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NGIG

The National Geriatrics Interest  
Group Publication

# Expanding *Horizons*

Changing Perspectives and Innovations in Geriatric Care





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The National Geriatrics Interest Group  
Annual Publication  
NGIG is a centralized medical student-led group with the goal of bringing together individual GIGs and creating Canada-wide education initiatives in the field of aging.

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# Letter from the Editors

Dear Readers,

Thank you for your interest in the fourth annual NGIG publication, the official student-led publication brought to you by the National Geriatrics Interest Group!

This year's publication highlights the theme "Expanding Horizons: Changing Perspectives and Innovations in Geriatric Care". With the challenges and opportunities that arise from our aging population, there have been innovations across clinical, education, healthy policy and research domains to improve geriatric care. Moreover, the shift in demographics demands a parallel shift in our perspectives on aging, both within healthcare and the society at large. We were delighted to have an exceptional number of submissions across Canada this year, reflecting a strong, shared interest to expand the horizons of geriatrics.

Our feature articles include original student research, a comparison of two career paths in geriatrics, an overview on caring for the LGBTTQI\* geriatric population and a novel student-run interprofessional mobility workshop. With respect to commentaries, our writers share their opinions on intergenerational programs to combat social isolation in the elderly, the need for cross-discipline collaboration in chronic disease management, the valuable contributions of the elderly to healthcare, lessons from other cultures on valuing the elderly, and ageism in our society.

Our creative writing section features compelling poems and thought-provoking reflections inspired by clinical and personal interactions with elderly individuals. We are also excited to include two original works of art, as well as students' landscape photography throughout the publication.

This initiative would not have been possible without the collaborative efforts of many dedicated people. We would like to extend our sincerest thanks to the students across the country who contributed to this publication, as well as our wonderful team of editors and the 2015-2016 NGIG Executive Committee. Lastly, we are grateful for the continued support and mentorship of Dr. Tricia Woo and Cindy Worrone from McMaster University.

If you have any comments or questions, please do not hesitate to contact us. We hope you enjoy reading!

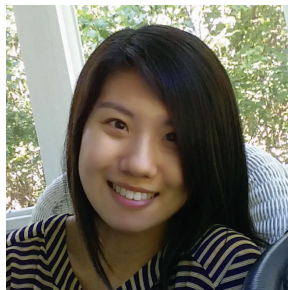
Sincerely,

2016 NGIG Publication Editors-in-Chief



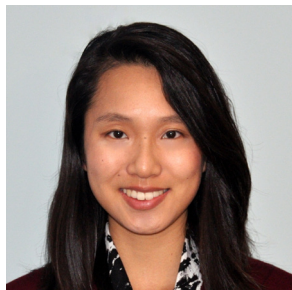
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*Selynne became interested in geriatrics after volunteering at a long-term care centre and actively pursued this interest through the UT GIG. She is very excited to be part of the NGIG Publication as Co-Editor-in-Chief for a second year.*



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*Janice was a past Co-Chair of Queen's GIG and feels that a strong education in Geriatrics is important in all fields of medicine. She taught herself graphic design, and has a passion for visual arts, especially acrylic painting.*



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*YY has been a passionate advocate for geriatrics as a Co-Chair of the Queen's GIG and member of NGIG. She is excited to bring her passion for geriatrics to her residency training in Toronto's Internal Medicine Program.*

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# Comparison of patient versus caregiver reporting of depressive symptoms in mild probable Alzheimer’s disease: A pilot study

Cristian Vadeanu, Amir A. Sepehry, and Claudia Jacova

## Abstract

**Objective:** A difference in reporting for depression in Alzheimer’s Disease (dAD) between patients and caregivers is noted in the literature, yet the research exploring this diagnostic challenge is scarce. We introduce a pilot study to examine the clinical challenge of selecting the most appropriate reporter for depression symptoms.

**Methods:** A cross-sectional, observational descriptive study was conducted with patients diagnosed with mild probable AD and accompanying knowledgeable informants. With the use of Provisional Diagnostic Criteria for depression of Alzheimer’s Disease (PDC-dAD), physicians assessed dAD. Subsequently, patients and caregivers were administered the 30-item Geriatric Depression Scale (GDS) followed by an in-house questionnaire.

**Results:** Data was captured from five dyads. A difference emerged between patient and caregiver reports, with all caregivers endorsing a higher number of GDS-probed symptoms compared to patients, while only one patient was diagnosed with dAD. For the in-house questionnaire, patients thought caregivers would answer in a similar fashion to their own responses while the caregivers disagreed. Caregivers raised additional symptoms including lack of insight and denial.

**Conclusion:** In this pilot study, we examined the feasibility of assessing patient and caregiver perceptions of depression in AD. While all patients were able to complete the GDS, most provided irrelevant answers to the in-house questionnaire. Patients consistently reported much less GDS items compared to caregivers. Further study with a larger sample can be used to develop a statistical impression of these differences, in addition to gathering more qualitative data.

## Introduction

Alzheimer’s Disease (AD) is a pervasive condition and a major public health concern that affects patients’ quality of life (1). Although clinical core symptoms of AD assist in the diagnosis, behavioral and cognitive heterogeneity, and concurrent co-morbidities complicate screening, prognosis and treatment (2).

The literature on the prevalence of depression co-occurring with AD (dAD) ranges from 0 to 86%, suggesting a lack of consistency in assessment, diagnosis, and screen-ing (3). dAD has shown to decrease patient quality-of-life, complicate treatment approach, and increase morbidity and mortality (4). Depressed AD patients exhibit decreased self-care capabilities and increased dependency, which indirectly affects caregivers (5). One of the challenges in the screening and diagnosis of dAD is obtaining accurate information about patients’ symptoms. Evidence has shown that dementia patients’ report of symptoms differs from those of informants. For example, one study showed that patients with early AD endorsed a higher number of items for Quality of Life (QOL) than their caregivers (6). Additionally, in other domains of assessment, informant rating had higher sensitivity and specificity for detecting cognitive impairment compared to patient assessment of these faculties (7).

When using depression scales, studies showed that caregivers report more depressive symptoms (in their care recipients) com-

pared to patient self-reports using the GDS depression scale (8,9). Other studies report this discrepancy to be most notable for patients with decreased levels of insight (10, 11). Additionally, another study described patients as self-reporting fewer depressive symptoms compared to both caregivers and clinicians (12). Though literature on discrepancy of reporting exists, limited research focuses on reporting differences for dAD and no studies explore this difference for dAD diagnosed with the new Provisional Diagnostic Criteria for depression of Alzheimer’s Disease (PDC-dAD).

This pilot study was designed to address two goals: 1) to assess feasibility of a patient-, caregiver-, and clinician-based cross-sectional assessment of depression symptoms in AD; 2) to collect preliminary data on the similarities and differences between patient and caregiver collateral reporting on parallel forms of the GDS, in addition to identifying patterns of GDS items endorsed by both reporters.

## Methods

Patient-caregiver dyads were recruited from the UBC Clinic for Alzheimer Disease and Related Disorders (CARD) according to the criteria outlined in Table 1. Caregiver participants needed to have frequent contact with the patient (at least 3-4 times/week).

Who can participate?
→ Patients who meet criteria for possible or probable AD (MMSE >10);
→ Are able to communicate in English;
→ Have a knowledgeable informant (i.e. someone who seems them at least 3-4 times/week).
Exclusions
→ Current alcohol or drug abuse;
→ Recent (<12month) head injury;
→ Presence of active delirium or psychosis;
→ A history of psychiatric disorders other than depression;
→ Any medical condition that could induce behavioral or mood changes (e.g., acute infections, nutrient deficiencies).

**Note:** MMSE: Mini Mental State Examination.

**Table 1:** The complete inclusion/exclusion criteria.

Patients from the CARD were assessed for dAD using the PDC-dAD by their physicians. The PDC-dAD was developed to specifically delineate depressive symptoms that manifest in AD from the primary symptoms of AD (13). The PDC de-emphasize cognitive symptoms and instead include symptoms commonly found in dAD including social withdrawal and irritability (13). Although the PDC are not yet part of the standard diagnostic armamentarium, according to a recent study they are the most sensitive and the best available tool for the diagnosis of dAD (14).

Both patients and caregivers were interviewed by physicians for the assessment of dAD. Physicians were blinded to patients’ depression screening scores. Aside from the use of PDC-dAD, physicians made use of patients’ past and current medical status including cognitive status and information on possible risks for developing depression, in order to formulate a dDA diagnosis.

Patients and caregivers were then administered depression scales and questionnaires by two research students. After obtaining informed consent/assent from both, the patient and caregiver were interviewed separately. The patients were given the Modified Mini Mental State Exam (3MS)(15) and the Geriatric Depression Scale (GDS)(16). The caregiver completed the GDS parallel form caregiver version (17). The GDS was utilized as the depression screening scale for this study because it is short, validated, dichotomized (has an easy to answer format), and cost-effective (18). Though the GDS was not designed to probe for symptomatology found in dAD, it has shown psychometric validity for use with the PDC-dAD (14).

An in-house open-ended questionnaire was then administered to allow dyads to elaborate on the GDS items and on possible discrepancies in reporting (Table 2). Patients and caregivers responded verbally to these questions that were read aloud by the researchers. Standard qualitative research methodology was used to probe for extra symptoms that participants were not already asked about and to allow participants the opportunity to express additional thoughts about the GDS items.

Cases	Age (Year)		Gender		Education (Year)		PDC-dAD status	GDS-30	GDS-IF-30	3MS	MMSE
	Patient	Caregiver	Patient	Caregiver	Patient	Caregiver	Patient	Patient	Informant	Patient	Patient
1	71	70	M	F	20	16	Positive	1	16	92	27
2	84	63	F	F	12	14	Negative	0	14	66	21
3	66	62	M	F	20	16	Negative	8	15	71	21
4	69	68	M	F	16	12	Negative	2	14	53	15
5	78	80	F	M	17	17	Negative	0	10	92	27
Average	c73.60	68.60	-	-	17.00	15.00	-	2.20	13.80	74.80	22.20
SD	C6.53	6.44	-	-	3.32	2.00	-	3.35	2.28	17.02	5.02

**Note:** 3MS: The Modified Mini-Mental State; GDS: the Geriatric Depression Scale; MMSE: Mini Mental State Examination; NA: Not available; PDC-dAD: The provisional Diagnostic Criteria for depression of Alzheimer Disease.

**Table 3:** Demographic representation of the cohort.

Post Interview Questions for Patients:
1. Is there anything else you would like to share with me regarding your mood, your well-being and how you feel?
2. Do you feel that you and your caregiver would describe your mood, your well-being and how you feel in the same way? Or would your caregiver describe them differently? What do you think they would say?
Post Interview Questions for Informants:
1. Is there anything else you would like to share with me regarding [the patient]’s mood, his/her well-being and how he/she feels?
2. Do you feel that you and your care recipient would describe his/her mood, well-being and how s/he feels in the same way? Or would your care recipient describe them differ-ently? What do you think that they would say?
3. Do you feel that the answers you have provided would have been different if we had talked a few months ago? Explain.

**Note:** Worded exactly as shown.

**Table 2:** Post-interview questions for patients and informants.

## Results

Five dyads, including AD patients with probable mild to moderate levels of cognitive impairment (MMSE range 15-27), participated in this study. Physicians diagnosed one of five patients for dAD. Caregivers were spouses (n=4), and daughter.

The GDS completion rate was 100% for both. Patients did not display any difficulties in understanding the GDS items, nor any pattern emerged to suggest systematic responding (i.e., all “Yes” or “No”).

Clear differences emerged between patient and caregiver reports. All five caregivers endorsed a higher total number of GDS items to describe patients than did the patients themselves, reporting on average 11.6 more symptoms. The single patient diagnosed with dAD self-reported one item on GDS, and the caregiver reported 16, showing discrepancy between diagnosis and self-report. For three dyads (patients not diagnosed with dAD), the patient self-report GDS scores more accurately reflected the diagnosis. For the last dyad, the patient’s GDS score was higher than the caregiver’s.

Overall, patients as a group endorsed eight of the GDS items, with each of “feeling restless and fidgety” (item 11), “having memory problems” (item 14), and not having a “clear mind” (item 30) endorsed by more than one patient. Caregivers as a group endorsed 28 items. Of these, “difficulty getting started on new projects” (item 20) and “not having a clear mind” (item 30) were unanimously endorsed, and “getting bored” (item 4), “preferring to stay at home” (item 12), “having trouble concentrating” (item 26), and “enjoying getting up in the morning” (item 27) were endorsed by four of five caregivers. No patient endorsed items 20 and 27. Neither patients nor caregivers endorsed the following items: “fear of something bad happening” (item 8), “worrying about the future” (item 13), and “feeling that it is wonderful to be alive” (item 15). A breakdown of items endorsed by patients and caregivers is presented in Table 4.



For the first open-ended question about anything else to share regarding the patients’ mood and well-being, two patients had nothing to add, whereas two answered in a positive way (“my mood is excellent...”, “I feel fine...”). Three caregivers noted decreased self-awareness in the patient with respect to their mood, one reported nothing, and the last answered irrelevantly.

In response to the second open-ended question about differences between patients and caregivers’ perceptions, all five patients believed that they and their caregivers would describe their mood, well-being and how they feel similarly. Of the caregivers who answered the question, none believed that they and their care recipients would describe these qualities similarly. One caregiver explained that the patient does “not recognize frequency/suddenness of pessimism/negativity; he is in denial and doesn’t want to talk about it.” The second caregiver mentioned that the care recipient would say that she “has no problems” and that the patient “does not realize the issues at hand”.

As for the third question, which was only posed to caregivers, four of five endorsed that their answers to the GDS would not have been different a few months ago.

Discussion

In this pilot study, we determined the feasibility of assessing patient and caregiver perceptions of patients’ mood and wellbeing with the GDS. We found that all patients and caregivers were able and willing to complete the GDS, and we observed a very consistent pattern of differences in the number of depressive symptoms endorsed, with patients reporting far fewer symptoms than their caregivers. The data do not support much agreement between patients and caregivers regarding the symptoms that were endorsed.

