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NGIG Publication

The Official Publication of the National Geriatrics Interest Group

Spotlight: Geriatric Education

The State of Geriatric Education
Recruiting a Faculty Mentor
Innovations in Undergraduate Education

Cover Art: "Mr. H Loves to Paint", Paige Zhang

Contents

Detail: "Skin Imprint in Silver I", Klara Pokrzywko

Letters

Letter from the Editors 3
Elizabeth Niedra & Selynne Guo

Letter from the Chair 4
Jasmine Davies

Spotlight: Geriatric Education

Recruiting a Faculty Lead: Moving Toward A Revitalized Geriatrics Curriculum 5
Amanda Canfield

Innovations in Geriatric Education: A Review 8
Christina Reppas-Rindlisbacher

The State of Geriatric Education: Interviews with Faculty 14
Amanda Chen & Bonnie Cheung

Featured Articles

Walk and Talk for Your Life 20
Celine Akyurekli & Jennafer Wilson

Alive Inside: Music Therapy in Dementia Care 25
Groonie Tang

Language Discrimination Against Older Adults 28
Selynne Guo

Gentle Persuasive Approach: Why it Matters to Medical Students 33
Jessica Wilson

Commentary

One-Diagnosis, One-Cure Thinking v. The Elderly: Caring for the Geriatric Patient With Multiple Morbidity 36
Colin Sui

Letter to the Editors: A Reflection on Geriatrics in Undergraduate Medical Education 39
Noam Berlin

How Art Educated Me About the Beauty of the Aging Body 41
Klara Pokrzywko

Medical Humanities:

Youth 44
Pauline Kosalka

You Are Still There 45
Linda Pan

Kay: A Love Sonnet 46
Jessica Teicher

A Fleeting Treasure 47
Gurmeet Sohi

Grandpals Penpals 49
Cindy Ding

Mr. H Loves to Paint 51
Paige Zhang

GIG Life:

Inter-Professional Education Event: A Local GIG Experience 52
Amanda Canfield

GIG Annual Updates 54
Various Schools

Resources & Acknowledgments 59

Letters

Letter from the Editors

Dear Readers,

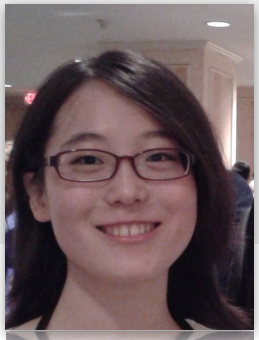
Thank you for picking up the third installment of the NGIG Publication, the official, student-led publication of the National Geriatrics Interest Group!

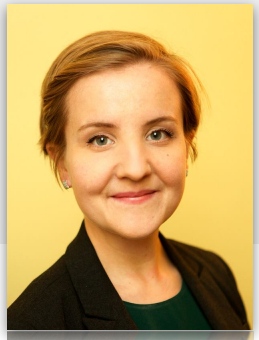
In past years, this publication has been a unique and powerful platform for geriatrics-minded students nationwide, to showcase their involvement in the geriatric research & clinical communities, voice their thoughts on the field of geriatrics and simply share their love of geriatric patient care. This year, the number of students with something to say is larger and more diverse than ever - we received an unprecedented number of submissions from across Canada, on everything from the gentle persuasive approach to fine art musing on the aging body.

This year, we have chosen Geriatric Education as our publication's spotlight topic. Across the country in recent years, geriatrics-focused students have heard escalating discussions around meeting the physician needs of the aging population through renewed focus on geriatric education; we hope that through the medium of our student-led publication, we might join our voices to this all-important conversation. Here, you will find student-curated pieces on some of the themes learners find most meaningful in the geriatric education debate, from faculty mentorship and curriculum renewal to cultural commentary on hidden curriculum in geriatric training.

We would like to thank the students from across Canada who volunteered their thoughts as contributing writers this year, and the members of the 2015 NGIG Publication Committee whose extra undertaking made this year's publication possible. Finally, we would like to thank Dr. Tricia Woo and Cindy Worron for their continued, critical mentorship and support of our publication, and all NGIG activities.

Thank you for supporting our publication, and giving each of our writers a well-deserved moment for their voice to be heard! If you have any questions, comments or suggestions for this ever-evolving NGIG initiative, we would love to hear from you. Happy reading!





2015 NGIG Publication Editors-in-Chief,

Elizabeth Niedra, McMaster University 2015

Selynne Guo, University of Toronto 2017

Letters

Letter from the Chair

Dear Readers,

It is my great honour and privilege to present to you the 3rd annual National Geriatrics Interest Group (NGIG) Publication. Medical students across the country have come together to make an impressive publication. Thank you for your support of this project which showcases the talent of Canadian students who are dedicated to improving the care of older adults.

My name is Jasmine Davies and I am the 2014-2015 chair of the NGIG. The NGIG is a group which unites students across the country with a common interest in providing exceptional care to older adults. By connecting the local Geriatrics Interest Groups (GIGs) at each medical school, students have been able to discuss their common interests, implement national education initiatives and increase awareness of the positive aspects of aging and Geriatric Medicine.

As in previous years, this year's executive team had done a great job of uniting students and implementing new initiatives. Along with the unique events which each local GIG holds, we have nationally continued the Patient Outreach Project and the Alzheimer's Society Initiative. As well, we have successfully implemented the new #whygeriatricswednesday initiative, which is a social media campaign focused on increasing students' awareness of the positive aspects of aging and working with the geriatric population. In addition, we continued to strengthen our connections with the Alzheimer's Society of Canada, the Canadian Geriatrics Society (CGS) and the Resident Geriatrics Interest Group (RGIG). We will again be holding a National Geriatrics Student Conference during the 35th Annual CGS Scientific Meeting in Montreal, and we encourage all students to attend.

This publication would not have been possible without the help of multiple individuals and organizations. I would like to thank the CGS for their continuous support, Dr. Woo for her invaluable mentorship, and the Canadian Academy of Geriatric Psychiatry for their financial support. Lastly, I would like to commend the many students who submitted articles and the publication team, headed by Elizabeth and Selynne, for their hard work and dedication. You all have made a publication to be proud of!

Lastly, but certainly not least, thank you for your readership and interest in the field of Geriatric Medicine. I hope you find our publication both informative and entertaining.

2014-2015 NGIG Chair,

Jasmine Davies, University of Western Ontario 2016

Recruiting a Faculty Lead: Moving Toward a Revitalized Geriatrics Curriculum

Amanda Canfield, University of Toronto Class of 2017

This past year, the University of Toronto School of Medicine created a new faculty lead position dedicated to reformatting geriatrics content within the undergraduate medicine curriculum. This position, the Faculty Lead for Care of the Elderly/Geriatrics, will allow for improvement of the scope and quality of content, related to the care of elderly patients, taught to medical students. This extremely important, given that the number of older adults in Canada has been consistently increasing in the past decades; approximately 5 million Canadians were over 65 in 2011, and this is number is expected to double by 2036. With this trend continuing, it is estimated that 25% of the Canadian population will be over 65 years of age by 2051[1].

The increasing proportion of older adults in the Canadian population has produced a larger demand for expertise in geriatric-specific issues, yet neither geriatric psychiatry nor geriatric medicine specializations are frequently pursued in Canada. In a Geriacast presentation on Geriatrics and Health Care in Canada, posted by the National Geriatric Interest Group, Dr. Robert Wong pointed out that in 2010 only 8 of 25 postgraduate positions in Geriatrics were filled (32%), while many other internal medicine subspecialties filled 85% or more of their seats[2]. Further, despite the increase in Canadian seniors from 2.7 to 4.8 million between 1986 and 2010, the number of trainees in geriatric medicine remained stable at 15-25 per year[3]. This data is not yet available for the geriatric psychiatry subspecialty, as it only began to be formally recognized by the Royal College of Physicians and Surgeons of Canada in 2010[4].

This pattern has worked its way upstream toward physicians in practice, thus prompting concern that there is a critical shortage of both geriatricians and geriatric psychiatrists. In 2012, the Canadian Geriatrics Society reported that there were approximately 230-242 geriatricians in Canada, equating to approximately 0.5

geriatricians per 10 000 individuals 65 years and older[5]. There is a similar shortage of geriatric psychiatrists in Canada; in September 2014, there were only 220 geriatric psychiatrists to care for a Canadian population of approximately 7 million older adults[4].

Despite the challenge of recruiting medical trainees to pursue geriatric medicine, in 2013 the Canadian Medical Association reported that 81% of geriatricians in Canada were satisfied or very satisfied with their professional lives[6] (similar data is not currently available for geriatric psychiatry). A recent Canadian Geriatrics Journal article, discussing possible factors contributing to faltering numbers of geriatric medicine trainees, cited inadequate exposure to geriatric content during medical school as a likely causal factor[4]. This was shown to be true in a 2009 survey of 16 medical schools across Canada, which found the mean hours of geriatric-related curriculum to be 21.8 during preclerkship years, with the University of Toronto having 20 mandatory hours. Mandatory weeks in geriatric medicine and geriatric psychiatry in clerkship were found to vary between schools; half of the medical schools had zero weeks dedicated to either subspecialty, including the University of Toronto. Overall, the University of Toronto had the fourth lowest number of mandatory hours dedicated to geriatrics in their undergraduate curriculum[7]. The new Faculty Lead position is a step in the right direction, towards increasing the number of hours medical students at the University of Toronto are exposed to geriatric-related content.

The new position seeks a faculty member with a strong passion for geriatrics, who will become an advocate for revitalized geriatrics curriculum with greater student exposure and engagement. Further, there will be opportunities for geriatrics-minded students to become involved in future curriculum development alongside the faculty lead, allowing for student advocacy of geriatric content. Promisingly, student advocacy has already been a part of the process – in December 2014, two second-year medical students, both executive members of the Geriatrics Interest Group at the University of Toronto, sat on the selection committee for the position and gave key medical student perspective on candidate recruitment.

Hopefully, both the new Faculty Lead for Care of the Elderly/Geriatrics and the opportunities for student involvement will allow for the integration of more geriatric-related content at the undergraduate level in future years. Ideally, this will provide medical students with adequate curriculum to not only develop a good understanding of geriatric-specific issues, but also to foster interest in the specialized care of elderly patients in their future careers.

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About the Author

Amanda is a second year medical student at the University of Toronto and is one of the co-chairs of the Geriatrics Interest Group, as well as VP Media and Technology of the National Geriatrics Interest Group. Amanda became interested in caring for older adults while working at a long term care home in high school. Since then she has developed a passion for promoting awareness of the unique health and social challenges of older adults, as well as fostering interest amongst students in the care of the elderly.

