indelible mantra that young people just aren't interested in this area of medicine. To my surprise (and secret relief) a few intrepid students from around the country, along with ALL of the members of the CGS Education Committee, were willing to bet on my crazy notions. With their assistance, the newly-minted Geriatric Interest Group (GIG) at the University of Saskatchewan and its McMaster counterpart joined ranks and started to search for student leaders around the country willing to unite as a national body. As it turned out, many young people did indeed have an interest in Geriatrics or had already established fledgling groups, and all they needed was the support of their peers and the excitement of creating a national forum to connect with others across the country.

With the help and enthusiasm of these students and their mentors, things moved quickly over the past three years. We started off small, helping to organize local Geriatrics Skills Days and attempting to secure funding, an area where the CGS came through for us loud and clear. We met lots of challenges along the way, including learning how to create an organizational structure and how to survive the logistics of holding regular meetings across several time zones. In spite of all the hurdles, we have created a solid network of medical students interested in the field of Geriatrics. We connected with local organizations within our communities, and brought in the very folks to whose well-being we are so committed. Take our "Face to Face with Alzheimer's" sessions, where members of the Alzheimer's Society's FirstLink support groups had a chance to share their daily lives and struggles with our students. These seminars were very popular and held value for both the students and the members of the Alzheimer's Society, while providing a template for many of the activities the groups pursued.

We shared all our resources, our achievements as well as our failures via an online "bulletin board", which allowed us to stay connected and find new ideas that could be translated into local needs. Our overarching goal was always to provide the logistical and financial support that these smaller groups needed, while allowing them the freedom to create programs and activities that suited their particular locales. In the end, what sealed the success of NGIG and its local chapters were these very personalized opportunities for medical students to interact with geriatric patients, connect with like-minded peers, and meet preceptors who served as positive role models in the early years of training.

I find it incredible that in the span of only three years, we have graduated to holding our first Student Annual meeting at the 2012 CGS conference in Quebec City, and this wonderful inaugural issue of our very own

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journal. I have set up the very first National Student Award in Geriatrics, which was presented at the 2012 meeting, and we hope to find the funds to create a few more. There is even international interest in what we have built, and I will be expounding on the NGIG's achievements at the upcoming AGS Student Chapter annual meeting in Texas. That's certainly a great deal of traction in a short period of time, and a wonderful way for students to learn leadership and organizational skills on a large scale.

I do have to mention a few key people, whose early support helped this group gain momentum and successfully develop on a scale that it has. Leah Nemiroff's (Dalhousie) super IT skills made us a presence on the Internet, while Katrin Dolganova's (Queen's) beautiful writing kept us in the public view. I would also like to thank Allison Mitchell (Saskatchewan), NGIG's second Chair, who organized my chaotic ideas into a well-oiled machine, and Alex Peel (McMaster) whose creativity and drive made our first annual meeting happen. We also had fantastic initial contributions from pioneers Ayaz Kurji (Queen's), Belinda Fung and Kathleen Nichols (Western), Judith Seary and Amanda Lo (Toronto), Carolyn Ranasinghe Wong (Calgary), Alyson Wong and Clara Westwell-Roper (UBC), Brenda Holyk and Sarah Hosseini (Manitoba) and Kyle Fisher (Alberta).

Just as integral to this endeavor were the Geriatricians of whom every single one was willing to support us in whatever capacity they could. Both the CGS Chair at the time of our founding, Dr. Angela Juby, and the current CGS Chair, Dr. Roger Wong, embraced us. We could not have asked for a better logistician than Dr. Tricia Woo (McMaster) who knew the answer to pretty much every question we ever had. At University of Saskatchewan, we had Dr. Jenny Basran, who helped us set up our Geriatrics Skills Day (which is now, by the way, incorporated into the U of S curriculum). Drs. Chris Frank (Queen's), Cornelia van Ineveld (U of Manitoba), Jasneet Parmar (U of Alberta), and Laura Diachun (Western) answered way too many of my (likely even stupid) questions and solved many conundrums, as has the rest of the CGS Education Committee. There are also numerous Geriatricians who took on the big task of helping these nascent groups grow (and I will single out Drs. Camilla Wong and Samir Sinha at U of T, who have been enthusiastic and always smiling supporters of the GIG idea!).

There are so many who have helped that it would take another article to list them all, yet we greatly appreciate everyone whose hard work contributed to our success. Last, but not least, we are lucky to have the current crew of innovators whose ideas continue to move the group forward with big plans in the works. We are moving forward with a national educational strategy in partnership with the Alzheimer's Society, we are creating new online newsletters, and our sister group the RGIG (Residents' Geriatrics Interest Group) is continuing to engage students interested in Geriatrics as we graduate to upper levels of our training.



Magda Lenartowicz

Magda is NGIG's founding Chair and current busybody. She has a degree in Gerontology and is currently a Resident in Internal Medicine at the University of Saskatchewan. Her goal is to make all medical students love Geriatrics as much as she does!!

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I am extraordinarily proud of the medical students who have put their limited extracurricular time into making the NGIG this vibrant and forward-thinking group. I am also very thankful, and humbled, to all these people who were willing to believe and join in my vision. I come from three generations of educators, one of whom was my intrepid Great-Grandmother who never stopped teaching in Polish, despite threat of death, as part of the Underground during WWII. It is she who often told me that the best way to encourage young people into action is to allow them to take their own interests and channel them into areas that need change. That is the premise for the foundation of the NGIG – to create a strong, student-driven national movement that provides opportunities for medical students to improve the care of older adults, in a way that engages them to innovate and express their own ideas and interests.

The only question left is - where do we go from here? I say, in my usual over-enthusiastic way: anywhere we want – and everywhere we may be needed. Things are surely changing in Canadian geriatrics, and we are proud to have contributed to the momentum. All you have to do is join in!

Magda Lenartowicz
 Contact: mlenartowicz@gmail.com
 University of Saskatchewan
 Founding Chair, National Geriatrics Interest Group
 Advisor to NGIG, RGIG Executive Member

No Pressure:

Preventing pressure ulcers in the elderly

By: Pavandeep Gill (University of British Columbia, 2015)

Pressure ulcers (also known as decubitus ulcers or bedsores) are common but potentially preventable cutaneous lesions. About 70% of them occur in patients over the age of 70.¹ These lesions are defined as areas of necrosis caused by compression of tissue between bony prominences and external surfaces². Pressure ulcers are often found in patients who are physically limited or bedridden due to illnesses such as CNS depression, spinal cord injury, stroke, and end-stage dementia². Immobility results in increased amounts of pressure, shearing forces, friction, and wetness², which can reduce the integrity of the skin. With age, many degenerative and metabolic changes also occur to the skin including thinning of the upper layer of the skin, changes in collagen structure decreasing elasticity, and reduced blood flow decreasing the ability of the skin to nourish and repair cells⁴. The compounding of all of these factors makes elderly patients especially vulnerable to developing these lesions. The National Pressure Ulcer Advisory panel classifies pressure ulcers into four stages³. These stages are summarized in Table 1.