The difference in symptom reporting between patients and caregivers, consistent with current literature (9,10,12) could be explained by decreased memory and level of in-sight, and/or possible denial. Additionally, it is possible that caregivers might have over-reported depressive symptoms due to burdens or other reasons not explored here. Thus, future studies are warranted to probe caregiver burden and depression with appropriate measures.

Though limited in sample size, this study suggests that for mild probable AD, patients’ reports on the GDS may be more reflective of the dAD diagnosis based on physicians’ impressions. Four of five patients deemed non-depressed, caregivers reported >10 GDS symptoms, a major discrepancy with those patients’ self-reports.

On the in-house questionnaire, the two additional symptoms that surfaced from caregivers’ responses were lack of insight and psychological denial. Additionally, all patients believed that their caregivers would report their symptoms similarly while the caregivers disagreed, possibly reflecting this denial and decreased self-awareness, which has been found to be common in patients with dementia (9, 14).

This study had several limitations. Firstly, there is the inherent assumption that the physician’s impression is accurate for the diagnosis of dAD. Physicians use not only the diagnostic criteria to diagnose, but also involve patients’ medical histories, neuropsychological data, imaging and biomarkers, and associated risks for developing depression. However, physicians also utilize reports from patients and caregivers, which poses a problem, as there is still no clear, widespread acceptance of which reports are more accurate and useful for various AD severities.

Finally, we did not explore caregiver burdens, levels of cognition, or caregiver-patient relationship. Evidence shows that caregiver burden affects variables such as time to medical presentation of patients with dementia and patient hospitalization (19). There are currently no accepted guidelines on the incorporation of caregiver burden into decision-making processes regarding choosing the most appropriate reporter.

While this pilot study possesses limitations, it has played a crucial role in assessing the feasibility of a future study, with more participants and a more refined in-house questionnaire for qualitative data collection. Having more dyads and including patients with more heterogeneous profiles (depressed and non-depressed, mild AD and moderate AD, possible and probable AD) could better assess the use of reporting for different AD severities. Involving scales that assess symptoms in the caregiver (e.g. care-giver burdens) could allow appraisal of the contribution of caregiver bias. Finally, refining the in-house questionnaire questions and prompts for collecting qualitative data will likely yield more insightful information regarding the etiology of reporting discrepancy, which will have potential for validity assessment and clinical utility.

Conclusion

This study assessed and confirmed the feasibility of analyzing differences in reporting between patients and caregivers for depressive symptoms in AD and provided insight into sources of bias in patients as assessed by the in-house questionnaire. Observational analysis of the five dyads indicates that mild AD patients may more accurately report their depressive symptoms compared to caregivers.

Because sources of bias in both reporters are arguably impossible to eliminate, it is likely that a combination of both reports should be used in the screening for dAD. On this note, perhaps patient self-reports might be of greater accuracy for mild AD (as observed here), while caregiver reports might be more useful for AD of highest severity due to decreased patient insight. Further studies are needed to explore what variables (e.g., severity, socio-demographic factors) need to be considered in order to determine the more appropriate reporter. Furthermore, future investigation, with large sample size, can determine whether both reporters are appropriate at acquiring separate pieces of information vital to diagnosis and screening.

**Acknowledgments:** Authors wish to acknowledge the help of physicians involved. Additionally we wish to extend our gratitude to patients and caregivers participating in this study.

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*Cristian is a motivated medical student, aspiring clinician and passionate researcher in the areas of geriatrics, emergency medicine and critical care.*

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1. Are you basically satisfied with your life?				I				0	1	
2. Have you dropped many of your activities and interests?	I		I				I	0	3	
3. Do you feel that your life is empty?	I							0	2	
4. Do you often get bored?	I		I	IP		I		1	4	
5. Are you hopeful about the future?			I			I		0	2	
6. Are you bothered by thoughts you can't get out of your head?	I			I		I		0	3	
7. Are you in good spirits most of the time?	I					I		0	2	
8. Are you afraid that something bad is going to happen to you?								0	0	100
9. Do you feel happy most of the time?	I			I				0	2	
10. Do you often feel helpless?			I				I	0	2	
11. Do you often get restless and fidgety?			I	IP		P		2	2	
12. Do you prefer to stay at home rather than go out and do things?	I		I	IP			I	1	4	
13. Do you frequently worry about the future?								0	0	100
14. Do you feel you have more problems with memory than most?	I			P		P	I	2	2	
15. Do you think it is wonderful to be alive now?								0	0	100
16. Do you feel downhearted and blue?			I	IP		I		1	3	
17. Do you feel pretty worthless the way you are now?	I							0	1	
18. Do you worry a lot about the past?				I				0	1	
19. Do you find life very exciting?	I			IP		I	I	1	4	
20. Is it hard for you to get started on new projects?	I		I	I		I	I	0	5	
21. Do you feel full of energy?	I		I				I	0	3	
22. Do you feel that your situation is hopeless?							I	0	1	
23. Do you think that most people are better off than you are?	I							0	1	
24. Do you frequently get upset over little things?	I		I			I		0	3	
25. Do you frequently feel like crying?				I				0	1	
26. Do you have trouble concentrating?			I	IP		I	I	1	4	
27. Do you enjoy getting up in the morning?	I		I	I			I	0	4	
28. Do you prefer to avoid social occasions?							I	0	1	
29. Is it easy for you to make decisions?			I	I		I		0	3	
30. Is your mind as clear as it used to be?	IP	I	I	IP		I	I	2	5	
Total (P)	1	0		8		2	0			
Total (I)	16	14	15	14		10				

Note: Representation of endorsement of GDS symptoms by item; most common items endorsed by pa-tients were 11, 14 and 30 (40% of patients endorsing each); most common items endorsed by informants were 20 and 30 (100% of informants endorsing each); there was 100% concordance on items 8, 13 and 15 (all dyads agreed on these items); items with the greatest disagreement were 20 and 27 (italicized, 80-100% of dyads disagreed on these items); P-patient endorsement, I-informant endorsement.

Table 4: Patient and informant reporting of GDS symptoms.



# A Journey Through the Eyes of a Patient

Szu-Yu Tina Chen

Mr. C kindly asked to take my coat as I entered Mr. and Mrs. C's home for our final visit. Even as supper began, things stood in stark contrast to only one year ago when Mr. C contributed to our thought-provoking conversations about ethics with ease. Today, hints of frustration surfaced as we began talking over the dinner table. His speech became more garbled and his once strongly articulated arguments fell apart. I sat attentively. I dissected every word and phrase but I could not make sense of his disorganized thoughts. My confused expression seemed to cause Mr. C more agitation. Hidden behind his large grin were growing signs of irritation and unrest. Mrs. C, looking more tired and worn than two months ago, expertly acknowledged his words and continued to facilitate the conversation between him, myself, and my colleagues.

Mr. C is a pleasant and warm-hearted man diagnosed with Alzheimer's disease. Along with Mrs. C, his caretaker, our bimonthly visits involve a group of students in interdisciplinary health professions: nursing, occupational therapy, genetic counselling, and medicine. I realized early on in my training as a medical student, there was little I could do to stop the progression of Mr. C's declining cognitive function. However, Mr. and Mrs. C continued to warmly invite us into their home and share their personal experiences.

When I think of how patients with Alzheimer's disease are portrayed in popular media, what comes to mind is a father who does not recognize his own son or a grandmother who still

thinks she is living in the 1970s. However, I became aware of far-reaching consequences on behavior and daily function in addition to detrimental effects on memory. These visits with Mr. C provided me with a patient's perspective on living with dementia. I saw worsening of symptoms in the evening known as "the sundowning effect" and I witnessed deterioration in self-care abilities. Most importantly, I saw how disease impacts friends, family, and caretakers. Although Mrs. C, his caregiver, shared with me matter-of-factly some of the struggles the family have faced since his diagnosis, I could only imagine their emotional turmoil. Here in this dining room, I have accumulated knowledge and understanding about Alzheimer's disease, and I also learned about the importance of all-encompassing patient-centered care.

At the first meeting, we discussed the fact that since patients pay for their health care, "clients" might be a better term to use. We drew the analogy of "patient-centered care" to a solar system, with the health care team as planets, the patient as the sun, and the avenues of self-care as moons. We added the self-care aspect to emphasize that health care professionals are also human and need to take care of themselves. In other words, the sun is at the center of the universe just as patient-centered care should be at the center of health care practice.

I reflect on how health care was first built on a patriarchal system; doctors commanded patients to adhere to tasks instead of assisting patients to achieve their goals. How far has our health care philosophy changed?

Centuries ago, when Galileo presented the heliocentric model to the world, he was imprisoned. Are we still seeing a persistent resistance to fully change our health care system to be more patient-focused?

One person's journey brought out many facets of life that I have not seen in my past clinical experiences. Like friends, we spoke of current events, such as physician-assisted suicide, scarcity of resources, and ethical issues. Like support groups, we talked about coping with chronic disease, particularly resilience in the face of stigma for mental health. Like family, we discussed our opinions, feelings, and hopes.

As I prepare to leave our meeting, I motioned to the guest closet only to find my coat missing. Mrs. C informs me this is not the first time and retrieves my misplaced coat from her bedroom. Walking away from Mr. and Mrs. C's home, I am left to wonder what the future holds for Alzheimer's care. For now, I know I will reassure my patients with these words, "I am on your side. We will work on this together."

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*Tina is currently a second year medical student at University of British Columbia. She currently serves as Co-President of the National Geriatrics Interest Group and formerly worked with the UBC Geriatrics Interest Group. Tina loves her experiences with geriatrics patients and looks forward to sharing her experiences.*

# Foggy Window

Emma Scotchmer

*The waves of memories don't come. I'm stranded. Lost behind a foggy window.*

A tear drops silently down her cheek.  
The moonlight enveloping her chair,  
alone in a room.  
A room with pictures;  
Memories that are supposed to help her remember.  
To her...it is filled with nothing...empty of life.  
It is not home.

She looks again at the clock and at the door.  
Frozen in time. He is gone. They are all gone. Her mother...  
Where is she? She hasn't come to see her! Why not?  
The memories, they are lost; the life she had.  
Swirling across the dance floor with her beau's twinkling eyes.  
Years of struggles and joys; raising two children.  
But now they are all gone, lost in the depths.  
Seeping through the cracks of her tangled brain.  
All she knows...is that  
She is not home.

She knows they come sometimes. They do.  
They look familiar...or do they?  
What are those nurses whispering about?  
Do they not know she is right here?  
Struggling to hear; to be a part of something.  
She had a life too.  
She had a home.

The door opens, her eyes clear.  
She can see a figure.  
He smiles and holds her hand.  
She is lost, confused.  
A feeling of fear consumes her.  
A face...what is it about that face.  
She knows him...but how?  
Does he remind her of home?

In her mind she wanders...  
I don't have any kids. Do I?  
No I cannot have any kids...I am only 20.  
I was seeing Sam at the time. So who is this?  
He holds my hand.  
Whispering meaningless words of affection  
Into my wrinkled ear.  
"Stop! Don't touch me! Leave me! I don't want this. I love Tom. Only Tom. Please please please...  
I want to go home."

He looks at me with a deep feeling that I cannot understand.  
Why is he still holding my hand?  
My fear consumes me. I struggle. I feel lost.  
"GET OUT!"  
He tries to clutch me harder and keeps saying loving words quickly, but I cannot hear.  
Two women run in...one looks like someone I know?  
I hear them whisper.  
"Tom, you better leave. I don't know why she does this. You better leave Dad.  
The nurse can help her. I know it's hard Dad. Please leave mum alone. It will pass like last time.  
Maybe she doesn't remember home."

I'm confused, trembling with fear.  
Who are these people? Why am I here?  
I feel a piece of paper slip into my hands as the man who touched me...  
leaves slowly.  
The door shuts with a quick click.  
I try to use my brain...the waves of memories don't come.  
I'm stranded.  
Lost behind a foggy window, trying to see through the clear cracks of light.  
I look down at the paper. I can barely read it.  
"Come to the swing dance with me Friday and then we can go home.  
Love Tom."

My eyes well up and I have a moment.  
A single moment of clarity.  
My husband, my love was trying...trying to keep away the fog.  
One simple message at a time;  
So that I can finally go home.

*This poem is dedicated to my best buddy, Grandma, who inspired me to advocate for older adults. Love you forever.  
You finally got to go home.  
(1925-2016)*

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*Emma did an undergraduate degree in Health Sciences from Western University where she discovered a passion for intergenerational learning and holistic care. She is part of the GiG at McMaster and loves listening to life stories from the elderly.*



# Career Choices: Care of the Elderly or Geriatric Medicine?

University of Toronto Geriatrics Interest Group

### Introduction

Today seniors represent the fastest growing age group in Canada (1). Unfortunately, the country is faced with a shortage of physicians possessing the required skills and knowledge to care for this population. Within our current healthcare system, physicians who specialize in caring for the elderly include geriatricians practicing geriatric medicine (GM), family physicians who have additional training in Care of the Elderly (COE), and geriatric psychiatrists. It is estimated that Canada has only one-fifth of the number of geriatricians that it needs and an estimated 20% of them are nearing retirement (2). The following commentary compares and contrasts geriatricians with COE-certified family physicians in order to assist current medical students gain a better understanding of and potential interest for such career options.

### Overview

COE physicians are accredited by the College of Family Physicians of Canada (CFPC), and geriatricians are accredited by Royal College of Physicians and Surgeons of Canada (RCPSC). Estimates from 2009 find that there are 130 COE physicians and 228 geriatricians in Canada (3).

### Length of Training

COE: Two years of Family Medicine residency training, followed by a 6-month or 12-month Care of the Elderly specialization training.

GM: Three years of Internal Medicine residency training, followed by 2 years of Geriatric Medicine sub-specialty training. See table 1 for Canadian universities offering COE and GM residency programs.

### Job Description

COE: Family medicine is the main primary care specialty in Canada, which focuses on care of the individual within the context of the family and community. Family physicians trained in COE often work with a patient’s chronic physical and mental health conditions (3,4). More commonly, COE physicians work in family health teams (outpatient clinics and house-calls), but may also work in hospital specialty clinics (e.g. memory and fall clinics), long term care facilities, geriatric day hospitals, or inpatient geriatric rehabilitation programs (5).