Innovations in Geriatric Education: A Review

Christina Reppas-Rindlisbacher, University of Toronto Class of 2016

Introduction

The physicians of tomorrow face significant challenges in caring for an increasingly complex patient population. As our population ages, nearly every physician will meet frail elderly patients and will require basic skills in assessment and decision-making within the geriatric context. Unfortunately, most medical schools continue to use a traditional disease-centered educational approach, with less consideration given to specific patient populations with multi-comorbid medical contexts, such as the elderly. When medical learners thus enter the "real" world of patient care, they often become overwhelmed by the complexity of problems presented by the geriatric patient[1]. An unfortunate consequence is that many medical students view geriatrics as an undesirable specialty[2]. Medical education must therefore evolve to challenge the stereotypes around geriatrics, and better prepare all learners to address the healthcare needs of our aging population. Fortunately, healthcare system educators are beginning to recognize the need to reflect demographic-centered issues in medical curricula, and teach the comprehensive approaches necessary to comfortably manage our older population.

The aim of this review is to describe the current practices and recent advances in geriatric education in medical schools across North America. By learning from each other's initiatives, we can collectively work towards enhanced medical education and improved health delivery to older adults.

Methods

A systematic review of the literature was undertaken to identify educational innovations and curriculum recommendations for training medical students in geriatrics. Literature included was published between January 2000 and February 2015; the search period was limited to after the year 2000 in order to minimize results from curricula and innovations that no longer exist. The databases Embase and MEDLINE were searched using the MeSH (medical subject headings) term "geriatrics" with the subheading "education". Geriatrics/education was combined with the MeSH term "students, medical" to identify 80 relevant articles. The database PubMed was searched using the terms "geriatrics" (in

title/abstract) combined with "medicine" (in title/abstract) and "education" (in title) and 44 articles were identified.

Articles written in a language other than English were excluded. There were no eligibility criteria for study design. All duplicate articles were excluded, and the remaining articles were screened on title, abstract and full text. Articles cited by another article for the description of the educational program were included as related articles. Articles describing content or evaluation of geriatric education for medical students were included.

Results

Of the 124 articles reviewed, 17 included articles reported on recent innovations in geriatric education in undergraduate medical programs. Three key themes pertaining to advances in geriatric education emerged from the literature: 1) direct contact with geriatric patients, 2) use of educational technology and 3) an interprofessional approach to geriatric education.

Direct Contact with a Geriatric Patient

While there is evidence to suggest there has been an improvement in teaching and assessment of medical learning objectives in geriatrics[3], negative attitudes towards geriatrics is still pervasive amongst medical learners[4]. While students may be receiving "knowledge-building" interventions in the form of didactic teaching, there is little appreciation for the complex reality faced by geriatric patients until clerkship stages of training. There are several medical schools in the United States that have introduced "seniors mentor programs" as a way to provide medical students with early clinical exposure to geriatric patients. This program provides a longitudinal experience for undergraduate students to be matched with and follow their senior mentors over a four-year period, both in the home and clinical settings. Medical schools such as the Medical College of Wisconsin[5], Ohio State College of Medicine[6], Duke University[7] and the University of South Carolina[8] have demonstrated that students' attitudes toward older adults were improved by such programs; students revealed that after completion of a program, they valued relationships with older mentors and held positive images of older adults[9].

An additional educational benefit of patient contact experiences appears to be their ability to foster development of students' overall patient-centredness, empathy and ability to "individualize" patients[9]; this notion of embedding an "empathy-building" component into geriatric education appears to be associated with further positive attitude change in medical students' and doctors' attitudes toward older adults.[10] An evaluation of one 3rd year internal medicine clerkship program in the United States found that while all participants gained geriatrics knowledge during their internal medicine clerkship, students who also performed a home visit had improved attitudes towards the elderly and enhanced skills in performing geriatric assessments.[11] The University of New

England College of Osteopathic Medicine went so far as to develop a program called “Learning by Living”, where students were "admitted" into nursing homes for two weeks to live the life of an elderly nursing home resident, complete with a medical diagnosis and "standard" procedures of care. Longitudinal data reveals that students developed and maintained strong patient-centered attitudes and skills, such as the use of eye contact, touch, body position, and voice cadence to enhance communication.[12]

Use of Educational Technology

Recent understanding in undergraduate medical education has recognized that students differ in learning styles, and benefit from learning methods that are adaptable to their learning needs and goals; this has fostered an explosion of educational technology, and the move away from lecture-based teaching.[13,14] Technology-enhanced instructional methods allow students to receive and learn new knowledge outside the classroom, or before and after clinical sessions. Initiatives such as the Portal of Geriatric Online Education (POGOe), available at http://www.POGOe.org, have been developed to encourage the free exchange of teaching and assessment materials in geriatrics, promoting geriatric education. POGOe is home to more than 950 geriatrics educational materials including quizzes, critically-appraised papers and videos. Assessment of POGOe found that the existence of a compendium of instructional and assessment materials allowed educators to concentrate more on improving learner performance in practice, and not simply on knowledge acquisition alone.[15]

Another interesting technological innovation in geriatric education is the new medical-teaching game GeriatriX (available free of charge at radboud.littlechicken.nl, using student number s1234567). The game was developed to attempt to address the complexity of medical decision-making in geriatrics. It prompts students to weigh the following three areas in their decision-making: (1) patient-oriented goals and preferences, (2) appropriateness of medical care, and (3) costs of medical care. After playing GeriatriX, medical students have a higher self-perceived competence in weighing these interacting considerations in complex geriatric medical decision-making.[16] Another study supported this conclusion, and added that students' self-perceived knowledge of geriatrics and their attitudes toward elderly adults improved after four weeks of playing GeriatriX.[17]

An Interprofessional Approach to Geriatric Education

An interprofessional approach to care is critical in geriatric medicine, where patients have complex healthcare needs requiring input from many disciplines. Geriatric education must similarly reflect this emphasis on interprofessional collaboration, in order to guarantee truly comprehensive and high-quality care of older adults. Several reviewed articles evaluated the effectiveness of interprofessional education initiatives on improving undergraduate geriatric training.

For example, a group of researchers at the University of Virginia developed a geriatric education workshop for both nursing and medical students, with a focus on transitions of care.[18] After completing the program, 90% of students were able to more effectively describe the interprofessional communication necessary to develop a patient-centered care plan, when transitioning patients between clinical sites; four of five students reported an enhanced appreciation of interprofessional teamwork.[18] Shrader et al. further demonstrated that students in medicine and pharmacy developed an enhanced appreciation of inteprofessional collaboration after completing a required interprofessional geriatric medication activity within a senior mentor program.[19]

In addition to providing an appreciation for other health disciplines, studies suggest that interprofessional educational approaches better prepare medical leaners to address the complex needs of older adults. The Cooperative Aging Program from Columbia University requires medical interns to conduct comprehensive assessments with well older people, supervised by an interprofessional team of preceptors. Preliminary efficacy assessments show significant improvements in students' attitudes toward, and knowledge of, older adults as patients, as well as in their self-assessed clinical skills.[20]

Discussion

Use of education technology, interprofessional approaches, and early clinical contact with geriatric patients are identified as key innovations in undergraduate geriatric education. Such initiatives in undergraduate medical education have the capacity to address key challenges faced in geriatric care later in training and practice, such as team-based care dynamics, patient transitions and readmissions, and multi-morbidity[21]. Residents further along in training may be unaware of the supportive services available to the elderly and of the opportunities for coordinated care using the expertise of multiple disciplines[22]. As patient care and health systems become increasingly complex, it is imperative that medical schools implement the education-strengthening strategies discussed in this paper to better address these challenges and knowledge gaps.

A noteworthy limitation of this review is a publication bias. Reviewed literature may not accurately reflect best practices and innovations in existing curricula, if those initiatives and innovations have not been published as formal research. Also, as in other medical education research, it is difficult to isolate the effects of single curricular interventions on relevant long-term quality of care outcomes; for example, one cannot concretely link improved learner markers described above, such as positive image of older adults, to key long-term outcomes such as choice of geriatrics as a career and practicing physician preparedness working with geriatric patients. Future research should explore such longer-term outcomes, as well as the impact of other,

still-emerging educational initiatives, such as reflective writing through narrative assignments[23] and mandatory geriatric clerkship rotations[24]. Finally, further research is required to establish consistent methods for evaluating new educational initiatives, in order to better determine best practices in delivering education in geriatric medicine.

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About the Author

Christina Reppas-Rindlisbacher is completing her 3rd year of medical school at the University of Toronto. She currently serves as Vice President – External Communication for the National Geriatrics Interest Group and is a former co-chair of the University of Toronto Geriatrics Interest Group. She received her B.Sc. in Life Sciences from Queen's University in 2011. Christina is passionate about pursuing a career in geriatric medicine and undertaking research to improve prescribing practices for vulnerable older adults with multiple conditions.

Spotlight: Geriatric Education

The State of Geriatric Education: Interviews with Faculty

Amanda Chen, University of Toronto Class of 2018
Bonnie Cheung, University of Toronto Class of 2018

Dr. Samir Sinha is the Director for Geriatrics at Mount Sinai and the University Health Network Hospitals in Toronto. He is also an Assistant Professor of Medicine at the University of Toronto and the Johns Hopkins University School of Medicine.

Q: What is the current state of geriatric education in Canada or in North America?

A: Currently, our biggest challenge is that geriatrics isn't a core part of standard training for any healthcare professions. When we look across the country, or the United States, we don't see the expectation for geriatrics to be a core component with the same emphasis as paediatrics, for example. You could say that most curricula mention the elderly and may have a certain level of focus, but there is no standard; in paediatric training, for example, one will do a formal rotation in clerkship in medical school. However, we don't do a formal rotation in geriatrics. Often, people think, "Well, you'll just pick it up as you go along." That's a challenge, because the majority of healthcare we're providing, in North America and around the world, is actually to older adults.

Dr. Cornelia van Ineveld is an Associate Professor and Program Director for Geriatric Medicine in the Faculty of Health Sciences at the University of Manitoba. She is the current Chair of the Canadian Geriatrics Society (CGS) Education Committee. She specializes in Geriatric Medicine. She works as a consultant in the St. Boniface and Riverview Day Hospitals and with the Geriatric Program Assessment Teams.

Q: What is the current state of geriatric education in Canada or in North America?

A: Good question. So I would say it's inconsistent. I think there is a lot of recognition that geriatric education is an important part of the curriculum, both at the undergraduate and postgraduate level. There have been many articles and statements that have come out from educational bodies, including directions and projects for undergraduate and postgraduate education, as well as lots of statements about re-envisioning education. They've all talked about the importance of preparing our trainees to look after older adults. So at a high level, there is a lot of recognition, which

Just like how we appreciate that with paediatric patients you have to dose medications differently, there are different ways of communicating and approaching care for the elderly. Increasingly, we're coming to realize this.