Table 1: National Pressure Ulcer Advisory Panel pressure ulcer classification

Stage	Description
I	Non-blanchable erythema of intact skin
II	Necrosis with superficial to partial-thickness involvement of the epidermis and/or dermis.
III	Deep necrosis with full-thickness skin loss extending down to underlying fascia.
IV	Extensive necrosis into the underlying fascia, possibly into muscle bone and supporting structures.

Pressure ulcers can cause severe or intolerable pain in patients and can reduce the quality of life of patients suffering from them³. They can even be life threatening should complications such as sepsis or osteomyelitis result³. Pressure ulcers also place a significant economic burden on the health care system. These lesions are very difficult to treat, with estimates for complete healing of pressure ulcers being as low as 10%.¹ The costs for managing a single full-thickness pressure ulcer can be as high as \$70 000 and in the US, an estimated \$11 billion per year goes towards treating pressure ulcers⁵.

All of this stresses the importance of implementing preventive strategies when caring for patients at risk for developing pressure ulcers. Despite popular belief, the incidence of pressure ulcers is higher in acute care hospitals compared to long-term care facilities and they often occur early, with most pressure ulcers

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appearing during the first two weeks of hospitalization.⁹ When patients are admitted to the hospital, they should be first assessed for their risk of developing these lesions using scales such as the Norton, Braden, and Waterlow which have been developed for this purpose.³ Once the initial risk has been assessed, preventive measures targeting impairments in mobility, nutrition, and skin care should be undertaken. Immobility should be addressed by using support surfaces for patients that reduce shearing forces and pressure. These include foam mattresses, cushions, and surface overlays filled with air, water, or gel. Excessive bed rest should be avoided in patients and they should be turned frequently, and dynamic support surfaces that alternate the pressure between the patient and the underlying surface should be employed. The nutritional status of patients should also be assessed as malnourishment has been associated with increased risk. Nutritional supplementation has been shown to be beneficial.⁵ The skin of high-risk patients, such as those who have sensory loss or are suffering from cognitive impairments that cause a lack of awareness, should be checked regularly for pressure ulcer development. Proper skin care, including maintaining adequate moisture, should be ensured as dry sacral skin as been shown to be a risk factor for developing pressure ulcers.⁵

A targeted preventive approach to pressure ulcers can ensure a better experience for hospitalized elderly patients and may be associated with fewer costs compared to treating them once they develop⁵.

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Pavandeep Gill

Pavandeep Gill is currently a second year medical student at the University of British Columbia. Prior to this, she completed three years towards a Bachelor of Science majoring in Pharmacology at UBC. Born and raised in Vancouver, Pavandeep is a loyal Canucks fan and can be found most summer days biking the Stanley Park sea wall or hiking the Grouse Grind.

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Postoperative delirium in elderly patients

By: Nitan Garg (University of Ottawa, 2014)

Introduction

It is well known that the Canadian population is aging¹ and as the elderly make up a larger proportion of the population undergoing surgical procedures, anesthesiologists will be faced with an increasing number of challenging cases. The reason for this is perioperative risk increases linearly with age due to reduced cardiopulmonary reserve and comorbid diseases.² A prospective cohort study of patients who had non-cardiac surgery demonstrated that 30-day all-cause mortality was higher in patients over the age of 80 compared to younger patients.³ In a separate observational study ambulatory surgical over the age of 65 had a higher incidence of any intraoperative complication—and more specifically, intraoperative cardiovascular events.⁴ This places more pressure on anesthesiologists to develop an anesthetic plan that predicts and prevents potential complications.

Postoperative Delirium

One of the most common postoperative complications in the geriatric surgical population is post-operative delirium (POD).⁵ Classic features of delirium include an altered level of consciousness, inattention, cognitive dysfunction, and disorganized thinking. The pathophysiology of POD is poorly understood but several predisposing factors for delirium, and predictors of POD, have been identified (Table 1).^{6,7}

The importance of delirium as a postoperative complication lies in its medical, social, and financial impact: delirium is an independent predictor of increased mortality and longer hospital stays.⁸ It is also associated with increased hospital costs per patient. Moreover, post-discharge institutionalization, rehabilitation, formal health care or informal caregiving services further contribute to its socioeconomic impact.⁶ Accordingly, finding measures to prevent POD has become a focus of research interest in anesthesia. These measures will be reviewed here.

Interventions

a) Regional vs. General Anesthesia

One area of anesthetic management that has been studied extensively is the use of regional versus general anesthesia to reduce the incidence of POD. The rationale behind this hypothesis is based on differences in physiological effects of regional and general anesthesia in terms of cerebral blood flow, oxygen delivery, and cerebral metabolism.⁹ A recent evidence-based clinical update reviewed eight randomized controlled trials (RCTs) evaluating the relationship between regional versus general anesthesia and POD. Seven of the eight tri-

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Table 1. Predictors of delirium and post-operative delirium

Delirium Risk Factors	Predictors of Post-operative Delirium
<ul style="list-style-type: none"> • Age ≥ 65 • Male sex • Dementia • Depression • Immobility • Sensory impairment • Dehydration • Malnutrition • Treatment with multiple psychoactive drugs • Multiple coexisting conditions • Metabolic derangements 	<ul style="list-style-type: none"> • ASA Class \geq III • Male sex • Baseline cognitive impairment • Depression • Smoking • Multiple medications • Multiple comorbidities • Alcohol use • Impaired functional status • Visual and/or hearing impairment • Laboratory abnormalities (anemia, electrolyte disturbances, renal insufficiency, hypoalbuminemia)

ASA, American Society of Anesthesiologists

als did not find a significant difference in the incidence of POD.¹⁰ It is important to note, however, that several trials did not use validated instruments to diagnose delirium and their sample sizes were considerably small.

b) Anesthetic Choice

Alternatively, different classes of anesthetic agents have been proposed to influence POD. The basis of this hypothesis is that intravenous and volatile inhalational anesthetics such as propofol and sevoflurane, respectively, exhibit differences in pharmacokinetics and potential for neurotoxicity. However, three RCTs comparing propofol and various volatile anesthetics have failed to show a difference in the incidence of POD.^{11,12} In addition, Leung et al. hypothesized that the use of nitrous oxide in combination with induction agents would be associated with POD due to its neurotoxic effect; however, nitrous oxide did not influence the incidence of delirium during the first two postoperative days.¹³

Thus far, the only the addition of ketamine to etomidate has been shown to influence the incidence of POD. Ketamine administered at 0.5 mg/kg one hour prior to surgery demonstrated significantly less POD and exhibited anti-inflammatory effects as demonstrated by a reduced serum CRP compared to etomidate alone.¹⁴

c) Level of Sedation

Besides choosing different anesthetic agents, the level of sedation and its influence on POD is also of interest. In an RCT where sedation was titrated according to electroencephalography with the bispectral index (BIS), lighter sedation reduced the prevalence of POD by 50%.¹⁵

d) Pharmacologic Prophylaxis

Neurochemical processes underlying delirium suggest that it is associated with cholinergic deficiency. For instance, haloperidol, a D2 dopamine receptor antagonist, that leads to increased release of acetylcholine,

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has been widely used in symptomatic treatment of delirium.¹⁶ Therefore, it was hypothesized that prophylactic treatment with procholinergic agents prior to surgery may reduce the risk of POD. In fact, RCTs have demonstrated that pre- and post-operative treatment with antipsychotic agents such as haloperidol and olanzapine are associated with reduced incidence of POD.^{16,17,18} Of note, however, olanzapine was associated with an increased severity and duration in those who did develop POD.