GM: Geriatric medicine deals with the prevention, diagnosis, treatment, and social aspects of illness in older adults. A typical day consists of: patient care, teaching or educational activities, administration and research. In a hospital setting, geriatricians work amongst an inter-professional team as consultants for other health divisions (6). Most of GM is practiced in academic health sciences centres as well as non-academic teaching hospitals, community hospitals and/or community clinics (5,6).

University	Care of the Elderly	Geriatrics Medicine
Dalhousie University	✓	✓
University of Laval	✓	✓
University of Sherbrooke	✓	✓
University of Montreal	✓	✓
McGill University	✓	✓
University of Ottawa	✓	✓
Queen’s University	✓	
University of Toronto	✓	✓
McMaster University	✓	✓
Northern Ontario School of Medicine	✓	
University of Western Ontario	✓	✓
University of Manitoba	✓	✓
University of Alberta	✓	✓
University of Calgary	✓	✓
University of British Columbia	✓	✓

**Table 1:** Canadian universities offering Care of the Elderly and Geriatric Medicine training.

### Job Limitations

Both fields of COE and GM allow physicians to become more comfortable working with the particular needs of the older adults in their practice, wherever they may be practicing medicine. The two specialties behold unique scopes of practice, which are briefly outlined below:

COE: Family physicians may still be required to refer their patients to a specialist to address patient concerns that are beyond their scope of practice or expertise. In addition, a busy family practice may not allow a physician to dedicate sufficient time to address the complexities of their older clients. Furthermore, family physicians typically have less protected time to conduct research or teaching; however, the flexibility of an independent practice may still allow for these activities. Finally, the training in COE places an emphasis on the behavioural changes of health, systems of support, and home care (3).

GM: Geriatricians will have a practice that is focused on the care of older adults, and will require a longer training period before becoming fully qualified. This may limit transferability of skills (e.g. working with a younger population). Furthermore, depending on the nature of their practice, these physicians may have less

time to practice medicine outside of an academic health centre (e.g. working in a community clinic, conducting home visits). Finally, the length of training is substantially longer than COE training (although many spots remained unfilled in each application cycle) (7).

### Conclusion

It is evident that both the COE and GM specialties will be a critical part of the changing tides of our healthcare demographics. Regardless of which specialty in medicine one pursues, a relatively high proportion of one’s patients will be older adults - notably in the fields of rheumatology, cardiology, orthopedic surgery, psychiatry, rehabilitation, behavioural changes of health, systems of support, home care medicine, and palliative care. We believe there is also an imperative that all medical students develop an understanding and appreciation of older adult health needs.

UofT Geriatrics Interest Group  
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*The UofT Geriatrics Interest Group is led by a group of first and second year medical students who are passionate about promoting geriatrics to the rest of the medical student body at UofT. They hold various events throughout the year, including panels, interprofessional events with students in various health care disciplines, meet and greet dinner with the Geriatrics faculty, and collaborating with the Alzheimer’s Society with a lunchtime talk and the annual Walk for Memories fundraiser.*

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# In Defense of the Old and Sick

Greg RL Costello

The metaphor of a “grey tsunami” conjures up the image of a huge, destructive, unpleasant and apparently unwanted onrush of elderly Canadians crashing into our fragile health care system. Indeed, in the future, medical professionals will be further strained with caring for increasingly frail patients. But there is another way to look at the impending situation. If we choose to see the old and sick not as a societal liability but as a great opportunity to exercise our humanity towards one another, we may emerge from the storm as a community with a deeper appreciation and capacity for compassion.

While on vacation in July 2013, I encountered a chatty middle-aged couple. Upon learning that I was a medical student, they asked what specialty I planned to pursue. After confessing an interest in Family Medicine they remarked, “That’s nice – you better be sure that you like old people, you’ll deal with a ton of them.” Though unintended, their tone made it sound like I should be prepared for an infestation of rats; the elderly being vermin to watch out for, avoided if possible, and properly dealt with when necessary.

That night I thought of other instances in which I had observed this attitude towards the elderly. In my first year of medical school, during a reflective exercise one of my classmates placed “youth” as one of the top three possessions that he would be most afraid of losing, as he feared the degradation of the faculties of his young frame and becoming dependent on others. Another time a colleague expressed disappointment with their family practice placement, partly because of the high percentage of older patients with “boring” chronic disease. I also noticed that some of our in-

structors lecturing on geriatrics seemed to be bashful about their specialty, as if they were embarrassed by their practice.

It is clear why physicians may feel frustration when caring for the elderly. Often the problems are unceasing until the patient passes. The adage, “You win some battles, but you lose all wars” carries the worst sting in geriatric and palliative medicine.

In a system that worships efficiency, the frail elderly represent a burden - their chronic problems do not lend themselves

well to a medical system built on tiny blocks of time. In a society that praises productivity, older individuals can be seen by some as less worthy of care simply by virtue of their level of “usefulness”. A young person is usually capable of returning to their job upon recovery from illness. An older patient with Alzheimer’s disease is only capable of returning to the care home, where they resume draining healthcare resources.

This attitude at first appears antithetical to a society that exalts the right of every citizen to equal access to health care and decries ageism and other forms of discrimination. Yet this view is so prevalent it goes unnoticed and leads to paradoxical public messages. For example, as the right to physician-assisted death for our sick and elderly is being granted in our courts, in our medical journals we are discussing how to combat the high rates of suicide among our youth. Huge programs are established to prevent suicide in universities, while we soften the language in our ethical code to allow our older and sicker patients to die by their ostensibly free wish, at our hands.

All of this just scratches the surface of these nuanced issues, and there are many ideas coming from all positions all the time. In light of this, I humbly posit the following view of the aged population, and by extension a perspective on all incurably ill, disabled and otherwise apparently less valued individuals. I suggest that their lack of function obscures a most precious ability: the power to keep us human.

Aristotle noted that the things that usually matter most to us are the most useless in the economic sense – beauty, art, games and sport. When we are overworked and stressed we are often told we must take a moment “to stop and smell the roses”, which seems to be an impractical action. But it is that very same useless gesture that brings us back to reality, back to being human. It is in engaging with these “useless” things that allows us to engage with one another and ourselves.

A powerful account of this observation with regards to the physically and mentally unwell can be found in the works of Jean Vanier, the founder of the L’Arche homes for the disabled. In the books “Our Life Together” (1) and “Becoming Human” (2), Vanier suggests that in caring for those who are weakest in our society, we learn about and strengthen that which makes us truly human: our capability for compassion. Our capacity for empathy, patience and charity towards our fellow humans is honed when working with those who need it most. In turn, those who seem to be the least valuable to society are in fact the most important; they force us to care for the sake of caring, allowing us to see our patients in a brighter light.

As the grey tsunami looms, physicians must decide how to respond to the increasing numbers of ill patients in our clinic and hospital rooms. Will we give into the temptation to be cold and hard towards the ones in most need, increasingly irritated at our own inability to return them to what

society views as healthy and productive? Or will we appreciate the challenges and opportunities for compassion that such individuals offer us? Will we focus solely on clearing the “bed-blockers” in pursuit of efficiency? Or will we keep at the forefront the person suffering from both their illness and our community’s failure to accept and support them?

The young and strong of today hold much power and even greater control over life and death than their predecessors. If the future purveyors of medicine fail to appreciate the importance of the weak to the humanity of society as a whole, who else will stand in defense of the old and sick?

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*Greg is a medical student based out of the Southern Medical Program at UBC. Graduating this year, he hopes to pursue a career in rural family practice while maintaining a special interest in palliative, critical care and emergency medicine.*

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# Use of atypical antipsychotics for behavioural symptoms of dementia in residents of long-term care

Amanda Canfield

## Introduction

Rates of dementia are highest amongst the older adult population. Of those in Canada over 65 years of age, approximately 6-15% are living with dementia (1). Among them, many exhibit behavioural symptoms as a result of their disease. Various terms have been coined for these behaviours, including behavioural and psychological symptoms of dementia (BPSD), neuropsychiatric symptoms (NPS) and, more recently, responsive behaviours. These behavioural symptoms of dementia are extremely prevalent in residents of long-term care (LTC) and include, but are not limited to, grabbing, screaming, cursing, and wandering. A Canadian systematic review using results from nine studies determined the median prevalence of any behavioural symptom of dementia in LTC residents to be 78% (2). One of the challenges of these behaviours is the limited availability of treatment options. While non-pharmacological interventions are widely accepted as first-line management, their use is not always possible given limited resources in LTC homes. Furthermore, even if non-pharmacological interventions can be instituted, they are not always successful. Currently, it is estimated that 25-40% of LTC residents with dementia receive one or more antipsychotic medications, of which atypical antipsychotics have been the most rigorously studied (3). However, this population of older individuals living in LTC is also particularly vulnerable to medication-related problems due to comorbidities, the physiological changes associated with aging, and polypharmacy. Therefore, careful consideration must be given before trialing an antipsychotic medication.

The aims of this review are to provide a summary of the evidence surrounding the safety and efficacy of atypical antipsychotics used for behavioural disturbances of dementia in LTC and provide a basic approach for their use that is guided by the literature.

## Methods

A literature search was conducted in MEDLINE and Pubmed to identify studies examining the safety and efficacy of atypical antipsychotics for behavioural symptoms of dementia in LTC residents. MEDLINE was searched using the MeSH (Medical Subject Headings) terms “long-term care”, “antipsychotic agents”, “dementia”, and “behavioral symptoms” as well as free-text words “safety” and “efficacy”. Pubmed was searched using the above MeSH terms and keywords as free-text words, including both American and English spellings for the term behaviour. The pooled results identified 49 articles. Results were then limited to review articles published in English with full-text availability. Duplicate articles were excluded. There were five remaining articles which were screened using abstracts and full-text. Studies that examined various treatment modalities were included, given they examined atypical antipsychotics.

## Results

Of the five articles reviewed for inclusion, three focused on the use of antipsychotics for residents of LTC with behavioural symptoms of dementia and will be reviewed here. These three studies include: Pharmacological treatments for neuropsychiatric symptoms of dementia in long-term care: A systematic review; Assessment and Treatment of Nursing Home Residents with Depression or Behavioral Symptoms Associated with Dementia: A Review of the Literature; and Approach to managing behavioural disturbances in dementia.

*Paper 1 – Pharmacological treatments for neuropsychiatric symptoms of dementia in long-term care: A systematic review (3)*

This Canadian systematic review examined randomized, parallel-group, controlled trials comparing medications with placebo, another medication, or non-pharmacological interventions in LTC homes. Study populations had to be exclusively from LTC homes or where LTC residents made up the majority of participants (>50%). Safety and efficacy of antipsychotics (N=19) were evaluated including the atypical antipsychotics (N=15) risperidone (N=6)(4-9), olanzapine (N=4)(7,10-12), quetiapine (N=3)(13-15), and aripiprazole (N=3)(16-18).

## Efficacy

Efficacy was rated using change in NPS reported on NPS rating scales for example, the Cohen-Mansfield Agitation Inventory. Results illustrated a significant reduction in NPS compared to placebo in two of the six RCTs examining risperidone (5,6), two of four for olanzapine (10,11), and one of three for aripiprazole (16). All other RCTs included in this systematic review comparing antipsychotics to placebo did not find significant results but demonstrated a trend towards an improvement in behaviours, with the exception of one examining aripiprazole that showed no difference (17). Efficacious doses of risperidone included 1.0 mg/d (5), 2.0mg/d (5) and 0.5-2.0 mg/d (mean dose 0.95 mg/d) (6). Efficacious doses of olanzapine included 5.0 mg/d (10), 7.5 mg/d (11), and 10 mg/d (10). The efficacious dose for aripiprazole was 10.0 mg/d (16). One study comparing risperidone and olanzapine found no significant difference in the reductions to NPS (7).

## Safety

Safety outcomes included all-cause trial withdrawals, trial withdrawals due to adverse events, and mortality. Risperidone at a dose of 1.0 mg/d was found to significantly increase mortality, while a dose of 2.0 mg/d increased all-cause trial withdrawals and withdrawals due to adverse events but did not significantly increase mortality (5). Olanzapine 15.0 mg/d (10) and aripiprazole 10.0 mg/d (16) were found to significantly increase trial withdrawals due to adverse events only.

Conclusions and Study Limitations

## Conclusions and Study Limitations

Overall, this systematic review concluded that of the atypical antipsychotics, olanzapine, risperidone, and aripiprazole have the best evidence of efficacy for behavioural symptoms of dementia in LTC residents. However, the known safety risks of these agents highlight the need for alternatives. The limitations of this article include the use of retrospective outcome measures using questionnaire ratings completed by nursing staff or caregivers versus direct observation of the behaviours by researchers. Another limitation is the exclusion of articles not published in English, as relevant articles may not have been captured in the results. Further, pharmaceutical companies sponsored many of the studies examined in this review.

*Paper 2 - Assessment and Treatment of Nursing Home Residents with Depression or Behavioural Symptoms Associated with Dementia: A Review of the Literature (19)*

This American review article found similar results to Paper 1, indicating a reduction in dementia-related behaviours with the use of risperidone or olanzapine. It examined peer-reviewed journal articles comparing medications with placebo and/or other medications. The atypical antipsychotics (N=5) risperidone (N=3) (4,5,20) and olanzapine (N=2)(10,21) were studied.

## Efficacy

With regards to efficacy, all of the studies included in this review article showed a trend towards a reduction in dementia-related behaviours compared to placebo. One RCT examining risperidone (5) and one RCT examining olanzapine (10) found statistically significant reductions in behavioural symptoms when compared to placebo. Of note, these two RCTs were also included in Paper 1.

## Safety

Safety was not examined in this review article.