Geriatric care is often more complex because older patients tend to have multiple competing chronic health issues. Therefore, managing their medical issues, coupled with any functional or social issues, is particularly complex. Ensuring that trainees have this skill and expertise will be essential to meeting the needs of the aging population. Currently, I think that all of our health disciplines should be encouraging a real core emphasis on geriatrics as part of all curricula. We have to make sure that even in our subspecialty-training, people get beyond their entry-to-practice education residency training; for example, a real first in North America has been our orthopedic surgery program here, which recognized that most of the patients that their orthopedic graduates will be seeing are older patients. U of T is the first school in North America that actually has an ortho-geriatrics rotation for all of its first year orthopedic residents, to make sure they build a good basis in terms of how to care for frail older patients, with hip fractures in particular. Therefore, they should be comfortable managing the medical, social, and functional complexity of the older patients they see, or at least appreciate how to work with geriatricians as well as within an inter-professional team managing the care of those patients. But these initiatives are rare I think is great.

But what's happening at the grassroots level has been inconsistent. You don't have a set curriculum across the country. You've got different hours, some schools with a lot of hours and some with very few, different ways it's taught, and huge variation in how many people are available to teach it across the country.

Q: What are the challenges faced at the systems level when trying to push forward geriatric education? Why do you think there are inconsistencies at the local and national levels?

A: At the local level, I think there are all sorts of challenges. For example, each school has a slightly different curricular approach. Some have a three-year program, some have four years, and some have integrated programs. You can't just create a cookie cutter curriculum, which is what creates a challenge for pushing forward geriatric education. This is a historic issue – everybody has a different curriculum, and trying to squeeze content in is very difficult. You're competing with other new topics such as interprofessional education, patient safety, teamwork, end of life, and pain. I'm in the middle of leading a whole area in our revised curriculum and I'm trying to get geriatrics in there, but there are so many competing demands within a curriculum that it's a challenge. The teaching capacity is also different by school, so that also makes it a huge challenge.

things, as opposed to the current standard way of practice.

Q: What have been the most successful initiatives improving geriatric education in the last 10 years?

A: think some of the most successful initiatives I've seen are, for example, having geriatric champions at our medical schools who can support geriatricizing the curriculum. For example, for case-based learning, ensuring that the cases covered are reflecting the population that future graduates will be treating is one way of making sure that a valuable geriatric lens is provided.

There have been a number of schools that have mandated that just as we have a paediatrics core rotation in clerkship, we should also have a geriatrics core rotation. The challenge within geriatric education right now is that a lot of people say, "Practically every patient the medical students are working with are older adults. So they're probably figuring out as they go along." But, we don't say that in the world of paediatrics. There is good evidence to show that there is real value when people get a very specific, concentrated clinical experience in geriatrics. They realize they're not just working with older people and picking up things by osmosis, but understanding how specifically to work with older patients.

Q: Who determines what is taught in geriatrics and what is the process of determining this?

The other thing is that each school is at a different stage for curriculum renewal. It is easier to incorporate additional content, such as geriatrics, in a new curriculum as it is in the process of development versus incorporating content into a pre-existing curriculum. Each school is at a slightly different stage.

Q: What have been the most successful initiatives improving geriatric education in the last 10 years?

A: One is that the Canadian Geriatrics Society (CGS) Education Committee led an initiative where they created educational objectives for undergraduate trainees, and that has been a tremendous initiative. All of the schools have been renewing their curriculum. The objectives have allowed people to go to the schools and say, "This is what you should be teaching. It isn't just me telling you, it is the national body telling you what you should be teaching." This has created some consistency across the country in terms of medical schools' minimal content.

The second biggest initiative is the Geriatrics Interest Groups. They have created a buzz amongst students, and that translates into a greater interest in the field. It's an informal curriculum but it creates a greater interest in the formal curriculum.

Q: Do you think geriatrics is easy to teach?

A: I think it depends. In many cases, universities don't have a geriatrics champion within their faculty, often because some schools don't have associated geriatric programs. In that case, you're really relying on curriculum coordinators to hopefully recognize the importance of geriatrics, and ensure that they establish it in some meaningful way in the curriculum. Some schools are lucky enough to have geriatricians involved in the curriculum development process, specifically, as an education coordinator in geriatrics education. For example, U of T just established an undergrad medical education coordinator in geriatrics for the first time. Other schools may also have these formal roles, or at least a geriatrician involved in championing geriatric issues in the curriculum.

Importantly, we're also seeing a rise in the number of Geriatric Interest Groups (GIGs) across the country. I think GIGs have a dual role; they can help bring people together at the undergraduate or resident level who are interested in geriatrics. But, I think this is also where people can say that they want geriatrics emphasized in the curriculum. There is always an opportunity to work with the educational coordinators or local geriatric champions to make sure that things they want to learn are emphasized in the curriculum. For example, within the GIG at U of T, there is a student who is working on developing a teaching module around the gentle persuasive approach, which teaches practitioners how to work with patients with dementia and behavioural issues. She organized training for 2nd and 3rd year

A: I think it can be a lot of fun to teach but at the same time challenging. We were recently asked to do internal medicine academic cases. They gave us four weeks to teach geriatrics, with topics including fecal incontinence, drug interactions, falls, dementia, and weakness. If you look at the title of the topics, you would say, "Why would anybody be interested in this?" We had to really work on how do we take this fascinating material and repackage it. Why would a resident or student come to two hours of lecture if we were teaching about fecal incontinence and falls? Yes, they're important and they should be there but they don't sound as sexy as heart attacks and arrhythmias. So it can be challenging to present the material in a way that interests learners.

Q: What do you hope to see in the future for geriatric education, and how do you think we can achieve this?

A: What we already have is a group of committed educators who talk to each other and meet face-to-face once a year. We also talk to each other throughout the year and we communicate by email. We have a group of very committed student leaders who are really excited about promoting geriatric education. We have a group of very committed and interested residents. These are all three good things.

What I really want to see in the next little while is getting these groups together beyond a conference call once a year. Let's

medical students to just see what they thought; she was pleased to learn that they found it highly relevant, and is now interested in seeing where this could fit in to the overall curriculum. With more trainees saying, "we wish we had this as part of the curriculum", change follows demand. Students have great ideas and will tend to where their learning gaps are as well.

Q: What do you hope to see in the future for geriatric education?

A: The vision I set out in our work developing Ontario's Seniors Strategy, and also now, as we're moving towards developing a national Seniors Strategy, reflects a need to ensure that every person training in Canada as a healthcare practitioner, whether they be a future doctor, nurse, social worker, or therapist, has the knowledge and skills ready to meet the needs of an aging population. So, I'd like to see that all training emphasizes care for the elderly at an appropriate level for that specialty, or that discipline. We also need to make sure that all of our medical school curricula across the country consistently and appropriately emphasize the right amount of training that would help people feel prepared and ready to care for an aging population.

I think right now I see too many people who are graduating, or currently in practice, who feel that they never got the full set of knowledge and skills to care for these patients. And it just makes their lives

have a dialogue, let's talk, and let's share ideas in a very concrete way. Ideally, if you look at the States, they have POGOE [Portal of Geriatrics Online Education] and it's fabulous because anybody who has a really neat educational project that they've piloted and tried can post it up there and can say, "Look! I've tried this in my residency, and it worked really well, and I'm prepared to share it with you." We don't have that in Canada yet. We've gone back and forth for a while about how we will make that happen. Do we put ourselves in POGOE? Do we have our own POGOE? I think the U.S. does a better job of sharing what they are doing. I think we are all doing really neat stuff in Canada. We are all excited, but we need to figure out how to share and exchange ideas in the same way they are doing it in the States.

I also see education heading away from lectures and more to web-learning, web cases, Twitter projects, video projects, and virtual reality. There are a couple neat projects in the States where students can do a virtual tour of a person's home to look for safety hazards.

To me that's where the future is: A platform for sharing across the country. A platform for regularly sharing ideas amongst students, residents, and educators and embrace new technology and new ideas.

more difficult as practitioners. Really it is our patients first and foremost who lose out when their practitioner may not be able to recognize or identify the opportunity to improve their health. So I think there's a lot of work that needs to be done, but I'm confident that at some point in the future, and I think we're getting closer to there than ever before, but still not quite there yet – where we can make sure, just as we give an emphasis to paediatric training, we will soon have an equally important emphasis around geriatric care moving forward.

The above transcripts contain selected questions from the full interviews. Please find the full interviews on the Canadian Geriatrics Society Student Website.

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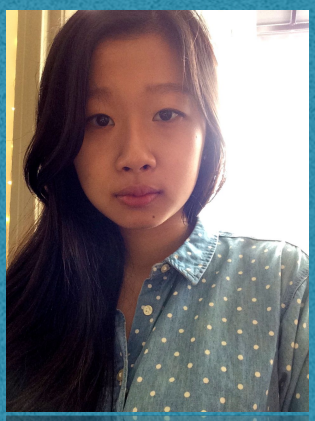
Bonnie Cheung is a first year medical student at University of Toronto. Prior to medical school, she completed a Bachelor of Health Sciences at McMaster University. She is currently the Clinical Workshops Coordinator for the Geriatrics Interest Group at UofT. Her interests in geriatrics developed while volunteering for the Hospital Elder Life Program, a patient-care program that prevents delirium, and doing neuroimaging research with elderly patients at the Rotman Research Institute at Baycrest.



Featured Articles

Walk and Talk for Your Life

Céline Akyurekli, University of British Columbia, Class of 2017
Jennafer Wilson, University of British Columbia, Class of 2017

Introduction

Social isolation and loneliness are prevalent issues among Canadian elderly, associated with increased hospitalizations and morbidity. Social isolation (SI) is a quantifiable measure of a reduced social network (number and quality of social, family and friend contacts) while loneliness (L) is the subjective measure of the negative feelings associated with the perceived lack of social network.[1] According to the Statistics Canada 2008-2009 Canadian Community Health Survey, 19% of seniors aged 65 and older reported feeling left out, isolated from others, or lacking companionship.[2] Further, a study by Kobayashi et al. found that 17% of randomly sampled seniors aged 65 and older in small towns in BC reported feeling socially isolated.[3] A meta-analysis of 148 studies examining social relationships and mortality risk concluded that poor social relationships negatively impact mortality to a level comparable with smoking 15 cigarettes per day, and is greater than other well-established risk factors for mortality such as physical inactivity and obesity.[4] Furthermore, falls, which are the leading cause of injury hospitalization in seniors and a significant predictor of mortality, have been directly and indirectly linked with poor social networks.[5]

Interventions that have shown promise in reducing SI and L and improving health outcomes are community-driven, involve small social groups (7-8 members), and educate participants on healthy lifestyle behaviours including exercise.[6] However, these interventions have not targeted factors that put seniors at increased risk of SI and L; namely, low-income and low-education.[7] Therefore, there is a need to further investigate sustainable, low-cost social health education programs.