While antipsychotics have shown clinical benefit, rivastigmine and donepezil, both agents with procholinergic activity used in the treatment of dementia, failed to demonstrate a protective effect against POD.^{19,20}

e) Specialized Geriatric Care

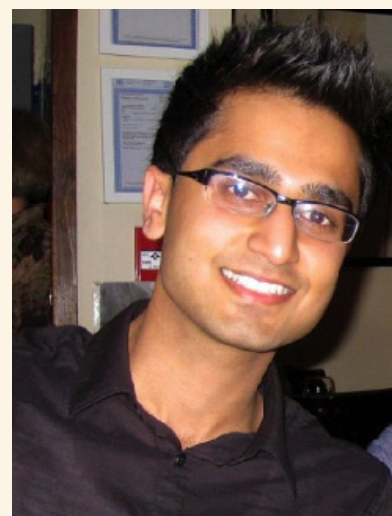
Finally, the principle underlying involvement of comprehensive geriatric care either preoperatively or postoperatively is identification and modification of risk factors predisposing patients to delirium. Marcantonio et al. demonstrated the benefit of a proactive geriatric consultation involving 10 items: adequate CNS oxygen delivery, fluid/electrolyte balance, treatment of severe pain, elimination of unnecessary medications, regulation of bowel/bladder function, adequate nutritional intake, early mobilization and rehabilitation, prevention, early detection, and treatment of major postoperative complications, appropriate environmental stimuli, and treatment of agitated delirium. This intervention reduced the incidence of delirium by 18%.²¹

In another example, post-operative orthopedic patients assigned to a specialized geriatric ward experienced significantly fewer days of delirium, fewer complications, and a shorter length of stay versus patients assigned to a conventional orthopedic ward.²²

These figures stress the importance of patient-specific collaborative care amongst anesthesiologists, surgeons, and geriatricians.

Conclusions

Overall, only select interventions aimed at preventing postoperative have shown clinical benefit. These include the use of ketamine as part of the induction cocktail, decreasing levels of sedation, pharmacologic prophylaxis with antipsychotics, and comprehensive geriatric care. Still, much of the evidence is derived from RCTs involving small sample sizes, very specific surgical procedures and patient populations, and heterogeneity in the use of tools to diagnose delirium; therefore, generalizability of these findings should be interpreted with caution. Rather, the current evidence should serve as a guide to testing of further hypotheses with the goal of developing more definitive guidelines on preventing post-operative delirium in elderly patients.



Nitan Garg

Nitan is a third year medical student at the University of Ottawa. Prior to beginning medical school, he graduated from the University of Western Ontario with an Honors Specialization in Medical Sciences. His research experience includes basic science and translational immunology, as well as clinical research in pharmacogenomics related to interventional cardiology. Nitán aspires to put his fascination with physiology and pharmacology to work by pursuing a career in anesthesia.

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FEATURED ARTICLES

The Current Geriatrics Landscape: Residency Prospects

By: Megan Clark (University of Saskatchewan, 2014)

As you might already know, becoming a geriatrician involves completing the first three years of an internal medicine residency program, then “matching” through the Canadian Residency Matching Service (CaRMS) to an internal medicine subspecialty geriatrics program. The internal medicine subspecialty application process happens between July to November during the third year of internal medicine residency.

Currently, Geriatrics programs exist at McMaster, Western, Dalhousie, Montreal, Sherbrooke, Laval, Manitoba, Alberta, Calgary, Ottawa, Toronto and British Columbia.

CaRMS reports state that of 421 year three internal medicine residents applying to general internal medicine and subspecialties in 2012, 11 (2.6%) chose geriatrics as their first-choice discipline. 13 of 407 applicants (3.2%) chose geriatrics in 2011. Initially, 20 English language seats in geriatrics were available, followed by 26 seats after reversion processes in the first iteration of the match. Only 11 of those spots were filled, presumably by the 11 who selected geriatrics as their first-choice discipline. Only 71% of all 421 third-year applicants matched to their first-choice specialty, with 8.8% going “unmatched”. Data for the second iteration of the match is not currently available.

It is likely that as Canada’s population ages, we will face an even bigger shortage of geriatricians. Another solution to the shortage is Care of the Elderly training programs available through the Canadian College of Family Physicians (CCFP) as one of many third-year enhanced skills programs for family doctors. Such Care of the Elderly programs have existed in Canada since 1989. In 2005-2006, the CCFP estimated that about 130 physicians across Canada had completed Care of the Elderly training.

These physicians sometimes practice in general family medicine clinics, but also often fulfill roles traditionally held by Royal College certified geriatricians. Some of these roles include consultants in hospitals and long-term care facilities, as well as teachers, researchers, and program developers. Fourteen Canadian universities currently offer 6 or 12 months of additional training in Care of the Elderly to family physicians who have completed a full two-year family medicine residency. These schools are the universities of McGill, Laval, Institut Universitaire de Gériatrie de Montréal, Alberta, Dalhousie, McMaster, Calgary, Toronto, Sherbrooke, Queen’s, Western, Ottawa, Manitoba and British Columbia. The application process is not through CaRMS, but through the individual schools, and involves submitting personal statements, reference letters, a curriculum vitae and an interview process.

Overall, the current landscape seems very hospitable to adventurous residents and physicians who want to fill a growing societal need and earn a fulfilling career working with older adults.

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Megan Clark

Megan is a third-year medical student at the University of Saskatchewan. She is currently enjoying her clinical clerkship. With an interest in Family Medicine, she is co-chair of her local GIG because she sees the importance of learning to be more patient-centred with our geriatric patients.

Challenging Negative Attitudes Towards Geriatrics as a Specialty

By: Katrin Dolganova (Queen's University, 2013)

It is Friday afternoon and the classroom is almost full to capacity – a rarity in today's Podcasting culture. What's more, the medical students' eyes and ears are fixed attentively on the speaker. The topic of discussion is how to choose a specialty – the medical field to match one's personality, preferences and aspirations. There is so much choice after all: family medicine, internal, surgery, pediatrics, radiology, pathology – not to mention the long list of subspecialties. How does one navigate through all these options and make a career decision? One important consideration, the speaker explains, involves an honest appraisal of one's comfort level of interacting with particular patient populations. Herein lies the caveat.



"We are all going to be geriatricians, unless we're pediatricians," the speaker reminds the students. Sideway glances of unspoken "Here we go again..." are perceptible throughout the room. With the "baby boomer" generation reaching retirement age in the next few years, looking after a predominantly elderly patient population is not a matter of personal preference but a certainty.

"How do you feel about looking after elderly, frail patients? What about end of life issues?" the speaker continues.

Nearby, someone whispers, "I'd rather deal with kids than demented people."