## Conclusions and Study Limitations

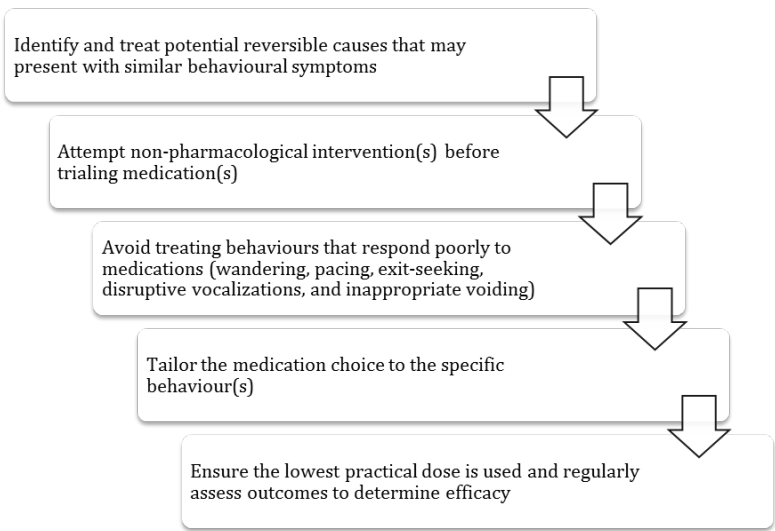
Overall, this review article concluded that olanzapine and risperidone have modest effectiveness in reducing dementia-related behaviours. A noteworthy limitation of this article is that funding was received from Janssen Pharmaceutica and Eli Lilly. Another limitation is that studies not indicating the percentage of subjects living in LTC were still included in the review if it was clear that at least some of the subjects were LTC residents. This resulted in the inclusion of subjects not living in LTC who may have been younger and healthier and therefore less susceptible to the effects of the medications studied. This may have influenced the reported efficacy of antipsychotic agents.

*Paper 3 - Approach to Managing Behavioural Disturbances in Dementia (22)*

This Canadian peer-reviewed article focused on outlining a practical approach to the management of behavioural disturbances in dementia in residents of LTC and hospital inpatients. It examined review articles and published RCTs. A summary of the described approach to managing behavioural symptoms of dementia can be found in Figure 1. Doses suggested in this study can be found in Table 1.

## Efficacy and Safety

Several of the studies examined concluded that 1.0 mg/d of risperidone is optimal in order to best balance efficacy and side effects (4-6). Of note, all three of these studies were included in Paper 1. One of the studies included in this article demonstrated evidence that while both 5.0 mg/d and 10.0 mg/d of olanzapine were effective for the management of behaviours, the lower dose was more effective



**Figure 1.** Approach to management of behavioural disturbances in dementia (Adapted from Omelan 2006)

Drug	Risperidone	Olanzapine
Dose (mg/d)	Start 0.25 Therapeutic dose 1.0 Maximum 2.0	Start 2.5-5.0 Therapeutic 5.0 Maximum 10.0
Side Effects	Postural Hypotension	Hyperglycemia, weight gain

**Table 1.** Recommended doses of risperidone and olanzapine for behavioural symptoms of dementia in residents of long-term care (Adapted from Omelan 2006).

(10). Again, this article was included in Paper 1.

## Conclusions and Limitations

This article highlighted the importance of trialing medications with a favourable risks-to-benefits ratio, specifically for behaviours that are known to be likely to respond to medications (Figure 1), and only after non-pharmacological interventions have been deemed unsuccessful. A noteworthy limitation of this study is the lack of a full description of the study selection in the Methods section. Further, the results did not include a summary of all the studies reviewed and the author of the article interspersed her own opinions, which created subjectivity to the presented approach.

## Discussion

While it is widely accepted that non-pharmacological treatments should be attempted first for behavioural symptoms in dementia whenever possible, antipsychotics are still widely used in LTC residents. Despite their prevalent use, risperidone is the only atypical antipsychotic with an indication from Health Canada for use in dementia (23). In February 2015, the indication was restricted to “short-term symptomatic management of aggression or psychotic symptoms in patients with severe dementia of the Alzheimer type unresponsive to non-pharmacological approaches and when there is a risk of harm to self or others” after new findings demonstrated a higher risk of cerebrovascular adverse events in patients with mixed and vascular dementia compared to those of the Alzheimer type (23).

The evidence presented in this review raises safety concerns with the use of atypical antipsychotics, such as adverse events leading to trial withdrawals and an increase in mortality. However, it also suggests that despite these safety concerns, careful choice of an appropriate dose of risperidone or olanzapine can limit these negative outcomes and the benefits of their use may



outweigh the risks in specific situations. It should be mentioned that meta-analyses that have more power to their results were not examined in this review and some have indeed suggested safety issues with the use of atypical antipsychotics including an increased risk of death (24) and cerebrovascular events (25) compared to placebo. This further reinforces the fact that clinicians must balance the risks and benefits of using atypical antipsychotics in an individualized manner. On the other hand, one must also consider that when non-pharmacological interventions fail, the treatment options for behavioural symptoms in dementia at this time are rather limited making antipsychotics a likely choice for management despite known safety outcomes. Further, there are currently no known studies comparing non-pharmacological interventions to pharmacological agents (3), making decisions regarding their respective use more challenging.

One of the noteworthy limitations of this review is the use of retrospective outcome measures using questionnaire ratings completed by caregivers as described for Paper 1. However, direct measures are challenging for large clinical trials given they are labour intensive. A second limitation is the inclusion of only articles published in English as this may have excluded relevant papers. This review also only included review papers with free full-text availability, which may have further reduced the body of literature. Paper 1 included many studies that were sponsored by pharmaceutical companies and Janssen Pharmaceutica and Eli Lilly sponsored Paper 2. This may have introduced bias to the sample.

### Conclusions

There is some evidence to support a modest benefit of atypical antipsychotics, particularly risperidone and olanzapine, in treating behavioural symptoms in dementia when compared to placebo. However, the safety of these medications must always be considered as adverse events have been found for both olanzapine and risperidone. As a result, non-pharmacological treatments should always be attempted first whenever possible. When these interventions are not possible or fail, the risks and benefits of trialing an atypical antipsychotic should be weighed on an individualized basis and safety, efficacy, quality of life, and dignity should be considered.

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*Amanda is in her third year of medical school at the University of Toronto. She currently serves as Vice President Media and Technology for NGIG and is a former co-chair of the GIG at the University of Toronto. She became interested in caring for older adults while working in a long term care home in high school. She has since 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.*

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# “I am still here.”

## Social Isolation in Seniors and Intergenerational Living

Emma Scotchmer

My shoes echo on the floor as I walk past empty faces staring at blank walls. A woman mutters as she paces. I am visiting my grandmothers with dementia. I see an older man struggling with his wheelchair. I help him to his room, and he invites me in. His life is upon the wall: artwork displayed alongside pictures of children and of him in the war. He tells me of a life that no one has time to hear; there are tears in his eyes. This pain and social isolation is widespread among older adults. We care about our children and their anticipated futures, yet we are sometimes frightened to care deeply for our older loved ones, perhaps due to a fear of loss and sadness. According to Statistics Canada, nearly 20% of seniors in Canada feel socially isolated from society (1). Social isolation in seniors is a Canadian health care problem because it can lead to risky behaviour, chronic disease, and impaired mobility (2). It may also cause depression, social stigma, and death (3). We need to build an understanding of aging as well as gain from the experience and knowledge of those who have watched the world change.

Locally and globally, innovative ideas, like dementia villages and new policies for seniors, are emerging. There has been social progress in Ohio where an intergenerational school has been created. This school fosters community through field trips, storytelling, gardening, and teaching for both older adults and children (4). Thus, it facilitates daily connections between older adults and children. Similarly, in York Region, a project called WS YOU 177 is encouraging intergenera-

tional collaboration to foster innovation for a healthier community (5). However, we rarely see a nursing home and a daycare in the same space. Although older adults and children differ significantly in certain aspects of their lives, growing up and growing old are both accompanied by a whirlwind of emotions, stress, and changes. Intergenerational engagement can reduce loneliness and social isolation in older adults, allowing for longer and healthier lives (6). Children can also feel a deeper connection and understanding towards older adults after involvement in intergenerational programs (7).

I am calling health professionals and the community to action: to stimulate a community grassroots approach to bringing purpose to seniors' lives. There is a need for intergenerational community centres wherein long-term care homes and daycares or primary schools coexist. First, the government should create evidence-based policies that increase social interaction and generate intergenerational bonds. Public retirement homes could save government tax dollars by renting to daycares. They already have care providers and entertainment. Moreover, willing older adults could help with the programming and care and family health teams could be set up to provide care for all generations.

Allowing multiple generations to live, learn and interact in the same space could improve their health and happiness. We are not that different after all. The older man was just looking for that feeling of hope and family again. Why not give him the chance to have that?

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MD Candidate, 2018  
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*Emma did an undergraduate degree in Health Sciences from Western University where she discovered a passion for intergenerational learning and holistic care. She is part of the GIG at McMaster and loves listening to life stories from the elderly.*

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# Our LGBTTQI\* Geriatric Population: Unique Care Needs of an Already Unique Population

Shayne Reitmeier and Aakanksha Sharma  
LGBTTQI\* and Geriatric Interest Groups at the University of Manitoba

The Geriatrics Interest Group at the University of Manitoba is a group rooted in the common interest of promoting care of the elderly. The group shines light on the discrepancy present in the number of care providers and the demand of care in the geriatrics field. Currently, in the province of Manitoba, there are only four geriatricians to provide care for the ever-increasing geriatric population. With this continually increasing need, the group works enthusiastically to expand its horizons while raising awareness and interest in geriatric medicine. The group shares an inter-professional vision, and works towards organizing events which incorporate students from Pharmacy, Occupational Therapy, Physical Therapy and Medicine. The LGBTTQI\* Interest Group at the University of Manitoba is a group dedicated to raising awareness about the unique health care needs of the LGBTTQI\* population. In medicine, students and physicians are privileged to encounter patients from all walks of life, which is why it is crucial that common stereotypes held about the LGBTTQI\* community are dispelled. By organizing various events throughout the year, the group strives to improve collegiality by bringing to light the challenges faced by LGBTTQI\*-identified patients, medical students and physicians. With this, the group hopes to encourage advocacy in both medical and non-medical communities.

This year, the Geriatrics Interest Group and LGBTTQI\* Interest Group were thrilled to host their first collaborative event on campus. The goal of this event was to shed light on the unique challenges faced by the LGBTTQI\* geriatric population. During this event, our groups were able to discuss a commonly overlooked aspect of the geriatric population: sexual health. We aimed to dispel stereotypes held about the geriatric population while educating our peers on the needs of the LGBTTQI\* population specifically.

On January 22, 2016, we hosted our joint event entitled “Our LGBTTQI\* Geriatric Population - Unique Care Needs of an Already Unique Population.” The event was a tremendous success with approximately 75 medical students and select faculty members in attendance. The three distinguished panelists for our event included Dr. Dick Smith (Physician, Founder & Medical Director of “Our

Own Health Centre” and member of the LGBTTQI\* community), Dr. Phil St. John (Section Head of Geriatrics) and Dr. Lynne Mitchell-Pedersen (Retired Private Counsellor with Interest in Sexuality). The event began with a viewing of the trailer for the “Gen Silent” documentary, to introduce the experiences of LGBTTQI\* elderly to the attendees. This was followed by a discussion with the panelists, who shared their experiences and expertise with the medical student body. All the panelists appreciated the organization of the event and acknowledged the stereotypes that were present at the time of their education. Dr. Smith discussed how the current geriatric LGBTTQI\* population had to face significant discrimination, mistreatment and stigma during their lives. He then elaborated on how these past experiences may be restricting them today, not only when they seek medical care, but also when they transition from their homes to personal care homes. Dr. Mitchell-Pedersen emphasized that this patient population deserves to be heard without being categorized based on their sexuality. She suggested approaches to help medical students build trusting, respectful relationships with these patients, in order for patients to share their thoughts and concerns without hesitation. Dr. St. John encouraged the medical students to self-reflect on their biases and understand their beliefs in order to feel comfortable asking patients about their sexuality. He recommended that physicians include discussions around sexuality as part of the standard patient history while providing optimal medical care.

After the panelists shared their clinical pearls, the floor was opened for a Q&A session to allow for student engagement. A few examples of the questions asked by the students included “How can we make our elderly patients feel comfortable in disclosing their sexuality to us? How do the medical and psychological needs of elderly LGBTTQI\* patients differ from young LGBTTQI\* patients? What resources are available in the society for the geriatric LGBTTQI\* individuals? How can we provide holistic care to the geriatric LGBTTQI\* patients? What is forcing the LGBTTQI\* individuals to go back into their “closet” and become generation silent as they get older?” These questions successfully stirred extensive dis-

cussion on a topic which is rarely spoken about not only within the medical community but also the community at large.

After the event, a survey extended to the attending students and faculty received supportive and positive feedback. Many students appreciated learning about the lack of resources available to this specific population—a population that is bound to increase with the aging baby boomers and more progressive societal attitudes towards LGBTTQI\* individuals. Many realized the great need to serve and advocate for this marginalized population, which at times, is quite segregated and socially isolated. The students and faculty were appreciative of the opportunity to explore this easily overlooked topic through this collaborative event.

Inspired by the incredible support and appreciation, both the interest groups plan to organize this combined event again next year. Our goal moving forward is to host the event on a larger scale and increase awareness about this population among incoming students. We would also like to expand our panel by recruiting geriatric LGBTTQI\* community members to share their personal experiences and unique challenges first-hand. This would also provide an opportunity for advice from a patient perspective regarding how physicians and health care providers can provide optimal holistic care to this specific population.

“To reach a port we must set sail—  
Sail, not tie at anchor  
Sail, not drift.”  
— Franklin D. Roosevelt

In conclusion, we believe that by organizing this collaborative event, we have succeeded in setting sail in a positive direction where optimal care is available to patients of all ages, no matter how they identify.