Intervention

"Walk N' Talk for Your Life" is a student- and community volunteer-run program that targets SI and L and improves health behaviours in seniors, through socialization, health education and physical activity. The pilot 10-week program was held in the common room of a local seniors' residence

building in West Kelowna, BC. Local residents over the age of 65 were invited to attend the program free of charge. Interdisciplinary UBC-Okanagan students (medicine, psychology, nursing, human kinetics and social work) and primary investigators led two-hour, twice-weekly sessions. Sessions began with a 30-minute Otago fitness program, followed by a 30-minute pedometer-based group walk. The Otago program, developed by researchers at the Otago medical school, has been shown to reduce falls and fall-related injuries by 30% and 28% respectively.[8] Moreover, a year after completion of the program, 70% of participants were still exercising.[8] Goal-setting was introduced at the beginning of the program and accomplishments and challenges were reviewed at each session. Methods used to motivate participants to reach individual goals included goal tracking sheets and a Walk Incentive Board, where distances to popular venues where mapped, and participants could track their walks between sessions.

The final hour included interactive health discussions of the group's choice. Topics chosen by participants included prevention and management of diabetes, nutrition on a budget, exercise as medicine, seniors' safety at home and in the community, over the counter and prescription medication interactions, prevention of osteoporosis, Alzheimer's and dementia awareness, men's health issues, eye health, falls prevention, and the benefits of music. Guest speakers from the community and UBC were recruited to present a topic of their expertise, or students researched and presented a topic. Participants were encouraged to engage in discussion and often shared personal experiences.

To be enrolled, participants first had to pass a Physical Activity Readiness Questionnaire (PAR-Q) or receive permission from their family physician. Baseline and end-of-program measures of functional fitness, cognition, and perceived SI and L were performed. Validated measures of functional fitness included grip strength, the 30-second sit-to-stand and the timed ten-meter walk tests. Cognition was assessed using the Montreal Cognitive Assessment (MoCA). Participants completed a questionnaire that assessed perceived changes in health knowledge and behaviours, fitness, and overall program satisfaction. 32 participants completed baseline and end-of-program assessments. Questionnaire data was analyzed by a statistician; data from functional testing and cognitive assessments is under currently review.

Questionnaire Response Results

30/32 (94%) of participants enjoyed the program and were very satisfied (84.4%) or satisfied with beinginvolved in the program.

I) Health Behaviour Education

Response	I learned more about diet (%)	I learned more about physical activity (%)
Strongly agree	53.13	59.38
Agree slightly	40.63	34.38
Neither agree or disagree	3.13	3.13
Disagree slightly	0	3.13
Disagree strongly	3.13	0
Don't know	0	0

II) Perceived Physical Fitness

Response	I increased my physical activity (%)	I improved my strength (%)	I improved my stamina or endurance (%)	I improved my balance (%)
Strongly agree	46.88	34.38	37.5	37.5
Slightly agree	28.13	25	18.75	31.25
Neither agree or disagree	18.75	21.88	28.13	31.25
Slightly disagree	0	3.13	6.25	0
Disagree strongly	3.13	3.13	3.13	0
Don't know	3.13	12.5	6.25	0

III) Socialization and Well-Being

Response	The program helped me socialize more (%)	The program improved my mental and emotional well-being (%)
Strongly agree	59.38	65.63
Agree slightly	18.75	21.88
Neither agree or disagree	12.5	6.25
Disagree slightly	9.38	6.25
Strongly disagree	0	0
Don't know	0	0

Conclusion

The "Walk N' Talk for your Life" program was highly acceptable, and appeared to improve participants' self-reported knowledge of health behaviours and their physical activity and fitness, socialization and mental and emotional well-being. Trained volunteer participants and students continue to sustain the program on a smaller scale. The major limitation of this preliminary data is that it is self-reported; analyses of functional fitness and cognition outcomes are underway. A formal, longer-term clinical trial is needed to determine if this student and volunteer-run program will improve physical fitness, SI and L, and lead to a decrease in falls and falls-related hospitalizations in older adults. We would like to acknowledge the contributions of the UBC-Okanagan students whose help and support made this research study possible.

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Céline Akyurekli and Jennafer Wilson are second year medical students at the University of British Columbia Southern Distributed site. Céline earned her BSc in Molecular Biology from Bishop's University in 2013. Jennafer earned her BEd in French Immersion and BSc in Biology from the University of British Columbia in 2012. Both are actively involved in the Walk N' Talk for Your Life program for seniors in Kelowna, BC.

Featured Articles

Alive Inside: Music Therapy in Dementia Care

Groonie Tang, University of Toronto Class of 2018

It would seem that there are many things to fear about old age: a changing body, the passing of loved ones, diminished freedom, and perhaps a loss of identity and purpose. For those with dementia, these changes may prove even more daunting, as a decline in memory precipitates a slipping grasp on one's identity. If memory is an integral component of a sense of self, preserving a person's memory of their past is arguably essential to maintaining their sense of identity.

"Alive Inside: A Story of Music and Memory" explores the ways in which music therapy can assist dementia patients in coping with memory loss and, ultimately, sustaining their sense of identity. Filmed in the United States, "Alive Inside" was released in early 2014 and received the U.S. Documentary Audience Award at the Sundance Film Festival. The documentary follows Dan Cohen, a social worker, on his mission to better the lives of those suffering from dementia by providing them access to music. He focuses particularly on those who feel imprisoned by long-term care circumstances ill-equipped to support them beyond a physical level. Getting to know the residents, he discovers their love for music and introduces each of them to an iPod carrying their favourite tunes from their youth. Remarkably, these patients are at once soothed and overwhelmed with emotion, where they had been only minimally responsive to visitors and outside stimuli. It is as the name of the film suggests, they are "alive inside" and readily "come to life" at the sound of music they once loved.

It is clear that the filmmakers were well-intentioned in their goal of improving quality of life for patients with dementia. The documentary ends with a plea to viewers to donate to their organization, "Music and Memory", which works toward universal access to music for nursing home residents with dementia. The premise of their idea is simple: if memory is vital to preserving a sense of self and music is capable of awakening that memory, then music can help one hang on to the vestiges of identity.

Furthermore, music accomplishes more than simply preserving memory and identity; as the documentary explains, people withdraw

from the external environment when their surroundings become unbearable, due to either physical, psychosocial or existential suffering. Music may ease such suffering, and provide a source of meaning and joy in the perceived absence of other purpose.

However, while there is merit to the solution presented in "Alive Inside", the film also leaves something to be desired; most importantly, the issue of institutionalizing people with dementia is inadequately addressed. Although it is too clear that no easy answer exists in caring for people with dementia, personal music devices are not an all-encompassing solution; while they may relieve a person's discomfort in long-term care, they are a limited measure of symptom relief, not a disease or lifestyle treatment. In an ideal world, people with dementia would have a better alternative to the current standard of institutionalized care, where through both medical and lifestyle intervention, they would be able to maintain their sense of purpose, hope, and self throughout the disease course; although their memory of the past would no longer be intact, their life in the present would nonetheless allow them to feel alive inside. Unfortunately, medical science and our healthcare system are far from ideal. Institutionalization in its current form, though an imperfect solution, is likely to remain the most viable way of caring for patients with progressed dementia.

Nevertheless, "Alive Inside" seems to take a step in the right direction, in exploring the ways in which the quality of life of institutionalized patients can and should be improved. Providing personal music devices is only the beginning; for example, programs allowing dementia patients to share in the joy of music, through collective dancing and singing, may prevent feelings of isolation and loss of hope by promoting meaningful human connections. Other interventions might encourage patients to develop meaningful connections in other ways, such as with animals or with nature.

It is important to note that if we are serious about improving the quality of life for dementia patients, interventions must also take place beyond the walls of long-term care institutions. For instance, the disproportionate value that our culture places on youth, and the negative stigma surrounding aging, can be hugely damaging for dementia patients who must battle bias against both aging and declining cognition. Attitudes of ageism affect how people interact with dementia patients and ultimately, how patients come to view themselves. If we can change cultural attitudes towards aging and prevent feelings of shame in those with dementia, we will have come a long way beyond music therapy in improving quality of life in dementia, and genuinely enabling patients to feel alive inside.

About the Author

Groonie Tang is a first year medical student at the University of Toronto, Mississauga Academy of Medicine. She developed an interest in geriatrics during her undergraduate years as a volunteer at Toronto Grace Hospital. Groonie wholeheartedly believes in the relevance and importance of quality care for elderly patients across all medical specialities and, as a member of the Geriatrics Interest Group at U of T, hopes to encourage interest in this field amongst her peers.

Featured Articles

Language Discrimination Against Older Adults

Selynne Guo, University of Toronto Class of 2017

"Bed blocker" and "silver tsunami" are two terms coined in recent years to describe the elderly population. Healthcare professionals coined the slang term "bed blocker" to describe older adults who are medically well enough to be discharged, but remain in the acute hospital bed for other reasons. The term has caught on in news media, and can be seen in newspapers such as The Guardian (UK), which printed the story "Court evicts NHS 'bed blocker'" on March 7, 2006.[1] "Silver tsunami", or "grey tsunami", is a similarly popular term in news media and online blogs; for example, The Economist published the article "The Silver Tsunami", which warns companies of the negative impacts of the ageing workforce (available online since February 4th, 2010).[2] Simple Google searches for these two terms will bring back pages of news articles from across the globe, and even a documentary, "Silver Tsunami" (2014).[3]

The connotations of these terms are less than pleasant; they are examples of a deeper underlying negative and prejudiced attitude towards older persons. Older persons are seen as disadvantaged and burdensome. This stereotyped view is one of two forms of ageism found by the Ontario Human Rights Commission (OHRC) during their consultation on ageism;[4] the other form is the structuring of services and systems such that the needs of older adults are not fulfilled. Recognizing such ageism allows us to take action to ameliorate the discrimination older adults face in Canada.

Language is one of our most important methods of communication. Through the use of specific, chosen wording, specific sentiments and attitudes are implicitly relayed, which is why discriminatory terms and language are disempowering and hurtful. The OHRC gives an example of a law professor telling his class that "those who speak English with a 'foreign' accent do not make 'good lawyers'".[4] The commission states that this statement is discriminatory, because it may be enough to create a "poisoned environment" for students in the class who speak English with an accent, because of their place of origin or their ancestry.[4] In the same way, terms such as "bed blockers", "silver tsunami" and "successful aging" subtly convey the idea

that the aging population is an unwelcome burden on our society, and may establish a "poisoned environment" for seniors.

In hospitals and then in popular media, older patients who are medically well to be discharged, but have other socioeconomic factors preventing them from leaving, are called “bed blockers”. A study shows that although not acutely unwell, these patients are still in need of ongoing care and/or rehabilitation[5]; many of them are awaiting transfer to another appropriate care facility. The term “bed blockers” itself relays the value judgment that acutely ill patients are more deserving of care than the elderly patients, reflecting a health care system that places more value in and more funding towards acute versus long-term care. Further, the term "bed blockers" places blame on the patients themselves for not being discharged, when in fact the problem comes from a lack of proper community support and long term care beds.