For the most part, these kinds of dismissive reactions and comments are not meant maliciously, and yet whenever the word geriatrics appears like an uninvited guest, a ripple of uneasiness, embarrassment or sniggering spreads across the classroom. Such attitudes toward geriatrics and care of older adults are not isolated and reflect widespread negative perceptions of older adults and aging. It does not have to be so.

Generally, society seems to value youth, beauty and vitality more than anything else, so it is easy to understand why even in medicine caring after the elderly does not carry with it a high degree of prestige. Yet aging is perhaps the most important element of human biology that medicine needs to embrace and understand today, since it is so intimately connected to many disease and illness processes. This is where the focus of geriatrics lies and where the future of medicine is likely headed. Just as the popular media is slowly starting to embrace the natural beauty in the images of adults over 40, so is the field of medicine beginning to see the care of patients aged 65 and older as an interesting, diverse, and highly gratifying work.

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Here, student leaders can make a difference by being role models for change in attitudes. It may not be easy at first to be one of the few students in a class willing to speak openly about the wonderful aspects of working with older adults. Sure, it might be embarrassing to put oneself on the spot like that, but I think we owe it to the generations that paved the way for us to now advocate on their behalf.

The problem is that today more and more of the complex geriatrics cases are seen in family doctors' offices, emergency rooms, surgical floors, and the general hospital wards, but health professionals and students are not trained well enough to provide the best possible care to these patients. This is where lies the importance of groups such as NGIG – to promote interest and education of future health care professionals in geriatrics, no matter which specialty the students chose to pursue. Additionally, as the number of geriatrics groups rises in Canada, the hope is that it will provide impetus for schools to revise the curriculums to include more extensive discussions on aging.



Katrin Dolganova

Katrin Dolganova is a 4th year medical student at Queen's University. She first became involved with NGIG in the early days of its inception after meeting Magda Lenartowicz at the 2010 CGS Annual Meeting. She held the External Communications position on the NGIG executive, writing articles in student journals to spread awareness about the field of geriatrics and the new student initiative. She also founded and chaired the Queen's Geriatrics Interest Group in Kingston, ON. Katrin will be starting her family medicine residency at Queen's this upcoming July. She is looking forward to specializing and pursuing a career in care of the elderly.

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Into the Future...

By: Dr. Magda Lenartowicz (University of Saskatchewan, PGY1 Internal Medicine)

I am a PGY-1. I am far enough from medical school to finally acknowledge myself as a physician, yet I am not far enough into my residency that I forget the anticipation-slash-trepidation I felt at its start. My heart no longer beats preternaturally hard in my chest when a code pager goes off, nor am I at a loss for words when woken up in the middle of the night to deal with a breathless, bleeding, delirious, insert-your-own-issue patient. Oh, the adrenaline rush is there, I would not make it through call if it wasn't, but it's not all-encompassing and overwhelming anymore. So it seems not only am I less anxious, but I am also developing a better sense of who I am, both as a person and as a new physician. I am learning what I can and cannot do well, and what I do and do not enjoy at work. I am also crazy enough to want to share these trials and tribulations, hoping that they will help you as you move towards residency.



Full Profile of Dr. Magda Lenartowicz can be found in 'Origin of NGIG' piece (Pg. 11)

1. Taking time... I have been known to say (once or twice... or a million times) that I (gasp!) "don't like the CTU." TheCTU is our clinical teaching unit and medical ward. Now, I will attempt to clarify this shocking (at least for a budding internist) position. For one, I like efficiency, and the medical unit is a large, unwieldy animal that is not easily made efficient. Two, it is a chaotic environment, full of things that have to be done quickly, with a strong focus on getting people moved on to the next level of their care. It does not lend itself easily to caring for some of my patients, namely people with cognitive impairment -- it's noisy, too bright, with too many unfamiliar faces blurring by every day. It leaves me feeling mentally exhausted at the end of the day, with a nagging feeling that I never quite get my patients sorted out the way I would like to. I realize that critical care or adrenaline-fueled, television show-like moments are not my thing -- they just give me a small heart attack each and every time. I like to take my time, I like to know all the details, and I like to have long chats -- and that's okay. We need all kinds.
2. Knowing my patients... the other bit of my disliking the CTU is its lack of time to know my patients. A very wise person said to me recently that physicians don't just work with

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a body, but with a person's belief system, and so they must find ways to effect healing within that person's frame of reference. I think this lends itself well to caring for older adults, as the issues with which they present are never easily dealt with via algorithm-like solutions. You have to know who they are outside of the health issue, and that takes time. This is good, since my brain is more like a multi-layered cloud than an algorithm.

3. "Social issues" are fun... I don't think I really saw this as a clerk as much, but there are patients whose visits are labeled as "social admissions." This means that their medical issues are not acute, and they have been brought to the hospital because their care needs are increasing. Many shy from this as figuring out what to do can be overwhelming and again, time-consuming. Me? I love sorting these things out, hunting down information, doing med reviews, talking to caregivers and GPs, trying to figure out what they need now. You really feel like you are making a difference.
4. Writing really, really long notes... this one is pretty clear. My daily progress notes have been publicly compared to the consult notes of the Geriatric team. I don't know how to make them shorter. Everything is important. Enough said.

I am irreverent, opinionated and occasionally whiny, but I love medicine and working with older, complex, fascinating people who require me to take the extra 10 (okay, more like 20) minutes to talk. I am learning why I am meant to be a geriatrician.

Magda Lenartowicz

PGY-1, Internal Medicine, University of Saskatchewan

If you have any comments or ideas on what makes a good geriatrician from your perspective as a med student drop me a line at magda.lenartowicz@me.com

COMMENTARIES

Reflection on Practice

Cognitive Aspects of Medical Decision-Making in Geriatrics

By: Dr. Christopher Frank (Queen's University, St. Mary's of the Lake Hospital)

Medicine involves complicated decision-making; large amounts of information are synthesized, often with significant time constraints and using information sources of varying degrees of reliability. The way physicians approach problem-solving appears to play a significant role in medical errors, and strategies we are taught in medical training may accentuate the problems. Geriatric care is a high-risk area for cognitive errors.

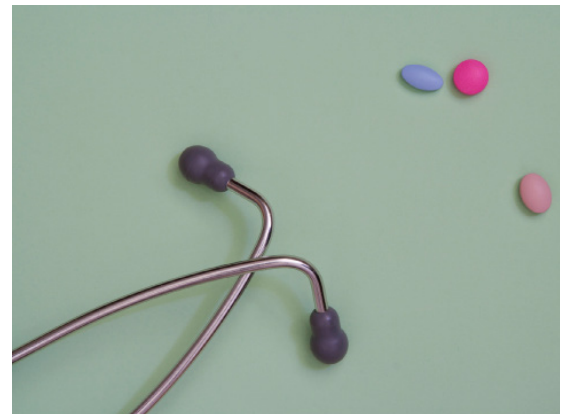
We assume that knowledge and clinical skills are the main factors in making a diagnosis/treatment plan. However, other factors include: personal, often unrecognized, biases, previous experience(s), and our awareness of how we are predisposed to approach a problem – often termed metacognition. Clinical decision-making involves combining our first impression gestalt with an analysis of the clinical facts in a balance that depends in part on level of experience (Dr. House?).