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*Aakanksha is extremely passionate about medicine and the role of physicians as patient advocates. The experiences she had volunteering at Seven Oaks General Hospital during her high school years sparked an interest in the care of the elderly. As a GIG representative at University of Manitoba, she raises awareness for the increasing needs of the growing geriatric population.*

Shayne Reitmeier  
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*Shayne is one of the co-founders and co-leaders of the LGBTTQI\* Interest and Mentorship Groups at the University of Manitoba, Faculty of Health Sciences. In 2015, Reitmeier was recognized by the Canadian Medical Hall of Fame for his leadership both on and off campus, and his dedication to LGBTTQI\* Advocacy.*

# When

Simone Banh

When I was young  
I was excited to grow up  
No curfews, rules or restrictions  
Life did not seem so tough

When I was young  
My mother told me to be patient  
The world was far too dangerous  
And my mind was far too vacant

When I was young  
I took risks and danced to my own beat  
I travelled the world and found myself  
Froze in winter; basked in summer's heat

When I was young  
I fell in love and held their hand  
I laughed, argued and cried  
Took on society's demands

When I was older  
I found myself in decline  
My body ached and my steps grew weak  
Could I age with grace? Asked my mind

When I was older  
I conquered life's afflictions  
Broke them down, made compromises  
Team of care guiding my decisions

When I was older  
My loved ones slipped away  
For we all must someday expire  
Their counts ahead of me by days and days

When I was older  
I was content by my younger years  
Memories stored away or on display  
I no longer had the same fears

When I was older  
I looked at your smiling eyes  
No longer wishing each day to grow up  
Instead wishing each day to become more wise

Simone Banh  
MD Candidate, 2016  
McMaster University

*Prior to medicine, Simone completed a Bachelor of Health Sciences at McMaster University as well. She enjoys creative writing and looks forward to providing care for the elderly.*



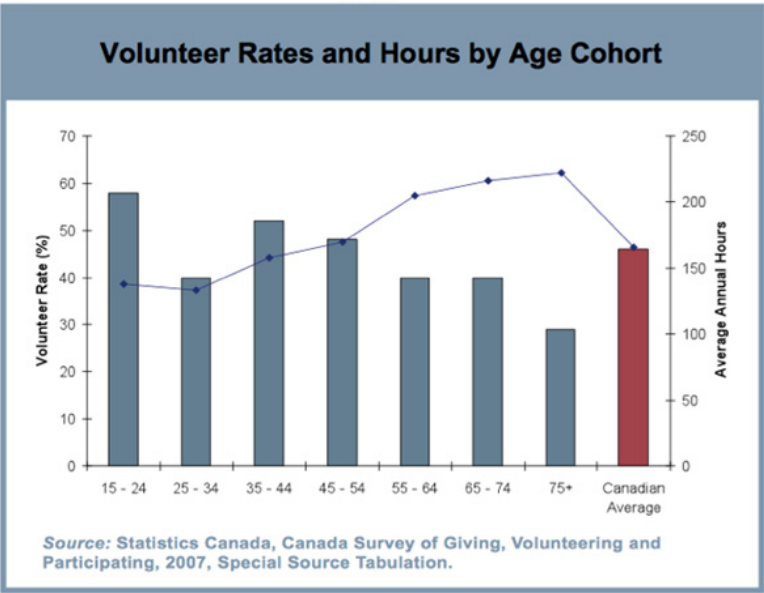
# Re-thinking Aging: Contributions of Seniors to the Canadian Health Care System

Jasmine Mah

### Background

It is a common fallacy that senior citizens and associated chronic diseases of advanced age will have adverse consequences on the Canadian health care system. The aging population will indisputably cause distribution changes to health care spending and policies; however, the concept that this population is to blame for rising healthcare costs has already been disputed by many health economists (1, 2).

In this discussion around the burden of the elderly on the health care system, we often neglect the positive impact that seniors make in health care. Older adults have indispensable contributions to the health system, but these are often overlooked and under-appreciated. This article examines three of these contributions, which include significant roles in the domains of volunteering, philanthropy and informal caregiving.



**Figure 1.** Volunteer rates and hours by age cohort. This graph has a dual y-axis; the bar graph represents the average volunteer rate per age cohort (%) and the line graph represents the average annual volunteer hours per age cohort. Note that while the rate of volunteering in seniors may be lower than other age groups (as depicted by the bar graph), the seniors who are able to volunteer contribute many more hours than the other age cohorts (as depicted by the line graph).

Three separate literature searches were conducted in Medline and Embase databases using the key term “impact” combined with “volunteer”, “donation”, “informal caregiving” and their respective synonyms. Papers were limited to a senior population over the age of 65 years. Grey literature and references of selected papers were also searched.

### Volunteering

In total, 46% of Canadians volunteer annually, contribute over 2.1 billion volunteer hours and equate to almost 1.1 million full time jobs (3). Baby boomers and seniors make up more than half of all community volunteers, contributing the most number of hours per person than any other cohort (See Figure 1 ) (3, 4). Seniors aged 65+ contribute approximately 218 hours annually per volunteer compared to 15-24 year olds who volunteer 138 hours per year (4). As a result, seniors are more likely than any other age group to be designated “top volunteers”, defined as the 25% of people who volunteer over 171 hours annually and account for 78% of all Canadian volunteer hours (4). Seniors are highly valued because they engage in meaningful volunteer roles with consistently high enthusiasm, flexibility, dedication and commitment (5). Seniors often engage in volunteer positions of administrators, bookkeepers or health care providers. Older adults are especially likely to volunteer in health care, third only to religious endeavours and social services. The 25% of seniors volunteering in health care often have meaningful roles as organization mentors and advisors (3, 6). In return, it is well established that volunteering has the symbiotic relationship of improving seniors’ independence and self esteem, managing chronic disease and preventing decline into poorer health (7).

### Donations

Similar to volunteering, the trend in offering community donations increases as the population ages. The average annual monetary donation from seniors aged 75+ is \$725 per person compared to \$431 for 35-44 year olds and \$143 for those aged 15-24 years old. The median amounts follow a similar trend with values of \$231, \$127 and \$30, respectively (8). Each year, the largest numbers of donations are given to health care organizations, especially hospitals and disease-specific foundations (7). Reasons speculated for this trend may include the facts that seniors are often mortgage free and have no dependents once their adult children reach financial stabilization (9).

### Unpaid Caregiving

Informal “caregivers are the invisible backbone of the health and long term care system in Canada” and are “individuals who provide ongoing care and assistance, without pay, for family members and friends in need of support due to physical, cognitive or

mental conditions” (10). The term can be used interchangeably with “unpaid caregivers” and often “family caregivers”.

The number of informal caregivers in Canada is estimated at 2.7 million to 4.5 million (10). The majority of these caregivers are over the age of 45 years old and one in four are over the age of 65 (11). Unpaid caregivers take care of 80% of care needs for individuals with chronic illnesses. The replacement value of informal caregivers’ unpaid contributions are between \$25-\$26 billion (12) and \$83.7 billion (13), depending on which factors are considered in the calculations. Collectively, caregivers of people with chronic conditions spend on average 15.6 million hours per week caregiving (14).

Also, unpaid caregivers are essential to maintaining the function, well-being and quality of life of their care recipients by assisting in activities of daily living and navigation of the health care system. They allow their care recipients to remain at home, promote patient-centered care and decrease the burden placed on acute and long-term care centers (15). As the population continues to age, there will be an increased reliance on these informal caregivers who not only provide biopsychosocial benefits for their loved ones, but also economic relief for the health care system.

### Conclusion & Recommendations

Clearly, seniors are making a positive impact on the health care system in the roles of informal caregivers, volunteers, and philanthropists. In return, these roles help keep seniors engaged as valued members of the community. As Canada’s population continues to age, we must dispel the myth that seniors are a burden on health care and encourage activities that promote aging in a positive and active way.

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*Jasmine’s experiences working with elderly populations at the Bruyere Research Institute and Baycrest Centre of Learning, Research, & Innovation have been markedly enlightening and rewarding. She believes that early exposure to geriatrics was a key factor contributing to her interest in this field.*

Kingston, Ontario  
Alex Astell  
Queen’s University

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# The Elderly

Nabeela Nathoo

White hair, small stature, hunched spines, frail  
Some emit an odor akin to that of milk gone stale

Decades of emotion are visible on their skins’ wrinkles  
Weathered faces showing pigmented spots like sprinkles

It is said you should never judge a book by its cover  
Analogous to dismissing the physical blemishes of one’s lover

Yet hurriedly, in the malls, on the streets, we pass them by  
Consciously or unconsciously, deaf to their silent cry

Over the years, they have lost their hearing and sight  
No matter how hard they try, it is often a futile fight

Some have lives plagued by chronic disease  
Deficits so obvious that nearly everyone sees

Gripping their walkers or sitting passively in their wheelchairs  
Their heads and eyes are kept downcast to avoid strangers’ stares

Many have lost their life soulmate  
Alone, outside of death’s door, they wait

Their vulnerability leaves them prone to a scam  
Nobody to stand up or fight for them, like a ram

Of them and their lives, we make no fuss  
Superficially, they appear to ride a separate life bus

In our sparse interactions, their ideas and values seem outdated  
Between our minds and theirs, the pathway is gated

Some may even consider them obtuse  
Within society, they appear to be of little use

But we forget that they were once bankers, engineers, doctors, teachers  
Teenagers who would drink cheap beer and make out behind the bleachers

On hot summer nights, they used to drink milkshakes, eat burgers and French fries  
In their prime, they attended fancy parties, ladies in gowns and gentlemen in bow ties

They seem to transition from decade to decade at an increasing rate  
Yet we lose sight of the fact that, one day, we will face the same fate

Although their mental and physical function may not be what it used to  
Their perspective has a richness to it, akin to the best coffee brew

We should, then, appreciate what their decades of life provide  
As, sadly, their memories may not last much longer before they subside

Within each one is a unique, incredible, full life’s tale  
Stories of war, marriage, children, numerous wins and the occasional fail

Imagine the lessons we could learn, the wisdom from them we would gain  
Listening to them, acknowledging their value, could lessen their loneliness and pain

They are, after all, one of us  
Of them and their lives, we must make a fuss

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MD/PhD Candidate, 2017  
University of Calgary

*Nabeela is an MD/PhD student at the University of Calgary. She completed her PhD in Neuroscience in 2014 which focused on using susceptibility weighted MRI in multiple sclerosis. She is passionate about brain health and care for those living with dementia.*

# Caregiving – Support for the Patient and Family

Linda Pan

The circle of life.  
Beautiful.  
Profound.  
The cared for becomes the caring,  
Just as the caring becomes the cared for.

The elderly frail lady sat in her wheelchair, looking puzzled, unfocused, and yet alert all at once. The tremor in her hands reveals her Parkinson’s diagnosis.

During the interview, she pauses to recollect memories of her multiple falls, and her recent move into assisted living - a major stress for her. Tears come, and I see her shoulders shaking.

Beside her is her son, looking over her. The hands of time have already gracefully brushed his hair with strokes of gray. He shares that his mom does not remember waking in the middle of the night, and ingesting the multitude of medications. I see the sadness, the frustration, the concern, the love, and the damage caused by overwhelming self-blame in both the mother and the son.

How do we as health care providers offer a glimmer of hope to patients and their families? Perhaps it’s the medications started on time, the resources offered, the referrals arranged, the listening ear for their struggles, the encouraging words... all with the overarching goal of continuously supporting their immensely difficult journey.

Linda Pan  
MD Candidate, 2017  
University of Manitoba

*Linda is studying in her third year at the University of Manitoba. She is thankful for these encounters with patients and families - always a learning experience, in the moment, and in reflection.*

Mt. Huangshan, Anhui Province, China  
Wilson Lam  
Queen’s University





# A Culture Shift in Aging: What we can learn from different parts of the world

Christina Reppas-Rindlisbacher

Last summer, I visited my large extended family in Italy, whose members are all descendants of my great-grandmother Lina. While the food and the scenery delighted me, I was particularly fascinated by the structure of the houses. As a medical student with an interest in geriatric medicine, it was heartwarming to see my great aunts and uncles living in apartments that were adjoined to their children's homes. In fact, most of the houses were built with the expectation that elderly parents would eventually move in. As someone who grew up in North America, where it is commonplace for aging parents to live in institutionalized homes where non-family members care for them, I found this surprising. It prompted me to reflect on how older adults experience aging differently in various cultures. What lessons can we learn from other areas of the world to improve the aging experience in our own society?

One of the ways that aging can be compared across cultures is through differences in the culturally accepted place of residence for seniors. In many East Asian countries such as Japan, 65 percent of those aged 65 and older still live with their adult children—a rate higher than in any other industrialized country (1). However, this number may start to decrease as more young people move to cities far from their aging parents' villages. Chinese culture also places high value on caring for elderly family members. In an effort to ensure that aging parents are cared for,

China passed a law entitled "Protection of the Rights and Interests of Elderly People" which mandates that children should go home "often" to visit their parents and companies give employees time off to make these parental visits (2). This is in contrast to the Canadian government, which places high value on childcare, granting up to a year of paid maternity leave, but only gives limited benefits for adults caring for aging parents. Canada grants employment insurance, in the form of a compassionate care benefit, to individuals caring for dying loved ones (3). However, nothing is available for caregivers who are providing a high level of care for a short-term illness or disability, such as a hip fracture or stroke.

Another reflection of how aging is experienced differently across cultures is the use of respectful language for older adults. Honorific suffixes such as *-ji* (Hindi) and *-san* (Japanese) enable speakers to add an extra level of respect to elders and other revered persons. The Hawaiian word *kūpuna* means elders and holds an added connotation of knowledge, experience and expertise (4). In Swahili, the elderly are called *mzee*, which expresses respect for knowledge, power and influence (5). While these societies revere their eldest members, our North American culture goes as far as portraying them as senile and incompetent in media and film (6). Negative terminology such as "bed-blocker" and "grey tsunami" is used to describe frail older adults in hospitals and the aging demographic. This may seem light-hearted and harmless to some, but it reinforces negative stereotypes and promotes the idea that the elderly are less valued or a burden to society.

Celebrations of aging are another example of how societies demonstrate respect for elders. A National Grandparents day exists in the United States and Canada, officially the second Sunday of September, but unfortunately it is hardly celebrated and not well known due to little media coverage compared to Mother's and Father's days. In contrast, Japan takes Respect for the Aged day (6) far more seriously. Free "obento" boxed lunches are distributed to the elderly, and small communities will often organize ceremonies where schoolchildren perform (7). The media also runs special features that profile the oldest Japanese citizens (8). This approach encourages society to view old age as honorable rather than something to be avoided.

Unfortunately, negative perceptions of the elderly that are pervasive in North American media and culture have the risk of being reflected in healthcare delivery. Older patients are undertreated in areas such as cancer care (9,10) and older individuals are often excluded or underrepresented in drug trials (11). It is important that all of us, especially health care professionals committed to eldercare, uphold the intrinsic, human and societal value of our aged population. Whether this

means speaking up when a colleague uses language like "bed blocker" or "social admission", advocating for better home care and community health services, or simply doing something kind for an elder on Grandparent's day. Canada's multicultural mosaic lends itself to learning from practices that honour aging in different cultures and countries. Instead of fueling the same age-old stereotypes, let's move towards building a society where we can proudly say that older adults are valued, admired and respected.