The “silver tsunami” or the “grey tsunami” equates the aging population to a natural disaster that strikes without warning, only leaving devastation behind.[6] Contrarily, the population has been aging for approximately the past 40 years. It is a slowly developing phenomenon that was predicted and well documented.[6] Furthermore, although prediction models vary greatly on the impact the aging population will have on Canadian health care costs, some of the best research shows that increases in inflation and technology will be of greater cost than the aging population.[7] Regardless of the economic impact of the aging population, older adults have a right, as recognized by the United Nations Principle for Older Persons, to be treated with the same high quality care and the same dignity as younger patients.[8] As such, it is unethical to do anything, including use discriminatory language, to imply otherwise toward older adults.

Even the more benign term and concept of “successful aging” confers a standard to the aging population, because where there is success, there is also failure. The idea of successful aging describes physical and psychosocial well-being into old age.[9] However, historically, the term “successful” was initially coined in opposition to “usual”, which means that only an exceptional subset of older adults could achieve this.[9] The term also implies that there is individual choice and effort to achieve this success, while discounting other restricting factors such as disability and poverty.[9] This assumption of individual choice and effort leads to judgment and a negative stereotype of the everyday older adult who fails to achieve this extra-ordinary “success” in aging. Due to these gaps in the definition, experts have identified the need to 1) expand the definition of “successful aging” to account for biopsychosocial factors, and 2) address how death and dying will be discussed in relation to “successful aging”, as they are inevitable endpoints of aging and life.[9] Regardless of these definition changes, perhaps the ultimate word choice – “successful” – will never be apart from the

implication that one can fail at something so natural as aging.

These three terms, discussed above, are only three examples of a greater attitude displayed in the public and the media, depicting older adults as a burden the economy and society. Media commonly reports an "apocalyptic view of demographic trends and an assumption of intergenerational conflict for scarce resources". [10] These views are fueling fears and resentment towards older adults, for endangering the financial stability of our government through unsustainable increases in health care costs and the Canadian Pension Plan.[10] All of this leads to ageist views of older people as burdensome, sickly and of less value.[10] This stereotyped view is only one behavioral manifestation of ageism seem by the OHRC during consultation on ageism.[4] These social attitudes lead to barriers that are otherwise not associated with the physiology of aging, for example, termination of older employees because they are no longer "trainable".[4] The World Health Organization's Missing Voices Report reveals that ageism and disrespect are major forms of elder abuse that occur globally.[11] Report participants felt that while disrespect is linked to verbal and emotional abuse, it is more pervasive as a poor social attitude.[11] The report gives an example from Kenya, where disrespect towards elderly patients is so blatant that the head of a hospital freely disclosed his belief that older adults were a waste of resources.[11] In addition to causing older adults to feel unwanted in hospitals, this type of disrespect enabled other forms of abuse, exploitation and neglect throughout the Kenyan health care system.[11] Although Canadian seniors are not subject to such blatant discrimination, they still live in social environments perpetuated by subtle forms of language discrimination.

The second manifestation of ageism reported by the OHRC is the failure to respond to the needs of older persons in the structuring of systems and services.[4] Ironically, an example of this systematic ageism included the imbalanced focus of healthcare on acute rather than chronic care;[4] In 2010-11, Ontario spent 34.7% of their health care budget on operation of hospitals, compared to 13.7% on both community care and long-term care homes combined.[12] This imbalance leads to a lack of accessible and appropriate long-term care, which in turn results in the longer stays of older persons in acute care beds. As evidenced by the "bed blocker" example, the two forms of ageism are interrelated and augment each other.

This accumulation of ageist language, stereotypes and behaviours defines our societal attitudes about aging. We live in a youth-centered society, where youth is equated to technology, innovation, and the future.[10] In contrast, aging is undesirable because it is associated with disability, vulnerability and decline.[10] Evidence of this belief is prominent in media and advertising, which are flooded with products that will help us fight against and avoid aging.[10]

However, this belief is not unchallenged. Many other cultures, throughout history and across the globe deeply respect elders for their experience, contributions and wisdom. [10] The OHRC suggests several methods to combat ageism including:

1) Acknowledging the contributions older persons as active participants in society, as employees and employers, volunteers, consumers, citizens, and individuals holding great life experience.[4]
2) Public awareness campaigns using written and audio-visual media to combat negative stereotypes and ageist attitudes about older persons. These campaigns can also be used to reach out to those suffering from ageism and empower them to respond.[4]
3) Initiatives in the education system involving intergenerational interaction, to break down barriers between generations and combat ageism from an early age, before the formation of negative attitudes.[4]

"Bed blockers", "silver tsunami" and "successful aging" are discriminatory terms used by the public and media that signal the presence of ageism in our youth-centered society. These attitudes stem from the value our society places in youth and the lack of value held in aging. This fundamental belief has caused systematic ageist structuring of social systems and services to favour the young, and harmful behaviours such as language discrimination.[4] Acknowledging and combating the existence of such wide-spread ageism is important for medical students and trainees, who will no doubt be in ample contact with aging adults. Actions by medical students to combat ageism can benefit not only individual patients through thoughtful use of language, but also elderly patients in general through system wide changes, such as advocating for improvements in long-term care.

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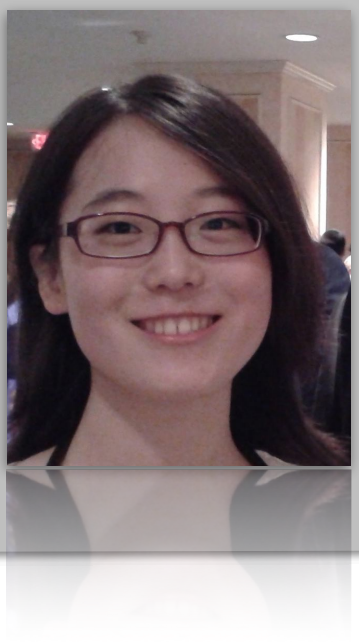
About the Author

Selynne is a second-year medical student at the University of Toronto. She is currently one of the co-chairs of the UOfT GIG. Selynne developed her interest in geriatrics from volunteering at a long-term care centre, and has been fostering this growing passion ever since.



Featured Articles

Gentle Persuasive Approach: Why It Matters to Medical Students

Jessica Wilson, University of Toronto

Imagine you are a 30-year-old woman. You wake up in the morning, look in the mirror and freeze in fear. The person you see in the mirror is an elderly woman you don't recognize. Later that day, you prepare to leave the house to pick your child up from school, but to your disbelief, people are preventing you from leaving your house. You become frustrated and anxious because your child will be dropped off in a busy area, and you must be there for her.

The examples listed above describe what some people living with dementia experience every day. There is an estimated 24.3 million people with dementia worldwide with 4.6 million new cases per year, totalling one new case every 7 seconds[1]. Of people living with dementia, studies demonstrate that upwards of 80% show behavioural changes, such as responsive behaviours[2]. Responsive behaviours are defined as aggressive and non-aggressive verbal and physical protective behaviours[3].

Currently, responsive behaviours and other such moderate to severe neuropsychiatric symptoms of dementia are managed through pharmaceutical restraints, such as antipsychotic and antidepressant medications[4]. In escalating situations, management includes physical restraints. The use of both pharmaceutical and physical restraints may lead to negative health outcomes, and are linked to an increase in morbidity and mortality rates[5]. Given the large proportion of dementia patients with behavioural changes, it is important for clinicians caring for this population to complete training in non-restraining management of responsive behaviours.

As co-chair of the Geriatrics Interest Group at the University of Toronto, I was introduced to the Gentle Persuasive Approach (GPA), where healthcare professionals are taught communication management of dementia patients exhibiting responsive behaviour. This training was implemented by the Ministry of Health as part of the Ontario Alzheimer's Strategy, and is currently provided to healthcare professionals in primary care facilities that specialize in dementia care[6]. GPA training provides trainees with basic knowledge of

dementia, and how it can manifest in various responsive behaviours[7]. Trainees who complete GPA training have an understanding of[7]:

- Person-centred care
- Responsive behaviour, and the underlying cause in persons with dementia
- The effect of dementia on the brain
- How to apply emotional, environmental and inter-personal communication strategies toward caring for patients exhibiting responsive behaviour
- Self-protection strategies and intervention techniques in caring for patients with escalating responsive behaviour

After my recent completion of GPA training through the Alzheimer Society Peel, two things became clear to me. The first was that persons with dementia have the need to be able to share, love and give, have competency and a sense of belonging, and feel hopeful for the future. The second and most impactful statement that I took from GPA training is that all behaviours have meaning. People with dementia do not express behaviours just because they have dementia; there is a reason behind their behaviour, which usually involves some aspect of their past experiences. Therefore understanding the personhood of each patient will help to understand the behaviour they are expressing. This concept seemed so simple, yet this has never been expressed to me in such a logical way.

I am currently running a pilot study to test the efficacy of GPA training with medical students. I predict that GPA training will improve medical students' knowledge and skill level when interacting with or managing patients exhibiting responsive behaviour. Training medical students in GPA may allow them to feel more competent in their clinical abilities, and promote patient-centred care when caring for dementia patients. Medical students may also learn self-protective and redirection strategies to ensure safe and positive outcomes, even in the case of escalating responsive behaviour. One of the few studies to evaluate the efficacy of GPA training in healthcare settings found a significant decline in physical aggression rates three months after GPA training was provided to staff[8]. This study also found that staff felt more competent and knowledgeable when caring for patients exhibiting responsive behaviour.

After personally completing GPA training, I believe that these skills should be taught to medical students before their clinical rotations, in order to properly prepare them for situations they may encounter on the wards. My goal as a medical student is to bring more awareness to GPA, and to encourage all medical students and other healthcare professionals that will be caring for dementia patients to complete GPA training.

To find a GPA trainer near you, the Advanced Gerontological Education website at www.ageinc.ca/ has a list of GPA certified trainers.

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About the Author

Jessica Wilson attends medical school at the University of Toronto, through the Mississauga Academy of Medicine. She currently serves as co-chair of the University of Toronto's Geriatric Interest Group. She completed a BSc in Biology at Algoma University and a MSc in Human Health and Nutritional Sciences at the University of Guelph. Jessica is passionate about pursuing a career as a family physician with additional training in Care of the Elderly, to practice in Northern Ontario.

Commentary

One-Diagnosis, One-Cure Thinking v. the Elderly: Caring for the Geriatric Patient with Multiple Morbidity

Colin Sui, University of Alberta Class of 2017

Our last problem-based learning case was about an elderly man having a stroke. He had the tell-tale symptoms: facial droop, contralateral limb weakness, sensory loss and a sky-high blood pressure. Being able to come up with the diagnosis was incredibly satisfying, but I couldn't help but wonder if I would be able to come up with it if the case wasn't as simple. What if he had symptoms related to his underlying diabetes and hypertension?