Many of the strategies that physicians use to make clinical decisions are not taught but rather are innate to humans as part of our evolutionary and cultural history. Many physicians are unaware of how our strategies can affect patient care but with publication of books like, “How Doctors Think”, there is increased public awareness of this issue.

Although we consider clinical decision-making to be a science, personal experiences and biases contribute to what is termed **affective error**. Our level of stress will affect our decision-making as will the degree of “compassion fatigue” we are experiencing. Issues such as transference may impact our use of investigations and tests and affect our treatment strategies. To give an example, care of an older patient may be affected by how much they remind us of grandparents.

The term “cognitive dispositions to respond” (CDR) describes strategies commonly used by physicians to deal with specific situations. They can get us into trouble if we over-use them or if we do not recognize the potential errors that can occur when using them. Table 1 shows a listing of common CDRs used by physicians (and lay people) in problem solving.

Outcome bias is a common issue, particularly with junior trainees. This is a tendency to opt for diagnostic decisions that suggest a good outcome (what they hope will happen rather than what they think will happen).



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When examining the JVP with trainees recently and having a difficult time, I noted that my estimation (or educated guess) at where it was visible was affected by where I hoped it would be.

I find that I'm prone to **omission bias**, which is rooted in non-maleficence. If given the option of doing something or watching and waiting, I tend to do the latter. While this can be helpful when working with frail older patients, I must always be aware of this tendency making clinical decisions. Trainees, particularly in fields such as internal medicine, often make **commission errors**, reflecting a preference for action versus inaction.

Sutton's slip refers to situations when a diagnosis seems very likely, leading the physician to jump to the conclusion that this is what the patient has rather than considering all possible options. It is named after the bank robber Willie Sutton who when asked why he robbed banks replied, "It's where the money is." This CDR can be particularly concerning given that the most common cognitive error of physicians appears to be **premature closure** - acceptance of a diagnosis before all other options have been fully verified.

How can we decrease the likelihood that the way we approach clinical problems may cause or contribute to medical error? Jerome Groopman suggests that physicians should "repeatedly factor into the analysis the possibility that he is wrong." Basic knowledge of CDR's commonly used by physicians can increase the likelihood that we will catch ourselves using an ill-advised strategy. Personal awareness of one's own predispositions is an important step, as is developing skills in "metacognition" to analyze and critique one's thought processes while problem-solving. Finally, always asking oneself, "What else can this be?" after a clinical encounter may ensure that alternative diagnoses are considered.

This topic should be included within medical school and residency curricula. Introduction early in the clinical years may balance traditional "bedside" teaching and role modeling that may promote excessive use of problematic strategies. Cognitive "de-biasing" strategies such as "think aloud" exercises and "cognitive forcing strategies" make sense despite a lack of evidence for reduction of error rates. Medical students, geriatricians and family physicians should consider reading "How Doctors Think", which is a readable and enjoyable introduction to the topic. "Thinking, Fast and Slow" is an excellent book by Daniel Kahneman, who won the Nobel Prize for applying this work to economics. It will affect how you view all decisions!

A better understanding of how we relate to patients when involved in their management will hopefully lead to better outcomes for them and



Christopher Frank

Dr. Frank is an associate professor in the Department of Medicine at Queen's University, and is Past President, Canadian Geriatrics Society (CGS). He is a Fellow of the College of Family Physicians of Canada and has CFPC Certification in Care of the Elderly from Queen's University. His main clinical areas are geriatric rehabilitation, acute care geriatric consultation, and palliative care. He is the clinical lead of Specialized Geriatrics at St. Mary's of the Lake Hospital in Kingston. Research interests have included end of life communication and seniors' medication use.

He also intends to ride his trail bike until he's at least 80.

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greater satisfaction in our clinical work.

Table 1

Cognitive disposition to respond (CDR)	Description	Example
Anchoring	The tendency to fixate on early impressions and failing to adjust in light of later information.	Seeing the large tumour on X-ray but missing the pneumothorax.
Availability	Tendency to accept a diagnosis as being more likely if it comes more readily to mind.	Missing an alternate cause of myalgia during a flu outbreak.
Diagnostic momentum	A diagnostic label may stick to patient when intermediaries such as other clinicians, paramedics, nurses and families start to apply the label.	High likelihood the label of dementia applied in hospital visit will be cited in the chart at future admissions.
Framing effect	The influence of how things are presented to the clinician affecting clinical approach.	How the resident describes the situation of the patient in the emergency department will affect your impressions of the diagnosis.
Fundamental attribution	Tendency to blame patient for their illness rather than examine underlying factors or look for missing causes.	Attributing the failure of pain management to the patient's personality rather than to using inappropriate medications for pain coming from neuropathy.
Gambler's Fallacy	The belief that if a tossed coin is heads ten times in a row, the 11th time will be tails.	After seeing several patients with a similar diagnosis such as ischemic chest pain, the physician assumes that the sequence will not continue
Representativeness restraint	"If it looks like a duck, walks like a duck, quacks like a duck, then it probably is a duck."	Any atypical presentation of illness in the elderly may be missed by physicians looking for a more straightforward presentation
Sunk costs	Sticking with a diagnosis because of the amount of time, energy and resources expended in making it.	Overlaps with sunk costs but with less emotional component.
Yin Yang out	Tendency to believe that nothing further can be done to make a definitive diagnosis once patients have been worked "up the Ying-Yang."	Overlaps with sunk costs but with less emotional component.

INTERVIEW PIECE

Interview with Dr. Samir K. Sinha

By: Emily Yeung, NGIG VP Internal Communications (NOSM, 2014)



Interviewee bio

A passionate advocate for the needs of older persons, Dr. Samir K. Sinha is the Director of Geriatrics at Mount Sinai and the University Health Network Hospitals in Toronto.

A Rhodes Scholar, after Dr. Sinha pursued his undergraduate medical studies at the University of Western Ontario, he obtained a Masters in Medical History and a Doctorate in Sociology at the University of Oxford's Institute of Ageing. After returning to pursue postgraduate training in Internal Medicine at the University of Toronto, he went on to the United States, where he most recently served as the inaugural Erickson/Reynolds Fellow in Clinical Geriatrics, Education and Leadership at the Johns Hopkins University School of

Medicine prior to taking on his current post as the Director of Geriatrics at Mount Sinai and the University Health Network Hospitals in Toronto.

One of Dr. Sinha's current favourite roles is serving as a Faculty Advisor, along with Dr. Camilla Wong, to the University of Toronto School of Medicine Geriatrics Interest Group.

Q: What is geriatrics ?

A: Geriatrics is a medical specialty concerned with all aspects related to the care of older patients. Other doctors tend to ask for the help of a geriatrician when faced with an older adult who may have a number of complex and often inter-related health and social care issues.

Q: How, when, and why did you choose to specialize in geriatrics?

A: It was my deeper love of working with vulnerable populations and realizing that the elderly are just that and need good doctors that made me start thinking about geriatrics as a career. The fact that it is a specialty that deals more than a single part of the body through its holistic approach made it feel like a spe-

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cialty that I would never become bored of.