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# Changing Perspectives on Chronic Disease: Improving Daily Management

Shabana Amanda Ali and Kristina Kokorelias

We know that the aging population will result in an increased prevalence of chronic disease, but we do not know what to do about it. Current health care systems that focus on cure rather than therapeutic care or prevention are not equipped to handle the growing cohort of chronic disease sufferers. An innovative approach is needed, one that leverages the potential of interdisciplinary teams to collaborate across sectors, from science to medicine to society. Traditionally, these sectors are isolated, where scientists are confined to laboratories while clinicians are focused on patient care. With little cross-talk between scientists and clinicians, research findings are seldom translated to the community settings in which they are most beneficial. We believe that a shift in medical, research, and societal perspectives are required to improve this communication, in order to design solutions that bridge disciplinary gaps, facilitate implementation of research findings, and improve daily management of chronic disease.

In the management of arthritis, the primary recommendation in clinical practice guidelines is self-management, which includes physical activity. Research has shown that moderate physical activity can relieve symptoms and reduce the overall progression of arthritis. Whether this information is conveyed to patients by their primary care providers is debatable. Family physicians may not have the time or specific expertise to explain self-management strategies to patients with arthritis. Ultimately, the disease progresses and becomes costly for health care systems, requiring medication and surgical intervention, such as total joint replacement. There is a need to facilitate translation of information between researchers, who optimize the type, frequency and duration of physical activity for patients with arthritis, and clinicians, who interact on the front line with this population. By bridging gaps between research findings and primary care, significant improvements can be achieved in the daily management of chronic diseases like arthritis.

The current literature on dementia highlights the diverse fields of research (e.g. clinical medicine, biomedical research, social sciences, psychology and cognitive science, and others); however, little research is conducted across domains. Clinical outcome studies that focus on finding ways to accurately diagnose dementia, develop treatments, and find cures are undoubtedly necessary for alleviating Canadians from the impact of the disease. However, they provide little information regarding the mechanisms of therapeutic change. While there are high impact and rigorous studies on pharmaceuticals, there are poor-quality studies on almost everything else. For example, creating a calming environment for people with dementia is one therapeutic technique that has gained popularity in social gerontology research, and is slowly gaining traction in the caregiving community. While higher-quality research is still needed, existing evidence suggests that a quiet environment, one without many sensors, can mitigate negative

behaviours and reduce anxiety for people with dementia. Yet, this very simple technique is often not "prescribed" in physician offices.

Arthritis can be diagnosed at any point during life, depending on the subtype, so individuals may spend decades living with this disease. For individuals with Alzheimer's disease, the most common form of dementia, the World Health Organization (2013) estimates that the median survival is 7.1 years. Therefore, strategies are needed to help those with arthritis and dementia live well during these years. Translating the scientific advances that occur in medical and applied research laboratories into improved care for aging patients is the major health challenge of our time. A shift in perspective is required to overcome this challenge and bridge the gaps among otherwise isolated health professionals. Better communication between scientists and clinicians will allow research findings – as simple and profound as increased exercise for arthritis and calming environments for dementia – to be implemented in the community settings where they can have the most impact. This will invariably lead to improved daily management of chronic diseases like arthritis, dementia, and others.

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# GRANDMOTHER

Cindy Ding

A Thai life insurance commercial flashes on the TV. It is a touching story about an unappreciative daughter who finally realizes her father's importance when he makes the ultimate sacrifice. It is sad. More commercials flicker across the screen, and half an hour later my grandmother's mid-day Chinese soap opera comes to an end. She struggles out of her chair with a grunt and goes to the kitchen. It is winter break, so I have nothing to do but to watch my grandmother go about her day. Watching her fills me with greater sadness than the commercial. Just like the father in the commercial, my grandmother would give up everything for her family. Yet even if she did, I wonder if anyone in our family would feel she was important.

*"My grandmother would give up everything for her family."*

In my job, I work with seniors. I love working with them, because they say things that interest and challenge me. At home, however, the last thing I want to do is to speak with my own mundane grandparents. Luckily, my grandfather has his fishing friends and seems to be content at home. My grandmother, on the other hand, has no tangible friends as far as I have seen. She refuses to go to the local seniors' recreation centre, and she scoffs at our elderly Chinese neighbours in her condescending Shanghainese way. Yet I know she craves companionship. She rambles to guests during the occasional dinner party we throw and to my family every day.

"The vegetables prices are going up again," she says for the sixth time during dinner. "Remember that one occasion eighteen years ago when I ran all over town trying to buy you a birthday cake?"

"No, grandma, I don't," I retort. Although I appreciate your actions, I will not remember them no matter how many times you ask because my memory does not date back to my toddler days. The thought of sending my grandmother to a home has certainly crossed my mind more than once.

A year ago, my family had a talk. At the time, I was fed up with how my parents yelled at my grandmother because she could not do things the Canadian way, and with how no one ever treated her with respect. I reminded everyone it is not her fault. She does not speak English. She wobbles around on metal knees. She is tied to her cooking and child-minding duties at home. Tears welled and emotions flowed and for a while,

I thought I had fixed it all. I participated in her dull chatter, praised her average cooking, asked about her plants, and helped her finish up her odd sewing projects. But eventually, I got fed up with her lack of friends, her lack of new experiences and conversation topics, and her lack of ability to find a place in society. I could not suppress my exasperation! I began to treat her like thin air or worse, like a broken tool that deserved to be thrown away.

In stark contrast, I can effortlessly tolerate senior patients at work who are similar to my grandmother. Perhaps it is because I only see them in a professional light, and do not hold them to the same standards as I do my family members. More significantly, I believe it is because I see the patients for only a few moments in a year, and I have more than enough patience to last me through those visits.

The seniors I work with lie on a spectrum: on one end, they can independently contribute to society and are well respected by their families. On the other end, they are physically or mentally ill with little to contribute, thus making them vulnerable to neglect and contempt. Although "contribution" and "respect" are often directly proportional, I deeply admire people who can disconnect the two. Perhaps it is in their upbringing to respect seniors unconditionally? Perhaps they have been influenced by personal experiences in which they were disrespected? Perhaps they are just remarkably patient; I have met a few such people.

Does my lack of tolerance make me a monster? I do not want to be one. I do not want

to be an angel to the elderly strangers at work and a devil to the old woman at home. I do not want my grandmother to live the rest of her life in this hypocritical sadness. Could someone please tell me: how do I give my grandmother a fairy tale ending?

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*Cindy is a second year medical student at the University of British Columbia. She coordinates the Grandpal Penpals Program, an intergenerational letter exchange and visit program for elementary students and elderly residents in care homes. She aspires to one day open a family practice with a diverse group of general practitioners, pediatricians and geriatricians; together, they will help to build a healthy community with people of all ages.*

# In The Fade

Kevin Dueck

*"Truth springs from argument amongst friends."  
—David Hume*

Starting medical school, I had hoped that along with learning about healing others, I would have the chance to engage my peers in complex and challenging conversations. Having found group discussions a valuable source of new perspectives, I particularly looked forward to a small group session on mortality and medicine. I anticipated my peers sharing their views and wrestling with those of others regarding death and our roles as future doctors. Surprisingly, and rather unfortunately, the realities of personal mortality, loss, and grief were largely glossed over. Since we will be involved in end-of-life discussions with patients, deep exploration of these issues is essential in order to

effectively communicate with those under our care. As members of the healthcare team, it is important to take the time for reflection and understanding of death and dying, as we face both our own mortality and that of our patients. Needless to say, I left the discussion disappointed and feeling out of place.

Over the next week the small group session remained in my thoughts. I wasn't sure if it was simply my personal discomfort with death, or rather that the discussion had truly missed the mark. Eventually, I brought up my disappointment and concerns with a classmate who attended the session with a different group and was met not with confusion, but an expression of gracious relief. He too had expected a deep conversation with peers and had left the session discouraged. This led to an extended dialogue about end-of-life issues, cultural values and what defines a "good life" and a "good death". We also touched on the purpose of medicine and our roles as future physicians. In essence, the deeper level of discussion was everything that was absent from the small group session. Over the course of our conversation, my views were challenged and we both gained a new appreciation for the complexity of issues surrounding mortality and medicine.

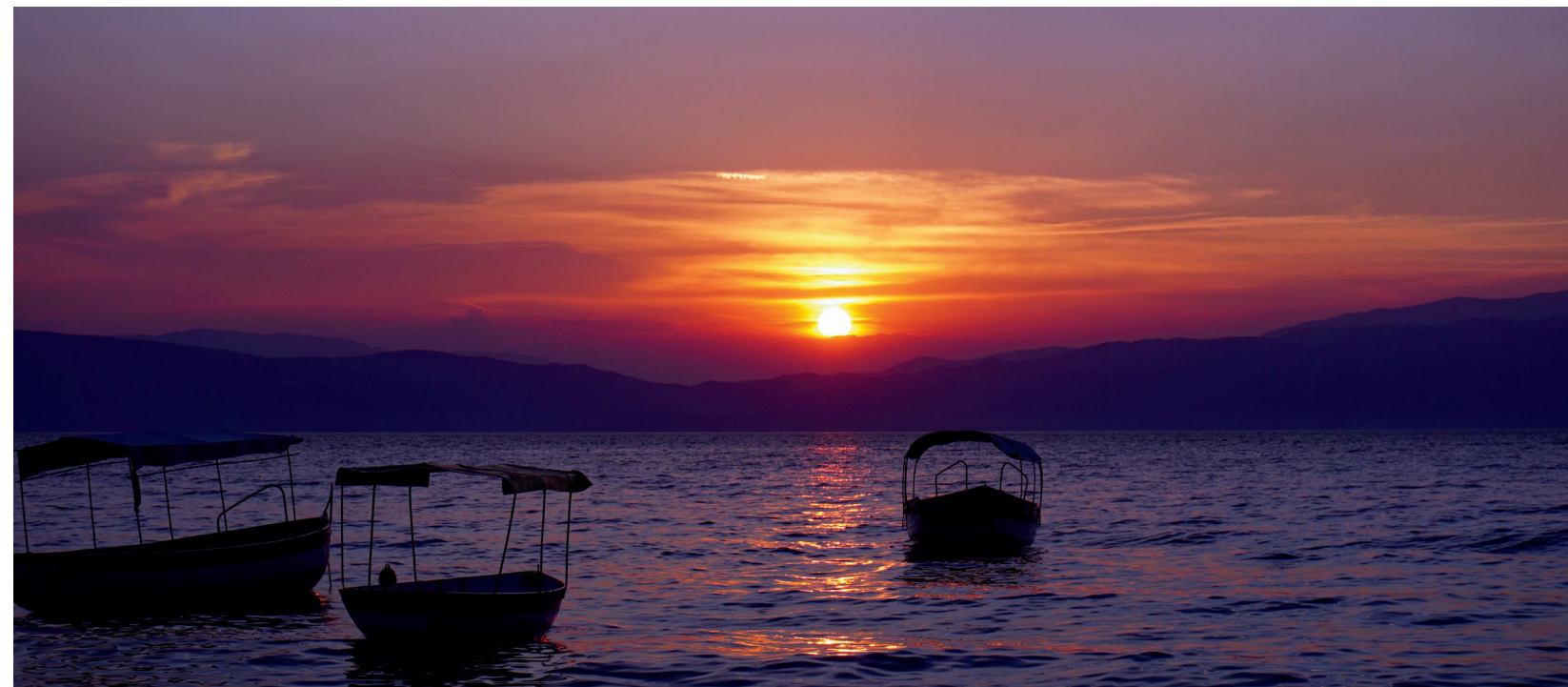
Since these small group discussions happened early in medical school, I looked forward to more open discussions with time. As I progressed further in my training, the need to reflect and discuss the complex nature of medical care became all the more apparent, especially surrounding issues of mortality. Unfortunately, the apprehension towards deep conversations continued in small group sessions throughout the entirety of medical school. As I graduate in a few months, I wonder how many deep insights and new perspectives may have been missed in these sessions. I hope others also found means to examine these difficult topics, as understanding the perspectives and values of others impacts our ability to connect with and care for our patients.

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Ohrid, Macedonia  
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Creative





# The Philosophical Case for Age

Hart A. Goldhar

A predominant undertone of our society is that old age is bad and youth is good. Nobody wants to grow old. With each successive birthday, we more actively attempt to disguise our true age. Individuals are undergoing procedures to make themselves more youthful, as if they could beat nature. Self-esteem rises from childhood into adulthood but declines markedly after approximately age sixty (1). Why does our society feel so negatively about aging? I present here my philosophical approach to the topic.

Youth means potential. As we walk the path of life, doors of opportunities close around us, and we become more differentiated, or fixed in our specific occupations and lifestyles. There is a sadness that inevitably comes with this door-closing phenomenon. A mid-life crisis might be understood as a deep internal spiritual conflict in which a person is forced to confront this realization, and fails to come to terms with it.

However, there is also a case to be made for differentiation. Consider a bag of many coins. A person who possesses such a bag can purchase any from a vast array of luxurious options, and there is a delicious thrill in considering the potential to buy all of these at will. However, when the day concludes and the stores close, and he or she returns home, the bag of coins is utterly worthless. Coins cannot be eaten or provide comfort. Potential, in and of itself, is useless.

Elderly individuals are fully differentiated, but they have lived lives. Many have achieved career successes, forged relationships, and produced children. Others have left marks in the world through the people they touched, ideas they shared, and inventions they created. Although these elderly individuals have cashed in their coins, they have gained tangible treasures in return.

Thus, in order to re-discover the beauty in aging, we must shift our focus away from the 'potential' and toward the 'actualized'. Each of us must think seriously about how to best cash in our finite bags of coins, thereby making our present moments meaningful.

I recall admitting a healthy 85-year old gentleman who had just arrived via ambulance after a 'face-plant' mechanical fall on the sidewalk. He was stable but diffusely bruised, and he would need some time to heal in hospital as well as increased home supports on discharge. He had mild cognitive impairment, and he was not very conversational.