Unfortunately, the geriatric patient with multiple morbidities is becoming the norm.[1] Worse yet, our medical training is based on an evidence-based approach, which focuses on single-diagnosis, single-cure thinking. Treating multi-morbid patients is more complicated than just treating each condition as separate entities, crossing our fingers and hoping that drug-drug and drug-disease interactions will not occur.[2]

Perhaps one of the root problems of our difficulty effectively managing multiple morbidities is a lack of research. We are often taught to follow clinical practice guidelines, and yet the guidelines are usually constructed around single health conditions, risk factors and treatments.[3] Even within the subset of clinical practice guidelines that discuss geriatric issues, only a handful provide recommendations for multi-morbid patients.[4] Another issue is the lack of geriatric representation within clinical trials.[5] Older patients and patients with multiple morbidities have been excluded from many trials – leading some to question the applicability of these results to the geriatric multiple-morbid population.[6,7] In addition, the clinical guideline recommendations are sometimes focused on slowing disease progression, which may not be the outcome that older adults are most concerned about. Drug recommendations for patients with multiple conditions rarely focus on quality of life outcomes, outcomes that may be paramount to our geriatric population.[7] In today's medical world, we need to take a step back from our avid reading of clinical practice guidelines and look at the patient in

front of us to understand what is important to the patient, and how we can move forward as partners in health care.

In 2011, 14.4% of our Canadian population was 65 and over.[8] This number is projected to increase to 24% in approximately 25 years.[8] To care for our growing geriatric population, there is a need for research into multi-drug regimens and clinical trials that appreciate and investigate the multiple morbidities that exist within our real-life population. In our clinical practice, we need to identify the priorities of patients and families;[7] we need to consider the harm and benefits of treatments with the patients' goals in mind, or risk prescribing infeasible treatment regimens that may lead to unintended harms, uncertain benefits or "near-total medicalization of patients' lives."[7,9]

We shouldn't treat multiple morbidity as a nuisance, but as the reality of our present and future medical practice. Our geriatric population is one of our most vulnerable populations, and within this group, our multi-morbid geriatric patients are the most vulnerable to health care gaps. Give the complexity of managing multiple morbidity, the discussion becomes focused on building relationships with patients, understanding their life goals, and caring for their health so that they can reach their goals. It's undoubtedly a challenge to care for our multi-morbid geriatric patients, but if not us, who else? When you are a geriatric patient and looking for someone to manage your frailty, diabetes and renal disease, wouldn't you too hope that you would have a good doctor to walk this last journey with?

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About the Author

Colin Siu is a second year medical student at the University of Alberta and the NGIG's VP Events. Colin is interested in innovative ways to deliver high quality care to vulnerable populations, including geriatric patients. He hopes to pursue a career in generalist medicine which caters to the needs of the community.

Commentary

Letter to the Editors: A Reflection on Geriatrics in Undergraduate Medical Education

Noam Berlin, University of Toronto Class of 2017

The first time I was ever truly speechless was upon hearing "I just want to die and end this already." Words spoken at Princess Margaret Hospital, by a cancer patient in her last days of life. I volunteered at the hospital for six months the year before I was accepted into medical school. I was trained by volunteer services to evaluate patient needs and direct them to available resources, but I often found that patients just wanted someone to talk to. At the time of this encounter, I was a new volunteer, having started the role after finally deciding that I would dedicate myself to a career as a physician.

Fast forward three years—I'm taking a history from a geriatric patient at North York General Hospital during my clinical skills training course. I asked her, "What are you looking forward to when you get out of the hospital?" I was expecting the answer to be uplifting, something she was excited about, something to put a smile on her face and keep her fighting her pneumonia. "I just want to be done with this," she said. "Done with being in the hospital?" I asked. "No, done with my life".

Three years later, and again, still speechless.

I've heard a lot about the epidemic of our time, the aging population, limited resources, and the significant shortage of geriatricians and allied health workers working in geriatrics. Shortage of space, shortage of expertise, and limited training; geriatric medicine isn't even a core clerkship rotation at University of Toronto. On team internal medicine, we will consult geriatricians for certain complex cases, and may interact with supervisors or mentors in that sphere, but how close will we come to learning that expertise and the unique nature of geriatric medicine?

These are complex patients we're talking about, with multiple comorbidities, multiple medications, multiple affected systems and multiple concerns to consider from the patient perspective. This will require significant interprofessional

contribution, strong patient advocacy, and proper management—starting to sound familiar? These are the non-medical expert CanMEDS roles that are too often pushed to the wayside, too often underemphasized, and too often disrespected in the hidden curriculum. Yet all of us will need these capabilities, especially when interacting with geriatric patients at some point in our careers.

Currently, we only get three half-days of geriatric clinical skills in second-year medicine at U of T. In those brief one and a half days, I was lucky enough to be placed with an inspiring supervisor, with a true passion for the non-medical expert skills required in geriatric medicine. Concepts introduced included "permissive hypertension", the importance of patient wishes, and compiling discordant prescriptions and management plans from multiple sub-specialists into one all encompassing plan, that also includes support where it's really needed—for example, from the PTs, OTs, and SLPs.

It's also important to note the obvious - that many medical students care deeply about the future lifestyle they will have in their chosen careers. However, I think I only got a glimpse of the longitudinal patient care in this discipline, with its amazing, 90-minute evaluations, providing you with the time to really consider the entire person in front of you. I've heard that the government has finally raised fees for this service so some strides are being made at that level, but I fear that students still have limited understanding of the advantages of this experience. How will my peers and I find out about this field, with the limited training we receive?

For these reasons and more, I believe training in geriatric medicine needs a huge push forward. It needs to be get a larger chunk of the undergraduate medical curriculum, and it needs to be incorporated and integrated, or at least referred to, in many other curricular experiences. With the expansion of the geriatric population, increased frequency of late-life chronic disease, and limited practitioners in this area, training should be expanded in both the pre-clerkship and clerkship years.

About the Author

Noam Berlin is a second-year medical student at the University of Toronto.

Commentary

How Art Educated Me About the Beauty of the Aging Body

Klara Pokrzywko, University of Montreal Class of 2017

I am a visual artist who draws inspiration from the study of the human mind, body and behavior, and I have been blessed to exhibit my work in galleries and museums worldwide. In recent years, I have also become a medical student at the University of Montreal, fostering a special interest in Geriatrics.

There is a lot of talk in the medical field about the scarcity of medical students interested in a career in Geriatrics. I believe that the choices of medical students often reflect the values of our western society, which fears death and places negative connotations on aging. Fear fuels distaste. So if people have distaste for the very concept of aging, they might project their insecurities on the older portion of our population. "Young" has become a sturdy synonym for "beautiful" by the media and all the companies that bank on our reliably constant search for eternal youth. What happened to aging gracefully?

One of the reasons I started making art is because it has the power to voice an opinion in a non-aggressive, yet powerful way. It can change the way people think and see. Art has the ability to break barriers, talk about taboos, speak of the unspoken and question values.

My art practice includes imprints of human bodies etched in various materials including silver, copper and silk. I work with models in whom I see beauty, form and interesting skin patterns. I later immortalize these impressions through various physicochemical processes that give birth to the artwork itself.

My most mesmerizing imprints are from the bodies of my elderly models. It seems that the lives they have lived - their very being - mark their bodies, and I am documenting this in a medium. Like an old tree, the shape of their silhouette is unique, majestic and graceful. Some elderly models are petite, some are corpulent, but all their figures give exceptionally gorgeous blueprints. Their skin is covered with fascinating, intricate lines, like grid systems sketched on the palms of their hands. Lines like little valleys sculpted around the eyes, contouring the lips, formed by the events and experiences they have accumulated over their lives.

My elderly models are often surprised in my interest in imprinting their 60+ year old bodies to make my art. Once an elderly model laughed “It’s a bit unusual to be a muse at my age, don’t you think?” “It’s a shame it’s like that”, I replied. Nonetheless, most of them modestly accept, and through the process of making art, I see their attitude change. The experience empowers them. Some feel that to be chosen by an artist (as inspiration for a work of art) is a grand compliment. If art is tied to beauty, whatever one's definition of beauty might be, then their bodies are given another definition through the artistic process. The work of art, which they have participated in making, has defied the popular perspective that older bodies are something to be hidden and even shunned.

Previously a minority, the elderly are growing in number. The Baby Boomers that broke many social taboos in their hippie days haven’t stopped yet. Furthermore, the art world has already been embracing the elderly as subjects for pieces for several years, and the interest is growing. Hopefully, art will continue to do what it does best, that is, present a different perspective, educate, and inspire change in how we view things, such as aging.

"Skin Imprint in Silver I"
Klara Pokrzywko, 2004
Mix techniques on Sterling Silver
2cm x 8cm
photo by Aleks Labuda

"Vintage Wine"
Klara Pokrzywko, 2009
Mix techniques on copper
49.5cm x 75cm
photo by Pawel Pogorzelski

For more of Klara's work, visit www.klara-pokrzywko.com, and look for her on Facebook and Instagram.

About the Author

Klara Pokrzywko has obtained a Bachelor of Fine Arts with Distinction and Honorary Mention from Concordia University in Montreal and a Masters in Arts Management and Cultural Policy from City University, London, UK. She has exhibited in various contexts including galleries in Los Angeles, Brussels, London, the Zendai Museum of Modern Art in Shanghai, the Metropolitan Art Museum in Tokyo and the Montreal Art Biennale. Klara is a second-year medical student at the University of Montreal where she currently serves as Co-Event Coordinator of the GIG. Her interest in Geriatric Psychiatry was solidified after doing an internship and research at the Douglas Mental Health University Institute in Montreal.

Youth

Pauline Kosalka, McMaster University Class of 2017

I was the girl who watched you
For just a glimmer in time
Drawing to a close.
Your body thinning and shrunken,
Absorbed into the reality
Of a world of light.
But around you, all seems darkness,
Your beloved weeping
At the impending farewell,
Announced not by a radiant angel,
But by a man in a white coat,
A shadow of what you are becoming.
You whimper and reach for your beloved,
The white hair a lie concealing your rejuvenation,
Curled body like a newborn babe
Calling for comfort and rest.

About the Author

Pauline is a first-year medical student at McMaster University. She graduated from the University of Toronto with an Honours Bachelor of Arts, majoring in History and minoring in English and Physiology. She is a co-chair of the Placebo Blog, which showcases the clinical reflections and literary talents of McMaster medical students. Pauline has volunteered at a retirement residence in the past and is now eagerly leaning how to provide good medical care for the elderly.

Are You Still There

Linda Pan, University of Manitoba Class of 2017

Dedicated to a lovely lady with dementia:

I see the lines Time has engraved on your pale complexion, I see the off-red sweater you wear day after day, I see you sitting defensively with your arms and legs crossed, I see you slouched on that green couch with a constant confused frown, alone.