Q: How did you prepare for a career in geriatrics?

A: I came to think about geriatrics after medical school when I took some time out to pursue further graduate studies in medical history and health policy in England. During this time I became fascinated with the policy issues related to the care of older adults, and this spurred my interest in geriatrics as a career when I returned to Canada to do my residency. After my first geriatrics rotation early in my first year of residency I started to look at the rest of my rotations with a geriatrics lens, and pursued research and further clinical training opportunities in geriatrics.

Q: What aspects of geriatrics do you like most?

A: I often tell people that what I love most about Geriatrics is that it give me permission to care for the whole patient. What further makes geriatrics fun is that we get the privilege of working as part of an inter-professional team. Sometimes patients come to me not doing well at all. But with their trust, support and partnership, it's very rewarding when you see these same patients flourishing once again in the community, at home, where they want to be. It's amazing when you realize that sometimes the smallest things can make such a world of difference and how much of what we prescribe as geriatricians is simply applied common sense.

Q: What are some challenges of being a geriatrician?

A: Sometimes despite all the good we try and do, patients still are unable to get better or remain independent. It's sometimes frustrating when you see the system not organized or resourced well enough to provide the care we know our patients need. What gives me hope, though, is that I have been able to

develop my career in such a way where I can use my expertise to influence positive changes to the system that is allowing us to provide the care our older patients need. I hope I can count on some of the readers of this piece to join me and others doing great work to shape a system to better care for our older patients and one day, eventually, us!

Q: Are there any elective areas you would recommend for students interested in pursuing geriatrics?

A: A good grounding in each medical specialty will be essential to being a great geriatrician. Neurology, psychiatry, rheumatology, cardiology and gastroenterology are the five principle areas of medicine that I tend to draw upon in caring for my older patients. Also, pursuing opportunities during my formal geriatrics training to work in nursing homes, rehabilitation centres and do house calls also allowed me to gain a better understanding of these unique care environments and how they can influence the care of my patients.

Q: What other advice do you have for students interested in geriatrics?

A: Geriatrics is the best specialty as far as I am concerned. The fact that you are already interested in exploring a career in this area shows me how much more enlightened you are than I was at this stage. Whenever you see an opportunity to learn more about geriatrics, take it. I am learning new things every day from my colleagues and especially my patients!

ART WORK

Grandma

By: Matthew Kennedy (University of Toronto, 2014)



"Grandma" is a portrait of my grandmother at 96, shortly before she passed away. I really focused on the beautiful character that age added to her face, sculpting her wrinkles and age marks with thick oil paint. This painting also captures the innocence, peaceful simplicity and endearing helplessness which developed as she moved into the last phase of her life – without diminishing her dignity or beauty.



Matthew Kennedy is currently a 3rd year medical student at the University of Toronto. He has always loved visual art, and has been drawing and painting since he was a child. Having no formal artistic training, he has developed his own style gradually over the years. Matthew has had numerous personal art exhibitions in Ottawa, Toronto, Galway Ireland and Charleston SC. In addition, he has had his art on the cover of the UBC Medical Journal, and has presented his art at 3 consecutive White Coat Warm Art exhibitions, part of the annual CCME conference. Painting is an emotional release for Matthew, and it has helped him keep life balance during his medical training. To see more of his art, visit his website at mattiej.k.wordpress.com.

ART WORK

Fading Life

By: Jacqueline Mouris (Memorial University, 2014)

My daughter sits diligently beside my bed,
Memories and worries swirl through my head.
Impending death I no longer dread,
In my years, love's been shared, kind words said.

How did this happen, why am I here?
I don't understand. Details are unclear.
A girl in a white coat wants to look into my ear,
She is kind and smiling, so I say, "Yes dear."

Along come the nurses, doctors and students,
Each rambling in med talk, of which they are fluent.
They discuss me not by name but by tests that are prudent,
And to top it all off ask details of my last bowel movement.

White coats check my heart, lungs and vital signs,
I know they mean well even if I may whine.
I smile faintly as I lay in my hospital confines,
And as my life fades, I remember the good times.

My food is now pureed; I don't like to eat.
With each passing day, I feel obsolete.
But I cannot complain, a life like mine can't be beat,
If given that chance for this life again, I'd hit repeat.

My life fades like water to the sea...an abyss,
I wonder, with death, what will I soon miss.
What comes next, I soon will know...
Goodbye Earthly world, to Heaven I go!



Jacqueline Mouris

Jacqueline Mouris is in her third year of medical school at Memorial University of Newfoundland. Prior to following her dreams of becoming a doctor, Jacqueline was a pharmacist in her hometown of Woodstock, NB. Jacqueline recently completed a geriatrics rotations in Saint John, NB and found it a rewarding experience.

ART WORK

Heritage

By: Crystal Zhou (University of Alberta, 2015)



In this piece, the intent was to show the most important elements against a background of simplicity. The long shape was chosen to echo the dimensions of traditional Chinese paintings. To the left and right are images of my beloved grandparents superimposed on multiple images which are reminiscent of facets of their persons. Beauty and serenity on the left, represented by the lotus and the Chinese scholar rock. History and culture on the right, through the tower and the calligraphy. In the centre, the character for “love” is a window to view an ornate door knocker, for love is the doorway to the soul.



Crystal Zhou is a second year medical student at the University of Alberta. In the copious amounts of spare time that all medical students happily possess, she enjoys taking her camera out for long walks on the beach, diving head first into books, and regularly serenading patients at the hospital with piano music. Though she considers the idyllic wilds of Red Deer her home, a part of her heart will always remain in Shanghai with her grandparents.

NGIG Internal Updates

Saskatchewan

This year, our Geriatric Interest Group hosted an Alzheimer Society Lunch 'n' Learn, a one-hour lunchtime talk from the FirstLink coordinator at the Saskatoon Alzheimer Society as well as a woman recently diagnosed with mild cognitive impairment and her husband. The FirstLink coordinator shared useful info for future referrers on dementia, the Alzheimer Society, and specifically the FirstLink program. The Alzheimer Society client and her husband spoke very candidly about their route to the diagnosis, how it impacted their lives and how they worked with the Alzheimer Society. They also gave some very insightful and helpful advice to the group of 50+ medical students who came to listen to them. So far, this event is our group's main one of the year, but we hope to host more events to help students learn about the both interesting and challenging geriatric patients they will certainly see in their training and practice. We also printed another 100 of our own GIG-produced GeriCards, thirteen-page clinical reference handbooks of assessment tools and pearls, mainly for the third-year medical students who went through our Skills Day. Geriatrics is an interprofessional, patient-centered discipline that always reminds us how much there is to learn and to share.

Queen's

Fall 2012 was a great term for the Queen's Geriatric Interest Group (QGIG)! We launched off our lunchtime speaker series with a mix of fresh new lectures ('Compassion and Literature in Medicine' with Dr. Shayna Watson; 'Driving in the Elderly' with Dr. Michelle Gibson) with a few old favourites ('Music and Memory: Learning from Dementia' with Dr. Jaclyn Duffin, 'How to Live to be 100' with Dr. Christopher Frank). The speaker series ended last term with a geriatrics panel featuring physicians who work in geriatric medicine through three different pathways: internal medicine, family medicine and psychiatry. This was the most successful series yet - with a record 70+ students in attendance! We wrapped up the term with an end-of-the-term caroling extravaganza at St. Mary's of the Lake long term care centre.