The day after his admission, he had an interesting visitor. Another 80-something year old gentleman rolled up in an electric scooter, and into my patient's room. I admired this display of kindness in visiting his sick friend, so I followed him in. I asked the visitor how he knew my patient, and he told me briefly how the two were long-time friends, as they had fought for Canada overseas in World War II, side-by-side, and they had kept up their close friendship to this day.

At that moment, my entire view of my patient changed—from that of a beat-up geriatric patient with a questionable short-term memory, to that of a war veteran in the twilight of his life; from the 'potential' to the 'actualized'. I would not say that this changed the care that we provided my patient, but it enabled me to admire him, and further invigorated me in caring for him and other geriatric patients too.

Apart from philosophical merits to age, there are also practical positives. Studies show that elderly individuals are happier and have more stable emotions (2), level-headedness in disturbing situations (3), and can resolve social conflicts more effectively (4), which derive from a wealth of wisdom, experience, and perspective. Further, Western culture differs starkly in its respect for elderly individuals when compared to other cultures, such as indigenous cultures, who look to elders for support, advice, and wisdom in all walks of life.

To conclude, I believe that our negative perception of aging is a microcosm of our approach to life more globally. Might the phenomenon of ageism stem from our society's obsession with productivity, competitiveness, and self-aggrandizement, at the expense of patience, wisdom, and loving relationships? If we imagine ourselves in ripe old age, reflecting on a lifetime of experiences, I think it is clear which is more important.

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*Hart is from Toronto, and studied undergraduate Biochemistry at Western. He has decided to pursue Internal Medicine with a passion for holistic patient-centered care in the setting of chronic disease. He enjoys teaching in medicine, and reading philosophical texts because of the wisdom they offer and the sense of meaning they help cultivate.*

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# Benefits of social interaction for older adults: Perspectives of two first-year medical students

Jorge Georgakopoulos and Tina Felfeli

From the early stages of development, social interaction plays a critical role in our daily lives. Although this holds true as we age, the importance of social interaction for older adults is often overlooked in health-care settings. As two first-year medical students, Jorge Georgakopoulos, a volunteer at London Health Sciences Centre's (LHSC) Victoria Hospital, and Tina Felfeli, a 2015 intern at Baycrest Health Sciences and Baycrest Centre for Learning, Research and Innovation (CLRI) in Long-Term Care, had the opportunity to experience the importance of social interaction for older adults. These two health centres in Ontario have implemented programs that aim to improve the quality of life for geriatric patients by enhancing their social interaction.

The "Volunteering in Surgical Care is Treasured" program (VISIT) is a volunteer program on the orthopaedic inpatient unit at LHSC's Victoria Hospital that offers visits to patients of all ages, with a particular focus on the elderly population. As a part of this program, Jorge made weekly visits to elderly patients recovering from recent invasive procedures. These visits consisted of conversations, reading the newspaper, playing cards, going for a walk and other activities that allowed patients to engage in social interactions. While many of the elderly patients Jorge visited were experiencing similar physical impairments, were too frail to return home, and were seeking permanent or temporary long-term care homes, they each presented with unique personalities. No matter what the activity, the elderly patients were always happy to share stories about their past life experiences, families, and friends; stories which served as an outlet for personal expression. Whether it was a story about their first kiss or the passing of a loved one, each memory struck emotions that seemed to elicit a positive response. From these social engagements, Jorge saw first hand how these interactions can bring about emotions that otherwise may not have been expressed if these patients had not been given the opportunity to partake in something they have done their entire life: social participation.

As a part of the Baycrest CLRI in Long-Term Care Summer Internship, Tina was paired with an older adult living in long-term care. Tina utilized art as a tool to enhance the social interaction and intergenerational bond between herself and the long-term care resident. Tina worked closely with her resident, a well-known portrait and abstract painter, who had lost his ability to discern colours following macular degeneration. By partaking in several visits to the art studio and with assistance from the art-therapy staff, Tina and the resident created beautiful art pieces together. The resident introduced Tina to different art techniques, such as how to properly hold a brush and to mix colors effectively, but most importantly, he taught her invaluable life lessons: to remain grounded, be grateful and learn from others. It was through social interaction with this patient that Tina was able to learn about his passion for art and ultimately re-introduce this long lost interest. Today, the resident continues to fulfill his

passion for painting and does not fail to put a smile on the faces of those around him everyday.

With an alarming number of elderly patients experiencing depression due to lack of social engagement, an extensive amount of research has demonstrated a vast array of health benefits associated with social interaction, including improvement in mortality, disability and depression (1). As two first-year medical students just entering their profession, they have learned invaluable lessons that they hope to apply in their future medical practices. Through their work with geriatric patients, they have had the privilege of listening to personal stories and learning about the life experiences that make each individual unique. While they both got involved in programs that aim to improve the quality of life for geriatric patients, what they did not realize is the impact these experiences would have on their own personal lives and professions moving forward.

Today, the success of the volunteer VISIT program at Victoria Hospital has led to its expansion at LHSC's University Hospital in London. Similarly, the Baycrest CLRI in Long-Term Care Internship Program continues to receive increased interest by students from a wide range of disciplines. Jorge and Tina hope that their stories will demonstrate the importance of incorporating social interaction in the care provided to older adult patients.

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*Jorge is a first-year medical student at Schulich School of Medicine and Dentistry. In the past, he has worked alongside LHSC's Volunteer Services in expanding the VISIT hospital-based program that aims to improve the quality of care for long-term care patients.*

Tina Felfeli  
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*Tina is a first-year medical student and executive member of the GIG at University of Toronto. Tina has been involved in the development of the new Geriatrics Curriculum at University of Toronto and has implemented mind-motor exercise programs for older adults living in long-term care.*

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# Mobility Workshop:

## Rehabilitation therapy students teach medical students valuable skills for working with geriatric patients

Guillaume LimFat  
Queen’s Geriatrics Interest Group

During our undergraduate medical education, the foundation of clinical skills training is largely developed by working with Standardized Patients (SPs) who take on different roles in order to recreate the variety of patient presentations that we, as future physicians, will be confronted with. They are an effective learning tool for medical students and play a crucial role in preparing us for clinical clerkship. However, this method of clinical skills practice is not without limitation. For example, medical students are accustomed to asking SPs to reposition themselves for various physical examination manoeuvres, which is always met with compliance, as it is an expected part of the SP’s prepared role. In the hospital however, patients often have limited mobility. New students soon realize that providing physical assistance with something as simple as transferring from a wheelchair to a bed is not a manoeuvre they had ever been trained to safely perform. Since SPs are seldom presented with mobility aids or limited bed mobility, the otherwise thorough curriculum of clinical skills has overlooked the development of these skills. As a result, the world of canes, crutches, walkers, and wheelchairs were still foreign to students, and they may be taken aback and unprepared as to how to proceed when met with a patient who says “I can’t do that on my own” for the first time during a physical exam.

Feedback from students in their clerkship rotations echoed this sentiment, and they proposed that the local Geriatric Interest Group (GIG) take charge in providing an opportunity for supplemental training through a mobility workshop. This was to be facilitated by the people who know mobility best: students from the School of Rehabilitation Therapy. The first Interprofessional Mobility Workshop was therefore planned by a collaborative team of students from the local GIG and representatives from the school of physical and occupational therapy, with the support of the Office of Interprofessional Education and Practice (OIPEP) at Queen’s University.

The main objectives of the workshop were as follows:

- 1. Introduce the role of PT/OT in patient care and indication for referral
- 2. Introduce mobility aids, and how to assess proper use and fit
- 3. Demonstrate how to safely reposition patients with limited mobility during physical exams
- 4. Demonstrate how to safely perform bed/wheelchair/rollator/chair transfers
- 5. Provide additional information on sources of funding aid for patients requiring mobility aids

A two-hour mobility workshop was facilitated at the large “laboratory” space within the Louise D. Acton building where rehabilitation students usually learn and practice their clinical skills. The space is suitably set up with realistic patient beds and has a large variety of mobility aids available. The volunteer rehabilitation students ran a series of 20-minute stations, with medical students split into small groups and receiving one-on-one instruction, providing ample opportunity to learn and practice the different techniques on each other.

Five different stations, as well as briefing and debriefing sessions, were designed in order to address the aforementioned objectives:

**Introduction: Role of rehabilitation therapists and basic concepts**

Discussion of the roles of PT and OT in patient care, particularly in the geriatric patient population, followed by an explanation of basic concepts of body mechanics and balance with focus on assuring safety for both the patient and the health care provider during any assistance maneuver.

**Station #1: Canes, crutches, and walkers**

Introduction to some common mobility aids, their proper use, and how to assess their fit for patients. Included a discussion on the progression of gait aids and accommodating different weight-bearing statuses.



**Station #2 Wheelchairs and wheelchair transfers**

Introduction to wheelchair use, wheelchair safety, different types/attachments, and red flags for improper fit. General overview of sit-stand transfers to and from wheelchairs.



**Station #3 - Bed mobility**

Manoeuvres to safely assist patients with limited mobility during physical exams, specifically with sitting up, lying down, and turning to the lateral decubitus position while on the bed.



**Station #4 - Transfers**

Techniques for safe patient wheelchair/bed transfers, rollator/bed transfers, and rollator/chair transfer, when done alone or by two healthcare providers.



**Station #5 – Gait and guarding**

Appropriate guarding techniques to assist a patient’s gait assessment and proper ways to “guide” a patient’s fall if it is inevitable.



**Debrief**

Discussion of effective collaborative practice and counselling patients on sources of funding aid for mobility aids.

Overall, the Queen’s Geriatric Interest Group’s first interprofessional mobility workshop was a highly successful initiative. Medical students enjoyed the hands-on instruction and insight into their peers’ roles while rehabilitation students found it a rewarding and enjoyable teaching experience. The local Geriatric Interest Group and the facilitators from the School of Rehabilitation received overwhelmingly positive feedback from students who attended the workshop, and were encouraged to continue the workshop as a yearly event. The Office of Interprofessional Education and Practice (OIPEP) also supported the annual continuation of this event following this successful pilot session. The next session is currently being planned by a new team of GIG representatives in their first year of medicine and facilitators from the School of Rehabilitation. Feedback indicated that the strength of the workshop stemmed from the fact that it was entirely student-run and specifically planned by students, for students, in order to address an identified need for supplemental training. Furthermore, it provided a fun and interactive setting for interprofessional collaboration and hands-on learning with peers in health care.

Guillaume LimFat  
MD Candidate, 2018  
Queen’s University

*Guillaume is a second year medical student at Queen’s University with an interest in geriatric medicine, clinical research, and knowledge translation. He is one of the senior co-chairs of the Queen’s Geriatric Interest Group and led the organization of the mobility workshop and geriatric skills night.*



# Declaration

Usman Saeed

I stood by you,  
When the storm thundered,  
And the lightening came crashing through,  
And when the fire raged roaring blue,  
Scorching away, slowly but mercilessly,  
The garden of beautiful memories.

I understood you,  
In moments of agony and confusion,  
With your teary eyes, blank and cold otherwise,  
Searching for a glimmer of light in the lands of darkness,  
Akin to a wounded warrior silently fighting,  
The ultimate battle long lost.

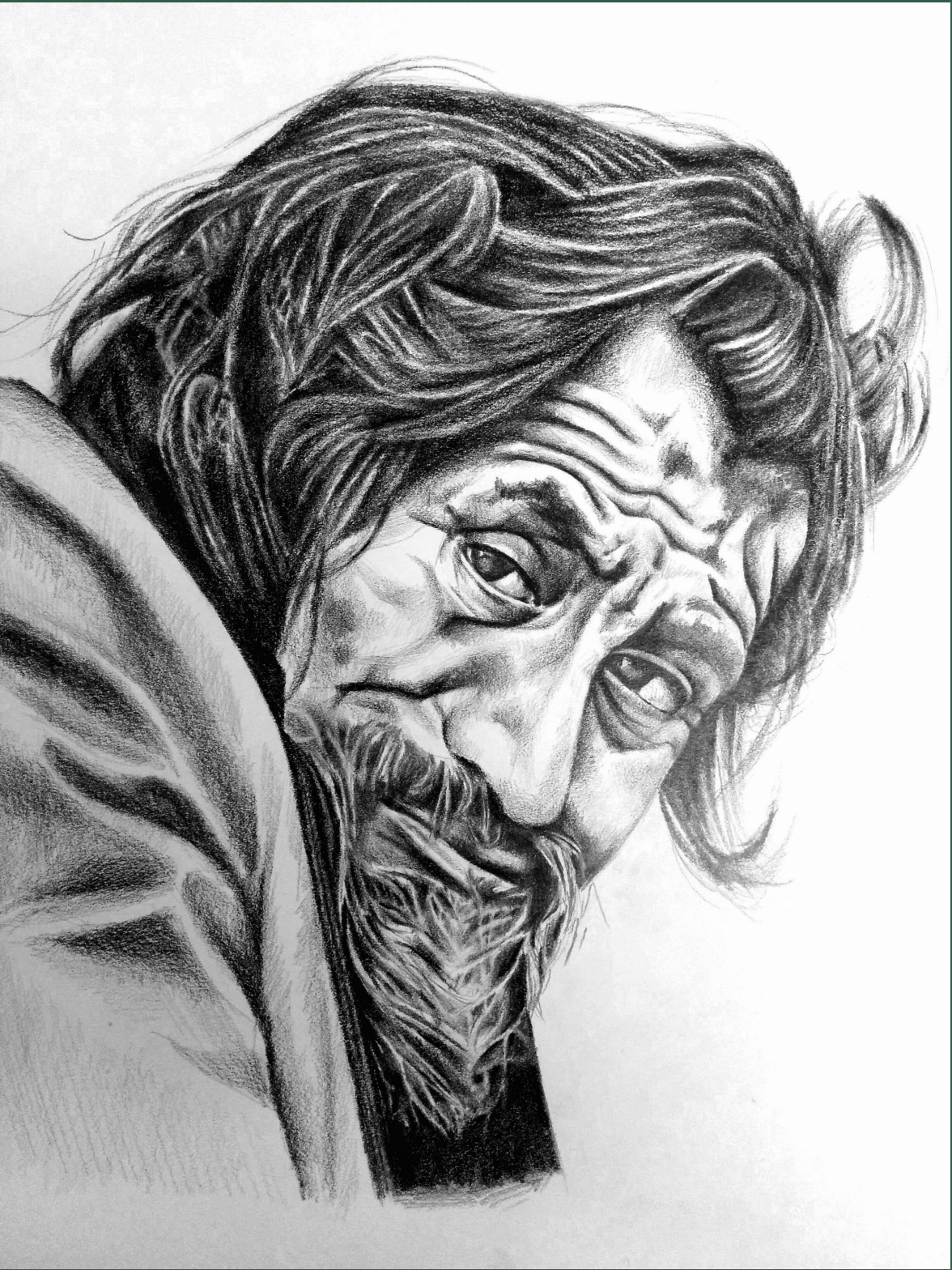
I admire you,  
For showing remarkable strength and resilience,  
And in those hours of fading existence when,  
The curtains fell and you subsumed within my memories,  
For we have shared these moments together,  
The moments to keep forever.