I sat down next to you.

I am awed by the beauty and spark in your blue eyes. I am surprised by your aphasic words and then beaming smile. I am thankful for your trusting nature, for how you turned toward me and held my hand. I am certain I will have a special place to remember the way you rolled up my sleeve that was too long, and the touch of your head on my shoulder as a form of embrace.

I am forever indebted to you.

I understand you.

I adore you.

You.

About the Author

Linda is studying in second year at the University of Manitoba. She is extremely grateful for the experiences where she is able to interact with the elderly, and feels thankful for these opportunities to learn, to appreciate, and gain insight into life through these human connections.

Kay: A Love Sonnet

Jessica Teicher, University of Toronto Class of 2018

Hands all covered in fine sifted flour,
She rolls out the pastry, careful to keep
The thickness just right. Grey hair in a heap
On her head, in her hand, whiskey sour;
She is glowing. But like the sun's last hour
She is fading. Buried a husband deep
And her son not long after. Not a peep
Of complaint, she ironed their last trousers.
Ask her my name and she wouldn't know me,
Though she's been there through every birthday and
Christmas and breakup and bloody scraped knee.
In lucid moments she asks to be free.
It's then I gently hold her wrinkled hand,
"There are pies to be baked, come and you'll see."

About the Author

Jessica Teicher is a first-year medical student at the University of Toronto. She graduated from McMaster's Arts & Science Program, where she cultivated her love of the medical humanities. She is thrilled to be involved with ArtBeat, the humanities hub of UofT medicine, and encourages you to check it out! Jessica's interest in Alzheimer's disease has been fueled by behavioural research using transgenic animal models, but can be primarily attributed to personal experiences with her beloved grandmother.

Medical Humanities

A Fleeting Treasure

Gurmeet Sohi, University of Manitoba Class of 2017

I'm going to tell a story, which has riddled my mind,
Unspoken feelings, haunting memories, buried inside.
A little girl, with so much love in her heart,
For this one soul, a minute or two, she could not be apart.
In these home movies, they play, you can't leave she cries,
Gentle and willing, she listens to the girl with a smile and a sigh.

The little girl grows, but the love gets only stronger,
She competes with the others – whose hug was longer?
A frock from abroad, a wardrobe for her dolls,
A hug for a few days passed, a Band-Aid and kiss after a fall.
No one can love me more, the girl is sure,
Not mommy, not daddy and her little heart soars.

Years pass and the older she gets,
Exams and papers, just mounding stress.
The visits get shorter and further apart too,
But that spark inside, the love over the years only grew.
Things are changing though, small differences she senses,
More worrying than usual, and the forgetfulness commences.

Then we lose him, she is there, but she doesn't know,
The smiles turn into confusion, the good moods turn low.
Months pass, “where is he”, she asks?
Doesn’t want to hurt her, at the temple the girl says, don't worry he'll be back.
The name of the girl occasionally gets lost at the tongue,

She doesn't take it personally, though the first time it stung.
The love is still there, what more can she ask for,
The eyes show the recognition, she needs no more.

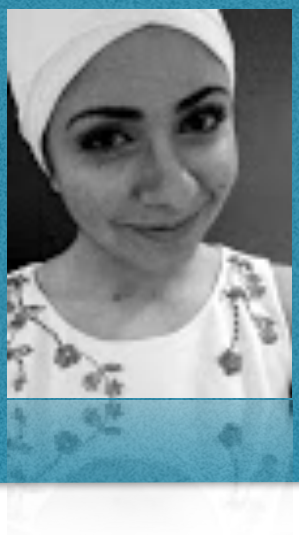
They say they may forget names, details, the tids and the bits,
The love is always there, in the eyes they say it sits.
Etched in her mind, little girl she is no more,
She pours over her last few visits, the recognition is gone,
The eyes, the windows, have closed their doors.

And this grown up girl, has never felt so little,
Because she has the memories, the good times, treasures to keep
But the one who has struggled and fought,
Been good and kind, sung songs for hours with a smile on her face,
Loved, and loved even more,
Her memories are gone, plundered and lost too deep.

And with that, the girl, she hopes,
That in a secret corner of the mind that she may never again see,
The love my wonder, my grandmother, had is still there for me.

About the Author

Gurmeet Kaur Sohi is a first year medical student at the University of Manitoba. She is currently a Medicine One Representative for the U of M's Geriatrics Interest Group. Prior to medicine, she completed a Bachelor of Science at Simon Fraser University and a Master of Science at the University of British Columbia. Gurmeet's interest in geriatrics is rooted from the experiences her own grandparents have had with the health care system. She is passionate about promoting care and spreading awareness about issues regarding the elderly population.



Grandpals Penpals

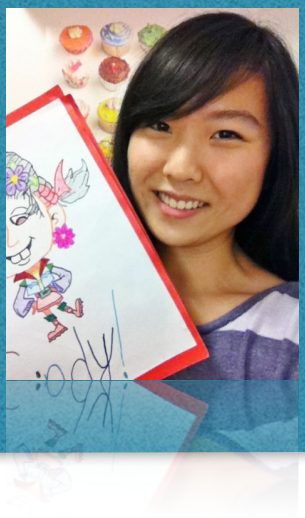
Cindy Ding, University of British Columbia Class of 2018

Description:

The Grandpal Penpals Program is an intergenerational letter exchange and visit program that pairs elementary students with the elderly living in care homes. The artwork, which showcases the handprints of the children, the elderly, and the university-aged program leaders involved, was created when Gr. 5/6 students from Carnarvon Elementary visited their "Grandpals" for the first time at Arbutus Care Centre. It is hung on the walls of the care centre to remind the elderly of the vibrant and loving children, with whom they shared an afternoon of games, crafts, cookies and friendship.

About the Artist

Cindy Ding is a first-year medical student at the University of British Columbia. She founded the Grandpal Penpals Program at Eagle Ridge Manor in 2010 when she realized that many of the elderly residents were isolated and lonely. In the UBC GIG, Cindy co-chairs the Grandpal Penpals Program and helps coordinate a speaker series. Cindy aspires to one day open a family practice with a diverse group of pediatricians, geriatricians and general practitioners; together, they will help to build a healthy community with people of all ages.



Medical Humanities

Mr. H is a 89 year-old man with dementia. He loves to paint.

Paige Zhang, University of Toronto Class of 2017

About the Artist

Paige Zhang is a 2nd year medical student and LEAD scholar at the University of Toronto who is interested in the medical humanities, health for marginalized populations, and public policy.

Description: I met Mr. H during our geriatrics clinical skills block where my partner and I got to know him over two weeks of interviews. He was deemed a "difficult" patient due to his memory loss, paranoia, and dementia. However, we explored his story further and got to know a man beyond a diagnosis. He was alone but cherished his independence. His thoughts were disorganized, but he was a brilliant artist who loved to paint.

I don't know what happened to him, but I knew he wouldn't be allowed to return home. I like to imagine that he's still painting.

Inter-Professional Education Event: A Local GIG Experience

Amanda Canfield, University of Toronto Class of 2017

Every year, the University of Toronto Geriatrics Interest Group (GIG) runs two Interprofessional Education (IPE) events. The first event, Geriatric Experience Day, takes place in the fall and the second event, Geriatric Clinical Skills Day, occurs in the spring. Each event is open to a maximum of 40 students from 11 Health Science Programs: Medicine, Dentistry, Kinesiology and Physical Education, Medical Radiation Sciences, Nursing, Occupational Science and Occupational Therapy, Pharmacy, Physical Therapy, Physician Assistant, Social Work, and Speech-Language Pathology.

The IPE curriculum at the University of Toronto allows professional students from these disciplines to acquire the knowledge, skills and attitudes required to successfully participate in collaborative, interprofessional practice. It consists of four core learning activities common to all programs, plus a long list of electives that students select from to meet their program's specific requirements; the two GIG-run IPE events are among the list of electives offered to students. The Undergraduate Medicine Program, amongst eight others, has made the IPE curriculum mandatory.

Both GIG-run IPE events consist of a case-based introduction that familiarizes students with a common geriatric patient clinical scenario. Students are then divided into interprofessional student groups that move through four stations run by different health care professionals. The events end with a debriefing session where students reflect on their experiences at the various stations. The stations are designed to introduce students to some of the unique, yet common, health and social challenges of older adults. The objectives of this design are to: improve student awareness and engagement in elderly patients' decline in health and wellness; increase students' empathy for older adults; empower students to advocate for improving the health and well-being of geriatric patients; and increase students' knowledge of the unique roles that various health professionals play in improving and optimizing patient function.

The Geriatric Experience Day focuses on providing students with the opportunity to put themselves in the shoes of older adults, which allows them to better appreciate their unique challenges. The stations at this event in October 2014

included Polypharmacy, Myths about Aging, Functional Impairment, and Restraints. Each station provided students with interactive activities. The Polypharmacy station used coloured candies to simulate the challenges of following a complicated medication schedule; the Myths about Aging station included a quiz of commonly held misconceptions about the aging process; the Functional Impairment station involved a relay where students were blindfolded and worked their way through a maze of chairs with the guidance of a colleague; and the Restraints station provided students the opportunity to try on various physical restraints that can be used in clinical settings when the benefits outweigh the risks.

The Geriatric Clinical Skills day uses hands-on teaching to improve students' clinical skills in the management of common geriatric issues. While the stations for this year's event are not yet finalized, last year's stations included Polypharmacy, Wound Management, Mobility Issues and Transfers, and The Mental Status Exam. This year's event, in April 2015, will also incorporate a student-run station. Here, executive members of the GIG, and a select number of students from other disciplines who share a passion for the care of the elderly, will build the facilitation skills necessary for success in leadership roles that they may encounter in their future careers.

Since the Geriatric Experience Day and Clinical Skills Day began five years ago, both events have continued to receive positive feedback from students. This year, the Clinical Skills Day event had a waitlist of 101 students. While the events are designed to be enjoyable, they also allow students to become more familiar with some of the common health and social challenges of older adults and the roles that each health professional plays in their management. As Canada's population of older adults continues to rise, it has become increasingly important that students from all healthcare programs are comfortable working on teams when managing common issues experienced by the elderly.

For more information, please visit: Interprofessional Education University of Toronto: http://ipe.utoronto.ca

About the Author

Amanda is a second year medical student at the University of Toronto and is one of the co-chairs of the Geriatrics Interest Group, as well as VP Media and Technology of the National Geriatrics Interest Group. Please see page 7 for full author description and photo.