Looking ahead through 2013, QGIG will continue the lunchtime speaker series with a special focus on cancer care in geriatric populations, as well as branching to interprofessional speakers (nursing, physiotherapy and pharmacy) to share their knowledge of geriatric care. We're also piloting a geriatric observership program connecting medical students with residents and physicians who work in geriatrics. Finally, last

year's Geriatric Skills Night was very well received and will return for its second run in late March, coinciding with the Geriatrics and Neurology curricular blocks. Facilitators will be teaching students commonly encountered geriatric presentations (falls assessment, medication reviews, approach to dementia).

Dalhousie

The Dalhousie branch of the GIG got underway at the Dalhousie Medical Student Society night way back in September 2012. We recruited new members to the society as well as two med 1 representatives. Welcome to Sara and Farhan - our med 1 reps! In November, members enjoyed getting to know all about careers in geriatrics at our society night featuring 3 geriatricians and 1 family doctor. We are very excited to announce our upcoming event - a panel discussion with 4 amazing guests on End of Life Law and Policy: Assisted Dying in Canada.

Ottawa

University of Ottawa's GIG has had a busy and exciting year! Since we are still a "new" interest group (2 years old), we knew that we needed to find ways to help increase awareness about our group and attract new members. We have successfully achieved this goal by partnering with

UPDATES AND NEWS : NGIG INTERNAL UPDATES

other interest groups on some of our events.

In Fall 2012, we started off with a talk from Dr. Helene O'Connor, a family physician who is currently completing her fellowship training in "Care of the Elderly." Her talk was directed at students interested in taking the PGY3 route into Geriatrics, though she did discuss the Internal Medicine route as well. After this introductory event, we had Dr. Bergeron, who presented a brief overview of Alzheimer's disease and discussed recent advances in research for this devastating disease (including the new Alzheimer's vaccine). Another highlight included a showing of "The Elder Project," a contemporary documentary that shed light on the lives of a few geriatric patients.

In the New Year, a big highlight has been our "GIG Dinner & Discussion" event, in which we were privileged to have four special guest speakers from Internal Medicine (Geriatrics): Dr. Barbara Power, Dr. Genevieve Lemay, and Dr. Mononita Roy; our members jumped at the opportunity to ask questions and get insight from individuals with fabulous life experience. Later this term, we look forward to hosting Dr. Michele Tremblay, a Geriatric Psychiatrist who will talk about her specialty and common mental health issues seen in the elderly.

UWO

Western's GIG has been spending this year trying to improve our interdisciplinary health group alliances. This year, we have run several talks that have been of interest to other allied health groups as well, including talks on sexuality and aging as well as elder abuse. Our main event, in

partnership with the Alzheimer's Society of London, has been our clinical skills day which has included an Aging Simulation Workshop run by the Alzheimer's Society in London.

Manitoba

This year, the University of Manitoba GIG has blossomed and become a respected presence on campus. So far, we have held 3 lunch-hour events. We started the year off with a screening of the movie "Young@Heart", about a choir that is intentionally comprised of older adults. The movie provided Dr. Lorne Sexton, a local psychologist, with a canvas on which he discussed and debunked myths about aging. In December, Dr. Phil St. John presented his fantastic talk about some of the cases he has come across while sitting on the Medical Examiner committee. The subject matter allowed us to promote the event with a CSI-inspired theme. Most recently, we had Dr. Barry Campbell, a Geriatric Psychiatrist, who brought geriatrics to life, walking us through a real case where poor understanding of geriatrics came at a great cost to the patient and the system (i.e. when you should not prescribe Pip-Tazo!). Among the important take-home points, Dr. Campbell explained why cardiac surgeons need to learn about geriatrics.

We have intentionally made interdisciplinary learning a priority of GIG. We invite students with the Medicine, Physician Assistant, Medical Rehab, Pharmacy, and Dentistry faculties to all of our events, with the goal of encouraging dialogue among the students and demonstrating the benefits to patient care that come with teamwork and diversity in skill sets. We are very pleased with the feedback we have been receiving

from all the students who have attended our events.

We are now planning and looking forward to our biggest event of the year: a Geriatric Skills Day. We are fortunate to have access to the PRIME facility at Deer Lodge Centre. We will have 5 stations, each led by a professional from the local multidisciplinary professionals who work with geriatric patients. Topics that will be addressed include elder-friendly environments, gait assessment, delirium, polypharmacy, and communicating with people with dementia.

UofT

The University of Toronto Geriatric Interest Group, co-chaired by Patrick Ong and Taryn Lloyd under the guidance of Dr. Samir Sinha and Dr. Camilla Wong, continued this year with many opportunities for medical students to explore the field of geriatrics. The year started with a "Geriatrics Career Night" which featured guests from diverse backgrounds including Dr. Don Melady (emergency physician), Dr. Mark Nowaczynski (family physician), Dr. Karen Ng (geriatrician), and Dr. Anne Langois (palliative care physician). Furthermore, students were able to chat one-on-one with staff physicians, residents, and fellows in a "Meet and Greet" which happened at the beginning of the new year.

Students were also able to learn more about diseases that are more prevalent in the older population such as Parkinson's and Alzheimer's disease. Jon Collins from the Parkinson Society spoke about the experience of a patient with Parkinson's. The Alzheimer Society talk will be held in the near future and will feature clinical pearls in the management of patients

UPDATES AND NEWS : NGIG INTERNAL UPDATES

with Alzheimer's. The GIG also held an "Interprofessional Clinical Skills Day" for students from different professions including medicine, nursing, occupational therapy, pharmacy, and physiotherapy. This provides an opportunity for students to work within a team setting while tackling different topics such as polypharmacy, MMSE, assistive mobility devices, and OT equipments.

The GIG also continued its "Mentorship Program", this year expanding the mentor roster to geriatricians in Mississauga. Moreover, the GIG is also working on establishing a "Geriatric Longitudinal Experience" for students to get a more formal and prolonged experience with geriatrics integrated into the medical extra-curriculum.

Alberta

The Geriatric Interest Group at the University of Alberta is over 60 members strong and growing! This year we have hosted talks by local geriatricians such as Dr. Adrian Wagg on what he loves about his career in geriatrics and Dr. Jasneet Parmar on assessment of decision-making capacity. We have also partnered with the Alberta Centre on Aging to expose students to multidisciplinary opportunities for research based careers in geriatrics and aging.

Calgary

The University of Calgary's geriatric interest group hosted a movie night for both the first and second year class, providing pizza and drinks for those who attended. We watched the documentary *House Calls* (2006), an film which documents a general practitioner visiting his patients who are otherwise unable to ambulate to

his office. We had two geriatric physicians speak and answer questions following the movie, and they were able to provide insight into the evolution of geriatric care in Canada.