*This poem is inspired by many lovely patients with dementia that Usman had the opportunity to interact with during the course of his clinical research. The poem acknowledges the continuous emotional struggles, and brings into light the loneliness that dementia patients often experience during the course of their illness. The author empathizes with them declaring that they are not alone in this battle.*

Usman Saeed  
MSc Candidate  
University of Toronto

*Usman is a Master of Science student at the Institute of Medical Science (University of Toronto) under the supervision of Dr. Mario Masellis and Dr. Sandra E Black. He is researching the effects of apolipoprotein-E gene on the hippocampal volume and memory performance across Alzheimer's, Lewy body and mixed dementias using structural neuroimaging techniques. Usman hopes to use his research to improve the quality of life and prognosis of all patients suffering from neurodegenerative dementias.*

# Artwork



While I Am Here

Annie Wang  
MD Candidate, 2018  
University of Toronto

*Annie is an amateur artist, podcast enthusiast, and avid traveler.*





### Envisioning the Age of Innovation

*There is an increasing demand for healthcare innovations to address the needs of a growing geriatric population. With the elderly patient as a starting point, our changing perspectives in geriatric care will give rise to new directions in research and innovative technologies, as this artwork aims to convey.*

Phoebe (Tsz Man) Cheng  
MD Candidate, 2018  
University of British Columbia

*Phoebe is a second year medical student at the University of British Columbia who believes that there's a special place in medicine for the arts and humanities. She aspires to share her reflections on life and learning through her artwork, and has participated in various exhibits that celebrate the art of medicine.*

## National Geriatrics Interest Group Team

### Co-Chairs

Christina Reppas-Rindlisbacher (Toronto)  
Tina Chen (UBC)

### VP Internal Communications

Laura Sutherland (Manitoba)

### VP External Communications

Paula Horsley (Ottawa)  
Amanda Chen (Toronto)

### VP Events

Cristina Negrean (Montreal)

### VP Finance

Alex Astell (Queen's)

### VP Media & Technology

Amanda Canfield (Toronto)  
Beth Deveau (Ottawa)

### VP Research, Knowledge & Translation

Bonnie Cheung (Toronto)

### Conference Chair

Evan Chong (McMaster)

### Publication Editors-in-Chief

Selynn Guo (Toronto)  
Janice Lee (Queen's)  
Victoria YY Xu (Queen's)

## Local Geriatrics Interest Group Updates

### University of British Columbia

The UBC GIG was proud to present 3 major events and 1 longitudinal patient-outreach program this year. We hosted an Alzheimer's Society Event to teach students about the daily challenges that Alzheimer's patients face. We then held a "Called to the Wards" Clinical Skills Event in which students learned approaches to sepsis, decreased LOC, arrhythmias and the cranial nerve exam in preparation for clerkship. In the near future, we will be inviting experts to explore the topic of sexuality in the elderly. Our patient-outreach is the Grandpal Penpals Program, which is a year-long letter writing and visiting program that connects elementary students to nearby seniors in care homes!

### University of Calgary

The Calgary Geriatrics Interest group had an eventful year in 2015. We began a "Geriatrics Perspective" series of talks that invited geriatricians or physicians working with elderly populations to host a "lunch and learn" lecture on common Geriatric presentations in the following specialties: Orthopedics, Endocrinology, Nephrology, Neurology (Alzheimer's Society), and Psychiatry. We hope to continue these talks in the coming year! We also hosted a tea with students and seniors at a local retirement home, presented an "Aging in Canada" panel discussion in collaboration with the Bioethics Interest Group, organized a screening of Still Alice, continued our relationship with the Alzheimer's Society, hosted our first journal club, and put together a fantastic interdisciplinary skills night! The skills night consisted of 5 stations: polypharmacy, mobility and ambulation in the elderly, neuro exam,



Anoka, Minnesota, USA  
Justin Lam  
University of Toronto



sexuality in the elderly, and a simulation station to experience what it is like to have Dementia. We have a large turnout for the event and it received lots of positive feedback from the participants. In the future we hope to continue to engage medical students and to develop more community initiatives as well.

### University of Manitoba

At University of Manitoba, our Geriatrics Interest Group consists of two second year medical students (Aakanksha Sharma and Gurmeet Sohi) and two first year medical students (Danielle Thordarson and Jade Parkas). The group works enthusiastically to raise awareness and interest in geriatric medicine. Some of the activities our GIG has organized this year include:

1. “Tales from the Medical Examiner” in October. A lunch-time session led by Dr. St. John, Section Head of Geriatrics Department, solving mysterious geriatric medical cases.
2. “SIGN-GIG Skills Event” in November. A session highlighting clinical skills such as gait, cranial nerves, and Parkinson’s specific examination.
3. “GIG-LGBTQI\* Event” in January. A Lunch-time session with Dr. St. John, Dr. Dick Smith (Physician, Founder & Medical Director of “Our Own Health Centre” and member of the LGBTQI\* community) and Dr. Lynne Mitchell-Pedersen (Retired Private Counsellor with Interest in Sexuality).
4. “Valentine’s Event” in February. We delivered flowers and cards to the residents in a Personal Care Home while collaborating with the Music Interest Group for a musical performance for the residents.

Some upcoming events for the remaining academic year include a skills night, a talk by the Alzheimer’s Society talk and family caregivers.

### McMaster University

McMaster’s local GIG started the year off with a lecture on Geriatric Psychiatry by Dr. Maxine Lewis, who provided students with insight into the intersection of aging and mental health. A Valentines Day outreach event at First Place retirement home gave students a chance to chat with aging individuals in the Hamilton community and learn more about their lives. Our biggest event of the year, Geriatric Skills Day, is approaching fast. We have secured a keynote speaker who will discuss sexuality and aging as well as several workshop facilitators in the areas of aging in the community, the three D’s (dementia, delirium, depression), elder abuse, polypharmacy, and cultural competency. For the first stage of this interprofessional event series, students were given the opportunity to learn about communication with older adults and practice their skills by interviewing older adults. Two collaboration events with the Alzheimer Society are also coming up in the spring.

### University of Toronto

The first few months of 2016 have been an eventful time for the Geriatrics Interest Group at U of T. In January, we participated in the Alzheimer Society’s Walk for Memories as part of the Cognitive Enhancers team. This outreach event was a collaborative effort between the Resident Geriatrics Interest Group, Pharmacy Awareness for Geriatrics, Internal Med-

icine Interest Group, Students Alliance for Alzheimer’s Team, and the Psychiatry Interest Group. Over 50 students registered for the Walk and various fundraisers were held by our partners throughout the month of January in support of the cause.

In February, we hosted our annual Geriatrics Meet and Greet dinner at Spring Rolls and were honoured to have geriatricians, residents and clerks talk to us about their journey. The food was spectacular and the night was a wonderful opportunity for first and second year students to socialize with those experienced in the field of geriatrics.

Currently, we are in the midst of planning our next events including an upcoming documentary screening of ‘Forgetful not Forgotten’ and an inter-professional education event which brings together students from diverse health professions who, through activities and facilitated discussion, will come to learn how to provide optimal care for their elderly patients.

### Northern Ontario School of Medicine

The Northern Ontario School of Medicine GIG held a talk in February about palliative care, brining in a local palliative care specialist. Through the session, students learned about what palliative care is and how to incorporate it into their care.

In March, we have planned a Geriatrics Skills Night, 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. We will also learn about dementia & cognition, bringing in speakers from the Alzheimer’s Society and a psychogeriatric resource consultant. Students will learn about cognitive testing tools and their practical applications, the different causes of cognitive decline and strategies for communicating with patients.

### Queen’s University

The students of Queen’s School of Medicine have been enjoying another successful year of events held by the local geriatrics interest group as attendance as our events are at an all-time high. This past February we held our

Kandy, Sri Lanka  
Paul Beamish  
University of Toronto

second annual interprofessional mobility workshop run by students from the school of rehabilitation therapy, and this was a very rewarding learning experience for all the medical students that attended, but also for the facilitator students from physiotherapy and occupational therapy. We are continuing to hold our bimonthly lunch-time speaker series as well as organizing weekend observerships in geriatrics at St. Mary’s of the Lake Hospital, which so far have been booked out every weekend, until the end of the school year. We feel very encouraged by the large interest in geriatrics amongst our student body this year and look forward to continue fostering this with more events and observership opportunities, as well as the geriatric workshop we are holding in April.

### University of Ottawa

Uttawa GIG has had quite a variety of talks so far this year and we are very excited about the additions we have made. This year our focus was to try and bring awareness to the different aspects of geriatrics and how it is important for any physician to understand that the elderly population is unique. Early in our year we gave in an introductory talk to introduce Geriatrics, then we brought in Dr. Blackmer to talk about an important new development in medicine that of physician assisted suicide, both talks had a great turnout. We also integrated two outings to our GIG this year, which included a visit to the theatre for a performance concerning dementia, entitled ‘Cracked: New Light on Dementia’ and our second visit was to a Retirement Home, to allow medical students to get some real hands on experience. In February, we had a very interesting talk that compared two pathways leading to careers in geriatrics ; Geriatrics residency through Internal Medicine and Care of the Elderly training program through family medicine. Another event that has a great turnout every year is the polypharmacy talk with Dr. Dalziel, which targets the issue of multiple drug interactions in the geriatric population. We also collaborated with the anesthesia interest group in order to discuss the



unique challenges of anesthesia in the older patient. Finally, a Senior physiotherapist, part of the Geriatrics Medicine Consult Team, gave us a great approach for exercise prescription and physical activity counseling in the geriatric population.

### University of Montreal

The Geriatric Interest Group at the University of Montreal is a small yet very dynamic team. We are happy to report that our conference on the Euthanasia Law by Dr. David Lussier, scientific Director of the Center Avant ge was an immense success. We hosted many interest groups and the conference room was full.

The next activity that we are planning is in a luncheon round table format, where we are inviting older adults and experts to talk to us about various geriatric topics such as: living with dementia, sexuality in the elderly, resurfacing trauma from past experiences such wars, genocides, and political immigration.

### Dalhousie University

Here at the Dal GIG started the year off with a lifestyles night that was well attended. We had a Geriatrician attend, that has years of experience, as well as a new grad just in her fellowship. They were able to answer everyone’s questions about lifestyle, career outlook, and job satisfaction. The next event was an opportunity for students to sit down with a patient, and partner in care, who are dealing with a diagnosis of Alzheimers. This wonderful couple really allowed us to explore their day to day life and some of the struggles they face. We also had a representative,

from our local Alzheimers Society, attend to add to our discussion around resources for patients and families in our area. Our next event will be a talk on physician assisted death, it will be open for all to attend.

### Memorial University

So far this year the MUN Med GIG has held a range of events aimed at engaging and educating medical students about issues in geriatric medicine.

We have hosted an Alzheimer’s Lunch & Learn where a representative from the local Alzheimer’s society came in to speak with students about this disease, early signs to watch for and ways to provide support. The talk was very well received and students were eager to obtain information about getting involved with the society. We also held an outreach event just before Christmas at one of the local personal care homes where students spent an afternoon singing christmas carols and socializing over tea, coffee, and home baked treats with the senior residents. Both parties thoroughly enjoyed the event and a similar afternoon is hoped to occur in the spring. We have held a number of bake sales which have been helpful in funding our group activities. Future events include hosting a career night featuring a number of health care professionals who work directly with the geriatric population. We also hope to arrange a regular biweekly activity group with one of the local 50+ groups to promote intergenerational collaboration and healthy aging. Through these various events we have and hope to continue gaining interest in the field of geriatrics among aspiring physicians.



Santorini, Greece  
Gurmeet Kaur Sohi  
University of Manitoba



# Partners and Special Thanks

Dr. Tricia Woo, MD, MSc, FRCP(C)  
Associate Professor, Division of Geriatric Medicine,  
Department of Medicine  
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Cindy Worron  
Administrative Assistant for Dr. Tricia Woo

Dr. Eric Wong, MD, PGY-3  
Internal Medicine Residency Program  
McMaster University



National Association  
of Federal Retirees

Association nationale  
des retraités fédéraux



The Canadian Geriatrics Society  
Dedicated to the Health of Older Canadians



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

We encourage all physicians with an interest in geriatrics and other allied health care professionals, medical students, residents, and fellows to join the Society. We also invite researchers in the field of aging to join our organization.

### Membership Criteria:

- 1) Regular — \$325.00 per year (Open to all Health Professionals licensed to practice in Canada)
- 2) Associate — \$50.00 (Open to Full-Time Residents/Fellows, Including MSc and PhD students)
- 3) Students — No Charge (Open to Full-Time Undergraduate Medical and Health Professional Students)

### Benefits of Membership:

The annual membership fee of \$325 provides members access to the following services:

- 1) Subscription to *Canadian Geriatric Journal* published quarterly, is the only Canadian journal dedicated to original research related to the care of the 4.4 million Canadians over the age of 65
- 2) Member-exclusive and accredited online CME courses
- 3) Professional secretariat office
- 4) Reduced rate to attend the Annual General meeting
- 5) Reduced fees to key conferences and other members-only resources

Become a member or renew your membership!

Visit <https://thecanadiangeriatricsociety.wildapricot.org/membership>





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