Local GIG Updates: 2014-2015

University of Ottawa

The 2014-2015 Geriatric Interest Group at the University of Ottawa has had a great year so far, promoting the field of geriatrics and increasing awareness among medical students about the unique health care needs of this population. We have held many events this year, including presentations and discussions about polypharmacy, osteoporosis and exercise, careers in geriatrics, new technologies used to rehabilitate and mobilize older adults, and other new research. Some of the events we have planned for the remainder of the year include presentations about Alzheimer's disease, falls risk and prevention, elder abuse, various career paths relating to the care of older adults, and palliative care. Members of our group will also be attending a half-day conference called Brain Talks, which will provide a multi-faceted approach to dementia and brain trauma.

University of Toronto

2014-2015 has been a busy year for University of Toronto GIG. We are hosting many events to promote geriatrics, and create learning opportunities for medical and other healthcare professional students. By the end of this year, we will have hosted two career panels with physicians in various specialties involved in caring for elderly patients. In addition, we will also have hosted two Interprofessional Education events. These events each bring together a variety of healthcare students to collaboratively learn about difficulties geriatric patients may encounter, and strategies to help manage geriatric patients. We have also hosted an Alzheimer's information session, a documentary screening in collaboration with the Alzheimer's Society, and two speaker events, one on geriatric research, and the other about aging and sexuality. We will also be hosting an outreach program to a Long-Term Care Centre.

McMaster University

The 2014-2015 McMaster GIG team is hard at work promoting Geriatric education and comfort working with elderly patients amongst the MD, PT, OT, Nursing and PA programs at McMaster University. Earlier this year, the team hosted McMaster's 3rd annual Virtual Dementia Tour in partnership with the Alzheimer's Society of Canada, which gave students the chance to walk in the shoes of an elderly patient. The team has also been working behind the scenes, supporting the development of the McMaster Curriculum on Healthy Aging under the mandate of the Labarge Optimal Aging Initiative. In the forthcoming months the team is working on putting together their annual Geriatric Skills Day, a full-day interactive workshop exploring various topics from elder abuse, sexuality and aging to wound care, and dementia.

Queen's University

The Queen's Geriatrics Interest Group holds lunchtime talks once or twice a month for medical students, with a range of topics including healthy aging, dementia, palliative care, and community resources for older adults. In addition, we have a weekend observership running throughout the year at our local geriatric hospital. Our biggest event each year is the Geriatrics Skills Night, where we have about 25 students move through 6 stations for the opportunity to practice their history and physical exam skills on geriatric medicine cases (e.g. history of a patient with delirium, physical exam of a patient with Parkinson's). A new event that we are planning this year is a workshop to learn how to use different mobility aids, such as walkers, canes, and wheelchairs. As well, we would like to have a meet and greet event between geriatricians, care of the elderly physicians, current residents and fellows and medical students.

University of Western Ontario

The 2014-2015 Schulich GIG has been working diligently to increase student participation in GIG events. Events so far have been well-attended and well-received. Last semester, we held a "Why Geriatrics?" introductory talk, where a geriatrician, a geriatric psychiatrist and a family physician with a special interest in geriatrics were able to speak about the different routes to practicing geriatric medicine. We also had a lunchtime talk about elder abuse, and a clinical skills workshop where students were taught about evaluating gait patterns and polypharmacy issues. This semester, we are planning a Valentine's Day visit to a local retirement home, a mix-and-mingle with geriatricians and another lunchtime talk presented by the Alzheimer's Society. We are looking forward to these events, and hope to continue increasing student awareness and engagement in issues relating to the health and wellness of older adults in the community.

Northern Ontario School of Medicine

The Northern Ontario School of Medicine GIG held an information session in November about Dementia & Cognition, bringing in speakers from the Alzheimer's Society and a psychogeriatric resource consultant. Through this session, students learned about cognitive testing tools and their practical applications, the different causes of cognitive decline and strategies for communicating with patients. In February, students had a lunch session with a geriatrician. This session was an informal opportunity for students to ask questions about the scope of practice of geriatricians, and what a typical day in practice would look like. Finally, we have planned a Geriatrics Skills Night in March, where students will be shown how various allied health professionals function as a complex team to serve the geriatric population. There, they will gain skills in communication, recognition of cognitive decline and mobility and safety, among other topics.

University of Manitoba

The 2014-2015 Manitoba GIG is excited to promote awareness and increase interest in the field of geriatrics for healthcare students. It is our goal to share our enthusiasm and passion for geriatrics with our fellow students, as well as bring forth learning opportunities to further education for those students who are already geriatrics-focused. One of our most exciting events is the Geriatrics Skills Day, made possible with the generous time of local geriatricians in Winnipeg. This year, we had wide-ranging topics from polypharmacy and safe environment to neurology and dementia. An important key element of this event is to promote an interdisciplinary learning environment, where the topics are applicable to students of Medicine, OT, PT, Pharmacy, and students in other health care disciplines. In addition to the skills day, other exciting events that have occurred or are in progress are designed to encourage fellow students to gain a deeper appreciation of geriatrics.

University of Calgary

This past year, the University of Calgary Geriatrics Interest Group hosted a number of events. These included a meet & greet lunch with geriatricians and Care of the Elderly family physicians, a lunch hosting the Alzheimer's Society, a talk on MSK conditions in the elderly, and most recently, a tea at a local senior's centre. The executive are excited about the incoming leadership and all they have planned for the upcoming year!

University of Alberta

This year's University of Alberta GIG has revisited successful events from the past, such as “Life of a Geriatrician”, an interactive Q&A session with Dr. Wagg, our own Divisional Director of Geriatric Medicine. We have also held new events, such as "Pharmacological Considerations in Geriatrics", where a pharmacist colleague reviewed the principles of pharmacokinetics and pharmacodynamics, and how to use them to optimize geriatric medical therapy. In light of the recent ruling regarding physician-assisted death, we also have hosted "Physician-Assisted Death: Exploring the Ethics." Given the prevalence of suicide and depression in the geriatric population, a "Suicide Prevention Workshop" was also held. These events were met with great interest from both of our pre-clerkship and clerkship-level classes. Future event topics include exploring the nature of care for patients with Alzheimer's Disease, communicating with those with hearing impairment, and polypharmacy issues in geriatric populations.

Memorial University

The MUN GIG is in the early stages of development, but has already hosted one session on Elder Abuse, which was a powerful learning experience for the audience of students. The presentation was given by a senior volunteer with the Seniors Resource Centre of NL who spoke of her experiences dealing with this prevalent issue over the past ~20 years. Our events are open to any students who may be interested in the field of geriatrics, or issues surrounding this area of medicine. For our next event, we are hoping to give a "patient perspective"-style session featuring a speaker from the Alzheimer's Society, to share their experience and suggestions for those working in geriatric healthcare. This year we are also planning to engage in volunteer activities in the community, such as visiting senior homes, participating in charity walks and helping with the promotion of these fundraisers. With an aging population, we hope to raise awareness around important issues and promote the field of geriatric medicine.

Dalhousie University

So far this year, the 2014-2015 Dalhousie Geriatrics Interest Group has held a Geriatrics Interest Group Night, that involved local clinicians working in the field of geriatrics meeting with students for an informal Q&A session and discussion of the growing opportunities in the field of geriatrics. Events that we are looking forward to in the coming months include a movie and discussion night, as well as fundraising efforts and participation in the Shannex Walk for Memories, an all-abilities walk with 100% of funds raised going towards the Nova Scotia Chapter of the Alzheimer's Society. The overarching goals of this year's executive have been to continue to promote awareness about the career possibilities in geriatrics, as well as creating linkages with community at large.

University of Montreal

For 2014-2015, University of Montreal's GIG has orientated its activities toward familiarizing medical students with elderly patients' medical, as well as day-to-day, challenges. In our events, we have addressed such delicate subjects as "Living as Elderly Without a Roof" and "Living with Alzheimer's Dementia". We held a conference with a local organization called "PAS de la Rue", which offers assistance to elderly people without roofs over their heads. It is a great, but unfortunately overlooked resource for doctors needing to discharge such patients in need of close follow-up; we wanted to promote its existence among students - future practitioners. For our next event, we invited a speaker from UCLA, Dr. Ringman, to present his latest Alzheimer's research; he will talk about the genetic form of Alzheimer disease, and we are looking forward to having such an expert with us.

GIG Life

In recognition of the value of our organization, we are grateful to the Geriatric Education and Research in Aging (GERAS) Centre for their generous sponsorship of the annual NGIG Research Award, to be awarded at the 2015 CGS General Meeting in Montreal, QC.

GERAS CENTRE

Innovation & Education that Transforms Senior's Lives

Website: www.gerascentre.ca

Find them on twitter! twitter.com/GERAScentre

CGS: Become a Member!

Who can become a member of the Canadian Geriatrics Society (CGS)?

We encourage all physicians with an interest in geriatrics, as well as medical students, residents and allied health professionals, to join the CGS.

Membership for medical students, graduate students and residents is free!

Benefits of membership:

- Subscription to the quarterly Canadian Geriatric Journal, the only Canadian journal dedicated to original research on the care of Canadian adults over 65.
- Member-exclusive, accredited online CME courses.
- Reduced registration rate at the CGS Annual General Meeting.
- Reduced fees to key conferences and other members-only resources.

Becoming a member or renewing membership:

Please download and complete the registration form, available at secretariatcentral.com/registration.

CGS · SCG

The NGIG would like to warmly thank the CGS for their ongoing support of our local and national initiatives.

About the Canadian Academy of Geriatric Psychiatry (CAGP):

We encourage all physicians with an interest in geriatrics, as well as medical students, residents and allied health professionals, to join the CAGP.

The CAGP is a national organization of psychiatrists dedicated to promoting mental health in the Canadian elderly population, through the clinical, educational, research and advocacy activities of its membership. It was founded in 1991, and is recognized as the voice of Geriatric Psychiatry in Canada.

Becoming a member:

The CAGP is pleased to offer complimentary memberships to medical students and residents in the membership category Member-in-Training (MIT).

Benefits of membership:

By joining CAGP, you are supporting the growth of geriatric psychiatry as a subspecialty in Canada! Benefits of membership include:

- A subscription to a quarterly e-newsletter with regional updates, links to resources and event information.
- Access to the CAGP website with a Members Only Section, which provides an opportunity to connect with colleagues across Canada.
- Discounts on meeting registration.

Geriatrics Resources

Canadian Geriatrics Society Student Website:

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

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.

The Canadian Journal on Aging: A refereed, quarterly publication of the Canadian Association of 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 on 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.

Congratulations to Our Award Winners!

Congratulations to Natasha Lane (University of Toronto) and Peng You (Queen's University), the winners of the 2014 NGIG Awards. Natasha was awarded the NGIG National Student Research Award, generously funded by the Canadian Association of a Retired Persons (CARP). Peng was the winner of the NGIG Student Leadership Award.

Natasha Lane with supervisor Dr. Walter Wodchis

Peng You with supervisors Dr. Frank and Dr. Gibson

The 2014 awards were announced at the 34th CGS Annual General Meeting in Edmonton, AB.

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