NOSM

The Northern Ontario School of Medicine (NOSM) has recently formed its first Geriatric Interest Group, and is the latest school to join the NGIG in 2011. The inauguration of the NOSM GIG has propelled and fuelled many different geriatric-related initiatives, creating many exciting interprofessional collaboration between students, the school, and the community. The NOSM GIG has organized its first ever Geriatric Skills Night back in March 2012, which was extremely successful and brought together medical students from different years, OTs, PTs, speech-pathologists, and geriatricians from the community. This year, we will continue to host different talks by geriatric experts to raise awareness of the unique challenges and issues facing the elderly population. Dr. McElhaney, a geriatric specialist at Health Sciences North hospital in Sudbury, is the latest to give a talk on promoting independence, which created a forum for discussion among students about how future physicians can prevent disability and promote quality of life among older adults in their practice. Other exciting initiatives at NOSM include interactive sessions in collaboration with Alzheimer's Society and patients living with dementia, and an interprofessional learning series that brings together students from different health-related professions to explore geriatric care and in rural and northern Ontario areas. As the year progresses, we will continue to organize events to expose students

to different skills and knowledge that are crucial to the field of geriatrics, with the goal of forming physicians who are prepared to care for this growing population.

UBC

Last term, the UBC GIG held a Dealing with Dementia seminar where we invited 3 speakers: Dr. Martha Donnelly, a representative from the Alzheimer's Society, and the caregiver of a patient with Alzheimer's Disease. The students had a wonderful evening listening to a personal heartfelt story from the caregiver and the journey he and his wife experienced after her diagnosis of Alzheimer's Disease. This term, we have several exciting events planned, including 2 clinical skills workshops focusing on issues surrounding geriatrics and polypharmacy, and heart failure in the elderly. In addition, we also held a Healthy Heart event at a local community centre in February. We will wrap up the year with a How to Navigate the Healthcare System presentation, where there will be a brief overview of how to educate seniors about how to access available medical services and providers. We will invite a senior from the community to talk to medical students about their experiences and challenges with the health care system. We hope the events will raise more awareness among medical students regarding unique considerations when caring for the geriatric population!

UPDATES AND NEWS : CGS ANNUAL CONFERENCE



Dear medical students,

The Canadian Geriatrics Society is hosting its 33rd Annual Scientific Meeting at the Toronto Marriott Downtown Eaton Centre Hotel in Toronto from April 18-20, 2013. This year's theme is entitled "Leading Edge Learning in Geriatrics" and features many opportunities to learn from the top geriatricians, family physicians, geriatric psychiatrists, and other health professionals with an interest in the care of older persons in North America. The National Geriatrics Interest Group is also holding a "Medical Student Half-day" during the conference. Please join us for this educational and networking experience.

Instructions for registration are as follows:

1. To register for the conference, with or without a grant, please visit: <https://www.etches.com/ehome/CGS/registration/?&>.
2. To sign-up for the "Medical Student Half-day" (at no additional fee and required for all recipients of the Travel Grant), please fill out the following form after registration is complete: https://docs.google.com/forms/d/1fW9HQO_g4ctBklymTaeabhjcQs_4svKz83lop0LBQw/viewform?sid=78ca1e6ef1913ded&token=FRITIDwBAAA.WpaXSt5TmB1GyoxWZj9CYQ.8uotyJJXallsLcSloML_VA

For additional information and the preliminary program schedule, check the Canadian Geriatrics Society website: <https://www.etches.com/ehome/CGS/75721/?&>. If you have specific questions, you can contact me, Patrick Ong, NGIG conference chair, at jannpatrick.ong@mail.utoronto.ca. I will contact all registered participants and recipients of the travel grant to confirm attendance to the Medical Student Half-Day.

See you there!

Jann Patrick Ong (University of Toronto, 2015)

NGIG Conference Chair

Société Alzheimer Society

Caring for people with Alzheimer's disease and other dementias is a long-term commitment for health-care providers. From diagnosis until the end of life, health-care providers are called upon to support and treat not only the person with the disease, but family caregivers as well.

The College of Family Physicians of Canada (CFPC) and the Alzheimer Society (AS) are invested in improving the quality of care for people with dementia and have been working collaboratively by engaging the physicians that support them. A new opportunity has arisen for the CFPC and ASC to provide workshops in collaboration with the National Geriatric Interest Group (NGIG) to increase awareness about Alzheimer's disease and dementia amongst medical students and new health care providers.

The goals of these workshops are to increase students' understanding of dementia and the complex impact it has on both the individual and their family members; increase awareness regarding community support services and resources; and to promote First Link® and programs provided by their local Alzheimer Society.

Workshops will be offered through select universities across Canada in the near future. For more information and to find out if a workshop will be offered in your local community, please contact your local Geriatric Interest Group (GIG) or the National Geriatric Interest Group representative at magda.lenartowicz@usask.ca.

Geriatrics Resources and Websites

Canadian Geriatrics Society Students Website

<http://www.canadiangeriatrics.ca/students/>

Tools and Guidelines

<http://canadiangeriatrics.ca/students/index.cfm/resources/tools-guidelines/>

List of Geriatrics Journals

- Canadian Geriatric Journal: the official journal of the Canadian Geriatrics Society. It is a peer-reviewed medical journal that publishes research and articles of interest to physicians and other health professionals who provide medical care to older Canadians. Instructions to Authors.
- The Canadian Journal on Aging: a refereed, quarterly publication of the Canadian Association on Gerontology. It publishes manuscripts on aging with a focus on biology, health sciences, psychology, social sciences, and social policy and practice.
- The Journal of the American Geriatrics Society: a comprehensive and reliable source of monthly research and information about common diseases and disorders of older adults.
- Clinical Geriatrics: practical information for clinicians whose patient base increasingly includes older patients. The Journal is committed to publishing superior, evidence-based, up-to-date, clinical information for clinicians who diagnose and treat patients ages 50 and older; it is also a practical resource for all healthcare providers.
- Journal of Geriatric Psychiatry and Neurology: brings together original research, clinical reviews, and timely case reports on neuropsychiatric care of aging patients, including age-related biologic, neurologic, and psychiatric illnesses; psychosocial problems; forensic issues; and family care. The journal offers the latest peer-reviewed information on cognitive, mood, anxiety, addictive, and sleep disorders in older patients, as well as tested diagnostic tools and therapies.
- Annals of Long-Term Care: Clinical Care and Aging: a peer-reviewed medical journal of the American Geriatrics Society, focusing on the clinical and practical issues related to the diagnosis and management of long-term care residents.
- Cochrane Systematic Reviews: systematic reviews of primary research in human health care and health policy. They investigate the effects of interventions for prevention, treatment and rehabilitation. They also assess the accuracy of a diagnostic test for a given condition in a specific patient group and setting.



NGIG Conference 2012 – Quebec City

Become a member of the Canadian Geriatrics Society !

Click on the application form that can be found on

<http://www.canadiangeriatrics.ca/default/index.cfm/about/become-a-member/>


Membership for medical students is free !



Canadian Geriatric Society/ Société Canadienne de Gériatrie

 ResGIG@gmail.com

 GeriatricResidentGroup

 @GerilInterestGp